Sector Wide Approach (SWAp) in Reproductive and Child Health Program in India

A Critical Review

Dissertation submitted to Jawaharlal Nehru University in partial fulfillment of the requirements for the award of the degree of

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CERTIFICATE

This dissertation entitled, **Sector Wide Approach in Reproductive and Child Health Program in India: A Critical Review**, is submitted in partial fulfillment of six credits for the degree of Master of Philosophy of the University. This dissertation has not been submitted for any other degree of this university or any other university and is my original work.

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We recommend that this dissertation be placed before the examiners for evaluation.

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"Inspiration and genius--one and the same"

Victor Hugo

Dedicated to the Genius
Late Mr. Mayank Sharma
(1975-2005)

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Bibliography

ABBREVIATIONS AND ACRONYMS

AIDS	-	Acquired Immuno Deficiency Syndrome
ANM	-	Auxiliary Nursing Midwife
AOP	-	Annual Operational Plan
AusAID	-	Australian AIDS Program
AWW	-	Anganwadi Worker
AYUSH	-	Ayurveda, Unani, Sidhi, Homeopathy
BCC	-	Behavioral Change Communication
CBO	-	Community Based Organization
CIDA	-	Canadian International Development Assistance
CHC	-	Community Health Centre
CMR	-	Child Mortality Rate
CNAA	-	Community Need Assessment Approach
CSSM	-	Child Survival and Safe Motherhood
DAC	-	Development Assistance Committee
DANIDA	-	Danish International Development Assistance
DFID	-	Department for International Development
DFWB	-	District Family Welfare Bureau
DHS	-	District Household Surveys
DOFW	-	Department of Family Welfare
DOH	-	Directorate of Health
DP	-	Development partners
DWCD	-	Department of Women and Child Development
EAG	-	Empowered Action Group
EC	-	European Commission
EmObc	-	Emergency Obstetric Care
EPW	-	Empowered Procurement Wing
FP	-	Family Planning
FMG	-	Financial Management Group
FW	-	Family Welfare

GAAP	-	Governance and Accountability Action Plan
GFAMT	-	Global Fund for AIDS, Malaria and TB
GMP	-	Good Manufacturing Practices
GOB	-	Government of Bangladesh
GOI	-	Government of India
HRD	-	Human Resource Development
HNP	-	Health, Nutrition and Population
HIV	-	Human Immuno Deficiency Virus
HMIS	-	Health Management Information System
HSR	-	Health Sector Reform
HSS	-	Health Service System
ICDS	-	Integrated Child Development Scheme
ICPD	-	International Conference on Population and Development
IAG	-	Inter Agency Group
IDA	-	International Development Assistance
IIM	-	Indian Institute of Management
IIPS	-	Indian Institute of Population Studies
IMEP	-	Infection Management and Environment Plan
IMNCI	-	Integrated Management of Neonatal and Childhood Illnesses
IMR	-	Infant Mortality Rate
JICA	-	Japanese International Cooperating Agency
MCH	-	Maternal and Child Health
MDG	-	Millennium Development Goals
M & E	-	Monitoring and Evaluation
MMR	-	Maternal Mortality Rate
MOHFW	-	Ministry of Health and Family Welfare
MOH	-	Ministry Of Health
MOF	-	Ministry Of Finance
MOU	-	Memorandum of Understanding
NACO	-	National AIDS Control Organization
NACP	-	National AIDS Control Program
NFPP	-	National Family Planning Program

NFWP	-	National Family Welfare Program
NGO	-	Non-Government Organizations
NHP	-	National Health Policy
NHSRC	-	National Health Systems Resource Center
NIHFW	-	National Institute of Health and Family Welfare
NPIP	-	National Program Implementation Plan
NPP	-	National Population Policy
NRHM	-	National Rural Health Mission
NVBDCP	-	National Vector Born Disease Control Program
ODA	-	Official Development Assistance
PEAP	-	Poverty Eradication Action Plan
PH	-	Public Health
PHC	-	Primary Health Center
PGR	-	Population Growth Rate
PMG	-	Project Management Group
PPP	-	Public-Private Partnership
PRI	-	Panchayati Raj Institutions
RCH	-	Reproductive and Child Health
RNTCP	-	Revised National Tuberculosis Control Program
RTI	-	Reproductive Tract Infection
SCOVA	-	State Cooperative for Voluntary Assistance
SHFWD	-	State Health and Family Welfare Department
SIP	-	Sector Investment Plan
SIDA	-	Swedish International Development Assistance
SPIP	-	State Program Implementation Plan
STI	-	Sexually Transmitted Infection
SWAp	-	Sector Wide Approach
TA	-	Technical Assistance
UIP	-	Universal Immunization Program
UN	-	United Nations
UNICEF	-	United Nations Children's Fund
UNDP	-	United Nations Development Program
UNFPA	-	United Nations Population Fund
USAIDS	-	United Nations AIDS Program

UT	-	Union Territories
VGAP	-	Vulnerable Group Action Plan
WB	-	World Bank
WHO	-	World Health Organization
WTO	-	World Trade Organization

CHAPTER 1
Introduction

India, sustains 17 percent of world's population in less than three percent of earth's land area.[1] In terms of health status of the population, India had been battling with the communicable diseases like Malaria, Tuberculosis, Leprosy, Typhoid, etc. since centuries. The emerging challenge of non-communicable diseases like cancer, asthma, mental disorders, HIV/AIDS and other life style problems is putting additional pressure on India's already ailing health service system. Population and its increasing growth rate had also been perceived as a problem in the country and hence enormous efforts were done to control the total fertility rate (TFR) and population growth rate (PGR) since independence. Various studies conducted in order to explore the reasons for higher fertility rates in India have suggested higher infant mortality, child mortality, malnutrition, need for additional manual labor, lack of awareness and education in women etc. as some of the important reasons.[2]

In order to deal with these health emergencies from time to time, the architecture of Indian health service system was conceptualized on the basis of the Bhore committee recommendations[i]. Today, the health services in India are governed by a separate ministry i.e Ministry of Health and Family Welfare (MOHFW). This ministry is subdivided into Department of Health (DOH), Department of Family Welfare (DOFW) and Department of AYUSH. Various national level programs on health emergencies like Malaria, TB, Leprosy, Reproductive and Child health etc. are running through this vast government infrastructure. This is networked in a way that there are subcenters at the village level that are integrated with Primary Health Centers (PHC), Community Health Centers (CHC) and District Hospitals at block and district levels. Further, for the tertiary care, these primary care institutions are connected through referrals to the state and centrally funded multi-speciality hospitals.

[i] Bhore Committee was set up by the government of India in 1943 to look into and suggest improvement in the Indian Public Health system. Under the chairmanship of Sir Joseph Bhore, the committee made many landmark recommendations in its final report in 1946. In its recommendations, it proposed a structure that was envisaged to be integrated from primary to secondary to other special referral service chain.

There is also a network of private sector service providers that exists parallely with this vast government system. The varieties of these providers differ on the basis of their nature, size, services, funding, infrastructure, geographical location etc. After structural adjustments and health sector reforms in India, their network has grown exponentially. The private spending in health sector has grown to an extent that it contributes approximately 4.2 percent of the GDP against 0.9 percent by the public sector.[3] Looking at the statistics from National Health Accounts India estimates-2001-2002, it shows that the total health expenditure was 4.6 percent of the GDP. Out of this, 20.3 percent was from public sector, 77.4 percent from private sector and the remaining 2.3 percent was from external support.[4] In terms of external support, various international organizations and UN agencies have been providing technical and material assistance to India at different points of time. These agencies include WHO, World Bank, UNICEF, UNFPA, USAID, Japanese Assistance, ODA (UK), SIDA, NORAD, DANIDA, German assistance etc.[5] These agencies had been funding variety of health sector projects in India through multilateral, bilateral or institutional funding e.g funding to NGOs and CBOs.[6] All these facts are important in terms of understanding the context in which this study is done.

This concept of project-based funding and operation had been much talked about between the donors and the Third world countries that need additional external funds for their development. These projects were always criticized for their limitations like fragmented implementation, duplication of tasks, uncoordinated efforts with the larger programs, disproportionate government and donor investments, inflexible and over designated funds and resources.[7] Criticisms were also raised as the project approach was creating a parallel system than developing the capacity and integrating with the already available systems. Also since the projects were of shorter term and with definite focus, they were found incapable to handle the larger systemic issues.

The multiplicity of projects and funders and non-sustainability of these limited projects were of equal concern for the national governments of the Third world countries as well as the donors from the first world countries. These concerns of health professionals over the traditional project approach not producing sustainable

improvements in the services and the interest of macroeconomists in trying to improve the allocation of the national budget and of donor flows between and within the sectors led to the discussions on newer strategies for coordination and sector wide development. In light of this, 1990's was a period of strategies that were evolved for better health sector management across the world and especially in the Third world countries that already had scanty resources. Thus for better aid and fund management and sectoral coordination, agencies like UN and European Commission (EC) invited strategy papers on sector wide approach[8] (SWAp). With this, in 1997, SWAp was formally accepted by many donor agencies in Paris Declaration[ii].[9]

Sector wide approach (SWAp) is defined as a method of working between government and development partners (DPs), as a mechanism for coordinating support to public expenditure programs, and as a way to improve the efficiency and effectiveness with which resources are used in the sector.[10] Though the formal evolution, concept and process are covered in the next chapter, it is important to mention here that this approach impressed many donor countries and agencies which game its support and formally adopted this approach in their policy framework to extend development assistance to many Third world countries.

This approach aims to increase the health sector coordination, enhance national leadership and ownership, increase effectiveness in aid and resource allocation and management, strengthen service delivery and management system, reduce transaction cost, avoid duplication of efforts and ensure equity and sustainability in the sector developments. Thus this approach is characterized by a single sector policy and expenditure plan, all significant funding supporting the sectoral policy under government leadership, adoption of common approaches across the sector and progress of all partners towards relying on government procedures.[11]

Many African countries like Ghana, Uganda, Tanzania, Zambia etc. have already adopted this approach. In this respect, it was a matter of curiosity to explore the

[ii]Paris Declaration represented the way forward in improving the impact of international assistance to health sectors in the developing countries, assuming legitimate and effective government is in place.

existence of SWAp in the Asian countries. During the literature review, it was found that countries like Bangladesh, Cambodia, and Vietnam are some examples from Asia that have already started initiatives in this direction. It was also noticed on the prime website of the World Bank (WB), which is one of the important multilateral funding agency for development assistance, that the funds by WB in the current Indian RCH program are also extended by following this sector wide approach. Also similar statements are available on the WHO India websites.[12]

> *"In India, the Reproductive and Child Health [RCH] phase II was developed using a sector wide program approach ... The funding mechanism is based on flexible and predictable funding in support of sector policies. While part A of the program is funded entirely for Government of India for basic maintenance of the program, part B will enable the states to design and implement the RCH program suiting their specific needs. This part B funding will finance approved state plans through a flexible pool of funds. This would contribute in enhancing the quality and scope of the RCH program by supporting innovations such as Public Private Partnerships, demand side financing, expansion of the program to the urban poor and other vulnerable groups."*
>
> *-WHO Country Office, India*

A bi-monthly newsletter of WB published in 2004 also clearly states the policy of WB in financing health sector in India through SWAp and other co-financing models.[13] The interest to explore the integration of SWAp in Indian RCH program was further strengthened by the mention of UNFPA and WB bringing in SWAp in the Indian RCH by January 2005. As the review of official documents and websites of government of India (GOI) on RCH program had no such mention, the enquiry into locating the components of SWAp in this national program became all the more important.

Thus this exploratory study was started with a view to identify, locate, critically analyze and comment upon the adoption of SWAp in the Indian RCH program. In this regard, it was important to first understand the history, evolution, concept,

objectives, policy, planning and process of SWAp. Secondly a clear understanding on the reproductive healthcare approach and RCH program of GOI, its concept, policy, components and process was equally needed. This study devotes exclusive chapters on these two concepts of SWAp and RCH. But to start with, it is important to clarify some of the concepts that have been used and mentioned at various places in this study.

Conceptual Framework

Health System: It is basically a constellation of various resources, services, institutions, actors and processes that collectively aims to ensure the well being of individuals & populations at a specific location at a time. The arrangement of these components of the constellation may differ from time to time keeping in mind the changing ideologies & approaches of its planners & participants.[14] For the purpose of this study, all factors of the society that directly or indirectly affect the health status and access to health services by the population are considered to be the components of health system. This includes all components of health service system, physical infrastructure like roads, transport, water facility, sanitation and sewage facilities, electricity, housing, geographical location etc. and other socio-economic components of the system like caste, class, gender, age group, culture etc.

Health Service System (HSS): The components of HSS includes *infrastructure* like hospitals, dispensaries, PHC, CHCs, etc, *personnel* like doctors, nurses, ANMs, *technology* like drugs, X-ray machines, education and training, policy, research and administration. This also includes all streams of medical sciences i.e Allopathic, Ayurveda, Naturopathy etc., all types of service providers including government and private (for-profit and not-for profit).

Health Sector Reforms (HSR): Broadly HSR means a significant and purposive effort to improve the performance of the health sector. It is not a temporary solution to a pressing problem of a sector and it always emerges from a deliberate process that employs rational analytic methods and hard evidence.[15] In the Indian context, the period after 1990s witnessed these reforms in health sector with factors such as substantial cuts in public funding in health sector, privatization of health services, introduction of user fee in the public system, public-private partnerships at various

levels, contracting-out to private players, introduction of concepts like community health insurance and other private health insurances etc.

Structural Adjustment Program (SAP): This concept means introducing changes in the nation's economy like the promotion of exports, liberalization in terms of de-licensing many categories of service and areas of operation, privatization of public-sector institutions to improve the technical efficiency of production, disinvestment in public undertakings etc. These changes were usually imposed upon debtor nations by their institutional creditors; for example the International Monetary Fund (IMF), forcing the debtors into a more open market economy. This process of SAP started since 1980s especially in the Third world countries including India. The HSR also were the results of SAP in the 1990s.[16]

Program: Programs are open ended and complex with many projects and activities, financers and implementation agencies under them. They account for both, total and recurrent costs. Above all, a program is a process with continuous planning and implementation.[17] In the Indian context, the National RCH program is defined and designed as a "Program" as it is a long term initiative by the DOFW, MOHFW. Also, as there are multiple agencies participating in funding, planning, designing, procurement, management, data collection, monitoring and evaluation etc. activities of the program, it qualifies as a program than a project.

Project: A Project always has a start and an end. It is self contained, simple and usually with one or a few financers. It is also implemented by one agency. The total project costing is always done from its start till the end to ascertain its outcomes and performance.[18]

Sector: The literary meaning of the term sector is "A part of a Whole". Economists define it as an area of the economy in which businesses share the same or a related product or service.[19] A sector can also be characterized by the group of similar activities and tasks which share some commonality amongst them. In reference to this study, "Health" is considered as a sector which contributes to the overall development goals of the country. In this context, family welfare or reproductive and child health is a sub-sector of the broader sector. But the prime policy

documents reviewed and used for the purpose of this study have used the term "sector" for FW and RCH also. Hence the issue of ambiguity and debate on the actual and operational definition of the term "sector" is also raised in the fifth chapter of this study.

Stakeholders: This is a term that has evolved from the discipline of market economics. In political and social policy literatures, this term is used for all those individuals, groups, communities, authorities etc. which participate, directly or indirectly, and may gets affected by any decisions made for/by/in the area that they participate.[20] For the purpose of this study, this term is used for all institutions like government, private sector, NGOs, CBOs, and external agencies who contribute in some way to the development of health sector.

Development Partners (DPs): Development partners are defined as those bilateral and multilateral development agencies that are formal partners to the government in health sector development in a country (i.e. the development partners that have signed the Memorandum of Understanding with the partner government).[21] In this study, the term "Development Partners" is used for all those external agencies and institutions that are contributing to the National RCH program in various ways. This may include monitory assistance by agencies like WB and DFID, and non-monitory assistance like "Technical Assistance" by WHO, participation in activities like monitoring and evaluation etc.

Reproductive Health (RH): Reproductive health addresses the reproductive processes, functions and system at all stages of life. It therefore, implies that the people should be able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.[22]

Reproductive healthcare is also defined as the constellation of information, goods and services that contribute to reproductive health and well being by preventing and curing reproductive health problems.[23] The RCH program of GOI is based on this approach and thus includes all the areas of RH of adolescents and adults including care and services for infants and children.

Reproductive and Child Health Program (RCH): RCH program is a national level program run by Department of Family Welfare (DOFW), Ministry of Health and Family Welfare (MOHFW), government of India (GOI). The program is based on the reproductive healthcare approach. The program also includes child, maternal and adolescent healthcare services.[24]

Reproductive and Child Health Project II: This is defined as comprising a sub-set of all activities in the RCH program-second phase.[25]

Hence with this background, the following **specific objectives** of this study were framed:

- To understand the concept of SWAp answering all 'What', 'Why', 'Where, When' and 'How' questions about it.
- To review and understand the concept and application of RCH program in India.
- To explore, identify, critically analyze and comment upon the components of SWAp in Indian RCH program.

Scope of the study

With the presence of SWAp mostly in the African countries, the study started with the review of articles on the experience of these countries with this newer approach. Having learnt that this approach is integrated in very few Asian countries, review of articles and reports on these countries like Bangladesh and Cambodia were also done. In the process, it was also noted from sources like WB that SWAp is also been put into RCH program of government of India to some extent. Hence this brought the interest to further explore on how this approach is integrated in the Indian context. Thus this study focuses on SWAp in India though some of the case

studies from some African and other Asian countries have also been mentioned for the purpose of developing a better understanding on this approach.

Although, as the approach talks about the sector, but due to lack of time it was impossible to study and review all the national programs in the health sector in order to ascertain the integration of SWAp in the total health sector in India. Since no policy paper of the government as well as specialized agencies on SWAp mentioned about the advent of SWAp in the Indian health sector, the study focused only on exploring the components of this approach in RCH program because there were already evidences from funding agencies of having adopted SWAp in funding the Indian RCH program-phase II. Thus the exploration of this approach and its integration, applications and future impacts in the entire health sector of India is still an area to be researched upon.

It is important to mention that as RCH program is in its second phase since 2005 and would continue till 2010, the impact analysis of this new phase with SWAp cannot be done at this stage. Many country specific examples and policy papers on SWAp mention that as SWAp is a long term process, its results and impacts on any sectoral program can only be reviewed after 7-8 years of its operation. In such a case, except for the progress, any audits of RCH program in order to ascertain the impacts of SWAp on it till the completion of the program phase would not be a wise proposition.

Methodology

The study is based on a systematic review of contents on two broad areas i.e Sector Wide Approach and Reproductive and Child health Program in India. The nature of data reviewed was primarily qualitative with a few quantitative data used from census and national health account reports. The literature reviewed was mostly factual and analytical in nature. Both e-text and print scripts have been used for the purpose of this study with the due consideration of time of publication and updates of especially the e-text.

For the purpose of data collection, various sources like policy papers, drafts of program plan, review articles, research studies, published books, contents from

specific websites of MOHFW, WB, DFID, and some sites specialized on SWAp, RCH, Indian Health Service System, aid-management and donor relations, program implementation reports and National Health Accounts have been used.

Also, along with this secondary data, focused discussions with the area experts especially those that are currently at the policial level especially in GOI and prime donors, were also done. As many review articles on SWAp were highly influenced by the perceptions of the respective authors, a special emphasis was given to locate such views and therefore critical discussions on their methodology, context and interpretations were done with the guides. Wherever any such interpretations are added, either by accepting or refuting these interpretations, due credit is given to the original authors.

Empirical data reviewed from all these authentic sources has been analyzed to understand the status of RCH and SWAp in different contexts. Also, to locate the concept and principles of SWAp in the Indian RCH, a list of parameters was prepared after the rigorous review of literature from policy as well as operational papers from parent organizations and implementing countries. Based on these, the entire RCH program was analyzed to examine whether it includes these parameters in its program plan and process. Finally based on this, the interpretations on SWAp in the Indian RCH program and the Indian health sector were drawn.

Structure of the study: Chapterization

This dissertation consists of six chapters which deal exclusively with the concerned issues. **Chapter one** of the study is aimed at orienting the readers on the background and context in which this study is done. The chapter also aims to direct the readers on areas that this research would look into. For the purpose of better understanding, the chapter elaborately deals with the research methodology, sources and nature of data used in this research.

Following this, **Chapter two** is completely focused on Sector Wide Approach. It tries to answer all queries like what, when, how, where, why on SWAp. It deals with the concept, definition, aims and objectives, principles, components, history, evolution and process of SWAp. The chapter also mentions some specific case

studies of countries like Ghana, Uganda, Zambia and Bangladesh which have already adopted SWAp in their health sector. At the end, the chapter brings forth many issues of concern regarding the concept of SWAp.

Chapter three is totally devoted to the RCH approach and Program. It starts with the concept of reproductive healthcare approach and its evolution across the globe. The chapter then discusses in detail about the history and limitations of various family welfare programs in India with the current advent of RCH program. The chapter follows on with the concept, objectives, coverage, components, planners and partners, financing, service provisioning, management, monitoring and evaluation mechanism, results, shortcomings and learning from the first phase of the RCH program. Leading from this, the chapter further discusses all the above areas in the second phase of the RCH program. Finally it comes out with comparison and discussion on the areas of concern in the National RCH Program in India.

Chapter four is one of the crucial chapters that tries to identify the concept, ideology, principles and components of SWAp at various levels in the Indian RCH program, especially in its second phase. It starts with throwing light on the architecture of Indian health sector planning and services and the data sources which mention the formal acceptance of funding partners on having adopted SWAp in the Indian RCH program. It further builds on the clarity of the parameters which would be looked for in the RCH program in order to determine the presence of SWAp in the program. Finally, by locating many facts from the RCH program, it tries to establish the presence of SWAp in it.

The broad areas where such integration is explored are: SWAp in RCH program policy and planning, RCH alignment with sector policy, RCH program following common sectoral approaches, initiatives in RCH program to enhance government leadership and ownership, partnership/joint efforts in RCH Program, common goals/common expenditure plan/common procedures for different stakeholders in RCH program, efforts for increasing predictability of funds, reduce cost, improvement in aid-management and resource allocation, transparency, accountability and sustainability in RCH program.

Chapter five is devoted to discussion of all those issues that have emerged from the second, third and the fourth chapter on SWAp and RCH. The issues related to the concept, definition, planning, process and operation of SWAp in Indian context have been analyzed and commented upon at a greater length. The chapter also raises many questions about the newer propositions added in RCH program in lieu of sectoral consolidation and reforms. Issues related to the role of donors in policy, planning, financing and program operations have also been dealt exhaustively. Finally, the chapter puts forth some of the suggestions at conceptual, policy and implementation levels.

Chapter six is the concluding chapter. It summarizes the understanding developed, key findings, emerging areas of concerns and suggestions based on this study.

Limitations

1. Due to the lack of time, the study could not elaborate the identification and integration of SWAp in other national health programs other than RCH.

2. There is lack of data and research on this new approach in India and hence it was very difficult to locate any books and journals devoted to SWAp from various libraries that were explored.

3. Despite repeated mails, the meetings for focused discussion on SWAp in RCH program with the team members and additional secretary, RCH program, MOHFW, could not be conducted.

4. Despite having written to eminent writers on SWAp in Europe and America that run specialized web portals on such approaches, no literature on India, except for few with policy propositions on SWAp, could be obtained

5. Absence of Indian experts in this field was also a big hindrance as in their absence, greater caution was required on the part of the researcher on the issues like the nature, source, context and publication time of the various articles to be considered for review.

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CHAPTER 2

Sector Wide Approach (SWAp): Concept and Application

Sector wide approach was conceptualized in mid 1990s though a realization of its need was envisaged much before in the 80s.[1] The period between 1960s to 1990s was the period of "Donor Controlled Vertical Projects" for the low-income countries or countries dependent on aid assistance. During the period, all major multi-laterals, bilateral and other international funding organizations favored "Project" over total system development. This was also due to donors' intention of committing earmarked funds for specific activities and retaining their control over those.

This favoritism for project funding led to more and more verticalization and disintegration of the health system in the recipient countries. The multiplicity of donors and projects became a problem for the recipient country governments as it demanded more managerial, financial and time wise inputs from the governments in dealing these multiple donors with different sectoral and project policies.[2] With such an arrangement, even the donors faced challenges like non-efficiency of funds with non-achievement of results as envisaged in the project plan, non-sustainability of efforts, invisibility of small project achievements on the sectoral progress etc.

The traditional project approach had many negative features like fragmented implementation, duplication of tasks, uncoordinated efforts, disproportionate government and donors investments, loss of manpower from government to individual projects, inconsistent accounting, auditing and inappropriate assessment of requirements, inflexible and over designated funds and resources etc.[3] The project approach was creating a parallel system of operation than developing the capacity of the already existent health service system. Also since the projects were of short term and with definite focus, they were unable to handle the larger systemic issues.[4]

Though the need for integrated program over vertical programs/projects was realized much sooner but it could not be materialized due to the boom in medical approach than health systems approach to health throughout 20th century. The health systems approach was brought to the centerstage in Alma Ata Conference (1978). **The definition wise clarification between a project and program, which is used in this study, is well explained in "Sector wide approach: an alternative to traditional project approach", Case study of Burkina Faso", 2003.**

Due to the varied limitations of projects, there was a need to develop alternative approaches. Also, as the need for increasing monitory support, declining/stagnant health status in developing countries and emergence of diseases like AIDS in 1980s and 1990s was realized as a huge challenge, it stimulated the donors and other partners like WB, IMF and other developing countries to think of more coordinated approaches than vertical and isolated projects.[5] In the same direction WB presented one of its reports in 1990s in which it proved that around 60% of all those projects that it funded did not meet their objectives.[6]

So with more and more recipient countries demanding a comprehensive system, various donor countries and organizations started discussions and agreements on adopting a more integrated approach to a sector than Project focused verticalization. Some of these new models were: a) Projects supporting a sectoral policy, b) Common plan, management, implementation and monitoring, c) Jointly agreed sectoral program with pooled funding, and d) Budget support.[7] The difference across these models is based on the degree of collectiveness between various partners in performing various functions.

All these developments show a clear shift from "Project" to "Program" approach, programs which are envisaged to be more comprehensive, sector-wide, are based on a sectoral policy which defines a future vision and function with a more efficient structural and financial management system.

So as mentioned above, SWAp has evolved from two major directions, firstly, the concern of health professionals that the traditional project approach has not produced sustainable improvements in services and secondly, the interest of

macroeconomists in improving the allocation of the national budget and of donor flows between, and within, sectors.[8]

This concern of macroeconomists towards developing a better, integrated and efficient system of development was thought to be addressed by initiatives like defining national priorities, capturing all funding and resources under one plan, developing realistic budget and expenditure plan through a rolling medium term budget framework. All these were thought to follow to sector specific policy directions and thus overall national development. At the implementation level, a comprehensive and integrated program was envisaged which would deal with all sectoral issues in an integrated manner. Such an arrangement is called SWAp.

With program approach taking a leap, the development partners (DPs) and the recipient countries required more funds through international and domestic development cooperation and support. This was (as now the sector) thought to be looked more comprehensively than compartments operating separate small projects.

Both, the limitations of project approach and concerns of macroeconomist were realized in certain international context. United Nations (UN), which brought in vertical disease control programs in health sector in 1960s and 70s showed a shift in interest from vertical to integrated and comprehensive health system approach in 1980s and 90s. Under its changing philosophy and direction to health system's development, it presented papers on SWAp in 1993. In 1997, this led to the formal conceptualization of SWAp in Paris Declaration.[9]

Along with UN, the other two major international donors namely World Bank (WB) and European Commission (EC) also showed shifts in their ideologies and hence areas and criteria of financing. WB in 1960s focused on projects of economic growth as it believed that only economic growth can alleviate poverty. In 1970s it started exploring the linkages between poverty and health and hence called for health policy papers. In 1980s it proposed structural adjustments in the larger economies of poor countries which also included adjustments in health sector to help finance services better. 1990s was the period when it emphasized on structural reforms, identifying different stakeholders in health sector, defining their roles,

evolving different models of health financing and investing in health etc. With the coming up of 21st century, the WB has adopted SWAp as its broad ideology for extending any further funding. With Poverty Reduction Strategic Program (PRSP), it tries to point out that the problem of poverty in the poor countries can only be dealt properly through comprehensive and integrated inter-sectoral planning, coordination and cooperation. Such an ideology and move shows the adoption of broad principles and concept of SWAp in WB's approach.[10]

With EC also having the similar philosophies and understanding on economic growth and poverty and structural reforms as that of WB, it continued similar project funding throughout 1960s to 1980s. 1990s was the reform period for EC when it talked about integrated development, aid to programs than projects and SWAp. In 21st century it realizes the link between poverty and disease and emphasizes complete sector investment than only projects.[11]

Hence with these examples it seems that the limitations of project approach and concerns of macroeconomist over sustainable financing has led to ideological transition in the major international funding agencies like UN, WB and EC also which has led to sector wide and program approaches than projects.

The introduction of the concept and principles of SWAp had started from social sector especially health and education. But today it is been adopted in many other sectors like transport, agriculture etc. This study would hence focus on the issues of SWAp in health sector only. Since 1997, the approach has been applied in more than 20 countries and their health sector, some of which are in the initial stages of the process.[12]

Concept

The available literature on SWAp defines this approach very broadly and differently hence arising confusion and ambiguity. Some define it as an "Approach"[13] and the others define it as "Partnership". There are definitions which call SWAp as a "Tool" whereas others which call it a "Framework". Some of the definitions of SWAp are mentioned below, which are propounded by the few renowned authors on SWAp in the last few years.

Definition by Mick Foster (2000):-

Sector wide approach is a method of operation where all significant funding for a sector supports a single sector policy and expenditure program, under government leadership, adopting common approaches across the sector and progressing towards relying on government procedures for all major activities.[14]

Definition by Andrew Cassels (1997):-

"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".[15]

Another explanation, though not a definition, is produced by the Inter-Agency Group on SWAps for Health Development (IAG) which says SWAp is a *partnership* between National (central, state, local) Governments, Funding Agencies and other stakeholders (NGOs, Private players, Civil Society etc) in the development of a sector. Together they agree on a *single sector development policy* and *financial investment plan.* This policy is framed in accordance with the overall country or state/province development policy to lead to the national development goals. Hence SWAp is a *mechanism for coordinating* support to public expenditure programs, and it aims to improve the efficiency and effectiveness with which resources are used in the sector.[16]

There are also definitions which define SWAp as a long term process under government leadership to help it develop a single sector policy (addressing both public and private sector issues), broaden policy dialogue, develop a realistic expenditure program, common monitoring arrangements and coordinated procedures for funding and procurement.[17]

Apart from the definitions presented above, Peters et al see SWAp as a way of building partnerships around technical elements like clear sector-wide policies and a medium-term expenditure programme.[18] Angers describes SWAp as a transition from donor-led, project dominated aid to a country-led national development strategy.[19] 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 lead.[20] 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.[21]

Tyson et al. on SWAp say that it is *a way of working between development agencies and the government and should not be viewed as a funding instrument.* At the same time this group of thinkers believes that by this way of agencies working together, trust evolves between the government and the development partners that helps the development partners feel confident in providing most of their resources as unconditional budget support to these governments.[22]

Cassels write about "achieving national human development objectives in the context of a coherent sector" but he does not get more specific on this. Also Foster and the other scholars quoted above refrain from more clearly stating what exactly is a "sector" and how wide should it be considered. They write about "sector-wide policies" and "national development strategies" but do not provide any operational guidelines to help countries define their sectors and hence sectoral policies.

From the above definitions, it is clear that SWAp is an outlook, that envisages a sector as coherent, that needs a single coherent policy which identifies sectoral priorities, that carries out realistic resource assessment and allocation, defines process and output indicators, all in order to ensure that the resources are utilized effectively in the planned direction to reach the sectoral goals. To achieve these goals, it promotes and suggests the need for sustainable partnerships and coordination between all stakeholders in a sector.

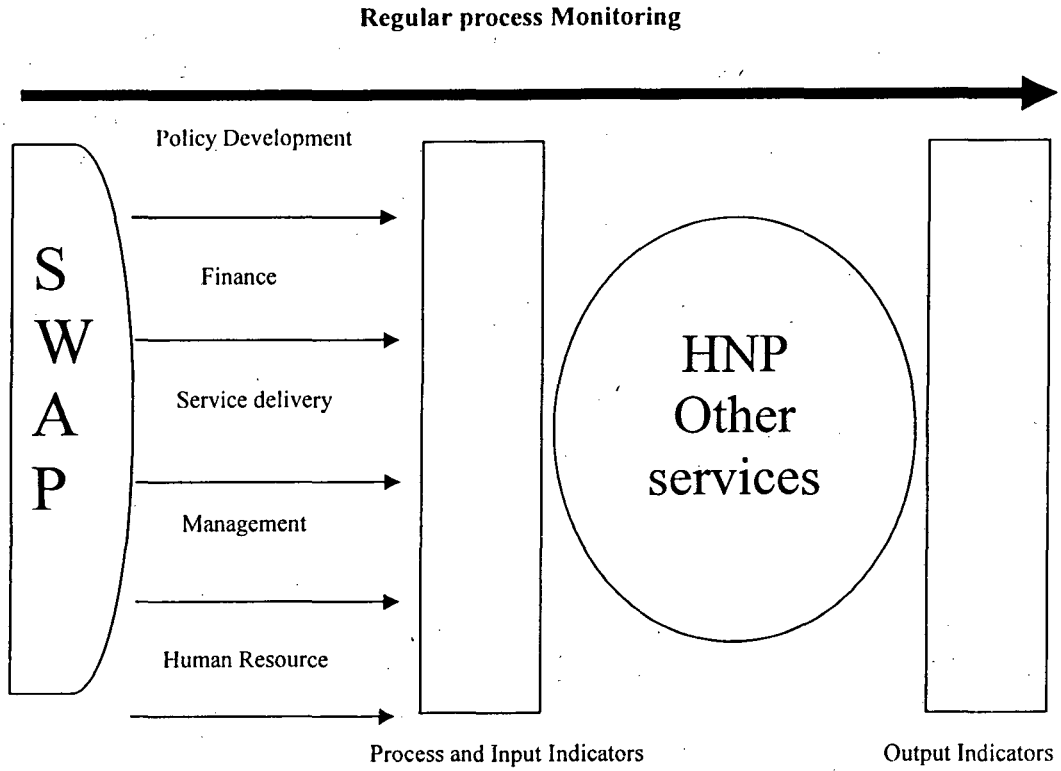
Hence SWAp is a continuous long-term process of working to lead to efficient working of a system or sector. It aims at enhancing *national leadership* and *ownership*, increasing *coordination* between stakeholders, *proper aid management*, proper *resource allocation and management*, *avoid duplication* of efforts, *reduce transaction cost*, *strengthen service delivery*, ensure *equity* and *sustainability* of efforts.[23]

Also, it is important to understand that the concept and various discussed definitions of SWAp are too vague and general to be adopted by any country. So as countries develop consensus on adopting SWAp, each component of it must be clearly defined in accordance to country's own context. Hence there can be no one operational definition of SWAp and it would depend on how the specific country and its partners view it in that specific context.

While adopting SWAp, countries need to define "*SECTOR*" in their own context. A sector can be characterized by group of activities and tasks that are important to be performed to fulfill the broader sectoral goals. To plan and perform these activities, a sector requires and involves few or many contributors who contribute to its policy, plan, fund, operation etc. These contributors and activities are similar as they are subjected in a single policy direction and aim to lead to broad sectoral goals. All these partners in the development of a sector are called *stakeholders*. They may include national, state and local governments; donor agencies and their native governments, NGOs, other private (for-profit and not for profit) organizations, civil society etc.

The conceptualization and operationalization of SWAp in a country requires it to undertake various steps like defining a "Sector", identifying its priorities, developing a sectoral policy, identifying available resources, capacities and gaps, identifying multiple sources of funds and resources to bridge the gap, designing a realistic expenditure plan, developing a phase wise sector program plan, implementing, managing, monitoring, evaluating, reporting and review of the sectoral program and policy.

A Conceptual Framework of SWAp



Source: Dr. A Issaka-Tinorgah "Implementing a Health Sector Wide Approach (Health SWAp) in Malawi, p.20, 2001

Operationalization of SWAp is a long term process and it works on certain principles like its application under government leadership. The process requires harmonization between various stakeholders on policy and planning issues. All must agree on a unified system of planning, financing, monitoring, reporting etc, which must be preferably the general mechanisms as followed by the local governments than those dictated by the donor. Another consideration is that currently SWAp just defines broad ideology and framework but the roles and responsibilities of different stakeholders may differ from country to country depending on how they see SWAp, mutual trust between them, need for coordination and the capacities of the stakeholders.

Some of the benefits of SWAp as proposed by those who propounded it are that over projects functioning in isolation, SWAp process increases predictability of funds and transparency of resource use, improves accountability, applies uniform

code of conduct for all SWAp members equally and uses evidence based approach to monitor performance.[24] Other prominent writers on SWAp like Mick Foster, Brown and Conway have also commented on some of the advantages and disadvantages of adopting SWAp. Their analysis sees SWAp from both donor and a recipient country's perspective.

How is SWAp for Donors and Governments?

	DONORS	GOVERNMENTS
Advantages	Ensure supportive policy environment for aid to produce sustained benefits; Have an influence on policy across the whole sector; Fungibility reduced; Aid benefits are broader, more sustainable and help build systems that last;	All resources support government strategy; Rules of the game reduce cost of dealing with donors; Builds capacity, does not duplicate; Possibly increased donor commitments on longer term in a earmarked form;
Disadvantages	Reduce visibility; Risk of association with decisions they disapprove of; Less scope to manage and control projects; Need to compromise on idea of best practice; Need to change procedures, relax tight control on use of donor funds.	Obligation to consult; High negotiation costs and uncertain returns; Donors slow to adopt e.g. adopt common procedures; Danger of lost momentum if preparation prolonged with slum in project commitments.

Source: Tyson, Stewart et al., Experience of Sector Wide Approaches in Health- A Simple Guide for the Confused, October 2000

Based on the experience of SWAp in various countries, there is a list of some basic identified conditions for the successful running of SWAp in a country.[25] The checklist is also claimed to help a country or donors identify whether their sectors require an initiative like SWAp. These essentials are:

- ✓ Where major expenditure in a country sector is through public sector
- ✓ Where number of donors in a sector is high and coordination is a problem

- ✓ Where donor contribution in a sector is high
- ✓ Where there is a willingness in governments to let donors help and influence their policy
- ✓ Where there lies a basic agreement between both on sectoral policy and strategy
- ✓ Where the macro-budget environment is supportive and predictable with confidence
- ✓ Where performance incentives are proportionate to the ultimate SWAp objective.
- ✓ Where the situation of the sector is manageable with **one than multiple** sectoral budgets etc.

Hence it shows that SWAp is a strategy which must be thought over by a country which has high donor dependence, which means poor or low-income countries. This means that any decision of a poor country to adopt SWAp would ultimately depend on its donor dependence. If the poor countries decide to adopt SWAp in accepting any donations or funds than promoting project or any earmarked funds, it is very much under question whether the donor countries would accept these conditions. Poor countries need funds to develop and rich donor countries always win the bet by forcing these poor countries agree to their conditions. Hence for the successful adoption of any new approach, it is very important that a meaningful consensus at global level is developed over this approach or between the partnering countries.

The other issue of major sectoral expenditures by the public sector is yet to be thought over more seriously. After structural reforms many of poor country's governments have shed their budgets in welfare sectors like health and have opened these sectors for more private investments. The case is imperative in Indian health sector where <20% health sector expenditure comes from public and the rest from private and out of pocket. The conditionality of structural adjustments was also by the similar funding agencies which are today proposing higher investments by local governments in their health sector. Now it is imperative to think on whether it is yet another condition by these donors on poor recipient countries that their

governments need to increase their public funding in the sector before they ask the donors to forward funds in newly adopted SWAp.

With taking up all these issues for discussion in the later part of the research, it is important to look through some of the important components, process and stages of Sector wide approach in a country.

Some of the important components of SWAp are:[26]

a) A clear sector policy and strategy
b) Code of conduct/MOU for all partners to help governance and grievance redressal
c) A formal government led process of donor coordination at the sector level
d) A formal government led process for common governance and management by the partners
e) A sectoral Medium Term Expenditure Program (MTEP)
f) An effective funding mechanism that ensures flexibility and predictability
g) A performance monitoring system to measure achievements towards objectives
h) Developing with agreed process, a harmonized system of reporting, budgeting, financing, procurement and management
i) A regular consultation mechanism involving all stakeholders

The above checklist shows just the broad requirements for the application of SWAp. As evident from above, SWAp applies lot of management systems and tools to realize each of these following steps that happen along the process of implementing or bringing in SWAp in a sector.

Process of SWAp in a Country:[27]

Step 1- Concept introduction to government, donors and other stakeholders

Step 2- Code of conduct/MOU defining roles and responsibilities of all stakeholders in the process

Step 3- Deciding on sector policy

Step 4- Making sector investment/expenditure plan keeping in mind the available, required and predictable resources

Step 5- Designing operational strategy

Step 6- Deciding on fund flow mechanisms

Step 7- Bringing effective financial management system in place

Step 8- Deciding and conducting regular financial audits

Step 9- Procurement

Step 10- Monitoring, review and evaluation

Step 11- Reporting and regular communication to all stakeholders on the process and outcomes

Note: It is essential to note that none of these steps take place between fine boundaries. It is simply for the purpose of understanding that this flow is been made. Also there is no definite time period for various steps or the entire process and the time period vary from country to country and according to conditions.

All along the process there are issues like decision making, dialogues on critical aspects, management and accountability issues, for which the system must be flexible enough to adapt and upgrade to the approved changes. More so, the system needs to maintain good governance with adequate representation and acceptance from all stakeholders to help resolve conflicting issues and facilitate decision making in order to help run the process smoothly.

In the process of SWAp, there are different stages that have been identified though there are no neat boundaries between these stages. Various countries, which have already adopted or are in the process of dialogue to formally adopt SWAp in their sectoral policies, have been classified in these categories:[28]

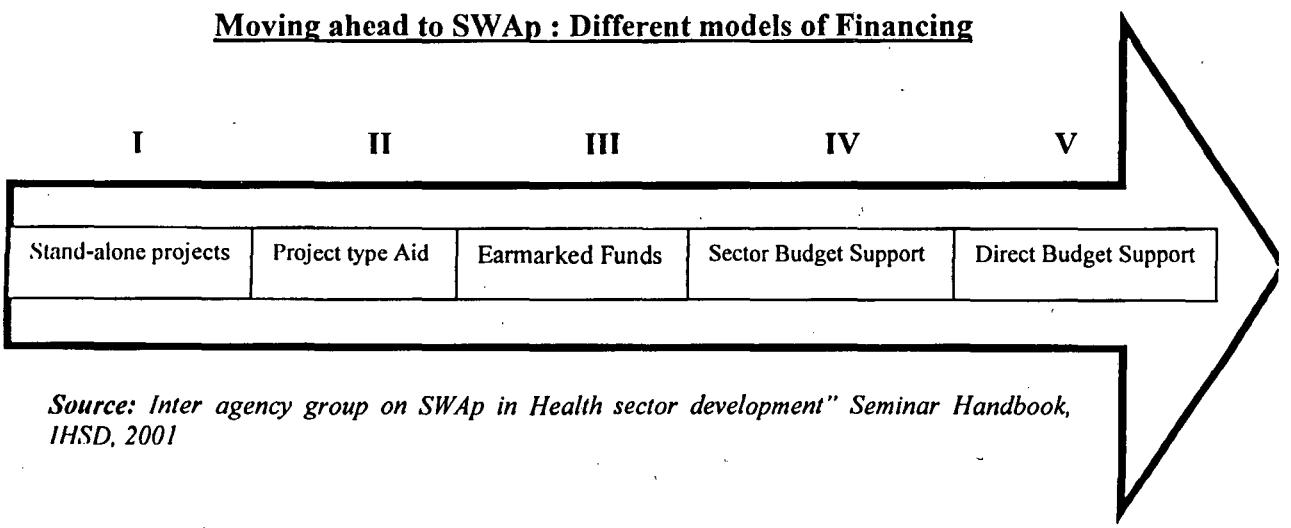
a. *Early SWAp* where at least a common policy and strategy between government and donors is agreed upon though the donors can keep funding the projects independently. (e.g)
b. *Middle SWAp* where there is a collective sector strategy and different combinations of financial models like pooling, basket funding, parallel funding or budget support takes place. (e.g)
c. *Ideal/Mature SWAp* where there is one sector policy, one funding and management plan and all funds flow through direct budget support with government being accountable for those funds. (e.g)

It is a matter of debate if there can be anything like "Ideal SWAp", if there is any country that has reached ideal stage in the last decade from the time of adoption of SWAp (1997-2007), how long could a process to ideal SWAp take and if it is just a vision, what is the feasible road to it.

Currently there are varied models/types in various countries adopting SWAp principles and definitions. These models, though not "ideal" but are very context specific. As the concept of SWAp has talked about cooperation between various players in financing the entire sector, there appear different views on financing, its control, mechanism of flow, accountability, use etc. Based on these issues and guidelines of donor countries, the funding agencies are adopting different models to support SWAp objectives.

There are funding organizations like CIDA, SIDA, DFID, WB, USAIDS, AusAID, UNICEF, UNDP, UNFPA, Danida, EC, Neitherland, Germany, Finland, JICA which have come forward to support SWAp but their funding modalities differ from country to country and within a country too.[29] SWAp concept though finally supports direct budget support by the donors to the partner governments but due to the limitations from their parent countries governments and due to the suspicion on the capacity of the partner governments in handling, utilizing and monitoring funds, many donors still prefer to fund the way acceptable to their governments than recipient governments. Their preferences and models of cooperation vary as shown in the diagrammatic representation below. There are also examples where many of these models by different donors are occurring simultaneously in the country's sector.

Moving ahead to SWAp : Different models of Financing



Source: *Inter agency group on SWAp in Health sector development" Seminar Handbook, IHSD, 2001*

I- A model where donor funded projects and government programs run separately

II- Here the government drafts the policy and the donors fund the activities or specific projects under it.

III- Here the government drafts the policy and donors follow it by giving earmarked/ dedicated funds with conditions to the sector/program/region.

IV- Here the government drafts the policy and donors pool funds into a sector but under the administration and partnership of both govt. and donors.

V- Here the government drafts the policy and program strategy and donors extend non earmarked and unconditional funds directly to the sectoral budget. By this government hold more responsibility and accountability to the donors.

Hence as more and more donors are moving towards cooperative development assistance, they are also simultaneously adopting other modes of assistance in the same country or different countries or sectors depending on the situation. The effectiveness of these models in operation is yet to be studied. Till date it is just the assumption that pooled financing or budget support is more advantageous and hence recommended by many authors on SWAp. The empirical evidence on this are yet to be explored.

SWAp in Health Sector:
Country specific examples and experiences

SWAp is adopted by countries of southern hemisphere which means mostly poor and low income countries. Countries in Africa, Asia and Latin America have adopted it. With SWAp in Health sector, some of these countries are: Bolivia, Ethiopia, Kenya, Nicaragoa, Rwanda, Ghana, Tanzania, Mozambique, Zambia, Mali, Uganda, Burkina Faso, Senegal, Malawi in Africa and Tazakistan, Vietnam, Yemen, Cambodia,

Pakistan, Nepal, **Bangladesh** in Asia.[30] These are those countries where SWAp had been formally adopted. Countries like Uganda, Ghana, Tazakistan and Bangladesh are few which had adopted SWAp since its conceptualization in late 1990s and today they are few of those with maturing SWAp in their health sector.

Ghana

In Ghana the vertical programs' integration started in the early 1990's with programs such as TB, MCH and Leprosy control being moved, incrementally, into existing institutional arrangements for service delivery. It is mentioned that the intentions of Ministry of Health (MoH) by adopting SWAp was to address the problem of the dominant role of donor projects in Ghana. The other objective was to bring the services closer to the users and communities and make the system more holistic and easier to access.

Ghana today has decentralized district health system in which the support systems like planning; procurement and transport have also been integrated. With this integration and change in approach, the health centers are structured in a way to provide integrated package of preventive, clinical and maternity services to the desiring communities.

In terms of financing, these services at district level, like those at national, regional and tertiary levels are supported in part by the Health Fund, to which 5 donors contribute on an annual basis. Whilst the Health Fund is disbursed separately from donor funds, it is budgeted for and reported on in an integrated way (budgets and financial reports are based on a combination of health fund, donor funds and internally generated funds). The proportion of donor funds being channeled through this pooling mechanism is increasing, and in 1999 was estimated at 39% of total donor funding.[31]

Zambia

In Zambia, the vertical programs were rapidly integrated in the national healthcare delivery structures in 1997 as part of a comprehensive restructuring of health service delivery and management system. This restructuring also aimed at increasing decentralisation and democratisation. The other purpose was to

strengthen the district health service system in order to provide basic package of health services to the needy. This move was supported by decentralisation of financial and administrative powers to the health boards.

Hence with this decentralization, a limited number of technical staff is posted at the central level (within the Central Board of Health) whereas all other implementation responsibilities are now shifted to District Health Management Teams supported by Provincial Health Offices. The function of Procurement is still centralised with districts ordering drugs and supplies from Medical Stores Ltd through the Central Board of Health. Zambia is experimenting with the 'district basket' concept with un-earmarked funds being channeled to districts (approximately 20% of donor funding in 1999). For this a 'basket steering committee' meets quarterly to monitor performance and approve allocations. Similar kind of experiments could be seen in Indian RCH-Second Phase Program.[32]

Bangladesh

In Bangladesh, the vertical programs were integrated into national delivery systems at the same time as the sector wide approach i.e 1998. The main impetus here was to increase government ownership of health policy and implementation and reduce the problems of multiple (over 120) donors funded projects.

The documents on Bangladesh say that now the country has single sector-wide program and all sectoral activities are managed within it with various line managers of government of Bangladesh being responsible for these. With SWAp being adopted, all the available funding is allocated according to a sectoral annual planning and budgeting process. Various line directors produce their own plans and these are coordinated with each other to produce an annual plan for the sector. Most vertical programs are costed in the annual operational plans (AOPs) of the two line directorates' i.e Family Planning and Health. The release of funds is managed at the centre. The central ministry compiles the "statements of expenditure" and the donors reimburse the mentioned amount.

However there are still many other separately funded activities but they are all jointly planned and monitored under the AOP. Their financing is also captured

under AOP. All this is an arrangement of a country and sector towards SWAp. Other than financing, procurement is still a highly centralized function. This is so as the process of decentralization has yet not taken place beyond the Directorates here.[33]

Uganda

Uganda is another third world country which has very high Maternal Mortality Rate (MMR). Here more than 60% of the deliveries occur without any birth attendant. The country has limited emergency obstetric care services and hence very small proportion of women who have complications get access to these services. The system handles very few caesarian deliveries.[34]

Uganda started ***Poverty Eradication Action Plan*** (PEAP) in 1997 with Sector wide approach. Its health sector strategic plan is the part of national PEAP and such an initiative was started in 2000. It received fund support from EU, UK, WB, Belgium, Netherlands, Denmark, Sweden, and Norway etc. A paper by V. Orinda et al. mentions that sector wide approach in Uganda has helped in facilitating policial change by bringing issues like Emergency Obstetrics Care and MMR into national agenda.[35]

With the above examples of how SWAp is been implemented in different countries, there are also examples of concerns on the poor functioning of SWAp in countries like Rwanda, Mozambique, Zambia and Tanzania. In Rwanda, the operation of SWAp is facing problems due to the lack of government leadership in a sector. In Mozambique, the problems are due to the poor relationship between Ministry of Health (MOH) and Ministry of Finance (MOF). In Zambia, the problems are due to frequently changing senior management teams. In Tanzania the problem is quoted to be due to the poor capacity of health ministry to attract additional funds.[36]

A recent comparative study conducted in 2003 on the application of SWAp also shows that the adoption of SWAp in Bangladesh Health and Population Sector Program has aroused multiple debates on the issues like ownership vs. partnership. The case of Bangladesh in this study raise many questions on the boundaries within which the donors can influence national strategies and beyond which the control

and leadership should be just in the hands of national governments or the parent ministry of that sector.[37]

With the experiences of all these countries with SWAp, it is clear that there are many issues which are unresolved or wide open for debates on the proposed sector wide approach. Though there is enough literature available on the concept and proposition of SWAp but there are very few studies conducted on the effectiveness and challenges faced or foreseen limitations of SWAp.

Discussion

The concept and operationalization of SWAp in some of the countries as discussed above point out many such issues which are unsolved and raise doubts about this new concept. The word "sector wide" itself raises questions on the boundaries or demarcation of a sector from the others. The other issue here is that as the context varies from country to country so would the definition of sector and its width. With such debates on the boundaries of a sector, there arise questions on the dealing of issues like HIV/AIDS which requires multiple sectors to coordinate and work together.

From the varied literature reviewed, it is been noticed that though SWAp talks of being sector wide but its application is mainly restricted to the line ministry or department like Ministry of Health and Family Welfare in Bangladesh. The influence of other sectors on the application and success of SWAp in one sector like health can be explained by examples from countries like Zambia. Here the operation of SWAp process in district health departments was found to be slow as the finances released from the finance ministry could not be accessed on time due to inaccessibility of banks in the near vicinity. This was mainly due to poor transport especially during the rainy season and hence the unavailability of staff in the banks for many days.[38]

As many of these issues are not covered when SWAp is integrated in Departments of Health or health sector but they are such systemic or multisectoral problems, which do alter the results and efficiency of programs working with SWAp.

Similarly, the issues of safe drinking water and sanitation, which have huge impact on people's health, are usually not considered as a part of the health sector. Hence it is a matter of debate whether defining a "Sector" with definite and specific boundaries is possible or should be at all considered.

As per the concepts, SWAp emphasizes on "national governments at the driving seat" and increasing "National Ownership" but it nowhere defines what it means by these words. The experience of Bangladesh MOH with SWAp in its national program clearly demonstrates the problems faced in the application of a concept when its components are not properly defined. The debate between Bangladesh's MOH and the donors over the convergence of its two directorates namely Health and Family Welfare (DOFW and DOH), which was proposed and promoted by donors but finally refused by government of Bangladesh (GOB) due to issues related to larger political economy in the country, shows the conflicts in the concepts and operation of issues like Leadership and Partnership. Following this refusal by GOB, some of the donors including WB, that had made long term commitments towards sectoral programs in health, withdrew its funds partially. Such actions show that donors are still powerful to an extent that they can affect the programs by withdrawing funds or reversing their commitments any time if their directions are not met. Hence before the acceptance and application of SWAp in a country, clear demarcation of roles, responsibilities and limitations of each partner involved in the process is required in order to avoid any tussles and misunderstandings between partners.

Another issue that is unclear in the concept of SWAp is "Increasing Ownership" of the government. The fundamental documents on SWAp are not clear on how this ownership would be increased. Though in the entire process, the responsibilities of the partner governments are increased in many ways, but there are thinkers who envisage and suggest that unless the partner government is given full power or responsibility of funds in its hands, their sense of ownership of the sectoral program would be partial.[39] In countries like Bangladesh, many donors are still not in favor of giving funds in partner governments' hands. In Ghana, the authority and hold on the reimbursement of pooled fund from external source is still in the hands of

donors. So in such cases, does increased responsibility than authority over funds mean increasing national ownership is a question to be thought upon.

The definitions and their interpretation on SWAp as mentioned above propose a view that with a stronger role of national governments in coordinating sectoral development and programs, the development partners must take a backseat and act just as a facilitator than coordinators. The definitions also mention that with SWAp, the aim is to bring together and coordinate a larger number of stakeholders in sector development. Another issue that can be pointed out here is that as Tyson and Foster view SWAp as a way of making the government responsible for coordinating funds while the others argue that SWAp is a method for coordinating all available resources in the health sector. Also there is lack of clarity on whether it is the coordination of funds, or activities, or partners or all in the process that SWAp proposes to emphasized.

The comparative study of Bangladesh, Uganda and Ghana explains the similarity in the mechanisms used by different countries in coordinating mechanisms like conferences, forums, committees etc. But there are still differences on the issues of whom to coordinate e.g in Uganda and Zambia the structure is decentralized and hence it is easier and possible to get the viewpoint of the civil society and other stakeholders at the local level through these mechanisms. But in cases like Bangladesh which is highly centralized system, the coordination is limited to formal groups of development partners and ministries. Hence the concept of SWAp has to be clearer on what, how and in what context it talks on the issue of coordination.

The broader concept also lacks clarity on the issues of levels of coordination, roles and responsibilities of each stakeholder in the process. Whether this coordination and partnership has to occur at the policy, planning, operation, management and monitoring level is still unclear. Jespers' comparative study mentions that the concept of SWAp on coordination talks about five different levels namely; *stakeholders, analyses, plans and policies, activities, resources and monitoring and evaluation.* The concept does not throw light on how it would be implemented in structures, which are decentralized (Uganda and Zambia) or highly centralized

(Bangladesh). Another important area of coordination is the function like "training" across the sector. Training is expressed as one area which consumes and wastes enough time with repeated and regular trainings from one or the other department (by the local staff from Zambia).[40]

The critics of SWAp however claim that the introduction of SWAp has increased the burden of coordination which is a time and resource consuming process.[41] In order to reach consensus between the development partners, community and the government, enough time is spent in just negotiating and discussing various approaches. The critics raise a question whether the adoption of a SWAp really reduces the administrative workload or it merely shifts the institutional capacity from evaluating, monitoring and reporting to negotiating, discussing and coordinating.

Another issue raised in the comparative study by Jesper et al is the absence of country specific definitions of SWAp. The study examines and shows that the definitions that are translated into action are not the ones which were mutually agreed upon. Instead the study illustrates how the individual partners define SWAp in their own way in day to day functioning. In such cases where the definitions are unclear, different for different stakeholders and not fitting the country context, the vision of SWAp can not be achieved.

There are also different views on the synergy or links between SWAp process and other already into process or required institutional reforms. The development partners in Zambia and Uganda consider the institutional reforms to be out of the SWAp agenda whereas the Bangladesh govt. agrees to have been asked for larger institutional reforms for the better implementation of SWAp.[42]

Considering the context of various countries where the nature of health service providers vary from a professional doctor, to private ones, local midwifes to traditional healers and religious organizations, it is been debated that who should be considered as a stakeholder and who all should participate in the SWAp process. As in countries like Uganda and Zambia, where church and missionaries provide large amount of services to a larger section of population and in Bangladesh, where the

traditional healers are important service providers, even the definition and categories of stakeholders to be included in the process would differ. Since all the above mentioned groups cater to large number of services coming under the umbrella of health sector, the question that is raised is on what grounds such groups should not be considered as one amongst the stakeholders in sectoral development. With this, there rises another concern of how would the state plan to bring all of such stakeholders on roles for their better representation in sectoral policy.

The broad idea of SWAp came from the international development partners as a response to the critique against their project-aid approach and SWAp was hence marketed as a more efficient and ownership-generating approach to development cooperation. The fact that the concept is so general in nature, this has probably helped making it popular amongst the partners in health sector including the low income country governments.

The concept proposes to ensure liberty to the recipient governments and other involved partners to edit or translate it so as to fit best into their own contexts and pReferences. This flexibility as the face value could be one reason for its acceptance by so many countries. Although almost every document published on 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. It seems that the flexibility of the approach to best fit in the country specific context, is not been utilized properly. Hence the absence of context specific SWAp definitions in the country strategic documents (MOU) and similar coordination structure in all the three countries despite the fact that Uganda and Zambia have highly decentralized whereas Bangladesh has centralized health service system is noteworthy.

The introduction of SWAp gives a clue to the distraction in the global health sector policies. As on one side where SWAp plans to integrate the whole sector under a single comprehensive program, UN has come up with a vertical Global Fund for AIDS, Malaria and TB (GFAMT).[43] This issue is important to a large extent as when the recipient country governments are planning to do away with

verticalization in their systems and lead to comprehensiveness and integration, would they be able to say "NO" to such a huge project fund is thought worthy. Also whether UN would appreciate any integration or coordination of this project fund with the larger sectoral budget must also be thought over carefully.

Another critique of SWAp that is being raised is that during the operationalization of SWAp, large amount of resources are spent on strengthening the managerial and institutional infrastructure at the expense of the quality of health services. Hence the question whether it is ethical and advisable to spend such a large amount of money on training accountants and district managers when on the other side there is high shortage of money to procure essential drugs are still to be answered by those who propose and appreciate SWAp.

The other concerns of participating government, donors and civil society organizations regarding SWAp must also be thought upon. The issues like external interferences or scrutiny of personal matters, interferences in policy matters, pressure and competition of ministries to attract external funds, inter-ministerial rivalries due to difference in allotment of funds etc should be considered in advance by the country governments adopting SWAp. Factors that are of concern for the donors are like accountability, matters of policial conflict, political unrest etc in the partnering country. Even the civil society organizations are unclear on their areas of participation, future of currently running successful projects etc.

Though macroeconomic instability and national and international political unrest could be some of the risks to the success of SWAp approach, lack of capacity building, poor implementation capacity, lack of donor coordination and consensus on sectoral policy and strategies etc would falsify the objectives of SWAp. These are some of the problems and issues confronted by the countries discussed in this chapter during their actual operation or functioning of SWAp in heath sector. Similarly, all these issues would also be considered they could be discussed in further chapters when we analyze the concept, application and limitations of SWAp in Indian Reproductive and Child Health Program.

Thus having understood SWAp in detail, in order to identify and discuss SWAp in Indian RCH program, a checklist of essential queries, which includes concept, principles, objective, process etc on SWAp is being prepared.

Essential Queries to explore SWAP in Indian RCH Program:-

1. Who has planned and done the preparation for the program?
2. What were the reasons for such type of planning in this program?
3. Are the approaches followed in the program consistent across the sector/sub-sector?
4. Does the program follow broad National Health Sector and Population Policy objectives?
5. Do all stakeholders have a common goal towards sector development?
6. Does it involve partnership/joint effort between stakeholders in planning, management, implementation, financing, procurement, M& E, reporting etc.?
7. Does it plans to improve coordination between various stakeholders?
8. Does it follow the GOI common procedures for all activities?
9. Does it have a single expenditure plan for the DPs and GOI?
10. Does it aim to increase predictability of funds?
11. Does it have flexibility of funds?
12. Does it plan to reduce the transaction cost?
13. Does it aim for proper aid management, resource allocation, transparency and accountability in the program?
14. Does the program ensure GOI leadership?
15. Are the general mechanisms dictated by donors/led by GOI?
16. Does the plan intend to increase national, state and district ownership?
17. Is the plan long term and has process with process and output indicators and continuous planning and monitoring?
18. Does it plan to ensure Equity in services?
19. Does it plan to ensure sustainability of the efforts?
20. Does it ensure uniform code of conduct for all?

Thus based on the above criteria, chapter 4 of this dissertation would try to identify and discuss the concept of SWAp, the principles and applications in the Indian Reproductive and Child Health (RCH) program. This would help in showing the existence of SWAp in the Indian health sector **the start of this integration could be seen from National RCH program than the entire sector.**

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CHAPTER 3

Reproductive and Child Health Program (RCH): India

The concept of reproductive healthcare globally has a history of various movements, ideological shifts and conceptual differences. This was linked with the evolution of Public Health (PH) as a concept in 18th century, the period which was also popularly known by the name of Thomas Malthus[i]. The period pronounced the link between poverty and population and later led to the other developments in public health like sanitary reforms in England and Wales (known as the advent of public health), discovery of germs and biomedicine in the 20th century etc.

With this century witnessing many wars and despair, the world went through the period of de-colonization and independence of many African and Asian nations. This caused a global political unrest and desperation of first world countries for power. This desperation led to a new era of neo-colonialism which meant strategies to intervene in the welfare sector of these newly independent small countries in order to influence their policies in a way that they are beneficial for the developed world. Hence the first world countries strategies like Family Planning (FP) and contraception to the growing population in third world was a Neo-Malthusian move, which aimed at birth and population control in these poor countries.[1] In order to introduce FP in these nations, various arguments based on eugenics, women health, population growth and economic development, human capital concept etc. were made by different lobbies from time to time. Despite contestation, finally

[i] Thomas Malthus- Malthus posited his hypothesis that (unchecked) population growth always exceeds the growth of means of subsistence. Actual (checked) population growth is kept in line with food supply growth by "positive checks" (starvation, disease and the like, elevating the death rate) and "preventive checks" (i.e. postponement of marriage, etc. that keep down the birthrate), both of which are characterized by "misery and vice". Malthus's hypothesis implied that actual population always has a *tendency* to push above the food supply. Because of this tendency, any attempt to ameliorate the condition of the lower classes by increasing their incomes or improving agricultural productivity would be fruitless, as the extra means of subsistence would be completely absorbed by an induced boost in population. As long as this tendency remains, Malthus argued, the "perfectibility" of society will always be out of reach (Ref. Weblink: The History of Economic Thoughts).

many third world countries including India, which was the pioneer (1952), implemented FP policy for population control.[2]

In Indian context, various National but Vertical Healthcare Programs[ii] like Malaria, Tuberculosis, Blindness, Leprosy etc. were started after independence. National Family Planning Program (NFPP) in 1952 was another vertical program in this basket. This NFPP started with a clinic-based targeted approach. Later with a view to cover larger population, it changed to an extension or outreach model in 1960s. Until 1978, the program targets for temporary and permanent sterilizations were coercively applied and attained. Though it was a larger international politics, the national political parties applied and enforced it for their own political gains by introducing incentives for those who comply with this approach. With India being an agricultural country with a view of requiring larger manual labor in number and other reasons like high infant and child mortality rate (IMR and CMR) due to many causes like malnutrition, infectious diseases etc., culture of family size being a personal matter of decision and that too by the elders in the family and finally the impact of this coercion for FP by the government, the people started shying away from FP and any such initiatives and finally resisted the move. This resistance was shown by overthrowing the Indira Gandhi government in the post emergency period[iii] in India (1975).[3]

The coercive FP approach was then changed to the National Family Welfare Program (NFWP), which emphasized on the health of the family including mothers, infants and children while also meeting the reproductive goals of the population and country. Further in 1980s and 1990s other related health programs like Maternal

[ii] Vertical approach to health programs was adopted as a solution to the given health problem by the means of single purpose machinery. This meant that all the services within a program are directed, supervised and executed either wholly or to a great extent by a specialized service group using uni-directionally dedicated health workers. This program model focuses on taking specific measures for a specific problem to get appropriate results in a shorter time span.

[iii] The Indian Emergency of [25th June 1975–21st March 1977] was a 21-month period, when President Fakhruddin Ali Ahmed, upon advice by Prime Minister Indira Gandhi, declared a state of emergency under Article 352 of the Constitution of India, effectively bestowing on her the power to rule by decree, suspending elections and civil liberties. It is one of the most controversial periods in the history of independent India (Ref. Wikipedia).

and Child Health Program (MCH), Universal Immunization Program (UIP), Child Survival and Safe Motherhood (CSSM) etc. were introduced.

The review documents from the Department of Family Welfare (DOFW), Ministry of Health and Family Welfare (MOHFW), Government of India (GOI) mention that all the past programs faced problems like heavy burden of disease among women and children, underutilization of existing large public facilities and manpower; poor quality of care due to shortages of supplies and improper staff behavior; inadequate support of front-line workers; inadequate mobilization of private and non-government organization (NGO) resources, program distortions due to excessive focus on method-specific contraceptive targets, top-down management, late fund disbursements and poor procurement capacities, inadequate integration, verticalization of programs, poor Information, Education and Communication (IEC) etc.[4] These were some of the reasons due to which a need for a better, efficient, single well integrated nation-wide program was realized.

During the last two decades, women's movements all over the world, especially the abortion debates in west brought to the center stage women's reproductive health concerns.[5] Added to this was the threat from HIV/AIDS and the population control lobby's fear of population bomb ticking in third world countries for the countries in the west. These were some of the reasons why World Bank (WB) also supported the Reproductive and Child Health (RCH) approach in the International Conference on Population and Development (ICPD) held at Cairo in 1994.[6] Hence today's RCH Program of many countries including India is the results of ICPD.

This concept of reproductive healthcare addresses the reproductive processes, functions and system at all stages of life. It implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.[7]

Thus with this background, GOI prepared its National RCH Program first time in 1997 and this was based on the life cycle perspective dealing with care at all stages of motherhood, infancy and childhood.[8] The program planning was done in order to evolve a single comprehensive nationwide program by merging NFWP, CSSM and other immunization programs. The program was initially started as a project under NFWP with a plan of evolving it to a single national level RCH program encompassing all activities under DOFW.[9]

The RCH Program in its first phase (RCH-I) was funded by GOI and WB. The first phase of the program continued till 2004 after which it was reviewed by the funders and this review further led to the launch of the second phase of RCH program (RCH-II) in 2005. The second phase of RCH was again funded by GOI and WB with two new partners namely DFID and UNFPA, though the funds extended by UNFPA were small and in the form of grants[iv] than loans.[10]

National Reproductive and Child Health Program
Phase-I with RCH-I Project

The National RCH Program was envisaged as a "program" and not a "project". For the purpose of convenience, the program period was kept as five years which was supposed to be considered as a project integrated in a program.[11] Thus RCH-I was run by DOFW, MOHFW, GOI. It operated as RCH-I project which was worth $268 million. Out of total RCH-I cost, $ 237 million was funded through International Development Assistance (IDA) by WB and the rest by GOI.[12] This means that more than two third of the RCH-I cost was born by WB in the form of soft loans[v]. Other than monitory assistance, it also received support from other development agencies like European Union (EU) through its Sector Reform Program and USAID through its Innovations in Family Welfare Program. The other development agencies like UNFPA and UNICEF also supported it in several districts, while WHO provided it with technical assistance. In addition, several other development partners like

[iv]Grants are the economic aid given to a person or institution or country for a cause. The Development Cooperation Directorate-DAC defines it as the Transfers made in cash, goods or services for which no repayment is required.

[v] Soft Loans are the financial assistance by the funding agencies where the repayment of funds obtained is required with a specific interest rate. When the period of return is decided to be long terms, such loans are called soft loans (Ref. DCD-DAC).

DFID, KFW and the Government of Japan etc. supported the immunization component of RCH-I, particularly the Polio immunization and eradication activities.[13]

RCH-I was implemented throughout the nation in all states and union territories (UT) with the funds released to these on the basis of their project performance. It covered approximately 600 districts of 30 States/UT and other 24 sub-projects implemented in the disadvantaged districts and cities.[14]

In order to deal with the problems of the existing programs, RCH-I aimed at nation wide implementation of this new policy on reproductive and child health, improve infrastructure, service coverage, quality, effectiveness, expand RCH service package and improve its management. Thus the ultimate objective was to lead to an integrated holistic reproductive and child healthcare program model. It aimed to bring coordination between outreach workers of DOFW and Department of Women and Child Development (DWCD), between DOFW and community investment plans and programs of Ministry of Rural Development, use of registered societies to help reduce fund delays and evaluation of quality of care through District Household Surveys (DHS), two of which were later conducted in 1998 and 2003.[15]

RCH-I design prioritized investment in public health (PH) system to ensure equity and geographical access. Its emphasis was mainly on upgrading and strengthening the existent structures than making new structures. It also envisaged the role of private sector in complementing PH system in improving access, operation, management, mobilizing and advocacy. For the purpose of implementation and resource allocation, it took population and epidemiological condition of different states and districts in mind. Thus based on the indicators like female literacy and crude birth rate, the districts were divided into A, B, C categories and appropriate funds and resources were allocated to them.[16]

RCH-I was implementation through District Family Welfare Bureaus (DFWB) under the supervision of State Health and Family Welfare Departments (SHFWD) and Coordinated by MOHFW. For specialized functions, management and technical consultants at both central and state levels were appointed. For inter-sectoral

convergence, it planned inter-ministerial committees and Project Management Committees for regular monitoring. Only the States and central levels were authorized for major procurements of items like vaccines, drugs, other logistics etc and that too from the selected organizations. For flexible financing or fund flow, State Cooperatives for Voluntary Assistance (SCOVAs) were made operational in each state.[17]

Talking about the RCH-I project results, majority of the funds were spent on either drugs or fee to the consultants. The other categories of major investments were trainings, workshops and civil works.[18]

Chart Showing Category-wise expenditure as % of Total Expenditure

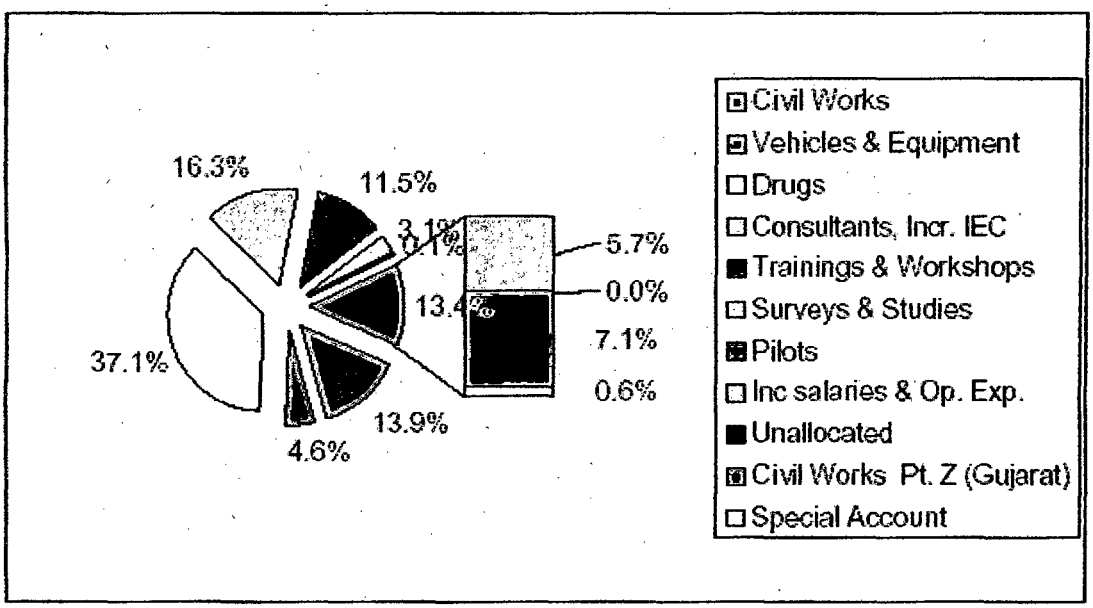

Chart showing category-wise expenditure as % of Total Expenditure

Source: Implementation Completion Report; India, Reproductive and Child Health Project, The Document of WB, May 27, 2005

With Gujarat earthquake coming as a contingency, a proportion of RCH fund was also diverted for this cause and in return WB allocated further funds in the later period.[19] Some of the key outcomes of RCH-I showed the overall decline in the coverage of FP component in the project period. The results though showed an improvement in antenatal care, post natal care had considerably declined. The percentage of institutional deliveries increased with a subsequent decline in home

deliveries but its public sector component in comparison to private sector showed a declined. There was also a sharp decline in routine immunization of infants and children, diarrhea, ARI management but an increase in polio coverage etc. In the post-project analysis conducted by GOI and WB in 2004, there were many criticisms brought forth in the project conceptualization, design, planning, organization and management.[20]

A) Concept, Plan and Design

The RCH-I evaluation report mentions that the project goals were over ambitious in relation to the set time period for operation. The definitions of the main components of RCH were so ambiguous that there was lack of clarity and overlaps in the activities. The working definition of RCH services which included CSSM program, treatment of Reproductive Tract Infections (RTI) and Sexually Transmitted Infections (STI) and Adolescent Health caused enormous confusion in the project implementers and led to the loss of focus on FP activities.

The report says that the project design did not identify factors, which were out of its control but had an effect on its performance. The project as other programs planned integration and coordination of activities but only at the ground level leaving apart the integration at the upper levels. Though the project approach talked about reproductive health and gender equality but it still stressed more on female sterilization than other male contraceptives. The report mentions that there was high reluctance by policy makers to talk on the issues of project's overemphasis on female sterilization. The project lacked clarity on the role of NGOs and civil society. The debates on the use and training of traditional birth attendants was still not resolved and this further created confusions hence affecting program results. It also said that RCH-I design was highly standardized (one size fits all) and was made without consultation of implementing states and other stakeholders like NGOs etc. The project plan also did not pay heed to the financial management policy which led to uncoordinated financing by different units of the project.

The project design also missed on the Human Resource Development Policy (HRD) despite the fact that Indian PH system had been battling with HR problems like brain drain to private sector and other countries, reluctance of doctors to serve

rural areas, high employee turnover rates, poor remunerations and working environment etc. since decades. Issues of privatization in health sector with modalities like regulation, cost and quality control were also not sorted out. In terms of monitoring, evaluation and supervision, since the project was so big and complex operating in different socio-economic contexts in different states, it lacked clarity in what it expects to achieve. It lacked practical guidelines for conducting assessment, consultation and its translation into a work plan etc. which were the prerequisites for decentralized planning, monitoring and evaluation. Also the report says that the parameters for assessing state's performance for deciding its further financial assistance lacked objectivity and verifiability.

The report says that the project plan did not consider prior-steps/preparatory measures for this sudden policial change (from FW to RCH approach) despite the fact that the project was brought forth at a national level which itself is huge and a complex structure. The project lacked IEC for providers. It missed on any plans to merge all state or region specific similar activities or projects with NFWP and further into this project/program. Though it was thought to decentralize procurement activity to states also, no plan to train and guide the state authorities on this was made. This was despite the fact that the procurement procedure, guidelines and process was decided and designed by WB and they were found to be very lengthy and complex.

B) Implementation, Monitoring and Evaluation

The project appraisal report mentions that as the project policy talked about target free approach but its implementation was found to be very poor in many states. The Community Need Assessment Approach (CNAA) was not properly applied as no prior training or orientation was given to the ground staff on data collection. Thus this improper CNAA affected the process of decentralized planning as in the absence of proper data from CNA exercise; many subcentres and PHC concocted their own plans hence incorporating it in District Health Plans. Centralized collection of CNAA plans reduced state's involvement in the process, whereas central feedback could not be conveyed actively to add further to program planning. Thus the survey data was not used in the planning at the local levels.

As the computers were provided to >500 districts, full reports were submitted only by 50% of these. The mechanism for internal audit or verification of these reports was absent. Hence they failed to contribute to bottom up planning as envisaged in the project objectives. As across programs, logistics was always a problem but the project did not pay attention to it in its plan. The reports claim that for the flexible fund flow, SCOVAs at state and district levels were a successful initiative but as it used the external consultants, they served only as an alternate patchwork than bringing suitable and sustainable change in the larger system. As SCOVAs helped to an extent in fund flow, many other sectors also started such units hence creating problem of multiple SCOVAs thus further complexity and confusions in the system. The delays in recruitment of SCOVA personnel and activation of its management structures, delays in audits and expenditure reports thus delay in the release of funds to implementing agencies, delays in finding suitable sites for civil works etc was also noted in the RCH-I period.

The project's performance based funding approach towards states which meant stopping fund flow to those low performing states was found inadequate as augmenting the management capacity of these states on long terms basis could have been a better preposition than stopping their funds.

In terms of human resource policy, an issue like regularization of contractual staff was not thought over. The project undertook less than expected hiring of additional ANMs and other project personnel in several large northern states such as Bihar and Madhya Pradesh. To improve the service delivery, 2000 staff nurses and 6500 ANMs were contractually recruited but the poor performing states still had staff shortage due to non-availability of skilled HR. This was a flaw, as the Medical Education system was not set in a way to fulfill the project's long-term goals. The report criticizes the placement of the main team leader project head in Washington though this complex project was running in India. This non-availability of lead staff locally affected the project in a way that the state governments were hard pressed to serve the interest of the other development partners (DPs) first thus neglecting RCH project.

In terms of services, the project talked about the extension of service package but no substantial efforts were done in this direction. Opposition by NGOs and feminist groups on introducing the long term hormonal methods in choices of contraceptives in the PH system though they were already available in private sector was not adequately tackled. The RCH Camp approach continued to be in use at many places but still with major emphasis on tubectomy. In order to improve the coverage, NGO partnership scheme was started which undertook efforts like demand generation, IEC, advocacy, counseling, innovative styles of service delivery but they also faced many problems during the process like poor management skills, delays in funding, inconsistencies in selection of NGOs, short project implementation period, high Staff turnover etc.

The report says that the project lacked a proper strategy on capacity building of IEC staff, designing curriculum, proper distribution plan, initiative to involve district education division etc. Due to these, IEC could not effectively address this big policial change hence making behavior change and proper service utilization difficult.

As per this evaluation report, RCH-I also faced uneven supervisory performance by WB before and after Medium Term Report, with some states hosting the supervision team six times in a year and some not seeing it at all throughout the project period. Supervision of Empowered Action Group (EAG) states by the center was more important which also did not receive adequate attention. The report points out the lack of coordination between 13 other IDA funded health projects with RCH-I. This also missed on the opportunity of optimum use of project resources. Hence multiplicity of externally assisted projects and difference in their own procedures, priorities and reporting formats created problems.

The report mentions that GOI took external assistance from WB in order to seek help for it to implement the policial change, operationalize newer initiatives like Emergency and Essential Obstetrics care (EmObc), RTI/STD clinic etc but the project diverted towards funding more of Polio Immunization initiatives thus giving poor results in its core/planned areas. It also mention about the poor operationalization of urban and tribal components of RCH projects. Finally it was

found that the states had weak governance and lack of public health orientation in their health service system which was also a big reason for poor project results.

Lessons learnt from RCH-I

Thus as the National RCH program was to be scaled from first to its second phase, there were many lessons learnt from RCH-I, both for the planners and implementers of the program. The broad lessons learnt included long term planning, increased state ownership, clarity in concepts and components in the new program phase, better performance monitoring mechanisms, capacity building of states and districts in project planning, utilizing and managing funds, procurement, management, data collection, monitoring and evaluation (M & E), a comprehensive human resource policy, clear policy on NGO, civil society and other private party participation, inter-sectoral convergence and coordination, etc. Also decentralization of roles like planning, implementation, supervision, information, M & E through Health Management Information System (HMIS), financing, training, IEC, etc. is suggested as measures which would increase state ownership, partnership and accountability in all participating partners in the program.

Hence looking at the problems confronted in the application of new RCH approach, **GOI in its submitted project appraisal report, admits to the need of larger sector wide approaches to lead to reforms in the system.** Thus the RCH program has contributed to the voice of those demanding sector wide reform programs by providing a closer look to the issues like social marketing, franchising, use of consultants, role of NGOs, HR policy, privatization in health sector etc.[21]

Thus some of the changes brought forth after these debates are like revised NGO-role policy (2003), which allows NGOs to participate in service delivery and increases opportunities of their greater interface with the state governments. Others like new "National IEC/BCC Strategy" and "Tribal health strategy/Tribal Development Plans" are some of the achievements towards larger sectoral reforms. Even the integration of RCH goals into Millennium Development Goals (MDG), National Population Policy-2000 (NPP), National Health Policy-2002 (NHP) and National Rural Health Mission (NRHM) hint at some integration between sectoral concepts through sector wide approach.[22]

National Reproductive and Child Health Program (NRCH)
Phase-II with RCH-II Project

The National RCH Program-Phase II is envisaged as a program and not a project. Only for the purpose of convenience, the program period of five years would be considered as project.[23] The program with a long-term vision in its second phase, aims to provide holistic reproductive healthcare, which is client centric and demand driven through primary healthcare system. It aims to develop into an integrated and participatory program to reduce regional variations in RCH. The basic program principles are that the health outcomes is a shared responsibility of state and communities (Decentralization), public private partnership wherever required, equity and gender sensitivity, security of reproductive rights, inter-sectoral linkages wherever needed, priority to vulnerable sections, voluntary and informed consent in case of FP services etc.[24]

The program aims to minimizing regional variations in the area of RCH and population stabilization by meeting the unmet needs of target population through the provision of assured, equitable, responsive quality services. The broad policial strategies adopted by the program emphasize on client centric, demand driven, evidence based, integrated, participatory primary healthcare program model. Inter-sectoral convergence and coordination and integration between and within sectors at various levels and partners is what the program broadly envisages.[25]

The specific objectives of the program are to increase Couple Protection Rate (CPR), Antenatal and immunization coverage, institutional deliveries and thus reduce the rates of Infant Mortality (IMR), Maternal Mortality (MMR), Total Fertility (TFR) and Population Growth (PGR). In terms of services, the program aims to expand the essential RCH services to all cities, towns, rural and tribal areas but with the preference to most vulnerable first. The program also aims at developing human resource personnel through training and enhancement of skills, strengthen institutions, improve management performance, state ownership, procurement, financial and other resource management, service delivery and monitoring.

At the level of broader sectoral policies, the program has brought forth and incorporated the issues like inter-sectoral convergence at various levels, integration of RCH program with National AIDS Control Program (NACP) and Integrated Child Development Scheme, introduction of Public Health as a specialization in medical education, review of the human resource policy, allowing eligible private players in service provisioning like running PHCs, involving voluntary level societies for brining funds into the sector, including gender, adolescent health, tribal and urban health as important components of this sector program.[26]

Some newer strategies put into place in RCH-II program were decentralized program planning based on need analysis of districts and states, Program plans to be prepared by states as under State Program Implementation Plan (SPIP), special attention to states weaker in terms of socio-economic parameters, capacity building in program management, newer monitoring systems to be introduced, new HR policy, new personnel on contractual basis in program finance and management, new decentralized BCC strategy, strategies to review and improve the quality and responsiveness of PH system, re-looking at private party protocol, exploring interrelationships between sectors etc.[27]

The program also differs from its earlier counterparts as the major funding DPs had agreed on common indicators and monitoring system for assessing program outcome. The program is decided to be evaluated on the basis of indicators like % of eligible couples using contraceptive methods (permanent/temporary), % of deliveries conducted by skilled worker, % of children between 12-23 months fully immunized, % of mothers receiving antenatal care as prescribed and the polio free status of India.[28]

MOHFW document on RCH-II-National Program Implementation Plan clearly mentions that RCH-II has adopted a program approach with bringing in key elements of sector management and sector reforms in order to strengthen the system.[29]

On the financing front, the entire program budget is divided into two sections. Section A includes activities financed by domestic budget support whereas Section

B is partially funded by external donors. As per the Ministry document, the entire program cost from 2005-10 is estimated to be Rs. 40,000 crores of which Section A accounts for approximately Rs. 19,774 crores whereas Section B costs around Rs. 20,226 crores.[30] Of the total program budget, approximately 80% is funded by GOI and the remaining 20% by other external DPs. This 20% external funding can also be differentiated in many ways as of this amount 46% comes as pooled fund by WB and DFID for RCH-II project activities, 31% is exclusively extended by other DPs for Polio eradication activities under RCH project and the remaining 23% is the fund extended by these DPs for state specific projects.

Also it is noteworthy that section B of the program budget includes the activities run under RCH-II project which has the financial support through pooled arrangement between external funders like WB and DFID with GOI. WB and DFID have extended their funds through their "Sector Investment and Maintenance Loan" policy. Apart from this, the project would also be supported by other bilaterally funded projects by other DPs like JICA, WHO, UNAIDS, UNFPA, and GTZ and KFW. This RCH-II Project totals approximately Rs. 10,045 crores of which 47% is by GOI, 35% by WB/DFID, 15% by other DPs exclusively for Polio eradication and the remaining by WB for procurement and polio eradication related activities.[31] The project appraisal document by WB mentions that its new approach to development assistance is essentially sector-wide and hence the RCH-II project components should be actually considered as larger program components.[32]

In terms of the institutional arrangements for the program, the program is said to be integrated with National Rural Health Mission (NRHM) which is a broad health sector program. RCH-II program runs under the supervision of the head of Empowered Program Committee i.e Secretary, Health and Family Welfare. The subordinate committee i.e National Program Coordination and Management Committee assists the other committee in coordination and management functions. Further down, there are various departments to look into the functions of policy on donor coordination, BCC, human resource management and governance issues, immunization, procurement, technical assistance (in child, maternal and reproductive health), training, financing, monitoring and evaluation etc.[33]

To look into the financial matters, the program has established Financial Management Groups (FMG), for management function-Project Management Groups (PMG) and for procurement function-Empowered Procurement Wing (EPW) has been established. For all types of technical support to the program at all levels, it proposes to establish a National Health Systems' Resource Center (NHSRC) at the central level. For effective management of procurement issues, the program has come up with a Governance and Accountability Action Plan (GAAP). Also, in order to introduce state ownership in program planning, the program has started with State Program Implementation Plan (SPIP). In this SPIP model, the center would consider some flexible funds under its overall program budget which would be disbursed to states based on their commitments made in SPIP to the center. Here the states would have the complete authority to utilize the fund according to their proposed SPIP. With this, the program has also come up with Infection Management and Environment Plan (IMEP) which sets the protocol for all programs to integrate strategies for safeguarding environment in their program plan.[34]

At the service end, the program has planned states and districts to offer services like ante-natal care, routine and Polio immunization, Vitamin A distribution, basic curative care, family planning services, social marketing of contraceptives, routine deliveries, operate Maternity Benefit Scheme, *Janani Suraksha Yojana*, urban family welfare services; services for adolescent health, vulnerable group health plan (VGHP), training, Behavior Change Communications (BCC), and support ongoing RCH related projects by other DPs.[35] Others than these, the program also plans to look at tasks of infrastructure and maintenance, supply of drugs and equipments, strengthening healthcare providers, targeting of services and strengthening service delivery.

The National RCH Program management function is highly decentralized between a team at the center including secretary of DOFW, joint secretary who would be the program director and a team of consultants. At the state level the program would be managed by State FW Bureau and at district level by the Chief Medical Officer and the District Medical Officer with the RCH officer. These state and district FW societies would be assisted by Program Management Units. These State and District

Societies/Bureaus would provide technical assistance (TA) for their respective levels. At the central level NHSRC would help in guidance and policy propositions like contracting out services, selecting teams for contracting, drug procurement, HR policy etc.[36]

For program Monitoring and Evaluation (M&E), triangulation between centrally supported Health Management Information System (HMIS), data from Panchayati Raj Institutions (PRI) and non-government organizations (NGOs), District Health Surveys by organizations like Indian Institute of Population Studies (IIPS), National Institute of Health and Family Welfare (NIHFW), and other quality studies by Indian Institute of Management (IIM) would be done. The periodicity of data would differ from monthly to quarterly, annual and final program reviews. The program would have a mid-term review in the year 2007-2008. The program performance indications are classified as process and outcome indicators which are commonly agreed upon by all participating DPs.[37]

RCH-II project, which is a part of national plan, has a major emphasis on EAG states like Orissa, Bihar, Rajasthan, Madhya Pradesh (MP), Uttar Pradesh (UP), three other newly formed states namely Uttaranchal, Chattisgarh, Jharkhand, and seven other north-eastern states. Also the new project plan maintains that the performance monitoring criteria for the EAG states would be different and more reasonable than other prosperous states this time. Hence in line with the broader program, RCH-II project aims at three components namely improvement in essential reproductive and child health services, technical assistance, monitoring and evaluation and polio eradication.[38]

Thus analyzing both phases of National RCH Program shows that there are many changes incorporated in the second phase and were missing in the first phase. Starting from the policy, RCH-I had a common policy of operation for all states whereas RCH-II has come up with a differential approach for different categories of states considering their socio-economic status and program implementation capacity. RCH-II in comparison to RCH-I has also taken into consideration the participation of states and districts in program planning by introducing SPIP thus has introduced decentralization in planning exercise. RCH-II program plan reflects

a model of management as it has taken into consideration all aspects like planning, organization, financing, procurement, personnel, training and capacity building, monitoring and evaluation, reporting, governance and accountability, transparency and finally overall program management. With respect to the flaws in RCH-I, RCH-II has put improved mechanisms for financial management into place with FMG and induction of qualified financial experts at all level, regular audits and accounting reports etc.[39]

Also to bring into Public Health approach (PH) into the entire system, RCH-II has started with service quantity and quality reviews and responsiveness, community demand and need assessment, introduction of PH as a specialization in medical education and introduction of public health managers at all levels of program. RCH-II has also come up with a national policy on BCC which is decentralized in a way to let the states decide their own objectives and design IEC to lead to BCC in the expected direction. It has planned to take into account the client's and providers' perspective on quality, access, responsiveness and other parameters. The introduction of Right to Information Act is another step into this direction. For RCH-II, inter-sectoral coordination, program and donor convergence, participation of all stakeholders are some key areas of work.[40]

Discussion

Analyzing the National RCH Program, it is evident that though reproductive health is an integral component of the overall health of an individual or community, the consideration of RCH as a separate sector by MOHFW, GOI and running a separate program under a separate department than DOH is something that is noteworthy. Despite the fact that the overall health outcomes of a community are a result of multiple factors than just clinical, the second phase of RCH program also misses on any mention of long-term strategies for larger socio-economic upliftment of affected population through health. Also with abortions being legal in India, the problems confronted by the mal-practices or misuse of prenatal diagnostic techniques like large number of female feticides are given no space in the program.

It is equally important to mention here that just putting together all programs under NRHM does not mean that they are integrated and holistic in terms of addressing

overall Health. The integration between programs at all level including policy and planning needs to be addressed more seriously. On the gender sensitization issue, as on one side the National RCH Program talks about gender equity and sensitization, its service basket shows the presence and concentration of services which are highly women centric.

Looking at the complexities in the country and within the states, RCH-I project should have started, as a project in weaker states with greater MCH needs first and if successful, should have been extended to the other states. Rather the project has gone the other way from nationwide application to state specific application. Also though the program strategy clearly mentions about its intent for inter-sectoral and inter-departmental convergence but its plans for ensuring donor-convergence and convergence of those projects which are similar in nature are not evident anywhere.

As evident from the large number of donors available for funding RCH program, the funds provided by these external agencies are very selective but the causal factors for the poor reproductive health of a population are not that precise and specific. The system through which this program operates also has its own persistent problems which affect the program functioning like lack of HR policy, lack of coordination between health policy directions and simultaneous preparation by other departments like education, employment to help realize the policy effectively, government's stand on role, effectiveness and regulation of private players in welfare sectors like health and education, the problem of evolving a sustainable financial model etc. These issues cut across all projects and programs thus prohibiting them from realizing their potential or results effectively. Unless equitable funds and attention (inclusive of funds through donor assistance) is not provided to these issues, fund flow only in programs like RCH and HIV/AIDS would not be able to give desired results.

Today privatization in health sector is an important area of debate. With studies like "Privatization in Health services: A South Asian Perspective" by Rama Baru and "Public-Private partnership in Indian Health sector" by Ramesh Bhatt showing the market failures of private parties in health sector in achieving quality, equity and effective coverage of the population, a deeper look at the involvement or promotion

of private sector in RCH-II programs and rather whole sector is needed.[41,42] It is also a matter of debate that in the absence of any regulatory mechanism, the private sector is promoted to exploit the vulnerable further under both RCH-I and RCH-II national programs.

On the issue of financial reforms, the WB proposed solutions of introducing user fee could not offer desired results and gain any public support due to many shortcomings and limitations in the very idea. Private and Community Health Insurance[vi] is a new concept in India which has a large market but currently captures <10% of Indian population (including public sector health insurance).[43] Looking at the funding patterns of the RCH program and project, the National RCH program has approximately 20% overall foreign funding in the forms of loans whereas the RCH-II project has more than 50% funding from external DPs as loans/credits. Of this, looking at the expenditure patterns in RCH-I program, more than 60% of the program funds go in recurrent expenditures like drugs, consultancies and staff salaries.[44] Hence with the issue of financial sustainability of such highly credited projects like RCH, the country needs to look at the financial management policy for the sector and not just the RCH program more seriously. The structures like SCOVA are just a program level initiative to ease and fasten the financial flow between levels and are hence successful in just bringing down the cost of transaction to a limit. But the need is for larger systemic reforms for long term financial sustainability of the sector initiatives.

Similarly, as the system proposes to add consultants at higher end for various tasks, it is just a by-pass created to achieve the short term project goals though larger issues like reasons for the lack of staff in the rural areas, reasons for higher employee turnover rate, need of more general than specialist doctors, need for more upgraded medical and paramedical educational and training institutions etc are some concerns which need systemic reforms with an effective and comprehensive

[vi] Health insurance in a narrow sense would be 'an individual or group purchasing health care coverage in advance by paying a fee called premium.' In its broader sense, it would be any arrangement that helps to defer, delay, reduce or altogether avoid payment for health care incurred by individuals and households (Ref. Health Insurance in India: Current Scenario).

HRD policy which would not only serve RCH program objectives but would provide solutions to the persistent human resource problem in all health sector initiatives.

As the WB project documents mention that it has followed sector wide approach in forwarding the funds into the new RCH program, one thing that is clear from both, MOHFW and WB, documents is that both consider RCH as a separate sector than a sub-sector in broader health sector. The other important thing to note is that within the "RCH Sector", the pooled funds by WB are highly earmarked in areas like section B of the National RCH program budget, Polio eradication, procurement activities etc. In contrast, the SWAp ideology promotes all international development assistance to be pooled in and accounted for in the larger sectoral government budget and these recipient governments should be entrusted to allot and disburse the fund as per the sub-sector's need based on their pre-agreed program plans with the DPs.

The role of donors in priority setting, program management and administration in the new RCH initiative could be seen from the list of DPs flooding funds in polio eradication activities (EU, DFID, DANIDA, CIDA, German and Italy govt, JICA, Rotary International, WHO, WB, UNICEF, USAIDS), numerous DPs like USAIDS, UNFPA, WHO, DFID, EU extending funds for recruitment, training, technical assistance of program personnel, funders like DFID, WB, EC proposing to bear the cost of PMU including the salaries of their staffs etc.[45] These examples also show how the group of funding agencies set the program priorities and their areas of investment at the name of being sector wide in approach. Though the idea behind SWAp is to reduce this external interference and enhance States' own capability and leadership to run its programs, such practices would never let SWAp be a success.

Finally the detailed analysis of the activities under DOFW shows that there are also many area specific projects run by agencies like EC, USAID and UNFPA. These projects also have activities which are aligned with the functions as under the broader RCH program. On these, the Project Appraisal Document released by WB says that such individual projects would continue to run the same way and the

document does not mention of any strategies or future efforts to coordinate these under the broader RCH program by building synergies with their respective funders to help in program integration. This is despite the fact that the broad RCH program policy talks of evolving a single comprehensive integrated sector wide program. Also, another fact that is important to mention here is that though the budgets of all these area specific projects are included in the overall National RCH program budget estimates, but they still run independent of the broad program model. All such issues of identifying and analyzing the areas based on which the DPs and GOI claim to have evolved the new National RCH Program with a sector wide approach, would be discussed in detail in the next chapter.

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CHAPTER 4

Identifying and Assessing SWAp in Indian RCH Program

From a systems perspective, the development goals of a country are dependent on the performance of many other subsystems/sectors like Industry/Agriculture, Health, Transport, Power, Water and Sanitation, Banking etc. The performance of each of these sub-systems affects the larger system as well as determines the functioning and results of the other interdependent subsystems too. Focusing on Health Sector, its interdependence with other sectors like transport, food security, water and sanitation, power etc are well established through many researches, which have emphasized on comprehensive integrated systems development of Health than a sector specific approach.[1] This was the view as proposed in Alma Ata conference (1978).

The other perspective i.e Sector Wide Approach emphasizes more on the sectoral development, which means more of in-ward than outward looking approach. The approach though also recognizes the interdependency of a sector with the outer world and hence also proposes its convergence with others wherever required. Leading from the definition of a "Sector" as mentioned in Chapter-2 of this dissertation, the health sector in India, which is led by MOHFW at the central level, is categorized in three broad departments i.e. Department of Health (DOH), Department of Family Welfare (DOFW) and Department of AYUSH (Ayurveda, Unani, Sidh and Homeopathy).[2] This classification of similar activities under a concerned department/sub-sector is done to facilitate the operation, functioning and management of similar activities under a broad umbrella.

In terms of areas of work, the health sector deals with the variety of problems like vector-born diseases, communicable and non communicable diseases, life style disorders, reproductive health disorders etc. To deal with these problems through its vast infrastructure, GOI has started various national level programs for National Malaria Control Program (Malaria), Revised National Tuberculosis Control

Program (TB), National AIDS Control Program (HIV/AIDS), National Vector-born Diseases Control Program (NVBDCP), Reproductive and Child health Program (RCH) etc.

Other than these centrally funded national programs, there are vast majority of local area and sector/sub-sector/activities or specific projects run by private for-profit and not-for-profit (National and International) organizations. These may include corporate, donor agencies, other country governments, NGO/CBOs and other community initiatives. Different state and district governments also run different sector specific program for its population. The magnitude of these projects depends on many factors like the availability of funds, manpower, management capacity, community acceptance, goal of the funding and implementing agency etc. But across the health sector, there had always been issues of lack of coordination and disjunction between various government run programs, donor funded projects, community and NGO initiatives. Hence the results seen are no concrete outcome in response to the huge amount of funds, efforts and manpower spent since years.

Now with the evidence of range of players/contributors participating in the development of health sector, the query remains whether they can work in coordination, follow the same policy, share the same goal, towards sustainable efforts; towards whole sectors' improvement etc. These are some of the areas SWAp has tried to take into consideration. This chapter would try to identify SWAp principles and objectives in the Indian RCH program and analyze the way they have been put into place.

In Chapter-2, SWAp has been described as an approach where all partners/stakeholders/contributors in a sector seek to work together towards the same goal, following the same sectoral policy and with a common budgetary/expenditure plan. With India being a vast country having a population of more than a billion, which is $1/6^{th}$ share of the total world's population,[3] its comparison with any other country adopting SWAP like Bangladesh, Uganda, Ghana etc would not be logical. For the countries with larger population size, the ideology of SWAP recommends that they may start towards SWAP from sub-sectors of a wider sector but in direction to contribute to the larger sectoral policy.

Hence in case of India, DOFW is a sub-sector and RCH program is said to be the broad umbrella program of this sub-sector running across nation dealing with all issues of Maternal, infant, child, adolescent and family reproductive healthcare. Also by IAG definition, SWAp is a mechanism of coordinating support in a public expenditure program and for improving the efficiency and effectiveness with which the resources are utilized in the sector (Sub-sector in case of Indian RCH). Thus according to IHSD 2001 handbook on stages of SWAP, India is in an early stage of SWAp by starting from FW sub-sector.[4]

Hence it becomes essential to explore what SWAP means to Indian RCH sub-sector when the participating donor agencies claim to have adopted this approach in this sub-sector wide program. Also MOHFW document on RCH II-National Program Implementation plan, which clearly mentions to have included the key elements of sector wide management (structures and process) within its design to maximize program success and sectoral reforms.[5]

While the study of the RCH program, there are some interesting indications explored which show some transition/movement from Project to Program to Sector and now towards Inter-sectoral arrangements. In this direction, Chapter 3, which studies the shifts in the formation, change of ideologies, merger of other smaller programs into broad RCH program also indicate a move towards sectoral consolidation.

After studying SWAp approach in chapter 2 and RCH program in chapter 3, it is been understood that the FW sub-sector, as analyzed from 1997 from the time of introduction of RCH program into it, shows some acceptance and integration of broad principles of SWAP in it. The most important amongst these is the coming together of prime donors to collectively fund the national program than their own individual projects. Starting with identification of the broad characteristics of SWAP in Indian RCH Program, the chapter would further lead to commenting on some of the critical issues in this approach and its application, especially in Indian context. All this would be dealt with in the next chapter. It is important to mention that the analysis and details mentioned in this chapter are broadly based on

"RCH Phase II-National Program Implementation Plan" published by MOHFW in 2005 and **"RCH II-Project Appraisal Document"** by WB in 2006.

To identify and discuss SWAp in RCH program, a checklist of essential queries, which include concept, principles, objective, process etc of SWAp is already mentioned in chapter 2. Hence this chapter would analyze Indian RCH program in order to answer all the related queries raised and mentioned in chapter 2 which are related to the presence of SWAp in any program or sector.

The further chapter would analyze whether RCH program in aliened with the larger Health **Sector Policy** and follows the **Common Sectoral Approaches**. It would look for various SWAp criteria and conditions in RCH **Program Policy and Planning**. It would also try to identify for factors which promote **Government Leadership and Ownership** in the program. In terms of **Partnership/Joint Efforts in RCH Program**, it would analyze whether the partners have **Common Goals**, have agreed to a **Common Expenditure Plan** and follow **Common Procedures**. As SWAp promoters mention about some of the benefits like **Increased Predictability of Funds, Reduced Cost, Improvement in Aid-management and Resource Allocation, Transparency, Accountability and Sustainability,** of adopting SWAp in any program or sector, this chapter would also try to identify for such efforts in RCH program.

COMPONENTS OF SWAP IN RCH PROGRAM

RCH Program aligned with the Sector Policy

Both the Program and Project documents mention that the new RCH program is planned with an overarching goal of achieving India's' **Millennium Development Goals (MDG)** of improved and better health for all.[6] As it aims to reduce IMR, CMR, MMR, TFR and increase contraceptive prevalence and couple protection rates that are also the goals of **National Health Policy (2002) and National Population Policy (2000)**, it can be said that the program is in line with the larger national development and sectoral policy.[7] Also, the RCH-II-NPIP includes many other concerns and approaches of NPP like population stabilization to sustainable

levels, extension and integrated delivery of RCH services, target free, voluntary and with informed consent FP, cater to unmet need of contraception etc.

Due to the long standing problems of poor effectiveness of individual projects, larger and newer challenges like HIV/AIDS adding up problems, countries undergoing sectoral reforms with larger economic restructuring, need for more funds in the development sector, all these situations led to the need of approaches like SWAp. Looking at last decade story of India, the increase in public sector and donors budget in FW in **9th and 10th plan** and now with GOI further planning to increase its total health sector budget from 0.9-2% in the **11th plan** (2008-13) under its **Common Minimum Program**, it was of interest for the macroeconomists to think of strategies for better integration and coordination of this increased budget to lead to reasonable and measurable improvement in FW indicators and thus health sector on the whole.[8]

Program Policy and Planning

National RCH program is the result of India's participation in International Conference on Population and Development (ICPD) held in Cairo in 1994. The conference threw light on the limitations of the then followed approach and programs by many countries and proposed to broaden it by introducing reproductive and child health concept.

With India signing to adopt this approach to broaden its target bound FW program, WB, **in 1995 conducted a review study of Indian Family welfare program** and presented its report to MOHFW.[9] Based on this review, **GOI with support from WB launched the National Reproductive and Child Health Program** in 1997. A broad change that was brought forth in this new program than its earlier counterpart was the abolition of method specific targets and a shift in ideology from population control to adoption of reproductive healthcare approach.

This new initiative was called as a "Program" as it aimed to be long term, tried to bring together all activities of DOFW under one umbrella, tried to integrate all development funds coming in this sub-sector into one program through pooling and

tried to involve all development partners to work together towards the common goal. For the purpose of efficient management, implementation and monitoring, it was decided to run the program in phases with first phase between 1997-2002 which also included RCH I project (pooled funding from GOI & WB) and the second phase operating between 2005-2010 including RCH II project (With pooled funding from GOI, WB, DFID, UNFPA).

Before starting to identify SWAp elements in RCH program, it is important to mention that this Program has a single expenditure or budget plan, which is divided into Section-A, and Section-B. Based on the broad program plan, the participating DPs had selected activities which they wanted to fund. Many of these activities, which fall in section-B of the broader RCH program budget plan, are thus co-funded by GOI, WB and DFID. Hence one thing that is evident is that the external support provided to National RCH program is not in the form of "Budget Support"[i] or "Sector Support". Rather it is a kind of "Earmarked Funding" which is based on the choice of external funders depending on their preferences. The rest of the proportion of funding in the broader program is solely done by GOI.

In Program planning, the sectoral analysis and pre-program studies for RCH program-first phase were done by WB and RCH program-second phase (especially RCH II project) were done by WB and DFID with other DPs like UNFPA, EU, USAID etc. Both the RCH projects were prepared by WB and DFID though GOI is also a 48% funding partner in it.[10] In a short focused discussion with the deputy director, RCH II, MOHFW, it was told that it is MOHFW which has prepared the National RCH Program Implementation Plan based on which the other pooling partners like WB and DFID have drown their own project plan documents. Hence one thing that is clear from this kind of planning exercise is that GOI has taken a lead to decide upon the broader sectoral policy and program and has accepted the proposition of external pooling partners to support the broader national program

[i] Budget support: Support to national budget through the ministry of finance and using government systems. This can be general budget support, where funds are not earmarked, or sector budget support, where funds are earmarked for a specific sector. (Ref: WHO SWAp guidelines)

through the projects integrated within the larger program than running separately with a separate machinery, policy and goals. This type of planning and financing falls between project-type aid and earmarked funding as explained in chapter 2 on SWAP.

Also the review of RCH program-first phase in 2002-2004 was conducted by GOI and WB. Based on the program assessment report, the second phase of RCH is planned.[11] Hence this shows **participatory pre-program review** and planning to some extent. But In actual terms, how participatory the process and planning was for GOI and what is the impact of this kind of an arrangement, would be discussed in the next chapter.

RCH Program with the broad Sectoral Approaches

On exploring whether RCH program follows the approaches which are consistent across the sector, it is found that the program is following GOI policy of centrally sponsored **target free approach** for FP in response to GOI's ICPD commitment. Also, GOI 9th and 10th Plan talk of moving away from **multiple vertical programs** and promote **Integrated Healthcare Approach.** In response, RCH program has planned to integrate and merge all FW activities and separate projects running under DOFW under one umbrella program i.e RCH. With the recent five year plans focusing on shift from **centralized to decentralized planning,** RCH program has already initiated it by introducing SPIP and DPIP provision to facilitate states' and districts' participation in program planning. These plans would be based on Community Need Assessment (CNA) surveys at household level thus also involving community's response in program planning.

After the health sector reforms, the participation of private sector (for-profit/not-for profit, domestic/international) in health, and the surge in evidences and publications highlighting the market failures in this sector, **Pubic-Private Partnership (PPP)** has become a buzzword across the sector. As the other health sector programs, RCH program has also integrated this into its framework by defining the type of partners, areas where they can participate, nature and type of partnership models, regulation through policy on accreditation both for public as well as private players

and establishing a broader policy on PPP which would deal with issues of PPP across health sector under all programs.

Procurement of goods, work and services is another area, which had been of concern across the health sector. The issues like quantity, quality, who to select for services/goods and on what basis, how to reduce transaction and storage costs, how to ensure better management, governance and accountability leading to ZERO corruption in this function as this activity absorbs more than 60% of the entire sector expenditure, were some of the concerns due to which an **Empowered Procurement Wing (EPW)** under MOHFW is formed. To help fight ill management and corruption issue, **Governance and Accountability Plan (GAAP)** is also formed to help this wing function better. Also, the inclusion and functioning of **Right to Information Bill** (2005) passed by GOI is an added weapon to promote transparency and fight corruption. This EPW wing will now look at the procurement related activities of all health sector programs. This can also be seen as a strategy by GOI to integrate common functions of different centrally sponsored health sector programs under one broad functional entity. *In the same direction, the WB document on RCH Project mentions that as the RCH program has introduced center to extend flexible funding to various states to perform innovative and client responsive activities under SPIP initiative, such an effort would also be extended to the other centrally sponsored health sector programs in the near future.*[12] Hence with this, SPIP would also be a sector-wide strategy.

As procurement, training of different cadre of personnel in health sector is also a common area, which cuts across all programs. Hence to deal with the common issues in training across programs, a **National Training Strategy** is formed. RCH Program and all the other national programs would have to also follow this strategy to update the clinical, managerial and communication skills of its personnel.[13]

Since the last few decades, the need for **intra and inter-sectoral convergence** was very much talked about in all programs and related sector forums. The 10th five-year plan also emphasized this convergence of various health sector programs within and also with the larger system components like water, sanitation, nutrition, food security etc which affect the functioning and results of these programs. The

RCH program also proposes to look forward to inter-sectoral joint program efforts with common objectives. The program talks about the initiatives like establishing **Convergence Policy and Working Group**, to look into all necessary areas of convergence within and outside health sector. This Convergence working group, along with GOI, will also be assisted by WHO/WB/DFID.

The RCH program has analyzed those areas which are directly and indirectly linked with its functioning and results and hence has proposed its convergence with departments like Health, Indian System of Medicine, Women and Child Development (DWCD), Human Resource Development (HRD), Education, Rural Development, Urban Development, Labor, Railways, Industry and Agriculture. The program goes in line with the 10^{th} plan initiative for convergence to add RCH messages in BCC by all these departments, efforts of increasing women literacy, employment, nutritional status, rising age of marriage etc. The program seeks to bring coordination between Auxiliary Nursing Midwife (ANM), School teachers, Anganwadi Worker (AWW), Mahila Swasthya Sangthan, Krishi Vigyana Kendra Volunteers etc.

The RCH program has also come up with a Joint Consultative Working Group between NACP and RCH Program to look into the convergence of common activities STI/RTI & HIV/AIDS. Hence the areas of convergence identified between **NACP and RCH Program** are RTI/STI, Voluntary Counseling and Testing Center (VCTC), PPTCT, BCC, Training, Condom promotion (Joint procurement of condoms by NACP and DOFW), blood safety and reporting.

Other than NACP, RCH II-NPIP document also examines the areas of duplication between **DOFW and DWCD** functions. Hence it proposes a detailed plan to converge those activities, which are common to both the departments and also the added activities, which can be performed in coordination with personnel of both the departments e.g AWW & ANM.

The convergence of **RCH program** into **National Rural Health Mission (NRHM),** which is a comprehensive health sector program and includes all the other centrally funded national programs, is an indication of Indian Health Sector

moving towards sectoral consolidation. Hence looking at the links i.e "RCH project under RCH program" and "RCH program under NRHM", an effort to shift from project to program and further to larger sector wide approach can be clearly seen. But to what extent this shift is holistic is yet to be discussed.

RCH program also brings forth the issue of **Donor Convergence.** This is introduced with a consensus that such a convergence is necessary to lead to some concrete and sustainable sectoral performance than the individual donors working with project-based ideology, funding separate, area specific, time bound, non-sustainable and non-replicable projects which produce limited results. Donor convergence actually means that all donors must come together in support of the sectoral policy to help the government achieve its objectives. In RCH program, along with GOI, three other major donor agencies namely World Bank, DFID and UNFPA have committed to contribute funds by putting their shares into a common pool. With this, the other external agencies have agreed to follow and support the governments' broad RCH Program Policy but have also expressed that they would continue to extend support to their area specific projects and also into activities like training, technical assistance, IEC/BCC, etc up till their present project cycle expires. Also many global funding agencies like WB, DFID, UNICEF, UNDP, USAID, UNFPA, DANIDA, CIDA, EC etc have come forward to in support of SWAp and all of them are partners in the current RCH program of GOI. *Under this Program, GOI has asked all development partners, whether pooling or not pooling, to execute an MOU to cover technical, financial, operational and reporting cooperation, whichever is applicable, in support of the broader program.*[14]

The issue of **Gender Equality and Equity** in terms of access to quality healthcare services to all irrespective of their socio-economic status is also taken into consideration in this program. The program includes a strategy of guiding all states to form a **Vulnerable Group Action Plan (VGAP),** especially for the marginalized castes and classes, in their SPIP. Also the special emphasis of the program on **Empowered Action Group States (EAG)** and northeastern states helps the program to include the issue of geographic inequity in service distribution. There is also an **Empowered Action Group under MOHFW,** which would **look after**

equity in health outcomes both in broad health sector and family welfare sub-sector.

Partnership/Joint Efforts in RCH Program

SWAp involves partnership/joint efforts between various stakeholders in achieving the sectoral goal. This partnership, varying with the relationship between governments and other partners and also based on the governments' broader policy on partnership, may occur in planning, management, implementation, financing, procurement, monitoring & evaluation, reporting etc. stages of a sector wide program.

In RCH Program, **Planning and pre-planning** both clearly show the role of donor agencies like WB and DFID along with GOI. With this, the DPs have also been mentioned to play a proactive role in policy and implementation bottlenecks in program with the government.[15] Whether it is a threat or a blessing and whether it is partnership or external interference would be known only through in-depth analysis of this issue in the next chapter. RCH program claims to have evolved through extensive consultation of GOI, DPs, NGOs, civil society etc. The program policy also talks of Public-private partnership, which it says is necessary to lead to the desired goals. In the program GOI has the function of making policy, planning its execution, service delivery, regulation of quality of services offered to people, accreditation etc. and various for-profit and not-for profit private organizations are promoted to take on varied activities like service delivery, advocacy and awareness generation, training and capacity building, construction and maintenance etc. Under PPP, the states governments, as per the needs of their SPIPs and VGHP are asked to contract out or contract-in services like BCC, Social Mobilization, service delivery & management of health services, social marketing and franchising etc to private sector.[16]

On **Program Financing**, out of the total program cost approximately 80% is born by GOI, 11% by other DPs supported projects and 9% by the pooling partners like WB and DFID. All these pooling DPs have extended this fund under their sector investment and maintenance loan policy to GOI. In the RCH project, which is the part of broader program, out of the total cost of Rs. 10,045 crores, GOI contributes

48%, WB/DFID/UNFPA contribute 35% through pooling arrangement, other DPs for Polio eradication contributes 15% & WB, specifically for Polio eradication and procurement activities extends 2% . This earmarking of funds by the DPs in the areas of their choice on the name of pooling is a matter of debate which would be dealt with in the next chapter. Such a partial and selective choice of funding puts a question mark on whether are the countries are really going sector wide when the partners still hold to their choices and priorities.

GOI claims to have brought many independent DPs under the broader program framework and aims to lead to better coordination between and with them in program management. In this regard, an MOU for cooperation under program approach between MOHFW and DPs is already been signed which is a basic agreement between WB, other DPs, GOI and specific states on basic characteristics, cost, financial plan, common monitoring and reporting mechanisms that would be undertaken in the program.[17]

The program financing and its operation would be looked after by MOHFW through Financial Management Group. FMG would have the responsibility of ensuring all financial and accounts related details on the program. It would ensure that the states employ staff and individual consultants to help their FMG function properly. For audits, an internal as well as external auditor would be put in place. The financial audits of state societies would be done by private Charted Accountant group (CA) with one CA from each state whereas the audit of DOHFW would be undertaken by DG-AGCR based on the terms of reference prepared by IDA.[18]

In **Program Planning**, under the decentralized program planning policy of GOI, the guidelines for the appraisal of SPIP are written collectively by GOI and the pooling partners. MOHFW has also developed Integrated Management of Neonatal and Childhood Illnesses (IMNCI) with **technical assistance** from WHO and UNICEF. Now IMNCI is to be implemented by all states under their RCH program.[19] Similarly, the IMEP is claimed to be developed in consultation with all participating stakeholders under the leadership of GOI. Also, the NHSRC which is established by MOHFW as a think tank for all kind of technical assistance to states, its interim support for advertising, recruiting and training for TA to MOHFW and

states is currently done by participating DPs. A collective advisory committee with MOHFW and DPs is in place to decide upon TA contracts and rules of business for NHSRC.

On **training component**, a core national training strategy is designed by DOFW and different central and state level institutions including experienced NGO are invited to conduct trainings based on this strategy. In RCH-I, the training modules were developed by the center involving other state institutions but in RCH-II, the center will only design the broad training module and let the individual states design their own specific modules as per their need assessment. For financial management and procurement, the training to states would be provided by NIHFW and SIHFW.[20] The program also leaves the space for DPs in order to participate in designing training modules and suggest on strategy, if interested. Thus this is how partnership and decentralization of training activity is established in this program.

On **Procurement,** the entire responsibility of procuring pharmaceuticals, drugs, equipments, and services is of MOHFW. To help manage this, MOHFW has established EPW. Along with GOI, WB is also funding food and drugs capacity building projects to strengthen regulatory framework for pharma sector. WB has also committed to provide consultant support to compare Good Manufacturing Practice Certification process (GMP) of GOI with that of WHO to help evolve a better process. For any procurement of goods, this certification is made mandatory by GOI and it is issued after inspection by a collective body consisting of center, state and independent experts. DFID has also proposed to provide TA to EPW through international procurement consultants who would work with local consultants to help build their capacity in procurement. All the DPs with GOI would also participate in regular procurement reviews. On procurement, the program document mentions an amount below which all the National Contract biddings would be taken care of by MOHFW. Beyond this value, the bids would be taken care of by independent consultants/UN agency unless capacity of government system is built.[21]

Finally, **Monitoring and Evaluation** of the program is also a joint responsibility of center, state, districts and DPs. Under this, CNAA is to be jointly carried out by

center, state and districts based on which the process of bottom up planning would take place. The other institution i.e IIM (Ahmedabad) is asked to help the center by monitoring the Program Management Units under its pilot stage. INDIACLEN (association of Indian medical college faculties) is given the task of quality management in pilot, which will be later taken over by M&E cell of the center.[22] The program would be evaluated through National Family Health Survey (NFHS), District RCH household surveys 2007-2010, census, Population research centers etc. On the whole, one integrated program monitoring system is agreed upon by all stakeholders and this would include monthly review by states, quarterly by center, half yearly through joint review missions by DPs and annually by GOI, DPs and the State.

It is mentioned in NPIP that this entire division of M&E would work under the leadership of MOHFW. All the DPs have also agreed to follow the common M& E strategy for state & district level program review. Consensus has been developed on program process and outcome indicators. The data collection and reporting is also planned to be the shared responsibility of MOHFW and DPs. Currently various methodologies of data collection are under pilot stages e.g UNFPA is providing consultant support for MIS (Management Information System), DFID for Community assessment and data triangulation, WB for household surveys.[23]

Common Goals

One of the principles of SWAp is that the goals and objectives of all the important partners involved in the program must be same or aligned. With RCH program, GOI aims to decrease the IMR, CMR, MMR and TFR at national level. In this direction, its prime objectives are to reduce decadal population growth, increase coverage of anti-natal care, institutional/safe deliveries, immunization, contraceptive prevalence rate, improve access to essential and quality FW services to deprived regions and people, improve management performance and institutional strengthening, increase state ownership, and work towards development of human resource and developing an effective M&E, procurement, financial and service delivery performance. Similar to this, the RCH project dominated by donors also aims to improve the essential RCH services, build capacity, strengthen institutions,

evolve a better M&E system and eradicate Polio. Though routine immunization is a big part of GOI fund in this RCH program, the DPs have extended more than 16% of their project fund selectively towards Polio Eradication. WB has earmarked Rs. 180 crores for Polio eradication and another Rs. 40 crore for procurement related activities under RCH project. Other DPs like USAID, UNICEF, CIDA etc have also extended earmarked fund under the project to Polio eradication activity. This is mentioned here as it provides an insight to the fact that though the DPs claim to have common goals for RCH program, but at the same time they are also keeping their priorities clear. This point would be further elaborated and discussed in the next chapter.

Common Expenditure Plan and Predictability of Funds

The RCH program has also tried to include the donor funding in the National Program Budget Cycle. Majority of the donor fund, including the pooled and un-pooled, has been taken into account along with MOHFW budget allocation for this program. A single expenditure plan is prepared which takes into account all the funds available for this program irrespective of the nature of its funder. The program financial cycle is also planned to coincide with the national financial year cycle i.e "April-March".[24] All the funds pooled in with GOI would be handled by FMG under MOHFW. Section B of the RCH-II program budget also has a provision of flexible funding for the states. This amount would be extended to the State FW societies/SCOVA on the basis of requirements mentioned by each State in their SPIP. There is also a provision of Performance Award Fund that would be 10% of the SPIP and would be based on the performance of states as committed in the MOU with MOHFW and DPs.[25]

Thus this estimation and predictability of funds from all available resources and partners would help in long term, better and integrated program planning than individual projects and national programs running in isolation. This would also make the financial management, audits and reporting easy. Further this would also facilitate total input and output or outcome analysis of the program.

Government Leadership and Ownership

Both the Program and Project documents mention that the responsibility and leadership of RCH program and project are finally entrusted on the Secretary, DOHFW, MOHFW, GOI. As the FMG runs under the additional secretary from GOI, it is said that MOHFW has the authority to increase or decrease the flexible funds to states based on their previous performance and audit.[26] At State level, principle secretary, DOHFW is said to provide leadership to the entire program. Both the NPIP and Project plan mention that any further consultation between different partners in the program would be undertaken under the leadership of MOHFW. As per the Program Plan, MOHFW would lead and be responsible for all the functions like Routine Immunization (though states would implement it), BCC (Broader policy to be framed by center and states to form specific policy using this framework), training (Center to take lead and states to design specific framework based on their needs), PPP (Center to form broad policy and look to issues like regulation, accreditation and states to use PPP wherever required), policy development and pilots (Finance, HR, M&E, PPP, Training, TA, Procurement etc.), and demand side financing through insurance or voucher schemes etc.[27] The center will also take a lead role in identifying the areas where states require capacity building and with the help of NHSRC and TA from DPs, center would have to bridge this gap.

The center would also be responsible for providing TA to states for making their SPIP, appraisal of SPIP, suggest modifications and conduct final audits of SPIP process and results. In order to help states implement their VGAP under SPIP, center would have to place a dedicated staff for coordination and monitoring of VGHP in every state.[28]

For all procurement related activities, center is said to take a lead role. The program plan documents mention that MOHFW would be entrusted to purchase and distribute all kinds of medical supplies and equipments to states unless the capacity of states for self-procurement is build and appraised. Along with this the center has the responsibility of maintaining the cold chains though states are responsible for

implementing routine immunization program. The program proposes that all procurements would be done in accordance to Essential Drug Policy of MOHFW. In RCH program, in order to increase ownership of states and districts, the initiatives like decentralized planning, states/districts to form their own SPIP/DPIPs based on CNAA, Center forwarding the funds from "flexible pool" to states, states allowed to use this flexible fund to implement innovative activities which are more responsive to the local people, states given the autonomy to design their own BCC and training material based on broad sectoral policy of the center, capacity building of states in procurement area, and finally the delegation of financial and administrative powers to SCOVA/State/District H&FW societies are taken to help bring ownership and hence responsibility and accountability in states and districts who are the prime implementing agencies of this program.[29]

As an additional responsibility of the center with the program and the project being built and run with the pooling DPs, the center is asked to provide a project audit report to all the pooling partners. Along with this, there is an additional conditionality from the pooling DPs that have extended their commitment to provide funds to this program in future. The DPs have asked GOI to ensure with an equal commitment of increasing the program budget in the coming five year plan in breach of which even the DPs may withdraw their committed funds.[30] Hence do such conditionalities spoil the actual spirit of SWAp is a question that would be discussed in the next chapter.

Common Procedures

The RCH project, despite being funded through pooled financing between GOI, WB, DFID, UNFPA & others, is running through the already existent structures of MOHFW. With common pooled funding, the DPs have agreed for uniform financial systems and reporting mechanisms for all partners. All financial and accounts reports of the project would be maintained as per the standards of Institute of Charted Accountants of India.[31] Thus DPs have agreed to depend on the internal systems of GOI for financial management and procurement requirements on a condition that these would improve. Also the project document by WB mentions that there is a policy of Uniform Code of Conduct for all partners in the project.

Even the consensus on uniform monitoring and evaluation system for al partners with consent on process and outcome indicators is a step in this direction.

Improved resource-management, transparency and accountability

One important preposition of countries adopting sector wide than project approach is that such an approach would reduce the cost of the program as the individual projects utilize separate funds to establish similar kind of structures like training division, procurement and financial management cell etc. separately. In RCH program, the common structures for program as well as project are established like EPW, NHSRC, FMG, PMG etc. This is an assumption that this commonality of service structures would reduce the program cost. This can only be empirically established after looking at the final program financial audit reports.

The direct flow of flexible and other central funds to the State Treasuries/SCOVAs, which now have the financial powers to disburse and administer the funds to the respective states, is one move that is introduced in the RCH program to help it reduce transaction cost and utilize resources efficiently. Also, with uniform procedures for financial management and reporting, the program aims to bring uniformity and lower program costs. The proposition and pilots of bringing in e-banking solutions for speedy fund flow between MOHFW and SCOVA/treasuries is also proposed with a long-term goal of reducing the transaction cost.[32]

Another initiative in this direction is the formation of Integrated State/District Health and Family Welfare Societies, which would merge all the different SCOVAs of various programs under one broad society and hence reduce cost of transaction. As earlier all the fund flow from DOHFW was centralized. Now with the decentralization of funds and transfer from FMG to SCOVA/State treasuries, the process has reduced the no. of fund related transactions from 1200 to 200.[33] This has thus also reduced the time taken for each transaction due to lessening extra paper work.

To improve aid management and resource allocation, a group of weaker states like EAG and northeastern states would be given preference in fund allocation. There

would be different Program Management Units to look after each of these groups of states. It is also mentioned that the SPIP and release of flexible funds based on state's commitment in MOU would ensure better accountability of states towards funds as the further release of funds from MOHFW would be performance based. Initiatives like performance awards and flexible funds are based on states' results as committed under SPIP are also introduced to motivate states work better towards improvement of people's health. The machinery like GAAP is planned to provide transparency and accountability in procurement system.

Sustainability

RCH Program is a long-term umbrella program of DOFW, GOI and is running since 1997 into phases. The program from RCH-I to new RCH-II has brought newer concepts like shifts from centralized planning, one size fits all policy, uniform performance indicators for all states in RCH-I to decentralized planning, evidence-based differential planning approach, special emphasis on EAG and northeastern states in RCH II. The program is a long term initiative with the commitment of GOI and other financing partners, emphasizes on institutional strengthening and sectoral reforms by bringing in initiatives like capacity building of states in making SPIP, TA to states in planning, financial management, procurement, M&E, training of districts, program management etc. For this the DPs have agreed to provide TA in planning, management, finances, M&E, procurement at all central and state levels. Also, NHSRC is a body planned for long-term facilitation of TA with the vision that the country would be able to build its own domestic resources for further program functioning and sustainability. In other broad sectoral reforms, GOI is considering the formation of a social marketing policy framework, draft legislation and also the private sector regulatory framework to deal with the needs of broad health sector.[34]

RCH Program planning is done in a way that it involves not only the result/output but also the process indicators, which would help the partners to trace the direction and pace of the program continuously. The program has also proposed the merger of DOH and DOFW at central level and merger of all health and family welfare societies at state level under one integrated society to help in sectoral

consolidation.[35] The program also includes the plan of upgrading medical education with integrating Public Health Management in the course curriculum of medical students in order to lead to better health sector managers along with clinicians. On financial sustainability front, GOI had been increasing its budget for FW sector since 8th plan and has committed to increase it from 0.9 % to 2% overall in its 11th plan.[36]

Though it is evident from the literature reviewed that the elements of Sector wide approach are present at all levels i.e policy, planning, financing, procurement, operationalization, management, monitoring, evaluation and reporting, but there are many issues which needs discussion on the way the program is been conceptualized with this newer approach. There are also debates on issues like sector/sub-sector, partnership, leadership, ownership, responsibility sharing, benefits and threats etc that needs detailed analysis and discussion before leading to any conclusion. All these aspects would be dealt in greater detail in the next chapter.

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CHAPTER 5

Discussion and Implications

Having identified the efforts of the government and partner agencies to integrate/follow sector wide approach in designing the new National RCH Program, there are many issues that emerge on **why and how** this approach is been put into use. This chapter would try to highlight some of these areas of concern. Further, the chapter would also discuss the broad concept of SWAP and its integration in RCH program and broader health sector. Finally the chapter would draw policy implications and summarize with the conclusion.

In Chapter 2, the dissertation has talked in-depth on the concept, principles, process and strategies of SWAp. With the government efforts to use sector wide strategies to bring sectoral reforms, there is a basic question that arises i.e why the government and the donors have initiated this change in approach from RCH program and not from any other health sector program like RNTCP/NVBDCP. To explore and answer this, though the current dissertation does not undertake an analysis of all the national health sector programs due to time constrains. Thus this study identifies the need for a more detailed and comparative study of all national health sector programs with RCH program, so that it helps to substantiate the point made above. But in all, this government's move of starting to integrate SWAp from RCH program provides a mileage to those critiques who always pointed out donors' and hence government's extra-preference to the areas like RCH, Polio and HIV than the other national health challenge.

On the definition of a "Sector", the WB project appraisal document (2006) states that as all family welfare activities of DOFW (MOHFW) have been merged into new RCH program, this new program becomes sector wide in nature.[1] GOI's RCH II-NPIP also mentions FW as a sector and brings up the issue of inter-sectoral convergence with other sector. These high level documents nowhere define a **SECTOR** and whether it exists with any limits or boundaries. In terms of inter-

sectoral linkages and convergence of RCH program with other areas/programs like HIV/AIDS (NACO), NRHM, ICDS etc, this explicitly means that both the donors and the government consider all these as different sectors and not the components of the same broad sector called "Health". As it is realized by the government that there is an overlap of activities across these programs e.g STI/RTI treatments, immunizations etc., a conceptual clarity on terms like sector and inter-sectoral convergence becomes important. Clarity on the issue whether sub-sector/programs can have fine boundary between them while functioning within a larger health system is also needed.

The concept of SWAp is too broad and lacks any operational guidelines for countries wanting to adopt it. In such ambiguous situation, it is completely in the hands of more powerful partners like donor agencies to interpret the concept in the way they want. This may also affect the very operationalization of SWAp in the recipient country. Finally such a thing would abolish the very basis of SWAp of government leadership as in such cases, the donors being powerful than the poor country's governments would define the rules of the game.

Also, SWAp requires a single sectoral policy but till date, India has separate policies for Health and Population. In an irony, it is been seen that the population policy had always evolved prior to the health policy in India. This thus shows that population policy had always led the overall health sector policy. With numerous health sector reforms and bringing in program or sector wide approaches, the ultimate need must be to start conceptualizing population/ family welfare under broad policy framework of health sector to help evolve a single sectoral policy. This would help in looking and planning for the entire sector comprehensively and in an integrated manner than one sub-sector gaining more weightage and priority at the cost of the others. Such a planning would also help in managing the finances better and lead to the equity in financing across sector.

Partnership

The RCH Program gives high importance to the issue of "Partnership". This is nothing new as the term partnership is the buzzword across the health sector nowadays. As the program proposes Public Private Partnership (PPP), in a country

like India where >80% of the healthcare expenditure comes from the private sector,[2] that too mainly by people directly approaching these providers to secure heath services, it is quite obvious who would rule and regulate whom in this partnership and to what extent.

The RCH program proposes to bring in private players, independently as well as in partnership with local, state and central governments to provide family planning and related services to the poor. In response GOI proposes to provide them with better incentives and training. As partnership is not just RCH programs' but the entire sector's issue, there are enough evidences where the government has tried to provide incentives to private players but no services in response were provided by them to the poor.[1] The greed for greater profits and affiliation to higher classes seems to drive the private players more than any such incentives provided by the government. With realizing the above mentioned factors and still promoting private sector without prior regulation and legal procedures being formed, established and implemented, the country would never be able to fulfill its principle of equity and quality in health services.

The program documents also miss upon the clarity on the definition of partnership. It is unclear whether it is between govt and for-profit enterprises/government and community (civil society or NGOs)/government and donors/any other combination. It is also unclear on the status of various parties involved in partnership i.e do all parties involved in the partnership enjoy equal status or does one restores greater powers and authority than the other. In such a case, the criteria for any decision on greater delegation of power and authority to one than the other is also need to be mentioned clearly.

In case of equal partnerships between government and the private sector, there are questions like how would the government be able to bring the private players (profit-oriented) to meet the real public demand than the market forces, how would it ensure that the private parties charge reasonable prices from the patients and

[1] Escorts Group was provided with government land on lease at highly subsidized rates with a condition of extending 25% of its inpatient services to poor and needy (Ref. New Policy for land to hospitals, The Tribune, Online Edition, Jan. 2005).

maintain best quality of services without bias to economic class of the patients etc. In such cases where two parties are working together with equal status but with different ultimate objectives or goals, as one is profit oriented and the other answerable to the public and hence people oriented, a clear strategy on how and who would take the ultimate decision at a point of disagreements is also needed and this is one area the program documents are unclear about.

As partnership is not just RCH program's but entire health sector's issue, it is important to explore whether there are any such successful and sustainable models of PPP in the world. Further exploring factors like the nature of those economies and society, years since these models are existent and aspects like whether such examples are comparable with Indian context are very important before any such proposition of promoting PPP in Indian health sector is made. Such an analysis is highly needed as privatization and addition of market principles in Indian health system were some of the propositions made by the same international donor/funding organizations which are now participating in RCH program and after a decade of operation of these propositions, many of them have failed to serve the purpose with which they were applied. Hence it is very important to study any such proposition in specific context where it is to be applied than just applying it because it is successful in some other country.

In another context of PPP, where two parties work together but one has greater authority and control over the other, it will be a big challenge for govt to persuade and bring profit making private sector entrepreneurs into this kind of arrangement as this would highly curtail their autonomy and power to take decisions and operate their way. The nature of arrangements and incentives mentioned in RCH program for those who would participate in such PPP shows that such propositions would only be able to lure or encourage small players in private sector who are facing difficulties in separate or independent operations and think that this kind of liasoning with GOI would help them earn at least regular incentives. The big fishes would still prefer to remain out of the net. These are some of the issues on partnership that the program misses to give a thought on.

On the areas of partnership in RCH program, the program documents state that all the financial audits, procurement, appraisal of SPIP etc. manuals are made by GOI and DPs collectively. In NHSRC (National Health System's Resource Center), which is proposed as a think tank for health sector, all the rules of the business are decided by both parties collectively. On procurement issue, all quality checks, certification and reviews, TA assistance, procurement beyond certain financial limit, etc are areas where DPs are participating in a big way. The financial audit of DOHFW is based on the TOR (Terms of reference) prepared by IDA.

Hence such arrangements raise many questions as when the total financial proportion of GOI vs. DPs in the program is in the ratio of 80:20, is the equal participation of DPs at all levels justified? Above this, isn't the accountability of GOI to DPs at various levels of program unjust?

Inter-sectoral convergence

On inter-sectoral convergence, which means convergence between those sectors that directly/indirectly affect the functioning or results of various health sector initiatives, there lies a similarity between what was proposed in Alma Ata in 1978 and what is proposed now by western countries as inter-sectoral convergence. The Alma Ata proposition of adopting comprehensive primary healthcare emphasized on looking at community health through public health perspective. This meant dealing and coordinating with all health system components like water, sanitation, power, transport, nutrition etc which have an impact on health of the communities. Thus the inter-sectoral convergence approach in RCH program documents identifies and proposes to link all those sectors and departments which contribute directly or indirectly to the functioning and results of RCH program. Except for a difference that Alma Ata proposition meant for the entire health sector planning and operation whereas RCH program sees inter-sectoral convergence only in lieu of the specific program functioning, the bottom line of both the ideologies remains same i.e *comprehensiveness in planning and operation, involving all linked sectors is essential for any sector/program success.* The involvement of different sets of organizations proposing the similar ideology but under different nomenclature at different time periods is also a point to be deeply thought upon.

The RCH program mentions to undertake convergence with NACP, ICDS and NRHM. But till date all the functions like planning, financing, staff recruitments, reporting and monitoring etc of all these programs are running separately. The matter of fact that convergence of similar activities and functions of NACP within the structure of RCH and integrating the functions of Anganwadi worker (ICDS), ASHA (NRHM) and ANM (RCH) shows that this **convergence is partial** as it is only at the implementation level and that too at the lowest cadre where the staff has no role other than following the disjunctly prepared policies of different programs. Hence whether such minimal convergence leads to sector wide development and much needed sectoral reforms is highly under question.

The program documents mention many examples which substantiate that the program has partial convergence like separate financial planning and management of RCH program and NRHM though RCH in second phase is an integral part of NRHM. The monitoring and evaluation strategy for all DPs together and DPs with GOI are also different. All the SCOVA's maintain separate financial books for credits under bilateral funded projects under RCH program like SIP by EC and those under pooling fund. Also, Part A activities of the National RCH program[ii], which need intensive investment for future program performance, are all funded by only GOI and only a proportion of Part B of the budget activities, which are more result oriented, are been supported by donors.

These are examples which show that the sector wide approach applied in this program lacks the clarity on the very concept and application of the ideology like convergence which means convergence at all levels, between all partners and in all functions.

The program documents also miss clarity on various aspects of donor convergence like the actual meaning of donor convergence, whether GOI has the power and

[ii] RCH Program Budget-Part A activities-program direction and administration, subcenters and salaries of ANMs etc, Urban FW services, funding to training institutions, grant to other national institutions, National population stabalisation fund, social marketing of contraceptives and their free distribution, sterilization and NFW insurance plan, travel of experts, conducting conferences/meetings, international cooperation etc.

authority over the pooled funds, whether the donor convergence under this program has come on certain conditions for GOI, the significance of this donor funding (20%) for the program, the decision of donors to withdraw further funding commitments if GOI does not accept any of their demands (case of Bangladesh), the effect of losing this fund on program sustainability etc. These are some critical thoughts which need to be pondered upon and are missing any mention in any relevant program document by GOI.

Role of donors in national policy and planning

There are numerous examples from the RCH program design which prove the increasing donor influence in national health sector planning and policy. Since 1972-1990, WB had only been extending support to NFWP in the form of state specific infrastructure development and training components. But since 90s, WB has shown a major shift in its policy with greater participation in Indian health sector policy, planning and decisions. The shift from FW to RCH program was also highly supported by WB. The current program assessment documents on RCH by WB and other donors clearly mention that now the participating DPs would play a more proactive role in RCH program policy and assessing implementation bottlenecks with the government.[3]

In RCH program, there are areas like inter-sectoral convergence where WB's HNP (Health Nutrition and population) policy framework is been used to help inter-program convergence between RCH-ICDS-AIDS etc.[4] in the so called government lead RCH program. For capacity assessment, which lays a very important hand in program policy and planning, all the studies at both country and state levels in the areas like planning, financing, procurement etc were funded by DFID and other external program funders.[5] The results of these assessment reports showed that the capacity of both the center and state in procurement and planning are very weak and needs further capacity building. For the capacity building in planning at both MOHFW and state level, all the process of advertising for the post, final recruitments, training of interim support etc were funded by USAID, EU, DFID, UNFPA, UNICEF and WHO.[6] Now there are two issues which need to be discussed here. Firstly, when the actual building blocks of the national RCH

program are been funded by the external donors, it is obvious that the government would not be able to keep the program totally devoid of donors' influence. The funding/financing on credits automatically adds obligations and conditionality on the recipient. Hence with this nature of financing, the program component is bound to be donor biased than country led.

Secondly, as all the pre-program assessment on capacity of country and states are done by participating donors and as these form the base for planning, developing and performing country's capacity building exercise, the question that arises is whether MOHFW conducted any assessment exercise to ascertain the capacities of these donors in providing right training and direction to the country. None of the program documents reviewed mention about any such exercise undertaken by GOI which means that the government presumes that any donor suggested strategy or offered program is perfect in itself and does not need any assessment before any decision to make it a part of the national program which affects millions of lives and billions of public money.

A similar example of policy level influence of donors is evident from the machinery named NHSRC, which is supposed to serve as the ultimate think tank of the MOHFW in the coming years. Since the RCH program proposes to establish this high level body for providing all kinds of technical assistance on various issues to center and state, GOI has agreed that unless fully functional, all the needed TA (Technical Assistance) for the program would come from these DPs. The question that arises here is that if NHSRC is the ultimate think tank for the program and entire health sector in the coming years, why is it funded by UNFPA, USAID and DFID? With this, the direction of Indian health sector in the years to come it evident.

The clauses on procurement policy in the program says that only those tenders/contracts valued less than $200000 would be considered as national/local level tenders and all those valued above $200000 would be treated as International Contractual Bids (ICB).[7] Analyzing this in the context like India which has huge public infrastructure and recurrent need for procurement of drugs etc., the tenders in the drug category are usually huge which would usually cross the specified amount

under the NCB category. This means that such a clause is indirectly a strategy to extend business and profits to the international bidders.

And also, when the Indian pharmas are to compete with the international pharmas, it is evident who would bag the contract based on lesser prices etc. Such policy provisions influenced by donor brains, without considerate attention on issues like capacity building of domestic drug industry, are some of the real future threats to our own economic and political security. Hence in Indian context, it is important to think on the ideas to encourage the domestic drug industry by promoting it with incentives and subsidies through government as such a step would be able to provide sustainable or long term solution to the issue like procurement instead of GOI importing drugs and products from external MNCs which are not trailed in Indian local settings and which go out of shelf soon in response to the competition in global pharma market.

With pooled financial arrangements between the partners, the program though deals elaborately with the issues of procurement of drugs/goods/services but there are many intricate issues which, if explored and discussed critically, would give clue to answering questions like who is really leading, owning and operating the program. On procurement, the program proposes to establish an EPW which would ensure and work under GAAP. Though the program documents say that all the procurement activity (except for issue of contacts beyond certain limit) would be undertaken under government leadership but before establishing or saying who is leading and under who's guidelines, there are issues which need to thought at length like:-

- ✓ Who has done the background work and has ultimately formed GAAP?
- ✓ Who is actually running and implementing EPW?
- ✓ Who are the part of EPW and GAAP, how are they selected, who selects them, what are their powers and duties?
- ✓ Who has made/is making the rules for procurement?
- ✓ Which are those agencies from whom the work/goods/services would be procured?
- ✓ Who would have the ultimate authority of deciding whom to extend the bid to?

- ✓ What would be the nature of products and work that would be procured?
- ✓ In case of medical technology and especially drugs which is a recurrent and all time need of health sector, what would be the effect of patenting on domestic players?
- ✓ What about the issue of subsidies to domestic pharma companies against the already developed MNCs?
- ✓ How would the program ensure capacity building of domestic/national service providers especially technology and pharma industry as without it, the program would lead to dependency on international market with flow of national GDP to the developed nations?

In India, major health sector expenditure goes into procurement of drugs and services.[8] With globalization and 1991 structural reforms, MNCs have got easy access to the markets of developing countries. As these MNCs receive good amount of subsidies from their national governments in the form of infrastructure etc, patent laws as a blessing of World Trade Organization (WTO), have made their business all the more safe by making the industries of developing countries with poor infrastructure and research potentials handicap. In such situations, where domestic players are unable to fight and compete with the MNCs, such sectoral policy pushes the patients to the mercy of these MNCs. This thus affects the poor patients in many ways like costly treatments pushing them to poverty, irregularity in continuation of treatments due to exorbitant costs of treatment, inaccessibility etc. Hence it is clear that bypassing domestic players for drug/technology/service to increasing dependence on external companies is neither economical nor a sustainable solution.

Thus as the program talks of sector wide approach which entrusts on building national capacities in systems than dependence on others, addressing this issue of capacity assessments, capacity building, more research related inputs, establishing quality assurance and price control bodies etc of the domestic health sector industry should be given utmost priority. The current program arrangements hint at the biasness of external donor partners, who are participating in procurement activity more than any other activity, towards the multinational health sector industries. Unless such donor and external industry's influences are minimized, the program cannot be called "Nationally led" and "Public welfare oriented".

Donor's shift from project to program approach

This shift of donor's preference for projects than programs was understood to be due to the limitations of multiple projects like duplication of work, increased costs, lesser sustainability, limited reach etc. But in the newer arrangement of SWAp where the donors form a group and pool funds to support larger government run program, there are many apprehensions on the issues like government's ability to reduce donor "GROUP" influence, donors' implicit intention of participating and later leading the policy making process in these low income countries etc..

The past experience of GOI and policy analysts on the influence of individual donors in NFWP (1952 onwards) raises the question whether the low income/developing countries would be able to handle/restrain the influence/pressure of this GROUP of donors now. On this issue, the RCH program does not cover any note on government strategy to control/avoid any influence/interference of donors in government's policies. In Indian context, it is important to understand that the RCH program establishes a relationship/partnership between a low income country at the receiving end and the rich developed countries/organizations at the donor's end. So it is recommended that unless such strategies for safeguarding the national domain from foreign influence are incorporated in the program, the influence of donors on government program is quite obvious to remain. And with this the RCH program could never be called a truly government envisaged, owned and led program.

Another issue is that the strategy of donors to participate in the larger government run programs is to help them give greater chances of influencing the government policies in contrast to their old style of working on area specific projects which kept their interests and influence limited. It is an urgent need for the government to think, plan and act on issues like these as any such vested motives would have long term and irreversible impact on country's economy, political system and above all, peoples' health in future. The current RCH program plan though mentions the similar explicit goals of GOI and DPs for the program but it does not answer on the issue of any checks on the hidden or implicit goals of the partners involved, which if unchecked today, may threaten national security and progress tomorrow.

Another area of interest for the donors, where their influence can be clearly seen in the program is **financing**. The external funding for the RCH program has come from partners like WB and DFID in the form of soft loans under their country assistance policy. Unlike this, UNFPA has extended financial assistance to the program in the form of grant. The loaning arrangement by WB and DFID means that the credit taken by the recipient government needs to be returned with fixed interest rates to the donors within decided period. Generally the practice of taking loans entails that the recipient has the authority and choice of decision over the spending pattern or areas where it wants to invest with a condition that it would return the amount within stipulated time limit. With the same logic, it is questionable that the donors, instead of taking a backseat, are influencing and directing the government to invest in specific areas of their own interest. Hence as the funds received for RCH program are in the form of credits, shouldn't the funders take a backseat without interfering in any of the government policy decision and arrangements for financing program functions unless asked for, is a question that arises here.

The other issue is that what about the reviews of the capacity of these donor agencies by GOI in areas like program implementation, planning, procurement, financial management, M&E etc. Shouldn't the government review and evaluate the success of various projects run by these donors, its past experience in functioning with these bodies and larger impacts of these partnerships on the country/sector when the donor agencies have the right or undertake the review of state economy, society, political scenario and current program status? This could be one strategy to help government find donors of their priority areas than government asking for favors from those donors who have pre-decided or committed areas to focus on and on their conditions.

Donor Dominance

Though the program strategy talks of government leadership and ownership, there are enough evidences in the program plan which proves donor dominance. The financial plan of donors in funding only Part B of the National RCH Program budget, that too only some specific activities shows their *selectiveness / earmarking*

of funds within the broader program. With donors calling the program sector wide having common policy, plan and financial arrangements, government leadership and ownership, such a selection of areas by them is nothing but a contradiction in vision, words and action.

Also there are *conditions* put forth by the donors for GOI in order to let it keep receiving regular funds for the program. GOI has agreed on some conditions while taking development credit from these DPs which have been mentioned in the previous chapter. In this regard, all GOI program financial and accounts manuals (program budgeting, accounting, financial reporting and audits) are designed in a way to satisfy this credit agreement conditionality.[9] There are also compulsions on GOI to maintain its actual budget in the program as in 2004-05 throughout program period without which further funds from the donors would not be extended. The other donor conditions of all National Contractual Bids and the relevant expenditure/cost to be treated as exports must be thought critically to identify the vested donor interests and threat to national economy[10].

Donor Dominance in procurement policy and planning is also evident through various examples. For procurement of services, contracts, works and goods, MOHFW will have to follow WB guidelines and procedures.[11] These WB documents form the basis of the guidelines prepared by MOHFW on procurement. All the contracts >$2 million for goods, consulting services to firms and work, all individual consultants contract >$50000, would be undertaken by a procurement agent based on quality and cost selection following WB guidelines.[12] This procurement agent will be selected in satisfaction to WB or in any other case; all these procurements will be made directly through UN agency. This Procurement agent will follow the WB procedures and guidelines of 2004. For emergency procurement also, the GOI is bound to follow TOR made with DPs.[13]

Those contracts below the above mentioned amount would be undertaken by EPW (MOHFW) who will work under the oversight of an international consultant.[14] The publication of information on these contracts would also be there in UNDP (United Nations Development Program) and DG market bulletins/websites.[15] As civil works are planned, to cover less than 10% of the total RCH project cost, here direct

contracting by local governments is allowed. All procurement of Oral Polio Vaccine (OPV) will be done by UNICEF through direct contracting.[16]

In terms of M & E of procurement activities, MOHFW would select an agency to check quality and quantity of goods and the MOHFW is bound to provide feedback to WB on the same. GOI is also bound to share all bid records and selected bids with DPs. Thought the Drug Controller of India would issue a Certificate of Pharmaceutical Product/ Good Manufacturing Practices (GMP) to the winning international bidder after inspection by 3 member team including members from center, state and an external expert, the process and guidelines of this certification is also provided by agencies like WHO and WB.[17] The program also mentions that all the TA for EPW would be funded by DFID. It also says that GOI does not have the authority to amend GAAP though it is the implementing agency for it.[18]

Thus in Procurement, from GMP certification, bid finalization, capacity building, TA, monitoring, procurement reviews, eProcurement project etc are all planned by WB. The Procurement Audits including the baseline studies on the requirement of capacity building for procurement are also done by these pooling partners like DFID/WB. Across all the above-mentioned areas, the dominance rather than participation of DPs can be seen everywhere in procurement. Though handling procurement related complaints is one area where DPs are not actively involved but here also they are to be conditionally updated by GOI on redressals from time to time. Hence Procurement is one big area where the maximum participation of DPs than any other area in NFWP can be seen.

Other than procurement, donor dominance in financing can also be seen as the DPs are funding depending on the convenience of their own country/government's approach towards project or program or sector wide approach and not because GOI prefers a policy/approach of program based funding. Looking at the total program budget plan, there are questions that arise like why is the GOI alone funding part A of the budget which includes activities like infrastructure building and institutional capacity building which are more absorptive in terms of expenditures and also do have less predictability and measurability of funds and results. In contrast part B is partially funded by DPs as it includes services which can provide measurable

results in response to the money spent. Hence if the DPs are keen in sectoral development than specific projects, they must make investments for overall sectoral development than just bits and pieces of the budget.

Leadership, Ownership, Participation and Responsibility

With all these ambiguities, the program documents are also unclear on the usage of terms like Leadership, Ownership, Responsibility and Participation. As evident from above, the rules and guidelines of the program functions at various places are been directed by the donors and GOI is stated to undertake/implement these. All such arrangements are done on the name of "*partnership*" but the final statements at the end of all sections of the program plan state them as taking place under "*GOI leadership*".

In terms of finances, the DPs have pooled the funds together and with GOI for the subset of program and they (DPs) plan to jointly disburse this fund. This means that the financial powers of the fund disbursement for this pooled money by DPs would remain with the DPs and not with the MOHFW though the implementing agency of the activities funded by such an arrangement are center, state and district govts. Hence the question arises that can a program obtain its objective of national leadership and ownership without having power and authority on all the funds put into the program.

Also, there are cases where GOI has to provide a six monthly report to DPs on the implementation of GAAP, it would need to take clearance from WB/DFID before the award of any contract, donors would decide on the states having completed institutional mobilization phase successfully, donors would hence decide on the performance awards to these states etc. In all such cases, it is none less than false or disguised leadership on the name of government.

As the donor influence and dominance in the areas of procurement and financing have already been seen in the chapter above, their involvement in M & E through various pilots that they are conducting on household surveys (WB), community monitoring (DFID), HMIS (UNFPA), and triangulation techniques (DFID) can also

be seen here. But for the sake of name, all these pilots are conducted under MOHFW.

Though GOI contributes higher share of funds in the program, still it is accountable to the other DPs in areas like financial audit, procurement, program results and mid-term monitoring reports etc. This is nothing less than added *responsibility* on the government than what the documents call as "Partnership". Also, as the need for pooled financing in a government run program is the realization and need of the external donors/countries/organizations, such an initiative cannot be called GOI *"owned"* or "Led" in real terms.

As per the budget details mentioned in RCH II-NPIP, the part A of the budget is financed by MOHFW which is approximately Rs. 20,000 crore. The part B of the budget has activities which are implemented by GOI but co-financed by WB, DFID, UNFPA and MOHFW in collective pool and other DPs as under area specific projects. Part B of the budget which also totals app. Rs.20000 crore, GOI's share of the total is 12000 crore, WB/DFID is 3775 crores and the other DPs investing mainly in Polio eradication and other area specific projects are Rs. 4500 crores.[19] This financial arrangement shows that more than 60% of the fund in part B and >80% in the entire RCH program is invested by GOI. Of the entire program, <10% of the fund is with pooled arrangements whereas the other 10% still comes through small area specific and agenda specific projects. Hence in such a situation, it is important to answer whether we need better and effectively managed and accountable internal systems to manage this 80% first or keep concentrating on building institutions to coordinate this small 20% donor fund.

Last but not the least, as the current financial arrangements in RCH program are mostly in the form of project-type aid, earmarked and sector specific funds, the NPIP nowhere talks of finally aiming/directing the donors to total budget support arrangement in the coming years.[iii] In such a situation, where the donors are already

[iii] Budget support is the ideal financing model that the Sector wide approach proposes both to the recipient and donor governments/organizations. support to national budget through the ministry of finance and using government systems. This can be general budget support, where funds are not earmarked, or sector budget support, where funds are earmarked for a specific sector. (Ref: WHO SWAp guidelines)

involved at almost all levels of program policy and planning, would it be possible for GOI to insist or direct these donors to extend budget support in the program in the future than any other forms of financing? These are some concerns which abolish the ideology of sector wide approach in the way it is applied in the current context.

Implications

1. A clear policy framework on SWAp by GOI for the entire health sector is required. This framework must address all conceptual issues of SWAp in Indian context elaborately. Since SWAp ideally needs to be implemented across all health sector program/health sector, it must address the comprehensiveness, integration and coordination in total health sector planning which is further executed through different national and state level programs.

2. There is a need for a clear government policy on donor issues. This policy must mention the conditions, areas and donors which the government would prefer to take donations from. The analysis of financial planning and distribution in RCH program shows that the program is more influenced by the donors than the majority financer i.e GOI. The policy also needs to be clear on the authority and control of government/all participating agencies, with ultimate powers to recipient government over the pooled or donated fund. Such a clause may differ according to the nature of funds seeked i.e credits, grants, donations or any other kind of aid etc.

3. To start with, government/involved institutions must conduct a study on all national health sector programs in details to identify the integration of SWAp in them, its history, models of financing, operation, monitoring and evaluation etc. All these must be compared with each other to help the parties realize whether they are extending extra attention or bias to a particular program or sub-sector in comparison to the others. Such a comparative study would also help government locate similarities, differences, extra favors or neglect to any particular program in response to the others.

4. Government policy papers must establish more clarity on the broad definition of a Sector. This is so because in comprehensive and sector wide model of sectoral planning where all functions and results of one sector are linked with other sector, it is very difficult to confine a sector like Health into a specific definition or boundary. The RCH program documents mention RCH as a sector though it is just a sub-sector within a larger system called health. It is not logical to apply the principles and vision of SWAp in a sub-sector as it abolishes the ultimate motive of SWAp, i.e sector wide planning. Hence the application of SWAp principles and strategies must uniformly be conceptualized and integrated (after public debates and in-depth studies) in the entire health sector policy and reforms than specific programs.

5. There is the need to merge both NHP and NPP to lead to a single sector wide policy framework. This would help in looking and planning for the entire sector comprehensively and in an integrated manner than one sub-sector gaining more weightage and priority at the cost of the others. Such a planning would also help in managing the finances better lead to equity in financing across sector.

6. Before proposing to integrate SWAp in Indian health sector planning, the government must critically look at the origin, ideologies, trends and shifts in this and similar concepts globally. This research establishes that SWAp as a broad concept is "too ideal" and impressive. But at the same time, the recipient countries have to be wary of the space this concept, through its broad framework, gives to the donors in influencing the recipient country's policy and planning.

7. There must be a clear strategy on partnership or extent of privatization and role of governments in health sector. A regulatory framework which addresses the issue of who would regulate whom, to what extent, in which situations etc. should be clearly defined. Evolve clear definition of partnership which caters to all types of partnership arrangements between different partners.

8. The program requires more clarity on the issue of convergence. It needs to identify that as it talks of sector wide approach, similarly the policy of convergence should also be framed in lieu of the entire health sector than just a Program. The clarity on the issue of donor convergence, the nature, levels, process, rules for operation within and with other partners outside, advantages and disadvantages etc. is still missing and needs to be developed.

9. A policy which is clear on the issues of any conditionality put forth by the donors before committing for funds, the areas where the government would accept and invest donor funds, the control and authority on the donor funds, the ultimate authority to take final decisions at the time of disagreement, the protection cover for the government if the donors withdraw funds in between etc. is needed to be formed by the government.

10. GOI must form a policy of conducting assessment exercises to review the capacity, feasibility and success rate of any proposition made by the external donors before it decides to accept it as the part of government run system and programs.

11. A policy by GOI is needed for capacity building of domestic pharma and health sector service providing agencies. The policy needs to be clear on how GOI would encourage and increase business from domestic players, how it would assure the quality of services and products delivered, how it would deal with WTO guidelines and pressures, how it would help the domestic players fight the global competition etc. Along with sops and incentives, the policy also needs to be clear on price control and quality audits.

12. With SWAp being implemented in many countries now, there are many examples which could throw light on the operational aspects and problems of SWAp in different contexts. Studies of these examples would also help in identifying the gaps and areas which are unclear in the conceptual

documents on SWAp. All such studies from different countries together would help the policy makers in designing an operational framework on SWAp. This would help the countries which have newly adopted or are planning to adopt SWAp in their policies.

13. Studies to analyze and evaluate effectiveness of different models of financing are required before it is assumed that budget support or any other form of pooling funds are more effective than other modalities.

14. To enhance the leadership qualities of the national governments, a complete and comprehensive policy on the capacity building of the governments at all levels in the areas like planning, financial management, procurement, operations and program management, monitoring, assessment and evaluation of various policies, processes and programs from time to time, effectiveness and efficiency audits etc. must be developed. The policy must also include the capacity building of governments in negotiating the costs, terms and conditions with other negotiating partners.

15. Timely assessment of the status of government leadership in the sector must be planned. Parameters for this need to be discussed and decided.

16. Measures and strategies to be devised to help maintain cordial relationships between various departments or ministries as the application of SWAp requires inter-departmental and sector coordination and convergence.

17. A rational Human Resource Development policy which decides on the issues like the tenure of personnel on the senior and strategic management posts as the frequent transfers or shifts due to varied causes affect not only the program operations but also the vision and planning process and thus waste time.

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[3] ibid, p. 23

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[5] ibid, p. 247.

[6] ibid.

[7] WB, July 2006, p. 23.

[8]WB Document, Implementation Completion Report; India, Reproductive and Child Health Project, May 2005.

[9] GOI, 2005, p. 328.

[10] ibid, p. 247.

[11] WB, July 2005, p. 74.

[12] ibid, pp. 68, 75, 79

[13] ibid, p. 79.

[14] Ibid.

[15] ibid., p. 74.

[16] ibid, p. 75.

[17] ibid, pp. 79.

[18] GOI, 2005, pp.193-200.

[19] Ibid., pp. 57-63.

CHAPTER 6

Summary and Conclusion

India being a welfare state, "Health" was referred to as the state subject. Thus the architecture of Indian health service system was designed in a way that the maximum number of sub-centers at the interface with the communities are connected to the larger upward chain of PHCs, CHCs, District, State and Central level multi-specialty hospitals. Majority of their functions were planned and funded from the top although their actual operations were supposed to be at the bottom with communities. To support this government led structure, a parallel line of private service providers, was always present though their number increased tremendously after SAP and HSR. Today, the sector is characterized by a variety of stakeholders that include government, private (for profit and not-for profit) and other international development partners.

These DPs had always played a crucial role in affecting national sectoral policies on behalf of the little funds that they contributed to the sector. The variety and uncountable number of area specific, target bound projects and the highly verticalized multiple national disease control programs are some of their contributions to the Indian health sector in the last fifty years.

Realizing the inability of project-based approaches to reap the desired results, the issues of emergence of newer health challenges like HIV/AIDS and the increasing need for financial assistance for health sector, the donor countries and agencies explored newer approaches like program-based funding and Sector wide approach.

SWAp was conceptualized in mid 1990s with a formal agreement on it between few donor agencies in 1997. SWAp is basically an outlook that envisages a sector as coherent, with a single policy that identifies sectoral priorities, carries out realistic resource assessment and allocation, builds mechanisms for sustainable partnership

and coordination and uses a common expenditure plan for all stakeholders to reach to the set sectoral goals.

As the international agencies like WB and UNFPA have claimed to have adopted SWAp in the Indian RCH program, this study identifies and analysis the areas and levels where the broad principles and concepts of SWAp have been integrated in the currently running RCH program of GOI. One basic criteria of SWAp in the Indian RCH Program is already being met with the arrangements like donors from different regions coming together and pooling funds into this program.

The other evidences like the alignment of RCH program with the broader national development goals like MDGs, NHP, NPP and five-year plans, use of common health sector approaches, contribution and coordination between various stakeholders in program policy and planning, partnership and joint efforts at various levels of the program, common expenditure plan, common sectoral and program related goals, common procedures adopted, efforts to reduce the program cost, work towards better aid and resource management, inculcate transparency and accountability, and finally and most importantly, efforts to augment government leadership and ownership are some to prove the presence of SWAp in the Indian RCH program.

At the level of program policy and planning, activities like sectoral and program reviews by the stakeholders especially donors, their participation in program M & E, pooled though earmarked funding by them and finally, RCH being the conceptualized as a long term program than project are some parameters which show the advent of SWAp in it.

The RCH program has adopted broader sectoral approaches by initiatives like shift from vertical to integrated program models, centralized to decentralized planning, use of PPP, integration of RTI Act, inter-sectoral convergence, integration of common functions like procurement, training etc. for all health sector programs, SPIP to be introduced in all health sector programs, gender equity, reduction in geographic disparities, emphasis on vulnerable group of population etc.

On partnership, the program involves stakeholders (mainly DPs) in pre-program and program level planning, in service delivery, training and capacity building, advocacy and IEC, infrastructure development and financing etc. Various other areas of coordination are program management, donor coordination, finances, procurement, TA, M & E and system of reporting.

With the common expenditure plan for all the government and other donor partners, the program ensures better predictability of funds and realistic planning. Also the uniform code of conduct, common financial, M & E and reporting mechanism for all partners and most importantly, RCH program and project being planned to run through the same existent health structure, are some other criteria of SWAp's presence in RCH program.

For cost reduction and better aid and resource management, the program involves initiatives like common procedures in finances, procurement, M & E, reporting etc., implementation of project and program through a common structure, e-banking, financial and administrative powers to SCOVAs and integration of all SHFWS/DHFWS into one entity etc.

The program proposes GOI to undertake overall leadership of the program, to lead all consultation exercises between the partners, run all routine immunization activities, make broader policy on BCC, training, PPP, TA etc, run pilots to facilitate policy development, undertake all procurement related activities, maintain cold chains and provide TA to states on various fronts. For ownership of the states in the program, the provisions like SPIP, SCOVA, CNAA, decentralization of BCC, training and capacity building etc. have been introduced in RCH program.

Thus all these evidences show the presence of SWAp in the Indian RCH program. But at the same time, the concept and application of SWAp in RCH program in the above manner are a matter of concern for all those that are interested in Indian health sector development.

These issues vary from the conceptual ambiguities on the definitions and terms like sector, partnership, inter-sectoral convergence, leadership, etc to other issues like

donor's dominance and influence on the national/sector/program policies, planning and implementation and the hidden agenda of them in shifting from project to programs etc. Thus the adoption of SWAp by the low income countries without a deeper insight and preparedness for it is put under question.

The adoption of SWAp by donors in funding RCH program first than any other health programs/overall health sector violates the spirit of them becoming **sector wide as they still remain sector specific**. Their claim of promoting program over project approach and thus the sector is negated by the fact that they are still running a **project (RCH-I & RCH –II) within the larger National RCH Program**. The fact that they are funding a part of RCH program budget with specific activities exposes their **selectiveness in funding.**

Analyzing the facts like increased involvement of WB in the Indian health sector since 1990s', the external DPs engaging in all pre-program assessments and sectoral reviews, their initiative in funding the prime decision making body like NHSRC, their increased participation in designing all manuals and guidelines in the areas like financing, procurement, M & E, their selectiveness in funding program components and finally their conditionality for pooling with GOI shows nothing other than **Donor Dominance in the name of Partnership.**

With this interference, it is the **false notion of leadership** that the donors are trying to inculcate in the Indian government. In terms of inter-sectoral convergence, the efforts being made in RCH program to establish linkages between NACO, ICDS and NRHM are only a reflection of **partial convergence** as they just show integration at the lower levels of operation than at policy and planning levels simultaneously. Although there is an **unequal proportion of program funding** by GOI and DPs, the **demand for equal participation** in sectoral planning is highly unjust.

Despite these limitations, it would not be wise to negate the notion and vision of SWAp. This is as health sector management and consolidation is the need of the hour to which SWAp offers a solution. But alongside, SWAp also offers an equal number of challenges and threats to the low income countries. The study shows that

SWAp is a very broad concept which seems to be "ideal" and "impressive". But at the same time, this broader concept provides enough space to the donors to influence the policy and planning of the recipient countries. Thus the recipient countries have to be wary of the space this concept provides to the donors through its broad framework.

Thus to inculcate and see national leadership and ownership in true sense, the need for an initiative like SWAp is to be realized by the low income countries themselves first. In this direction, the donor countries may begin by extending funds for evolving newer researches and innovative models from these recipient countries on better sector management. Thus based on the understanding of these countries on various approaches, it should be completely left to their discretion whether they prefer to adopt/reject/evolve a newer model of sectoral consolidation and financing. In cases where the countries are willing to move forward with SWAp in their health sector planning, financing and operations, these countries must plan and come out with a clear national and sector specific policy on SWAp.

Such a policy must be clear on the issues such as broad national and sectoral development policies, preparatory steps and stages of the government towards adopting SWAp, policy on leadership development of the governments at various levels and its timely assessment, the government's stand on various donor issues etc. The policy must also be clear on the role and involvement of private sector though various arrangements and the areas and levels of inter-sectoral convergences. Clarity on the nature and mode of sector financing, capacity building of national pharmaceutical, technology and service sectors and human resource development strategies is also required. Most importantly, the capacity assessment of donors as well as other stakeholders by government and a clear policy and strategy of the government to minimize the donor influence in national policy and planning must be well thought and sought by the governments.

On the donor issues, the concerns like authority and control of the recipient government over the overall funds especially when the obtained funds are in the form of loans is a matter of debate. Also the proposition of donors to take backseat than influencing financial allocation across sector must be seriously followed by

these funding partners. The issue of clarity in terms of the areas where DPs and other stakeholders would be allowed to operate after their complete assessment in the national interest must be well thought about. The consensus on the issue that in case of disagreements, the national governments must have the ultimate authority to take final decisions in the larger interest of the country is one of the most important issues that need to be addressed in the national policy on SWAp.

Finally, any such strategy would not be successful unless the group of donor countries and agencies, which claim to have adopted SWAp for better and effective functioning of the health sector in these poor countries genuinely cooperate. In this case, a long term strategy for developing consensus on SWAp between donors and recipient countries must be promoted. A consensus on shift in policy from project to program and larger sector along with agreement on the change in mode of financing from earmarked to sector or budget support funding must be collectively agreed upon by this group of donors.

As there is always an unequal relationship between recipient and donor entities, along with the capacity building for increasing the bargaining powers of the recipient governments, the donors must also take steps to create an atmosphere for open and unconditional dialogue. Hence unless such initiatives from both the prime partners of sectoral development are taken, any approach including SWAp would remain ineffective in achieving its objectives.

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