

COMMENTARY

Sector-wide approaches (SWAps) in health: what have we learned?

David H. Peters,^{1*} Ligia Paina¹ and Finn Schleimann²

¹Department of International Health, Johns Hopkins University Bloomberg School of Public Health, Suite E8-132, 615 N. Wolfe St., Baltimore, MD 21205, USA and ²The World Bank, 1818 H. St NW, Washington, DC 20433, USA

*Corresponding author. Department of International Health, Johns Hopkins University Bloomberg School of Public Health, Suite E8-132, 615 N. Wolfe St, Baltimore, MD 21205, USA. E-mail: dpeters@jhsph.edu

Accepted 8 November 2012

Sector-wide approaches (SWAps) in health were developed in the early 1990s in response to widespread dissatisfaction with fragmented donor-sponsored projects and prescriptive adjustment lending. SWAps were intended to provide a more coherent way to articulate and manage government-led sectoral policies and expenditure frameworks and build local institutional capacity as well as offer a means to more effective relationships between governments and donor agencies. The global health landscape has changed dramatically since then. Although many countries have undertaken SWAps, the experience deviated considerably from the early vision, and many of the problems in national health systems persist. SWAps have contributed to the development of robust national health policies and transparent expenditure frameworks as well as strengthening institutional capacity, though the levels of success vary widely. Government stewardship of donors and local stakeholders as well as their political will to implement health strategies also vary highly. Although SWAps are geared towards consensus building policy changes at the national level, in the face of urgent global health concerns, notably the HIV epidemic, donors often by-passed SWAp arrangements through global health initiatives intended to address international priorities. Yet, a key to sustaining global health initiatives is how well they can be integrated into national health systems, a task requiring a return to SWAp principles. Despite shortcomings, SWAps have remained a popular approach for supporting alignment, harmonization and improved accountability between donors and country governments, increasing predictability of aid and reducing fragmentation. The future of SWAps will depend on stronger government oversight and innovative institutional arrangements to support health strategies that address the need for both targeted initiatives and stronger health systems to provide a wide range of public health and clinical services. For development assistance to be more effective, it will also depend on better discipline by donors to support national governments through transparent negotiation.

Keywords Sector-wide approaches, health policy, international cooperation, developing countries, health reform, health expenditures

KEY MESSAGES

- SWApS were developed in the 1990s to overcome problems of fragmentation of programmes and overly prescriptive donor assistance, and held out much promise to enable national governments to develop and implement comprehensive health policies and strategies.
- SWApS have remained a frequently used approach despite their shortcomings and the persistence of problems in national health systems. SWApS have contributed to the development of national policies, transparent expenditure frameworks and strengthening institutional capacity, but with wide variation in experience.
- Although SWApS were designed to build consensus on policy and programmatic changes at the national level, in many cases SWAp arrangements were by-passed in the face of urgent international priorities and global health initiatives, such as those addressing the AIDS epidemic.
- The future of SWApS and global health initiatives will depend on stronger government oversight and strategies that are able to address the need for both targeted initiatives and sound health systems and for donors to be better disciplined in supporting national governments through transparent negotiation.

Introduction

Sector-wide approaches (SWApS) in health were developed in the early 1990s in the context of widespread dissatisfaction with fragmented donor-sponsored projects and prescriptive adjustment lending, with the purpose of supporting government led health sector policies, strategies and local institutional capacity to improve health (Cassels 1997; Peters and Chao 1998). In a number of countries, governments and development agencies were openly discussing new modalities for support to the health sector (notably Zambia, Sierra Leone, Ghana, Bangladesh and Pakistan), with organizations such as the World Bank and Danish International Development Assistance (Danida). Both the World Bank and Danida explained the rationale and possible modalities for support (respectively labelled 'sector investment programs' and 'sector program support') through discussion papers and guidelines (Danida 1994; Harrold 1995). The term SWAp was eventually adopted by a wide group of development agencies at a meeting held in Copenhagen in February 1997. By the end of the year, Cassels (1997) had documented the state of thinking on a new sectoral approach in a publication sponsored by the World Health Organization, Danida, Department for International Development (UK), and the European Commission, that was based on extensive consultations with government and development agencies involving both country-specific programmes and global settings.

The SWAp was characterized as a sustained partnership led by national authorities whose purpose is to improve people's health. All significant funding for the sector is intended to support a set of national policies, strategies and expenditure frameworks, supported through common management systems, usually developed through institutional reform and capacity building, and with a set of processes for negotiating strategic issues, including the review of sectoral performance (Cassels 1997). The first analysis in the peer-reviewed literature on the design and experience in SWApS was published the following year by Peters and Chao (1998), who described the great promise and potential risks of SWApS. The authors noted that with the end of the Cold War, there was a proliferation of international health donors and initiatives that was increasing the fragmentation of national health programmes, while at the same time demanding higher

accountability from recipient governments. There was considerable optimism that SWApS would offer a new way of conducting business between governments and donor agencies in a more coherent and effective manner. There were also many risks and questions left unanswered by the SWAp approach, which Peters and Chao (1998) identified as whether countries should undertake a SWAp, how SWApS would work in different contexts, how to develop and implement national policy, expenditure and institutional frameworks, how to address priority health programmes and how governments and donors should take on new roles.

The global health landscape has changed substantially since these early efforts, and whereas many countries have undertaken SWApS, the experience has deviated considerably from what was envisioned in the 1990s. Many of the symptoms due to the limitations of development assistance to support national programming in health have persisted. The purpose of this article is to examine what has happened with SWApS in the health sector since their origins, and to draw lessons learned and implications for SWApS and donor relationships with national governments. This paper revisits the same questions highlighted in the 1998 paper (Peters and Chao 1998), examining their relevance for today.

Why have a SWAp?

The original reasons for engaging in a SWAp have not gone away, as problems with fragmentation, duplication and parallel programming in the health sector had increased by the early 2000s. Perceived by many as a 'magic bullet', SWApS received considerable support from the international development community in the 1990s, and even the first few years of the 2000s, as SWApS continued to evolve in health and other sectors. Donors and country governments were eager to reduce duplication, decrease transaction costs, increase equity in resource allocation and sustainability, and improve aid effectiveness (Hutton and Tanner 2004). The development community welcomed SWApS in response to inefficiencies in foreign aid investment, including fragmented, project-based aid administration, the development of parallel, unsustainable channels for implementation, and weak or in-existent links to host country

government policies and plans (Cassels 1997; Peters and Chao 1998; Walt *et al.* 1999; Vaillancourt 2009). One major driver for donors and governments alike was to increase country ownership. The core aspects of a SWAp—the policy, expenditure and institutional frameworks—are a reasonable approach to develop a health sector even without donor involvement, though a SWAp was also intended to provide a basis for donor engagement with national authorities.

During the 2000s, SWAps consistently featured on high-level international policy discussions. For example, the 2003 Rome Declaration on Harmonisation endorsed SWAps as a key tool for improving aid effectiveness (Rome Declaration on Harmonisation 2003). The SWAp strongly influenced the 2005 Paris Declaration on Aid Effectiveness, the 2008 Accra Agenda for Action, and the subsequent International Health Partnership (Rome Declaration on Harmonisation 2003; Paris Declaration on Aid Effectiveness 2005; International Health Partnership Plus Global Compact 2007; Accra Agenda for Action 2008).

Although there is no formal international record-keeping on SWAps, by 2009, the World Bank had documented health sector SWAps in 28 countries, most of them in low-income countries in sub-Saharan Africa (Vaillancourt 2009). Currently, SWAps continue to feature in health reform discussions worldwide. Two recent examples include the SWAp in the Solomon Islands and health sector reform in Orissa, India (Gopalan *et al.* 2011; Negin and Martiniuk 2012). Although SWAps did not singlehandedly become a ‘magic bullet’ solution to country-led aid coordination and management, they remain a popular approach for supporting harmonization, improving accountability between donors and country governments, increasing predictability of aid and most importantly reducing fragmentation (Laaser and Epstein 2010; Mirzoev *et al.* 2010; Negin and Martiniuk 2012).

Context of development assistance in health

The architecture of development assistance in health has changed significantly since SWAps were first introduced. Global health initiatives, such as The Roll Back Malaria Partnership (created in 1998), Stop TB Partnership (started 2000), the Global Alliance for Vaccines and Immunizations (GAVI) (started 2000), The Global Fund for AIDS, TB and Malaria (started 2002) and the President’s Emergency Plan for HIV/AIDS (PEPFAR) (started 2003) are each examples of global efforts and programmes focused on priority diseases and interventions, and have all emerged since the first SWAps were developed. They exist in part because SWAps did not cater to the targeting of specific priority health conditions or interests of international agencies at a time when epidemic spread was increasingly seen as a global emergency. Rather, SWAps encouraged countries to develop their own policies and to allocate resources based on local priorities, often resulting in limited resources being spread thinly and without the level of targeted efforts towards conditions that were viewed internationally as requiring ‘massive effort’ (World Health Organization 2000), an initiative that contributed directly to the formation of the Global Fund for AIDS, TB and Malaria, and the articulation of the Millennium Development Goals. In many ways, it seemed that development agencies had lost faith in national governments to implement health interventions

effectively, especially through broad approaches that were usually funded at <\$10 per capita, and they were taking back the reins of control to pursue a more targeted set of priority interventions. Private foundations, notably the Bill and Melinda Gates Foundation, are also playing an increasingly influential role in the health sector.

The explosion in the number of global health initiatives and philanthropic and other private organizations involved in the health sector is now one of the principal reasons why demand for SWAps has continued. SWAps are intended to serve as a platform for bringing both old and new actors together, in the spirit of harmonization, alignment, and transparency around country-led health policies and processes. Whereas not all actors have a seat at SWAp negotiations in a country, they tend to contribute to increased coordination and alignment efforts in policy and programme design and implementation in countries where they exist (Vaillancourt 2009; Negin and Martiniuk 2012).

More broadly, the private health sector is responsible for a growing share of service delivery in low- and middle-income countries and, as it becomes more organized, has the potential to become an influential factor for public health policy and practice. Because of SWAps orientation around government programmes, and the delivery of public services, they often have done little on policies needed to address the private provision and financing that is a growing concern in most low- and middle-income countries. Some have even argued that they have undermined the effectiveness of the private part of the health sector (F. Schleimann, unpublished data).

High-level partnerships such as the Health Metrics Network, the Global Health Workforce Alliance, the Catalytic Initiative to save a Million Lives and numerous other initiatives have been formed to address more systemic issues. In recent years, all actors have realized that it is imperative to strengthen the health system in general as the necessary foundation for both general service delivery and more targeted interventions.

In practice, this diversification is a key challenge for countries as they try to implement policies and programmes through SWAps. An increased number of actors translates into more agendas and diversity in financial management and reporting, and increases government’s need to manage relationships with donors (Walt *et al.* 1999).

Have SWAps influenced national policy, expenditure and institutional frameworks?

SWAps have contributed to the development of robust national health policies by using them as the basis for actor negotiations and programme evaluations (Walt *et al.* 1999; Vaillancourt 2009). Before SWAps, the absence of clear linkages between available health resources and usually comprehensive national policies allowed for the rise of parallel priority programmes undermined the credibility of these policies (Peters and Chao 1998). Furthermore, SWAps provided the platform for linking measurable indicators from the national health policy to resource allocation.

SWAps are intended to produce a shift from policies that are driven by external aid agencies to those driven by domestic

influences (Peters and Chao 1998). The extent to which SWAps have contributed to this is unclear. Ghana and Tanzania are examples where large, flexible pooled funding empowered governments to use the funding to pursue their decentralization policies. Yet, even among countries that have undertaken a SWAp, none exist where all donors have signed on to the SWAp. For example, despite of strong commitments, the Zambia SWAp did not succeed in serving as a common framework for external assistance (Chansa *et al.* 2008). Specific policy initiatives and their interaction with local stakeholders are probably more influential than whether the country pursues a SWAp. In Ghana, for example, the establishment of a Ghana Health Service (1996) and later the National Health Insurance Scheme (2003) had greater influence on the pathway the health sector took in Ghana, though neither was dependent on the SWAp itself, and both were largely driven by domestic interests, and occurred while the country was implementing a SWAp.

Despite the intentions of the 1990s, overall trends in external assistance suggest that the locus for decision making on such assistance is still far from domestic governments. On one hand, a comprehensive national expenditure framework can better capture long-term donor commitments and contributes to improving the predictability of external aid (Vaillancourt 2009). Yet, global health initiatives, such as PEPFAR and the Global Fund, appear to drive policy through selected country allies, often bypassing local policy and management processes and creating their own processes, with insufficient attention to the unique country context in which a larger set of health programmes are implemented. On the other hand, the nature of dialogue between governments and development agencies has changed remarkably since SWAps began. Sector issues used to be discussed in very fragmented way, with almost exclusive focus on specific projects and interventions and without reference to broader national strategies and overall funding to the sector. The joint annual reviews of the health sector, a feature of most SWAps, have changed the nature of discussion to consider broader issues in the health sector in a more systematic way. Since 2009, the principle of joint reviews has been systematically expanded to the assessment of new health strategies by a Joint Assessment of National Strategies and Plans (JANS) approach of the *International Health Partnership Plus* (2012).

By design, the expenditure framework developed with a SWAp promotes transparency in resource allocation and accountability for donors and country governments in their progress towards improved technical and allocative efficiencies. The expenditure framework facilitates the evaluation of SWAps and holding governments and donors mutually accountable to their commitments, though this often has considerable transaction costs (Chansa *et al.* 2008). In Zambia, data from the medium-term expenditure framework showed that there was an uneven flow of resources to sub-national levels under the SWAp (Chansa *et al.* 2008). In contrast, the experience in Tanzania and Ghana showed that pooled funding arrangements under the SWAp actually increased funding at district levels, though in Ghana there continued to be difficulties with funds getting to more peripheral levels (World Bank 2007).

The number of projects supporting disease-specific efforts outside the SWAp increased in the last 10 years of SWAp

implementation in Zambia (Chansa *et al.* 2008). The authors propose that this trend occurs in other countries with health sector SWAps, where by 2003 pooled funds accounted for less than half of all donor resources (Chansa *et al.* 2008). New initiatives under the *International Health Partnership Plus*, which many consider as the new face of SWAps, are promoting Joint Financing Arrangements to align different modalities of public financing of the health sector in a country for planning, accounting, and auditing purposes, rather than emphasizing the pooling of donor funds (Ministry of Foreign Affairs of the Netherlands 2007; *International Health Partnership Plus* 2011).

The effectiveness of SWAps to strengthen country institutional frameworks has also been mixed, despite considerable efforts in these areas. SWAps were designed to strengthen and use national management systems, monitoring mechanisms, and procurement channels, with the broader purpose of building capacity and incentive structures and creating sustainable health systems (Walt *et al.* 1999; Sundewall *et al.* 2006; Vaillancourt 2009). The extent to which countries achieved these goals varies from setting to setting and depends on the nature of the relationships between donors and their commitment to strengthening the local capacity (Sundewall and Sahlin-Andersson 2006). Individual countries have improved systems for planning, budgeting and procurement, or in the area of health management information systems or systems for human resource management. Aside from the widespread introduction of annual health sector performance reviews, it is not easy to identify a set of management arrangements that have been consistently strengthened across countries involved in SWAps (Walford 2007). For the most part, none of the country SWAp implementations was able to rely exclusively on host country institutions and institutional structures (Walt *et al.* 1999; Sundewall *et al.* 2006; Vaillancourt 2009). It is the lack of local capacity, particularly in systems for procurement, disbursement and financial management, which contributes to difficulties in aligning donors behind national expenditure frameworks (Vaillancourt 2009).

SWAps and priority programmes

SWAp impact on country programmes and health priorities varies by setting. Although SWAps are designed to strengthen the linkages between health priorities and the national health policy, tensions could arise depending on the local context and the extent to which donors in a country sign on to this approach. During early SWAp implementation, experts were unsure as to how SWAps would interact with priority programmes (e.g. for HIV/AIDS, tuberculosis and malaria, or other programmes focused on child or reproductive health) (Peters and Chao 1998). Governments and organizations from low- and middle-income countries have had relatively little influence over the topic or design of the new global health initiatives. The selection of participating countries in these initiatives tends to arise from opportunities created by international and domestic actors that are already involved in a particular programme area, often through parallel processes created by external agencies, rather than from demand from countries that emerge out of domestic policy-making processes.

Only a few evaluations have specifically examined the interaction of priority programmes and SWApS, and the rigor in their methods varies widely and their results are mixed. One subset of studies examined priority programmes such as HIV/AIDS and maternal health in the context of SWApS. For example, in Ghana—one of the oldest SWApS implemented, *Atun et al. (2011)* found that Global Fund HIV/AIDS programmes were well integrated within broader health systems functions, such as financing, planning, service delivery and demand generation. Inefficiencies were identified in the areas of governance and monitoring and evaluation, where parallel structures were developed (*Atun et al. 2011*). In another study based in Ghana, *Okiwelu et al. (2007)* found that despite strong commitment to the SWAp, several safe motherhood programmes continued to be implemented, typically by bilateral donors. The geographic and technical focuses of these activities were not always aligned with the SWAp agenda, therefore potentially diluting the efforts to meet the targets set out in the national health policy. Furthermore, their implementation typically used separate channels for fund disbursement and evaluation (*Okiwelu et al. 2007*). A recent report by Advocacy to Control TB Internationally (ACTION) criticized the World Bank and others because they believe that SWApS had not done enough to control tuberculosis in Africa, although they did not evaluate the country's SWApS in terms of what countries actually intended to accomplish through their SWAp (*Skolnick et al. 2010*).

Another subset of studies examined the effect of SWApS on essential health services, in a context in which SWApS have been implemented along multiple priority programmes. In Malawi, *Bowie and Mwase (2011)* evaluated the SWAp's technical efficiency. The authors found that SWAp investments in cost-effective essential interventions led to increased coverage despite funding shortfalls (*Bowie and Mwase 2011*). In Zambia, *Zinnen et al. (2009)* found improvements in quality of care during the time when the SWAp was introduced, although specific attribution was not possible. A review of World Bank health projects completed between 2003 and 2005 found that SWApS were significantly associated with greater improvements in health services or health status than other organizational approaches, like budget support or specific disease programmes, which were much less likely than SWApS to have measurements of results that demonstrated change in health services or outcomes (*Subramanian and Peters 2009*). At the same time, a World Bank study of six country SWApS found that mixed results were common, and that often only modest achievement of national health targets occurred (*Vaillancourt 2009*). A joint external evaluation in Tanzania concluded 'programmes, projects and activities implemented under the SWAp have contributed to improvements in health outcomes and to some improvements in the quality of health services at community level' (Cowi, Goss Gilroy, Inc., and EPOS 2007). Overall, the level of integration between basic care and priority services and their successful delivery depends greatly on strong government leadership (*Vaillancourt 2009; Atun et al. 2011*).

Role of governments and donors

In a SWAp, donors are expected to relinquish their influence on the selection and management of the projects they finance in

exchange for participation in the process of policy development and resource allocation (*Cassels 1997; Peters and Chao 1998*). Although the SWApS in the seven countries studied by *Vaillancourt (2009)* succeeded in establishing country-led partnerships and changing the dynamics between governments and donors, this is not always the case. SWAp experience to date signals that the readiness of donors to change their role in the SWAp highly depends on donor policies, the extent to which national governments can resolve conflicts with and among donors, and also on the implementation context (*Walt et al. 1999; Vaillancourt 2009*). In addition, it is possible that initial donors' enthusiasm for SWApS underestimated key financial and institutional gaps within country health sectors, as well as the time and commitment necessary to achieve improvements in health outcomes. Under pressure to be accountable on progress towards high-level commitments, such as the Millennium Development Goals, development partners have often bypassed the SWAp in favour of parallel arrangements that allow them to achieve quick success in targeted areas, to the detriment of broader health sector strengthening.

The role of the government in a SWAp is also variable, and can change over time. The principal strength of the SWAp approach is its emphasis on country ownership that is led by national governments. This is also its Achilles heel in that SWApS depend heavily on the capacity and political will of the country's government. As a result, great plans may not be effectively implemented. Although multiple aspects of a country's readiness to engage in a SWAp were explored, it was not possible to assess government capacity to act as a steward of other health sector actors, nor its political will to strike a balance between comprehensive approaches, such as primary health care, and priority programmes and between national and sub-national priorities. In Uganda, for example, the Ministry of Health was lauded for their stewardship in SWAp design (*Jeppsson 2002*), though over time, its performance declined and was not corrected through the relationships with donors in the SWAp (*Oliveira Cruz and McPake 2010*). Locally, while national government actors have been the original target of SWApS, it is clear that high level planning, which excludes managers at sub-national levels, can result in shortfalls of resources for key programme priorities (*Dodd et al. 2009*).

The roles of other stakeholders in SWApS have also been inconsistent. The private sector, a heterogeneous yet important component of most country's health sector, has usually been marginalized in policy discussions and consideration of the expenditure and institutional frameworks. Multiple definitions and interpretations exist for coordination and specific roles, leading to conflicts among SWAp actors and hindering SWAp partnership arrangements (*Hill 2002; Sundewall et al. 2006; Vaillancourt 2009*).

Conclusions

When SWApS were initiated in the 1990s, it was expected that the development of health sector institutions in low- and middle-income countries and the achievement of health goals would require long-term engagement and coherent strategies. Yet, the imperatives and opportunity at the turn of the millennium turned towards shorter term and more targeted

global health initiatives. As attention now turns on how to sustain and build on the gains of the global health initiatives as well as the fundamental need to strengthen health systems, recognizing that many countries will not achieve MDG goals in health (Subramanian *et al.* 2011), there is an increasing need to revisit how SWAp principles can be practised. The country-specific orientation of SWAps is important to recognize, both in terms of learning lessons from individual countries, and in moving forward with initiatives to support effective policies and institutions, including those that address larger issues of private health markets and the broader determinants of good health.

Just as development agencies have lacked discipline in the pursuit of multiple (well-intentioned) interests, national leaders have pursued inconsistent policies that can undermine SWAp principles, and promote inequitable or ineffective health interventions. The future of SWAps will depend on innovative institutional arrangements to support both targeted and comprehensive strategies that address relevant issues in each country where they are pursued, and better discipline by development agencies to support national governments through ongoing dialogue and negotiation.

Funding

This work is supported in part by The Future Health Systems Research consortium, which is funded by the United Kingdom (UK) Department for International Development (DFID) for the benefit of developing countries (grant number H050474). Finn Schleimann is an employee of the World Bank. The views expressed are not necessarily those of DFID or the World Bank and its Executive Directors.

References

- Accra Agenda for Action. 2008. *Accra Agenda for Action*. Accra, Ghana: Third High Level Forum on Aid Effectiveness. <http://www.oecd.org>, accessed 20 March 2012.
- Atun R, Pothapregada SK, Kwansah J, Degbotse D, Lazarus JV. 2011. Critical interactions between the Global Fund-supported HIV programs and the health system in Ghana. *Journal of Acquired Immune Deficiency Syndrome* **57**(Suppl. 2):S72–6.
- Bowie C, Mwase T. 2011. Assessing the use of an essential health package in a sector wide approach in Malawi. *Health Research Policy System* **9**: 4.
- Cassels A. 1997. *A Guide to Sector-Wide Approaches for Health Development: Concepts, Issues, and Working Arrangements*. Geneva, Switzerland: World Health Organization.
- Chansa C, Sundewall J, McIntyre D, Tomson G, Forsberg BC. 2008. Exploring SWAp's contribution to the efficient allocation and use of resources in the health sector in Zambia. *Health Policy Planning* **23**: 244–51.
- Danida. 1994. *A Developing World: Strategy for Danish Development Policy towards the Year 2000*. Copenhagen, Denmark: Ministry of Foreign Affairs.
- Dodd R, Huntington D, Hill P. 2009. Programme alignment in higher-level planning processes: a four-country case-study for sexual and reproductive health. *International Journal of Health and Planning Management* **24**: 193–204.
- Gopalan SS, Mohanty S, Das A. 2011. Challenges and opportunities for policy decisions to address health equity in developing health systems: case study of the policy processes in the Indian state of Orissa. *International Journal of Equity Health* **10**: 55.
- Harrold P. 1995. *The Broad Sector Approach to Investment Lending. Sector Investment Programs. World Bank Discussion Paper*. Washington, DC: The World Bank.
- Hill PS. 2002. The rhetoric of sector-wide approaches for health development. *Social Science Medicine* **54**: 1725–37.
- Hutton G, Tanner M. 2004. The sector-wide approach: a blessing for public health? *Bulletin of the World Health Organization* **82**: 893.
- International Health Partnership. 2007. *A Global "Compact" for Achieving the Health Millennium Development Goals*. London, UK.
- International Health Partnership Plus. 2011. *Harmonization and Simplification of Financial Management*. http://www.internationalhealthpartnership.net/CMS_files/documents/harmonization_and_simplification_EN.pdf, accessed 30 March 2012.
- International Health Partnership Plus. 2012. *The International Health Partnership and Related Initiatives (IHP+)*. <http://www.internationalhealthpartnership.net/en/about..>, accessed 20 March 2012.
- Jeppsson A. 2002. SWAp dynamics in a decentralized context: experiences from Uganda. *Social Science Medicine* **55**: 2053–60.
- Laaser U, Epstein L. 2010. Threats to global health and opportunities for change: a new global health. *Public Health Reviews* **32**: 54–89.
- Ministry of Foreign Affairs of the Netherlands. 2007. *Nordic Plus: Practical Guide to Joint Financing Arrangements*. <http://www.norad.no/en/tools-and-publications/publications/publication?key=109785>, accessed 20 March 2012.
- Mirzoev T, Green A, Newell J. 2010. Health SWAps and external aid—a case study from Tajikistan. *International Journal of Health Planning Management* **25**: 270–86.
- Negin J, Martiniuk A. 2012. Sector wide approaches for health in small island states: lessons learned from the Solomon Islands. *Global Public Health* **7**: 137–48.
- Okiwelu T, Hussein J, Adjei S, Arhinful D, Armar-Klemesu M. 2007. Safe motherhood in Ghana: still on the agenda? *Health Policy* **84**: 359–67.
- Oliveira Cruz V, Mcpake B. 2010. The "aid contract" and its compensation scheme: a case study of the performance of the Ugandan health sector. *Social Science Medicine* **71**: 1357–65.
- Paris Declaration On Aid Effectiveness. 2005. *Paris Declaration On Aid Effectiveness 2005*. Second High Level Forum on Aid Effectiveness, 2005. <http://www.oecd.org>, accessed 20 March 2012.
- Peters D, Chao S. 1998. The sector-wide approach in health: what is it? Where is it leading? *International Journal Health Planning Management* **13**: 177–90.
- Rome Declaration on Harmonisation. 2003. *Rome Declaration on Harmonisation: Harmonising Donor Practices for Effective Aid Delivery*. First High Level Forum on Aid Effectiveness. <http://www.oecd.org>, accessed 20 March 2012.
- Skolnick R, Jensen P, Johnson R. 2010. *Aid without Impact: How the World Bank and Development Partners are Failing to Improve Health Through SWAps*. Washington, DC: ACTION—Advocacy to control TB internationally. <http://www.action.org/site/publications/swaps>, accessed 20 March 2012.
- Subramanian S, Peters D. 2009. Evaluation of changes in health results in world bank-assisted health projects. In: Peters D, El-Saharty S, Siadat B, Janovsky K, Vujcic M (eds). *Improving Health Service Delivery in Developing Countries: From Evidence to Action*. Washington, DC: World Bank.
- Subramanian S, Naimoli J, Matsubayashi T, Peters DH. 2011. Do we have the right models for scaling up health services to

- achieve the Millennium Development Goals? *BMC Health Service Research* **11**: 336.
- Sundewall J, Sahlin-Andersson K. 2006. Translations of health sector SWAps—a comparative study of health sector development cooperation in Uganda, Zambia and Bangladesh. *Health Policy* **76**: 277–87.
- Sundewall J, Forsberg BC, Tomson G. 2006. Theory and practice—a case study of coordination and ownership in the Bangladesh health SWAp. *Health Research Policy System* **4**: 5.
- Vaillancourt D. 2009. *Do Health Sector-wide Approaches Achieve Results? Emerging Evidence and Lessons from Six Countries*. Washington, DC: The World Bank.
- Walford V. 2007. *A Review of SWAps in Africa*. London, UK: HLSP Institute. <http://www.hlsp.org/LinkClick.aspx?fileticket=6G8sLo59BYI%3D&tabid=1796&mid=3485>, accessed 20 March 2012.
- Walt G, Pavignani E, Gilson L, Buse K. 1999. Managing external resources in the health sector: are there lessons for SWAps (sector-wide approaches)? *Health Policy Planning* **14**: 273–84.
- World Health Organization. 2000. *WHO Calls for Massive Effort Against Diseases of Poverty (Press Release)*. Geneva, Switzerland: Geneva. <http://www.who.int>, accessed 20 March 2012.
- Zinnen V, Mwisongo A, Robert A. 2009. Health sector reforms and quality of care at the district level in Tanzania. *Tropical Medicine and International Health* **14**: 32.