Thesis for doctoral degree (Ph.D.) 2009

HEALTH SECTOR AID COORDINATION IN ZAMBIA

Jesper Sundewall

Karolinska Institutet

Thesis for doctoral degree (Ph.D.)
2009

HEALTH SECTOR AID COORDINATION IN ZAMBIA

FROM GLOBAL POLICY TO LOCAL PRACTICE

JESPER SUNDEWALL

Karolinska Institutet

From the Division of Global Health
Karolinska Institutet
Stockholm, Sweden

HEALTH SECTOR AID COORDINATION IN ZAMBIA

FROM GLOBAL POLICY TO LOCAL PRACTICE

Karolinska Institutet

STOCKHOLM 2009

Published by Karolinska Institutet.

ISBN 978-91-7409-562-3

Printed by
REPROPRINT AB
Stockholm 2009
www.reproprint.se
Gårdsvägen 4, 169 70 Solna

To my family

For knowing how to love me

ABSTRACT

The volume of foreign aid to the health sector in low- and middle-income countries and the number of donors involved have increased in recent years. During the last two decades, more attention has been directed towards better coordination of donor resources and activities, particularly in the health sector. Models and agreements for how to improve the coordination of aid, such as the sector-wide approach (SWAp) and the Paris Declaration, have been launched. Significant effort has been invested in designing models for coordination, but comparatively little time has been devoted to studying how these models are implemented or what effects they have had. This thesis explores and analyses how health-sector aid coordination is implemented, from its definition in global policies to its practical application at the local level in Zambia.

Aid coordination is analysed from the perspective of policy implementation. All four studies described in this thesis were conducted in Zambia, a country with extensive experience of coordination of activities and resources in the health sector. A case-study design was applied, which combined qualitative and quantitative methods for data collection. Non-participant observations, semi-structured interviews, document review and data on financial and administrative accounts were used. In total, more than 100 interviews were conducted with key actors: donor representatives and government officials. Findings were compared with nationally and internationally agreed indicators for efficiency in resource allocation and aid effectiveness.

Findings showed that coordination is "translated" as it is adopted, being adapted to suit the existing administrative structures in different contexts. Translations varied more between actors than between different institutions. In general, actors were content with how health-sector aid was coordinated, although stakeholders had different ideas about how such coordination should be implemented. In Zambia, coordination efforts that started in the early 1990s have so far contributed little to the efficient allocation and use of resources in the health sector. Indicators for aid effectiveness showed that the coordination of resources at the district level is still a challenge since the number of external partners is increasing and the predictability of resources is not improving.

Coordination of health-sector aid has led to changes in the ways that development aid is organized. In practice, however, the effects of these changes are still limited. The lack of effects is explained partly by observed decoupling between policy and practice, as processes are adjusted to match the actors' needs and fit into the local context. The actors' different understandings of how coordination is implemented and the fact that many resources are still uncoordinated weaken government ownership and are contrary to the global agreement of the Paris Declaration.

Keywords: *Zambia; health sector; aid coordination; implementation; policy; SWAp; Paris Declaration.*

LIST OF PAPERS

I **Sundewall J** and 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**(3): 277–287.

II **Sundewall J**, Jönsson K, Cheelo C and Tomson G. Stakeholder perceptions of aid coordination implementation in the Zambian health sector. Submitted.

III Chansa C, **Sundewall J**, McIntyre D, Tomson G and Forsberg BC (2008) Exploring SWAp's contribution to the efficient allocation and use of resources in the health sector in Zambia. *Health Policy and Planning* **23**(4):244–251.

IV **Sundewall J**, Forsberg BC, Jönsson K, Chansa C and Tomson G (2009) The Paris Declaration in practice: challenges of health-sector aid coordination at the district level in Zambia. *Health Research Policy and Systems* **7**:14.

These papers will be referred to in the text by their roman numerals, I–IV.

LIST OF FIGURES AND TABLES

CONTENTS

LIST OF ABBREVIATIONS

CHAZ	Churches Health Association of Zambia
CIDA	Canadian International Development Agency
CSO	Civil Society Organisation
DANIDA	Danish International Development Agency
DAH	Development Assistance for Health
DFID	Department for International Development
EC	European Commission
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GHI	Global Health Initiatives
GNI	Gross National Income
IHP	International Health Partnership
JICA	Japan International Cooperation Agency
MACEPA	Malaria Control and Evaluation Partnership in Africa
MAP	World Bank Multi-country HIV/AIDS Program
MDG	Millennium Development Goals
MTEF	Medium-Term Expenditure Framework
NGO	Non-Governmental Organisation
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
OECD-DAC	OECD-Development Assistance Committee
PEPFAR	President's Emergency Plan for AIDS Relief
PIU	Parallel Implementation Unit
PRSP	Poverty Reduction Strategy Papers
Sida	Swedish International Development Cooperation Agency
SIP	Sector Investment Programme
SWAp	Sector-Wide Approach
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNZA	University of Zambia
USAID	United States Agency for International Development
WHO	World Health Organization

SOME DEFINITIONS

Aid	External resources provided to countries as grants, loans, subsidies or in-kind donations (synonyms: development assistance, external assistance, development aid)
Aid coordination	Any activity or set of activities, formal or non-formal, at any level, undertaken by recipients in conjunction with donors, individually or collectively, which ensures that external inputs to the health sector enable the health system to function more effectively, and in accordance with local priorities, over time (Buse and Walt, 1996)
Aid effectiveness	The ability of aid to enable countries reach their own development objectives (OECD, 2008b)
Alignment	Donors base their overall support on partner countries' national development strategies, institutions and procedures (Paris Declaration, 2005b)
Development assistance for health	Financial and in-kind contributions from channels of assistance to improve health in low and middle-income countries for health (Ravishankar, Gubbins et al., 2009)
Effect	The way in which an event, action, or person changes someone or something (synonyms: outcome)
Efficiency	The quality of doing something well and effectively, without wasting time, money, or energy
Harmonisation	Donors' actions are more harmonized, transparent and collectively effective (Paris Declaration, 2005b)
Official development assistance	Official financing administered with the promotion of the economic development and welfare of developing countries as the main objective and which are concessional in character. ODA flows comprise contributions of donor government agencies (bilateral ODA) and to multilateral institutions. (OECD, 2008b)
Ownership	Partners exercise leadership over their development policies and strategies and coordinate development actions (Paris Declaration, 2005b)

PROLOGUE

Some time about halfway through my doctoral studies, I was sitting in the office of the United Kingdom (UK) Department for International Development (DFID) health officer in Zambia. DFID was at this time the lead donor in the Zambian health sector and it was this officer's responsibility to facilitate donor coordination in the sector. At the time, we had already met on several occasions, both for interviews and in meetings, and we knew each other well. We chatted informally and at one point I asked her *"How many donors do you coordinate?"* She hesitated then answered *"Fourteen, but that is my best guesstimate"*. Her response was striking but, in retrospect, not surprising. It was in fact a very revealing expression of the crux of aid coordination. That is, aid coordination involves an imprecisely defined group of actors who, driven by their own interests, are involved in financing and implementing vastly different activities, through a multitude of processes. And the challenge of coordination is to bring all these actors and processes together under a common framework in a specific contextual setting.

The idea for this thesis originated in work I undertook in 2002–2003. At that time I was employed by the Swedish International Development Cooperation Agency (Sida) to conduct a study on the sector-wide approach (SWAp – a model for development aid aimed at improving coordination of development aid) to health in three countries: Bangladesh, Uganda and Zambia. For some reason, my employers believed that a recent graduate like myself would be the right person for the job. The study explored the early experiences of the implementation of the SWAp model in the health sector in these three countries.

During the numerous interviews and observations I conducted during my month-long visits to each country, it struck me that although SWAp had been in effect for a number of years in each of the countries under study, and although all stakeholders claimed to support it, the actors had very different ideas and understandings of what the model actually implied. This finding took me, perhaps naively, by surprise. I had assumed that since all countries were implementing a SWAp, and all partners formally endorsed it, a joint understanding of the model would exist. Stimulated by the elusiveness of the SWAp model, I started to investigate the existing research on the topic and quickly realised that empirical studies of SWAp implementation were scarce in the scientific literature. Further reading led me to think that the SWAp model was perhaps merely a practical application – a tool to achieve improvements in aid and in particular coordination of aid. All this led me to the following question, which guided investigations in the first two articles (I and II) of my thesis:

How is aid coordinated?

This question might seem trivial, but what I set out to understand was not only what models are used to coordinate aid but also how different actors apply the models in a specific context.

As I continued to explore the literature, I expected, given the strong support for coordination, to find evaluations and reports assessing its effects. This was, however, not the case. Given the amount of attention given to coordination in the aid debate,

there has been remarkably little assessment of its effects. One obvious reason for the lack of evidence is of course the difficulties involved in determining cause-and-effect relationships and outcomes in the SWAp model, as has been confirmed by large donors such as the World Bank and by my own meetings with government officials and donor representatives during the course of my work. With such difficulties in mind, papers III and IV of my thesis focus on this very question, or more specifically:

What have been the effects of aid coordination?

As will be discussed in this thesis, understanding the effects of coordination implementation is not an easy task. There are numerous challenges, in particular, in deciding what to measure and how. The reader hoping to find an answer to the question of whether coordination is good or bad will be disappointed. It is not my aim to make a judgement on what has been achieved so far, but rather to improve our understanding of how coordination is implemented and how it can be assessed, and what the challenges are in this process.

My approach to the topic of health-sector aid coordination has been multi-disciplinary. While my educational background is in the social sciences, or more specifically, in business and economics, the studies described in this thesis were conducted at the Karolinska Institutet, a medical university with a strong positivistic tradition. Here I worked within the area of health-systems research, a field that is populated by researchers from very different academic backgrounds. My supervisors both have educational backgrounds that are different from my own, one being a natural scientist, the other a political scientist, while my collaborating partners at the University of Zambia are all economists. During the course of my work, sociologists, nurses and pharmacists (to name but a few) have also provided scientific input. While it has not always been easy, I regard the multi-disciplinary approach as a major strength of these studies. People with a background in medical sciences have, in particular, provided useful guidance on issues of methodology, while the social scientists have challenged me from a more theoretical perspective. The challenge for me has been to merge these, sometimes disparate, world views and create a thesis that meets a high scientific standard and that is also relevant and useful for aid practitioners.

Stockholm, August 2009

Jesper Sundewall

1 INTRODUCTION

In an article in *The Economist*, published around the time of the Ghana meeting on Aid Effectiveness held in September 2008, it was stated that aid is *fragmenting*; i.e. there are too many donors, financing too many projects using too many different procedures (The Economist, 2008). It is generally agreed that fragmentation of aid has negative implications for aid effectiveness, i.e. the extent to which aid efforts achieve the intended results. Better coordination of resources and activities has been seen as a way to overcome these problems. Or, as expressed by Buse and Walt (1997), coordination is a means to an end to manage resources more effectively and thereby contribute to overall health-sector objectives. The term "coordination" is used to describe and label a variety of processes, from formal and informal discussions between donors and governments in aid-receiving countries, to agreements and contracts for how aid should be disbursed and implemented. It has led to the launch and widespread adoption of models for how aid should be organised and implemented, for example, the sector-wide approach (SWAp) model and sector investment programmes (SIP). International agreements for how to better coordinate aid have been developed and formalised through the Paris Declaration on Aid Effectiveness and the International Health Partnership (IHP).

The discourse on coordination is by no means new. In Zambia, the focus of this thesis, the importance of a coordinated effort towards development, which is in line with national priorities, was formulated and emphasized shortly after independence in 1964. From the very beginning, the government, under the leadership of the republic's first president, Kenneth Kaunda, laid out national development plans that were designed to be the guiding strategy for the country's development. Even at this stage, Kaunda highlighted the fragmented nature of donor support to Zambia and the lack of coordination of donor efforts with national plans. Kaunda stated that the fact that donors were unable to provide predictable support, that their planning horizon rarely spanned further than the coming two to three years, crippled Zambia's ability to make long-term plans (Kaunda, 1966; p.144) What is relatively new, however, is that coordination is now included as a formal strategy in development cooperation.

A recent literature review showed that aid coordination was the subject of 21 peer reviewed journal articles published in 1994–2007, 11 of which were labelled as "empirical analyses" focusing mainly on experiences with implementation (Gilson and Raphaely, 2008). While this might as appear to be a considerable body of evidence, it should be highlighted that seven of these articles were published in a single journal issue – *Health Policy and Planning* 1999; 14(3). Early studies on coordination have often been prescriptive in character, accounting for how coordination is intended to be implemented – not how it is implemented in reality (Buse and Walt, 1997; Walt, Pavignani et al., 1999a). The few studies on exploring implementation that were identified were limited in scope, and focused on describing the formal processes for coordination (Buse, 1999; Lanjouw, Macrae et al., 1999), relied on input from a limited number of key informants (Pavignani and Durao, 1999) or focused only on the support of a certain donor (Brugha, Donoghue et al., 2004). The only study found to focus on health-sector aid coordination in Zambia described the intended rather than actual implementation of coordination (Lake and

Musumali, 1999). So far, research on coordination has been targeted at the global and the national level.

The literature review conducted in preparation for this thesis showed that few studies explored coordination at lower levels of the health system, despite the fact that in most countries receiving development assistance the majority of health services are delivered through administrative structures below the national level. The Global HIV/AIDS Initiatives Network study on effects of global health initiatives in three districts in Zambia is a rare exception, although it focused specifically on funds for HIV/AIDS (Frontiers Development and Research Group, Royal College of Surgeons in Ireland et al., 2008).

Therefore, while coordination has now been on the agenda for some 20 years, there is still little documented about how it is implemented in practice. Despite the attention given to the idea of coordination, relatively little interest has been directed towards the relationship between coordination and the actual practice it is expected to generate in a certain context. Such lack of interest is commonplace in studies of aid models (Mosse, 2005). Also, while models themselves are important, we know that when they are implemented there are often differences between policy and practice, between talk and action (Brunsson, 2003).

Aid coordination is high on the development agenda, and thus understanding its implementation is critical to assess its appropriateness and expected outcome in a given context. Such information would provide policymakers in recipient countries as well as donors, with a better evidence base for how to organise development assistance. Aid coordination is a global idea, with the intention to be implemented at lower levels. Therefore it is relevant to study its development from a policy at the global level to its practical implementation in a specific context. Zambia makes a particularly interesting case to study as it is a highly aid-dependent country with a strong donor presence and has worked with aid coordination for a relatively long time, since the health reforms of the early 1990s. Coordination in Zambia was based on a clear national health policy and a national health strategic plan (Kalumba and Musowe, 1998). Furthermore, a common funding mechanism exists – the "district basket" – for pooling of health-sector resources. The basket is a way for donors to collectively fund service delivery at the district level using a standard set of procedures (Lake and Musumali, 1999).

1.1 Overall objective

The overall objective of this thesis is to explore and analyse the implementation of health-sector aid coordination: from how it is defined as a global policy to its practical application at the local level in Zambia, in order to provide a better understanding of how coordination is implemented and how it can be improved.

1.2 Specific objectives

Studies I and II focused on the policy and implementation of coordination of health-sector aid in a global and national perspective. More specifically, I sought to:

- Analyse how a model for coordination is translated when implemented in different contexts and to what extent these translations trigger changed practice (study I).

- Explore stakeholder perceptions of aid-coordination implementation in the health sector in Zambia in order to determine whether aid is organized in line with joint agreements and plans (study II).

Studies III and IV analysed the effects of the implementation of aid coordination at the national and district level in Zambia. In particular, these studies aimed to:

- Explore whether the envisaged effects, in terms of allocation and use of resources, have been achieved during the implementation of coordination, using the Zambian health sector SWAp as a case (study III).

- Analyse implementation of health-sector aid coordination at the district level in Zambia in relation to global and national indicators for progress (study IV).

2 BACKGROUND

2.1 Aid and development

Aid coordination is better understood in the light of general development in aid to foreign countries. The origin of foreign aid can be traced to the 19th century, but aid as most us know it has existed since the end of World War II. Its first manifestation was the Marshall Plan, led by the United States of America (USA), to rebuild Europe after the war. The plan laid the foundation for the European post-war recovery. Aid was, in the wake of the recent worldwide conflicts, very much driven by security objectives. Popular arguments state that aid has generally been driven by, and reflected, donor interest. However, it has also been stressed that much of development aid has been for humanitarian purposes. Although aid was driven by the economic interests of donor countries, aid programmes were essentially promoted to stimulate economic growth and alleviate poverty in poorer countries (Lumsdaine, 1993; p.32).

Since the beginning, the character of aid and aid mechanisms has shifted several times. A categorisation by the World Bank of the different phases of aid (International Development Association, 2007) gives the following picture:

- **Cold-War aid architecture** (1946–1989)
    - Post-war security aid (1946–1959)
    - Economic development assistance (1960–1969)
    - Commodity shocks (1970–1979)
    - Structural adjustment (1980–1989)
- **Post-Cold War aid architecture** (1990–present)
    - Post-war transition (1990–2000)
    - New millennium development (2001–present).

After the first phase, which was heavily dominated by the USA, a broader programme for development assistance emerged. In 1960, the Organisation for Economic Cooperation and Development (OECD) formed the Development Assistance Group (which became the Development Assistance Committee – DAC – in 1961). DAC was set up to create a more equitable sharing of the aid effort and laid the foundation for the aid system we have today (Führer, 1994). Aid in the 1970s was much plagued by the oil-price crisis and falling commodity prices. These exogenous shocks shook countries with economies that were dependent on the export of raw material, for example Zambia, whose economy was, and still is, largely based on income from the sale of copper. The 1980s saw the introduction of the structural adjustment programmes introduced by the World Bank and the International Monetary Fund (IMF). The focus of the structural adjustment

programmes was initially the development of macroeconomic policies in low-income countries (Hjertholm and White, 2000), and such programmes sprang from economic problems experienced by several poorer countries. The granting of loans from the IMF and the World Bank became conditional to the receiving countries implementing a set of reforms. The reforms were generally aimed at liberalizing the market through privatisation of state-owned enterprises and deregulation of financial markets.

Since the 1990s, the focus of most of the countries and institutions providing development assistance has been poverty reduction. Low- and middle-income countries have been encouraged and supported to development national poverty-reduction plans, so-called Poverty Reduction Strategy Papers (PRSP), which outline how the country intend to combat economic poverty. Similarly, on a sectoral level, there has been a focus on countries developing strategic plans to cover the coming three to five years. In these plans, the overarching goals for sectoral development are laid out. The plans are also supposed to be matched by a financial framework, commonly referred to as the Medium Term Expenditure Framework (MTEF).

2.2 Volume of aid

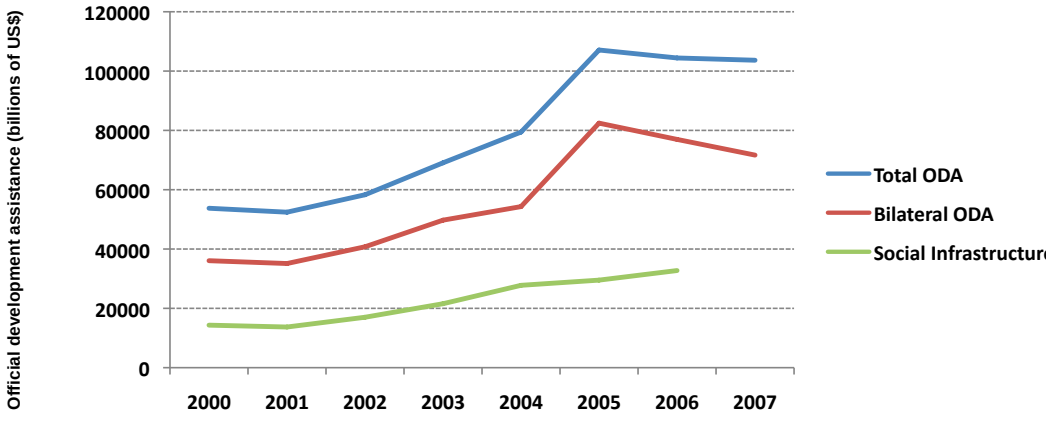
From the 1960s, the volume of aid grew steadily until the 1990s, when a marked decline was noted. The decline followed, and is partly explained by, the end of the Cold War. Another contributing factor was the general economic decline that many European countries experienced (Hjertholm and White, 2000). Since the turn of the millennium, the volume of aid has grown as a result of a variety of measures including increases in traditional aid, debt relief and innovative financing mechanisms. The world's wealthiest nations, the G8 group, pledged increased financial support for poor countries, in particular in Africa, at the 2005 G8 summit in Gleneagles, Scotland. The G8 pledges included substantial debt relief and also a commitment to reach the target of allocating 0.7% of gross national income (GNI) for official development assistance (ODA) by 2015 (Gleneagles G8 meeting, 2005). If this target is met, it means that the European Union countries would more than double their ODA.

As can be seen in Figure 1, total ODA from the OECD countries has increased by almost 100% in the last seven years, with the share of bilateral aid remaining fairly constant. The development of aid to social infrastructure, which includes health and education, shows an even larger increase having more than doubled between 2000 and 2006.

For health aid alone, OECD estimates show that there has been a sharp rise in both bilateral and multilateral funding during the last decade (OECD, 2008c). A recent tracking study of development assistance for health (DAH), which also includes contributions from non-governmental organisations (NGOs), shows that DAH increased from US$ 5.6 billion to US$ 21.8 billion between 1990 and 2007. This review concluded that while DAH channelled through the United Nations (UN) system and the development banks has decreased, new channels for the distribution of DAH have developed in the shape of The Global Fund to fight Aids Tuberculosis

and Malaria (Global Fund), the Global Alliance for Vaccines and Immunization (GAVI) and NGOs (Ravishankar, Gubbins et al., 2009).

Figure 1: Trends in official development assistance from OECD countries, 2000–2007



Data for social infrastructure for 2007 not available.

Source: OECD/DAC database

The Global Fund was launched in the early 2000s with the aim of mobilizing much needed extra funding for the three principal infectious diseases affecting low- and middle-income countries. During the same time period, the US Government launched the President's Emergency Plan for Aids Relief (PEPFAR). PEPFAR has a massive budget for the treatment of HIV-positive individuals. As a result of these and other initiatives, 32% of all ODA for health in 2002–2006 was provided for HIV/AIDS-related activities (World Bank, OECD et al., 2008). Another major global initiative is GAVI, a public–private partnership aimed at securing funding for, and stimulating the development of, vaccines for low-income countries.

With the introduction of the abovementioned global health initiatives (GHIs) came a renewed discussion on whether, and if so how, resources should be integrated in government budgets. Brugha and Walt (2001) argued that by including the funds from GHI in national budgets, transaction costs would be reduced but with the risk of delaying reaching their targets. GHI are continually being criticised for being too vertical and project-oriented, failing to consider the system-wide implications of their activities (Ooms, Van Damme et al., 2008). This perceived conflict between a more vertical approach, with a clear focus on a specific disease and activities, and the horizontal, with a broader, more systems-based approach, is not new, as Uplekar and Raviglione (2007) have recently pointed out; the issue has been subject to discussion since the 1970s.

2.3 Aid modalities

Development assistance is provided through different mechanisms. In each country, and each sector of each country, the total aid package is commonly distributed through a mix of several mechanisms. A simplified description of the most common mechanism for delivering health-sector aid would include *project aid*, *sector budget support/pool funding mechanism*, and *general budget support.*

Project aid: Traditionally, donors have channelled aid to recipient countries and implemented them through a project-by-project approach or, as they have also been labelled, through "vertical" programmes (Mayhew, Walt et al., 2005). Under a project approach, each donor insist on its own priorities, reporting systems, financial year and disbursement conditions (Adams, 1989). A common criticism of this approach is that it undermines the possibility of establishing a coherent health-sector strategy and can lead to fragmentation and duplication of donor efforts (Peters and Chao, 1998). Another frequently voiced concern is that a project approach increases transactions costs, i.e. the costs of managing and delivering aid (Buse and Walt, 1997).

Sector budget support/pool funding mechanism: Sector budget support and pool funding mechanisms are efforts to provide more predictable funding for a sector, or part of a sector. Commonly, sector budget support means that resources supporting a specific sector are channelled by the donor through the national Ministry of Finance and are thus accounted for using national systems (EuropeAid, 2007). Pool funding mechanisms work in a similar fashion, gathering resources from several donors. The main difference from sector budget support, however, is that pooling of funds normally does not cover the entire sector. For example, in Zambia there is a mechanism for pooled funding of resources for district health care. The use of resources from both sector budget support and pool funding are supposedly based on country-led strategies for sectoral development.

General budget support: General budget support, or budget support, is the most recent aid modality to be introduced. In brief, it means that donors channel their resources directly to the national budget without earmarking their resources for a specific use. Donors adopting a general budget support approach normally do so in order to provide less conditional support to the implementation of a country's national poverty reduction strategy. General budget support has been promoted using the argument that it increases the emphasis on government ownership and could provide more long-term and predictable support. However, budget support has also been associated with increased fiduciary risks and difficulties in performance monitoring. (Koeberle and Stavreski, 2006)

In response to the observed shortcomings of the project approach, new agreements and models for how to better coordinate aid efforts have been launched. These are further elaborated in the following sections.

2.3.1 Sector investment programmes and the sector-wide approach

Sector investment programmes (SIPs) were launched in the 1980s but did not take off until the mid 1990s (Kapur, Lewis et al., 1997; pp 38–39). SIPs were driven by similar arguments as those promoting aid coordination in the late 1980s, i.e. that a project-by-project approach had undermined government ownership. Conflicting donor priorities and different administrative routines had further constrained recipients to manage and lead the development process. (Harrold and associates, 1995)

The SIP model never fully took off, perhaps because of its close association with the World Bank and regional development banks. Instead, only a few years later, the sector-wide approach (SWAp) model was formalised and presented in a joint publication from the World Health Organization (WHO), the Danish International Development Assistance (DANIDA), DFID and the European Commission (EC). The document, which quickly became a reference for work with SWAps, defined the model as:

> *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.* (Cassels, 1997; p.11)

A quick comparison reveals many similarities between the SIP and the SWAp models. Both emphasize that the process should be recipient-led with common arrangements and involve, preferably, several donors. The SWAp model was soon redefined. Foster and Brown (2000) argued for the existence of a common expenditure framework and Walford (2003) emphasized that all significant funding agencies should support a shared policy and strategy. The SWAp was launched with the health sector in focus and it was adopted in several countries (e.g. Bangladesh, Ghana, Kyrgyzstan, Malawi, Mozambique, Tanzania, Uganda and Zambia). Over time, it has also transferred to other sectors, in particular, education. Although the SWAp model is now widespread, a surprisingly large share of all ODA for health is still not provided according to the DAC definition of "sector support": only 7.7% in 2002–2006 (World Bank, OECD et al., 2008).

Many of the early publications on the SWAp model were found in the so-called "grey literature" – mainly consultancy reports and commissioned studies. More recently, the model has also been the subject of publications in peer-reviewed journal articles. The SWAp has been promoted forcefully with the arguments that it increases coordination of the health sector, promotes country leadership and ownership and strengthens management and delivery system (Hutton and Tanner, 2004). Garner et al. (2000) argued that the SWAp can dramatically increase the effects of aid. At the same time, however, it comes with the risk of making things

worse, as the money donated might be spent in unproductive ways. The main objective of the model, however, is to increase donor collaboration and consolidate local management of resources (Hill, 2002). Experiences from Uganda showed that the SWAp model shifted the way donors and government collaborated. Instead of entertaining a dialogue on various technical areas, the discussion moved to cover the entire health sector (Jeppsson, 2002). Evaluations of the SWAp in Bangladesh and Ghana also indicated that the introduction of a SWAp led to a more holistic view of the health sector and a reduction of projects (Independent Evaluation Group, 2006; Independent Evaluation Group, 2007). So far, however, the effect of the model remains inconclusive (Murray, Frenk et al., 2007). It has been suggested that donor priorities may compete in the SWAp and evaluations of this, and other aid mechanisms, are therefore needed (Task Force on Health Systems Research, 2004). Critics of the SWAp have argued that the model has not led to the changes expected; the process is still very much donor-led, project financing is still commonplace and harmonisation has been weak (White, 2007).

2.3.2 International agreements

Despite the increased attention to coordination and the launch of the SWAp model, the effectiveness of aid was still being questioned. At a high-level meeting in Rome in 2003, attended by representatives of a substantial number of governments and multilateral organisations, an international dialogue on aid effectiveness was initiated. The Rome meeting concluded with a declaration on harmonisation of development assistance. While this was a starting point, it was not until two years later, during the subsequent meeting in 2005, that the discussion really produced results.

At the next meeting in Paris 2005, the participants agreed on a common declaration aimed to increase aid effectiveness – the Paris Declaration on Aid Effectiveness – which has, to date, been signed by more than 130 countries and 28 international organisations. The declaration is built around five thematic headings encompassing critical issues, namely:

- *Ownership (partner):* Partner countries exercise effective leadership over their development policies, and strategies and co-ordinate development actions.
- *Alignment (donor-partner):* Donors base their overall support on partner countries' national development strategies, institutions and procedures.
- *Harmonisation (donor-donor):* Donors' actions are more harmonised, transparent and collectively effective.
- *Managing for results:* Managing resources and improving decision-making for results.
- *Mutual accountability:* Donors and partners are accountable for development results.

(Paris Declaration, 2005b; OECD, 2007)

To monitor progress, twelve indicators related to the three themes were developed, each with an attached target, which was to be attained by 2010. As one of the signatories of the declaration, Zambia is committed to working in the spirit of the Paris Declaration.

It is important to mention that the Paris Declaration is a broad agreement covering all aid activities and not only health. With the large number of signatories, the Paris Declaration has broad support and legitimacy. In September 2008, the Declaration was followed up at a high-level forum in Accra, Ghana, in which leaders from all the nations and organisations that had committed to the Paris Agenda participated. Discussions during the meeting identified three major challenges in the quest for increased aid effectiveness (Ooms, Van Damme et al., 2008):

- Country ownership is key;
- Building more effective and inclusive partnerships; and
- Achieving development results – and openly accounting for them – must be at the heart of all we do.

In addition to responding to these challenges, countries and organisations pledged renewed commitment to meet the targets set out in Paris Declaration by the year 2010.

The most recent initiative for health-sector aid coordination is the International Health Partnership (IHP), launched in 2007 by the UK Prime Minister, Gordon Brown. Zambia was one of the first countries to sign the IHP, which is not so much a new aid modality or agreement, but rather a tool to reinforce commitment to the Paris Agenda. During the launch, three specific IHP objectives were presented: provide better coordination among donors; strengthening health systems; and supporting countries' health plans. Improved coordination will be achieved by increased endorsement of strategic plans and better organisation of how these plans are financed. Strengthening health systems is enforced in the IHP, being seen as crucial for building on medical successes so far. Finally, IHP partners have committed to assist aid-receiving countries in developing national plans that reflect the needs of the citizens of these countries (Alexander, 2007).

Since signing the IHP, Zambia has worked in line with the IHP framework to assess the country's situation with regard to the Millennium Development Goals (MDG) and the Paris Declaration and identify the main barriers to further progress. According to the stock-taking report presented by the Ministry of Health in February 2008, the main barriers consisted of constraints and resource gaps in funding the health sector, the lop-sided nature of resource allocation and increasing fragmentation. The health system also has weaknesses, particularly in the lack of human resources, erratic drug supply and supply-chain management, equipment and infrastructure development (Ministry of Health, 2008b). The identified barriers should then serve as a results-and-performance assessment framework for monitoring implementation (Ministry of Health, 2008a).

2.4 Aid coordination

As previously mentioned, aid coordination has had a prominent position on the development agenda for the last 20 years. Increased attention has been paid to this issue as a result of the increasing number and diversity of external agencies, as well as a general increase in the volumes of aid (Buse and Walt, 1997). In the early days, the term "coordination" was used to cover different activities, from informal meetings between actors in development to formalised consultative meetings between donors and recipients. The essential components emphasized were (Ross, 1990):

- Exchange of information;
- Common understanding of policy, objectives and priorities; and
- Common programmes and projects that are jointly supported.

The call for increased coordination has mainly been driven by arguments of efficiency and effectiveness – efficiency in terms of better use of resources and effectiveness in terms of better impact and outcome of aid efforts. In the World Bank *Investing in health* report of 1993 it was argued that:

> *The efficiency of aid for health can be greatly enhanced through better coordination of donor projects and policies. Fragmentation of external support in the health sector is a long-standing problem in many countries and imposes a heavy burden on already overextended officials. (World Bank, 1993;* p.167)

Much of the early literature was focused on coordination of *donors* and not on coordination of *aid*. In the health sector in Zambia, the Ministry of Health focused on coordinating resources and not donors at an early stage, as all attempts to coordinate the latter proved unsuccessful (Kalumba and Musowe, 1997). Although it could be argued that there is little difference between the two, there has been a shift in the rhetoric and in more recent years the focus has shifted to coordination of resources and activities. In this thesis, no distinction will be made between donor coordination and aid coordination, but they will be treated as mutually exclusive.

According to Buse and Walt, donor coordination refers to:

> *Any activity or set of activities, formal or non-formal, at any level, undertaken by recipients in conjunction with donors, individually or collectively, which ensures that external inputs to the health sector enable the health system to function more effectively, and in accordance with local priorities, over time.* (Buse and Walt, 1996)

The definition offered by Buse and Walt is very broad. It is worth highlighting that this definition emphasizes that coordination refers to activities conducted by the donors and recipients collectively: it is not a "one-man show".

Furthermore, Buse and Walt (1996) propose five principles for determining how aid coordination should be implemented:

1. The ministry of health should take the lead in managing and coordinating external resources.
2. Donors should provide technical assistance to enable the ministry to assume the leadership function.
3. External resources should be coordinated, managed and deployed as part of a national health plan.
4. The government should encourage multilateral and bilateral agency involvement in the formation of the national plan and attempt to achieve genuine consensus on the final product.
5. Donors should attempt to subvert their administrative requirements, commercial and other interests in pursuit of the objectives of the plan.

(OECD, 1992; Buse and Walt, 1996)

The first point means that the ministry of health should be the link for all donor support, to avoid duplication of efforts. The second proposes that when capacity within the ministry of health is insufficient to shoulder the responsibility for coordination, donors should not assume this role themselves but should provide support for the ministry to enable it to take on this responsibility itself. The third point in effect means that all donor support should be aligned with the national plans, i.e. following the priorities as formulated by the ministry of health. The fourth point is commonly expressed in the inclusion of donors in central processes for formulation and follow-up of the national plan. This includes donor participation in the planning process, their involvement in monitoring and evaluation teams etc. The fifth and final point refers to donors making an effort to simplify and harmonize donor requirements. Specific donor requirements on fund management, reporting etc should be subordinate to the goals of the national plan. The principles proposed by Buse and Walt should be interpreted as the first concrete suggestion for how the perceived inefficiencies of not coordinating aid could be managed.

Intuitively, coordination seems attractive; *coordinated* is always superior to *uncoordinated*. Aid coordination is not an end in itself, but a means to make development aid more effective. Buse and Walt (1997) argue that coordination is a tool to enable the health system to work more effectively. Similarly, the stated ambition of the Paris Declaration is to increase the effectiveness of development aid (Paris Declaration, 2005b). Finally Dante (2003) presents coordination as a tool for increasing effectiveness, but also for making aid more efficient.

A challenge to understanding and analysing coordination is not only the complexity of the concept itself, but also the fact that coordination is also closely linked to other notions in development aid and is commonly expressed using other terms. In the Paris Declaration on Aid Effectiveness, the terms “harmonisation” and “alignment” are used to describe activities that are closely linked to the definition of coordination presented above; a comparison with the definition offered by Buse and Walt reveals clear similarities. Alignment is defined as the principle that donor support should be based on, and in line with, recipient countries’ plans and procedures. Harmonisation, on the other hand, refers to donors developing common arrangements and to relying

on joint evaluations and analyses (Paris Declaration, 2005b). Therefore, a pragmatic approach to understanding alignment and harmonisation is adopted in this thesis and both alignment and harmonisation are treated as components of coordination.

Coordination has also been closely coupled with specific aid models; in particular the SWAp. Many of the texts on SWAp cite coordination as a core feature of the model and, similarly, literature on coordination makes frequent reference to the SWAp model as a means for improved coordination of resources and activities (Cassels and Janovsky, 1998; Walt, Pavignani et al., 1999b; Foster, 2000). Thus, in this thesis, the SWAp model is treated as an example of implementation of aid coordination in the health sector.

2.5 The context: Zambia

2.5.1 Country profile

Zambia is a landlocked country in sub-Saharan Africa with about 12 million inhabitants.

In 1964, Zambia gained independence from the UK and Kenneth Kaunda became the republic's first president. The struggle for freedom was comparatively free from violence and the country has since been spared from major political turmoil. As the price of copper (the main export of the country) plunged in the 1970s, the economy completely collapsed; once the second richest country south of the Sahara, Zambia is today one of the poorest nations on the continent. Kaunda held power for over 25 years until, in 1991, he was compelled to step down and make way for a new leadership.

Since 1991, Zambia has performed several relatively free and fair elections. In 2006, Levy Mwanawasa was re-elected for a second five-year term. However, Mwanawasa suffered a stroke at an African Union meeting in Cairo in June 2008 and died in August that year, forcing the country to hold presidential by-elections in October 2008. This election was won by the vice-president, Rupiah Banda, who was also the acting president, who defeated the main opposition candidate, Michael Sata, by a narrow margin in an election characterised by very low voter-turnout. Sata unsuccessfully challenged the result in court claiming that the result for Rupiah Banda was inflated.

Zambia is endowed with rich natural resources in the form of different minerals, mainly copper. Yet the country remains one of the poorest in the world, ranking 165th in the Human Development Index (UNDP, 2007). The majority of the population lives in economic poverty and suffers from a heavy burden of disease, which has brought life expectancy down to about age 40 years (World Bank, 2007). The HIV epidemic has hit Zambia especially hard; about 15% of the population is infected with HIV. In recent years the economy has stabilised and the country is now enjoying an annual real growth in gross domestic product (GDP) of about 6% (CIA, 2009).

2.5.2 The health system in Zambia

In the early 1990s, Zambia embarked on an extensive programme of health reforms with the stated aim being to:

> *...provide the people of Zambia with equity of access to cost-effective, quality healthcare as close to the family as possible…* (Ministry of Health, 2005b; p. I)

The main aim of the reform was to decentralise health services and separate policy-making and executive functions at the national level (Lake and Musumali, 1999). It has been acknowledged that the decentralisation reform has led to increased funding being available at the district level. A positive outcome, in terms of improved health of the population as a result of the increase in finances, however, has not yet been observed. Another key feature of the reform was the introduction of a cost-sharing mechanism. In the early days after independence, Zambia had a policy of free health care for all. However, with the deteriorating economy there was a decline in both availability and quality of health care. Cost-sharing was therefore introduced to increase local revenue generation and improve accountability (Atkinson, 1997). With decentralisation, districts have been given significant responsibilities for the management of funds and services. A "bottom-up" planning process has been implemented, from community to central level, whereby each level develops its own action plan and budget (Bossert, Chitah et al., 2003).

A useful overview of a health system can be obtained by describing it according to its functions. According to the WHO *World health report* 2000, a health system has four core functions whereby the first three are inputs into number four – delivering services.

- Stewardship (oversight/regulation);
- Financing (collecting, pooling and purchasing);
- Creating resources (investment and training);
- Delivering services (provision).

(WHO, 2000)

Stewardship: The government is the main organization responsible for policy setting and regulation of the health system in Zambia. Until 2006, the Ministry of Health applied a model in which a purchaser function was established and separated from providers from which it was expected to buy services on behalf of care-seekers. Responsibility was divided between two agencies: the Ministry of Health was responsible for policy setting and regulation and the Central Board of Health for service provision. Nowadays, the functions of the Central Board have been incorporated into the Ministry of Health and the Central Board has been dissolved (Wake, Sundewall et al., 2008). While the public sector has fairly well developed policies, the opposite is true for the private sector. The most recent policy work mentioning the role of the private sector dates as far back as 1991 (Ministry of Health, 1991). While policy is important, however, many countries with well

developed policy frameworks and regulations have struggled to enforce them (Bloom and Standing, 2008). In Zambia, for example, there is a large number of informal providers (e.g. traditional practitioners and drug vendors) who operate outside the regulatory arms of the government.

Financing: Total health expenditure in Zambia in 2006 was estimated at US$ 58 per capita (Ministry of Health, 2009). However, government expenditure on primary health care was less than US$ 10 per capita. This is well below the estimated cost of covering essential health services, which has been calculated as between US$ 17.8 (Ministry of Health, 2009) and US$ 22.7 (Nakamba-Kabaso, Cheelo et al., 2006) per person per year, as defined by the basic health-care package. The main financial contributions come from the public sector (24%), development partners (42%) and households (27%) (Ministry of Health, 2009). Public health services at the district level are mainly financed through regular government allocations from the central level, but also from donor funds, special programme funds and patient fees (Wake, Sundewall et al., 2008). In 2006, it was decided that user fees in public health-care facilities in rural areas were to be abolished in order to improve access to health services for the poor. Although user fees have constituted a relatively small share of the total health expenditure of individual facilities, and the government has promised to compensate facilities for their revenue loss, early reports have highlighted some difficulties with this reform. While utilisation has increased, additional allocations from the government have not been able to fully compensate for the loss of revenue.

Creating resources: The third function of the health system is concerned with creation of resources, both human and monetary, in the health system. While there is a need for considerable investments in the physical infrastructure in Zambia, the greatest challenges are related to staffing. It has been stated that the country is facing a crisis situation in human resources for health care (Ministry of Health, 2005a), with a lack of qualified staff at all levels. Three factors are the main contributors to the depletion of the workforce: loss of health workers to other countries; inadequate numbers of students enrolled in medical training; and the HIV/AIDS crisis (Kombe, Galaty et al., 2005).

Delivering services: The government is the main provider of health services in the country. In 2002 there were 1327 health facilities in Zambia, of which the government owned and operated more than 80% (Central Board of Health, 2002). The second-largest providers of health care are the mission-run facilities operating under the umbrella of the Churches Health Association of Zambia (CHAZ). CHAZ and the government have been collaborating closely for a long time and CHAZ facilities are operating more or less as government facilities and are financed mainly with public funds. There is a growing private-for-profit sector, especially in the major towns and along the railway lines. An important group of providers are the traditional health-care providers. The exact number of traditional providers is not known, but there are indications that it exceeds 40,000, by far outnumbering the approximately 1000 medical doctors active in the country (Banda, Chapman et al., 2007).

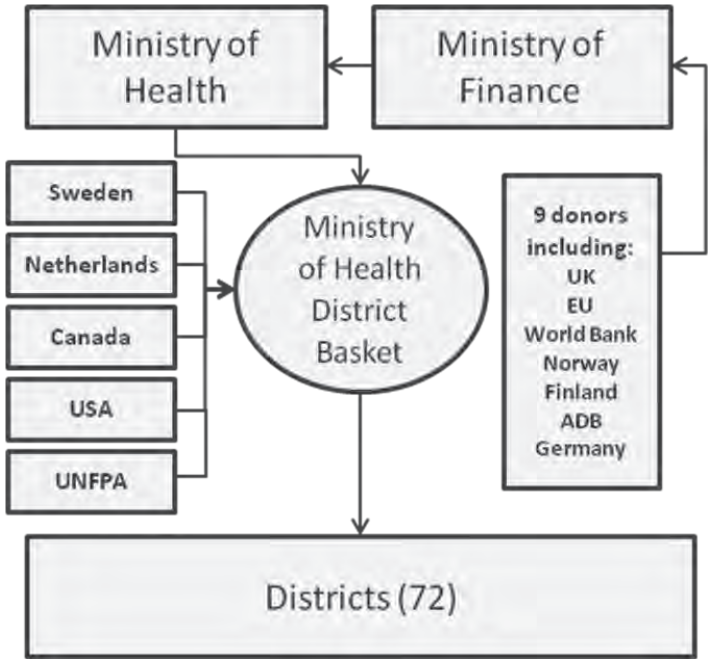
2.5.3 Aid in the health sector in Zambia

In Zambia there is widespread donor representation in the health sector. The main donors in the sector can be grouped into three categories: bilateral donors, multilateral donors and global health initiatives. Bilateral donors are national aid agencies providing aid from government to government based on bilateral agreements. In the Zambian health sector, the main bilateral donors are DFID, the Swedish International Development Cooperation Agency (Sida), the Canadian Development Agency (CIDA), the US Government, the Netherlands, the Japanese International Cooperation (JICA) and the Republic of Ireland. Multilateral agencies providing support include the European Union, the World Bank, the United Nations Children's Fund (UNICEF), the United Nations Fund for Population Activities (UNFPA), and WHO. Large GHIs represented in the Zambian health sector are the Global Fund, PEPFAR and GAVI.

The health sector in Zambia uses the SWAp as an umbrella for the coordination of sector aid. In essence, this means that the sector follows a five-year national strategy – the National Health Strategic Plan. This document outlines the overall plan for health-sector development. The government, in collaboration with donors and other stakeholders – NGOs, civil society organisations (CSOs) etc. – has developed the plan, and all actors have committed to adhere to the outlined priorities. Each year, a health-sector action plan is developed, which translates the overall strategy into concrete action on an annual basis.

Donor contributions to the health sector follow the three basic models presented earlier – project aid, pooled funding and general budget support. Project aid is distributed independently of government financing mechanisms, normally direct from the donor to the implementing organisations. Pooled funding and general budget support are distributed through government financing mechanisms. Pooled funding are contributions directly to the Ministry of Health district basket. General budget support is channelled to the Ministry of Health, via the Ministry of Finance (Figure 2).

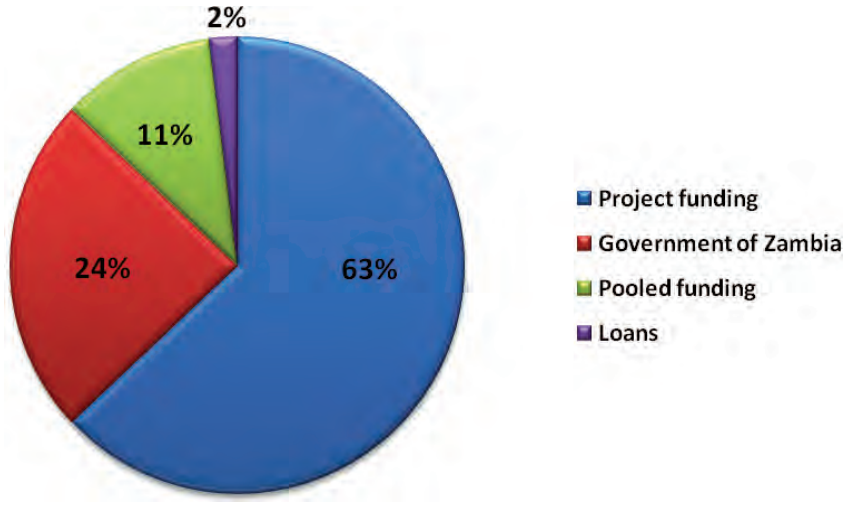
Figure 2: Overview of the pool funding mechanism, the "district basket", in the Zambian health sector



ADB, African Development Bank; EU, European Union; UK, United Kingdom; UNFPA, United Nations Fund for Population Activities; USA, United States of America

The Zambian health sector is highly dependent on foreign aid. The donor share of the total health budget (which includes staff salaries) is about 32%. In terms of funds for actual activities only (excluding personal emoluments and drugs), an internal Ministry of Health review in 2007 found that donors contribute about US$ 345 million to the health sector. This should be compared to the Government contribution to activities, which according to the 2007 action plan was estimated at US$ 110 million (Ministry of Health, 2007).

Figure 3: Distribution of donor and government funds for service delivery in the health sector in Zambia, 2007

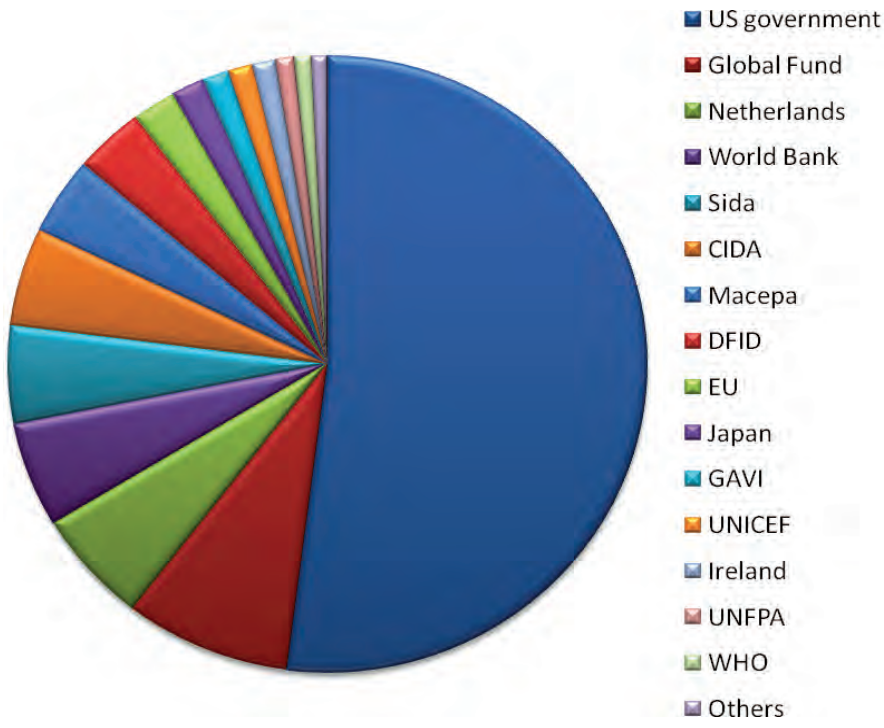


Source: Ministry of Health, 2007; and unpublished documents.

As can be seen in Figure 3, the majority of funds for service delivery are provided as project funding. A large part of these funds consists of resources from the US Government under the PEPFAR programme. Pooled funding, through the basket mechanism, constitutes a mere 11%. The low figure for pooled funding is partly explained by the fact that DFID and the EC have moved over to budget support. Thus, their support is indirectly reflected in the contribution made by the Government of Zambia. When interpreting this figure, however, it is important to bear in mind that resources are not necessarily non-coordinated simply because they are provided as project funding. The projects funded could still be included in jointly agreed plans and agreements.

Development assistance to Zambia has grown in recent years. In particular, there has been an increase in project funding for HIV/AIDS, which has mainly been used for a massive scale-up of antiretroviral therapy for HIV-positive individuals. The scale-up in project funding further explains the low share of pooled funding. Today, the biggest donors in the health sector include: the US Government, the UK, Sweden, Netherlands, the EC and the World Bank. If broken down by donor (Figure 4), the dominance of the US Government becomes clear; this donor contributes more than half of the donor resources to the sector.

Figure 4: Donor funds pledged to the health sector in Zambia in 2007



Source: Ministry of Health internal review, unpublished.

CIDA, Canadian International Development Agency; DFID, United Kingdom Department for International Development; EU, European Union; GAVI, Global Alliance for Vaccines and Immunizations; MACEPA, Malaria Control and Evaluation Partnership in Africa; Sida, Swedish International Development Cooperation Agency; UNFPA, United Nations Fund for Population Activities; UNICEF, United Nations Children's Fund; US, United States; WHO, World Health Organization.

There is a formal structure for coordination of health-sector aid involving the Ministry of Health and the donors. There is a hierarchy of meetings, which has been formally agreed upon by most major partners in the health sector (Figure 5).

Figure 5: Overview of coordination structures in the Zambian health sector

At the annual consultative meeting, progress from the previous year is reported and action plans and budgets for the coming year are reviewed. The sector advisory group, held twice per year, reviews performance indicators and release of funds for the sector (Ministry of Health, 2005b). The next level constitutes monthly policy meetings addressing general health-sector-related issues (Ministry of Health, 2006b). Finally, for day-to-day management and technical discussions there are a number of technical working groups and sub-committees for specific issues and areas (e.g. health financing and child health).

Furthermore, there is a Memorandum of Understanding between the Ministry of Health and the majority of the donors in the health-sector which states that cooperating partners should appoint a lead donor who is mandated to make statements on behalf of the group (Ministry of Health, 2006b). To coordinate a joint position, donors have internal meetings once a month – normally held just before the meetings of the policy consultative committee or sector advisory group.

3 ANALYTICAL FRAMEWORK

This thesis explores and analyses the implementation of health-sector aid coordination and its associated challenges and effects. The implementation of coordination includes a wide range of activities, from informal discussions between actors to formal agreements between governments and donors. In the literature, the term "implementation" refers to the execution of a selected option (Brewer and Leon, 1983; p.40). In this thesis, implementation refers to applying in practice the idea of coordination in the context of the Zambian health sector.

Public policy is a complex phenomenon and its implementation involves several actors and is influenced by many factors (Howlett and Ramesh, 2003). Two perspectives are central when analysing how policies are implemented: the "top-down" and the "bottom-up" perspectives.

The top-down perspective, on the one hand, assumes a separation of policy formulation and implementation. The lower levels of a system merely put into practice the intentions of the higher levels (Buse, Mays et al., 2005; p.122). A top-down perspective takes a rational approach arguing that goals are set through policies and success or failure is determined by whether or not the goals were achieved (Pressman and Wildawsky, 1984; Hill and Hupe, 2002). Although the top-down perspective limits the role of subordinates in the implementation process, they are not completely excluded. Van Meter and Van Horn (1975) have presented a conceptual framework for policy implementation that recognized the input of lower levels in policy formulation. This framework, however, still represented a top-down approach as the executors' input was supposedly provided before implementation commenced.

The bottom-up perspective, on the other hand, assumes that implementers of policy are important, not merely as executors of policies provided to them but also in informing those higher up in the hierarchy (Buse, Mays et al., 2005; p.124). These "street-level bureaucrats" have some power over how they apply policy handed down to them (Lipsky, 1980; pp 13–14). Through this discretion, be it limited, street-level bureaucrats can to some extent reshape policy to meet their own ends. What Lipsky argues is that the decisions taken by the street-level bureaucrats, which are based on their particular situation, become the very policy that they will implement. And this policy might look different from that handed to them. Furthermore, the bottom-up perspective highlights the fact that policy is continuously re-negotiated during implementation. Throughout the implementation phase there exist ongoing political processes, which means that implementation cannot be fully detached from other stages of the policy process, namely agenda-setting, policy formulation and decision-making (Barrett and Fudge, 1981).

In Zambia, the Ministry of Health is the main counterpart for most donor agencies and carries the main responsibility for implementing policies in the health sector. However, donor agencies are also highly involved in implementing aid coordination through their involvement in the dialogue at national level. Furthermore, front-line staff, i.e. staff in district health-management teams and health centres, is responsible

for district-level implementation of policies. Consequently, the Ministry of Health cannot implement policies independently, but is dependent on the actions of the actors involved. The interplay between the actors involved in policy implementation thereby becomes particularly interesting.

Each case of policy implementation has characteristics that are commonly associated with the bottom-up and the top-down perspectives. Both perspectives are tools for analysing policy implementation and each has its inherent flaws and limitations. As I assume that all actors involved in implementation have some influence over the process, I use a combination of the two perspectives in order to provide a better understanding of coordination of health-sector aid. On the one hand I apply what can be interpreted as a top-down perspective to analyse how policies at the global level are implemented at the national level and how national policies are implemented at the district level in Zambia, focusing on the intentions of aid coordination at the respective levels. At the same time, I explore how actors at the national level relate to policies at the global level, and how district-level actors implement directives from the national level, an approach that follows a more bottom-up logic.

Policies for aid coordination were first formulated at the global level; the development of the SWAp model, the Paris Declaration and the IHP were all results of discussions between several countries and development agencies. Thus coordination can be understood as a global model, which has spread to countries receiving aid around the world. I assume that global policies, when implemented locally, are understood differently and they are likely to be redefined. Policies are defined by how they are implemented and thereby filled with meaning (Czarniawska, 2005; p.54). The redefinition is done by both “small talk” in the corridor, but also through formal decisions and agreements; i.e. both through formal and informal means.

The planned and unplanned processes by which ideas are communicated and spread from one context, or one social group to another has been explained using the concept of diffusion (Brown, 1981; Rogers, 1983). Diffusion theory has a mechanistic view on how ideas are spread; ideas are formulated where there is a wealth of ideas and are spread to where ideas are lacking (Czarniawska, 2005; p.106). The focus of diffusion theory is on how ideas are spread and adopted. As Jönsson (2002; pp 25–26) argues, the concept allow for connecting global and local policy-making, focusing on the pattern of adoption of new ideas. However, similarly to Jönsson’s analysis, my focus is not on the pattern of adoption as such, but on what happens to ideas when they are spread and implemented in different contexts. Theorists have argued that when ideas and models are spread, as ideas travel from the global to the national and lower levels, they are subject to translation. According to Latour (1986), the spread in time and space of anything is subject to the influence of actors who can modify it or add to it in various ways. Ideas are rarely adopted without modification when introduced in a new context. It means that a standardized idea can be read and understood in different ways (Czarniawska and Joerges, 1996). A translation perspective also implies that not only can the idea be understood in different ways, but meanings can also be added and/or removed to fit the context in which it is implemented. The fact that ideas are unclear can help to keep actors

together as it enables them to translate the idea to conform with their own preferences (Sahlin-Andersson, 1989).

In this thesis, translation theory is applied as a tool for understanding how coordination is implemented in the Zambian health sector and enables me to analyse actors' different interpretation of a seemingly identical model. My starting point is that the coordination of aid is broadly accepted by actors in the health sector in Zambia as both relevant and useful. This consensus is expressed in policy documents at the national level and in international agreements at the global level. As coordination is defined in rather vague and broad terms, however, my hypothesis is that individual actors will have different understandings of what it implies in terms of changed practice.

In other words, it is well established that aid coordination as an idea has diffused and been adopted in the health sector in Zambia. This is a development that is clearly in line with international trends in development cooperation and the reasons for it are therefore of less interest than the result of this adoption.

When implementing policies, however, things rarely turn out as planned. Regardless of whether implementation follows a top-down or bottom-up logic, it is common to observe "decoupling", or differences in the implementation process (Meyer and Rowan, 1977). Differences between policy and practice, between talk and action, have been commonly observed when new organisational ideas are spread and implemented. Such differences occur when formal rules and informal norms disagree. Decoupling is thereby a way for organisations to perform practically desirable activities while maintaining their organisational legitimacy (Nee and Ingram, 1998; p.35).

The above suggests that coordination will not only be understood differently, but also that it is likely to be implemented in different ways in different contexts. Understanding policy implementation, however, is difficult as it is a political process shaped by the complexity of the system and the capacity of the government (Buse, Mays et al., 2005). Therefore, developing an understanding of the factors influencing implementation is important. According to Walt and Gilson's (1994) framework for analysing health-policy implementation, the *content* of health policy is a reflection of some or all of the dimensions; *actors, process* and *context. Actors* refer to those involved in policy reform, *process* is a description of how issues get on the agenda and how they fare once there, and finally *context* describes the politics, ideology and culture in which policy is implemented. The concepts of actors, processes and context are therefore useful to understand implementation of aid coordination. In this thesis, actors are considered in particular in the light of the different interest they carry and power relationships between them. Aid policy in particular is influenced by actors outside government; international donors have a clear influence in many countries (Walt, 1994). Processes describe the various structures and mechanisms through which aid is coordinated. Finally implementation is understood in the light of the Zambian context.

The implementation of coordination is not an end in itself but is expected to yield positive effects in terms of improved aid effectiveness. "Effects" or "outcome" refers to the result of actions, i.e. causality is implied. The effects of coordination could be

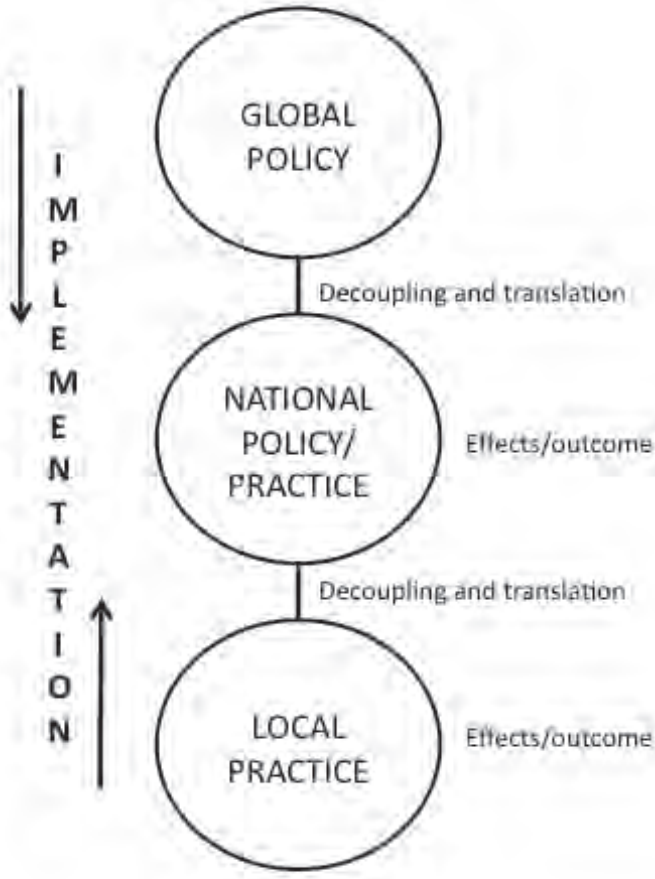
addressed from numerous angles. With a broad approach, effects in terms of improvements in people's health or in production of health services can be analysed. There are, however, obvious limitations and difficulties inherent in the use of the word "effect". It is difficult to establish causal relationship of particular aid efforts as there are, in any system, several parallel processes ongoing and the individual effect of each is difficult to isolate. What are, for example, the effects of a sector budget support to a ministry of health on national life expectancy or on immunisation coverage? How do you attribute a reduction in HIV prevalence to increased spending on HIV?

The outcome, or effects, of coordination are, in this thesis, estimated using indicators for aid effectiveness and efficiency in the allocation and use of resources. Aid effectiveness refers to the ability of aid to achieve the intended results, and efficiency refers to making better use of resources. The Paris-Declaration indicators do not measure aid effectiveness as such. Instead they are based on assumptions that by changing how aid is distributed, current constraints to aid effectiveness will be reduced. In this thesis, the intentions of coordination as stated in models and agreements are analysed and discussed in relation to results from the country level studies. In study III, nationally and globally accepted benchmarks are used to analyse the performance of the Zambian health sector since the introduction of the SWAp model in the health sector. In study IV, the results are compared to the targets of the Paris Declaration on Aid Effectiveness[1].

To summarize, I see coordination as a way of organizing development aid, which is carried out through organisations' implementation of policies for coordination. As illustrated in Figure 6, I assume that policy implementation takes place both from the bottom-up and top-down. These policies are a product of the actors involved, the processes through which they are implemented and the context in which implementation takes place. In the implementation process policies for coordination are translated and decoupling between policy and practice will occur between the different levels, which has implications for the effects of coordination efforts. Using these analytical concepts, I attempt to identify the main interpretations, implementation issues and effects of health-sector aid coordination in Zambia.

[1] For a more detailed discussion on indicators and measurements used, see section 4: *Methods*.

Figure 6: Identification of the main challenges to implementing health-sector aid coordination in Zambia: analytical framework of this thesis



4 METHODS

This thesis can be described as what Robson (2002) refers to as "real-world research", i.e. research conducted in real-life situations, trying to make sense of a complex, relatively poorly controlled and generally messy situation. For this purpose, the four studies in this thesis all used a case-study design. The overall case is implementation of health-sector aid coordination in Zambia and each study represents a case within the case. In studies I and II, a combination of interviews, document review and observations was used. Study III to a larger extent relied on archival records, including budget figures, which were complemented with interviews. For study IV, data were collected through interviews and official planning documents, but also through a review of archival records – mostly receipts, bank statements and cash books. In studies I, II and IV, all data collection was conducted by myself.

Case studies have frequently been used in studies of development aid. Most of the studies identified in international journals used a case-study approach (not necessarily labelled as such) when reviewing experiences of aid coordination (Buse and Gwin, 1998; Buse, 1999; Lake and Musumali, 1999; Jeppsson, 2002; Shiffman and Wu, 2003). Similarly, consultancy reports on SWAp are also commonly case studies (Foster, Brown et al., 2000; Brown, Foster et al., 2001; Kasumba and Land, 2003; Hutton, 2004). The reason for the popularity of the case study is most likely to be because it allows for the researcher to focus on the case under study and can accommodate several research questions and methods for data collection. The following sections of this chapter further elaborate on the methods used.

4.1 Study design

Studies I and II focus on the idea of coordination and how it is turned into practice. Using the concepts of translation and decoupling, I attempt to understand how coordination is implemented in a country context. In studies III and IV, outcomes of coordination at the national level (III) and the local (district) level (IV) are analysed. At the global level, the focus is mainly on the policies for coordination, while moving down to the national and the local levels, there is an increasing focus on the actual practice.

Studies III and IV are based on the assumptions that so far, coordination of health-sector aid has had little effect on how activities and resources are coordinated. Like study II, study III is focused on coordination at the national level in Zambia. The study assesses the contribution of coordination to the efficient use and allocation of resources by comparing the situation pre- and post-SWAp, and relating the findings to the stated targets of the model. Finally, in study IV, implementation of coordination is studied using district-level data from Zambia. The findings from the study are then compared to the globally agreed targets of the Paris Declaration.

4.2 Case studies

A case study revolves around an identifiable phenomenon that can be isolated and researched, although it is closely linked to the context in which it is being studied (Merriam, 1994; pp 24–29). The case study is thus a valuable research tool for understanding the dynamics present within a specific setting (Eisenhardt, 1989). A case-study approach is useful when the question "how" is asked. It is a common approach in studies aiming at describing and explaining processes and relations. Case studies are often used when studying a contemporary event, or set of events, over which the researcher has little or no control (Yin, 2003; p.9). The overall study design for this thesis can be seen as what Creswell (Creswell, 2007; p.74) refers to as a "collective case study", in which multiple cases are selected to illustrate an issue. In this thesis, four studies of different aspects of health-sector aid coordination are included and each illustrates a separate case.

The decision to use a case-study approach was based on the fact that the notion of health-sector aid coordination is itself elusive, without clear boundaries. So far, limited research has been conducted in the area of health-sector aid coordination and thus there are no established approaches for how it should be studied. By using a case-study approach, it was possible to obtain a deep understanding of how aid coordination is implemented.

Stake (Stake, 2005) argues that a case study is not a method of research but a choice of what is being studied. The focus of a case study is on the *case*, not on the methods of enquiry used. The flexible design of a case study was seen as particularly useful as my approach to the topic of health-sector aid coordination was initially very broad. Although each study must be carefully designed, case studies are by nature flexible as they allow for modification during the course of inquiry. In the first study, I set out to seize and comprehend the notion of coordination, a concept widely used and defined in the global development cooperation discourse. In the subsequent studies, the enquiry became more focused, exploring coordination at different levels in Zambia, from the national level to district level. As my understanding of the topic grew, the focus of the studies also changed and by focusing on the particular case under study I did not limit myself to a predetermined method for data collection. As the details of the case emerged, the study design could be modified where necessary; data could be collected using several different sources and this thesis thus relies on and profits from both qualitative and quantitative data.

In the literature, case studies are usually associated with qualitative methods for data collection, although quantitative data may also be included in this type of investigation. Qualitative case studies allow for, and even try to preserve, multiple realities (Stake, 1995). Providing "thick" or detailed descriptions of different perspectives is seen as a way to better understand the complexity of the phenomenon being studied. All the studies presented in this thesis are based on the assumption that there are different understandings of how aid is and should be coordinated. Thus the multiple realities provided by respondents in in-depth interviews, particularly in studies I and II, were used to illustrate and analyse the complexity of coordination.

4.3 Data-collection methods

4.3.1 Interviews

In all four studies, semi-structured interviews were used as a method of data collection. The interviews followed a broad interview guide that outlined the topics to be covered. Depending on the answers from the respondent, the interviewer could probe for additional information and, if necessary, change the line of enquiry. According to the literature, semi-structured interviews typically follow an interview guide, or script, which can include anything from broadly defined topics to detailed and carefully worded questions (Kvale and Brinkmann, 2009; p.131). A key issue when conducting qualitative interviews is the interviewer's ability to build trust with the respondent (Dahlgren, Emmelin et al., 2004; p.80). Trust-building can be done in several ways, e.g. conducting preparatory visits, being relaxed and aware of non-verbal communication and avoiding applying pressure on the respondent to obtain answers.

As important as trust is the researcher's ability to establish a rapport with the respondent; this is critical to enable the researcher to see the situation from the viewpoint of the respondent (Fontana and Frey, 2005). In order allow time for the building of a rapport and to strengthen my ability to understand the respondents' perspective, ample time was set aside for interviews during all four studies. For study I, one month was spent in each of the countries studied. This allowed me to establish contact with the respondents well in advance of the interviews. It also allowed time for follow-up interviews to be carried out where necessary. Studies II, III and IV were all conducted in Zambia, where I have spent several months per year over the last four years. Most of the respondents in study II were people whom I have met regularly over this period. Such interactions over time have led to the development of mutual trust and respect, and thus to a more open and frank dialogue, less influenced by politics. In study IV, several days were spent in each district to allow for follow-up interviews where necessary. Throughout the course of work for this thesis, more than 100 interviews were conducted with donors, government staff, representatives of key stakeholders and health workers.

4.3.2 Observations

In study I and II, observations were used as a method of data collection. Observations can range from the formal to the casual and often serve as a source of additional information about the topic being studied (Yin, 2003; p.92). The observations recorded by the researcher can be useful to determine whether the respondents really do what they say they do, or to better capture a phenomenon or specific components in more detail (Dahlgren, Emmelin et al., 2004; p.72). Observation is a good complement to other methods of data collection; for example, to confirm what is reported in interviews (Patton, 2002; p.306), not in the sense of verifying statements made during the interview, but to provide an additional perspective and contribute to a better understanding of the case in question.

Observations made during meetings as described in this thesis were all passive in the sense that I did not participate in the dialogue of the meetings. During data collection for study I, observations were used to observe how stakeholders define SWAp in

action. In all meetings, I observed how different actors defined SWAp and also how they discussed issues of ownership and coordination. In study II, observations were used to explore and account for the formal structures for health-sector aid coordination. Observations also provided insight into which actors actually participated in the meetings and typical issues discussed.

When conducting observations, there is always the risk that the mere presence of the researcher could influence the events observed (Patton, 2002; p.306). The meetings observed in the above-mentioned studies were very varied in character: some meetings were large gatherings of over 100 participants, most of whom were not aware of my role, while in smaller meetings, such as donor or donor–government meetings, all participants were aware of the reasons for my presence.

4.3.3 Documentation and archival records

Additional major sources of data for this thesis were documentation and archival records. Documentation encompasses everything from letters and agendas to studies and public documents. Archival records can include, for example, service records, organisational records and survey data. Together with interviews and observations, documentation and archival records constitute four of the most commonly used data sources for case studies (Yin, 2003; pp 85–86).

To a varying degree, all four studies relied on data from documentation and archival records. In study I, documentation was used to explore how concepts were defined in country policies. Study II used documentation to investigate the formal structures and processes for health-sector aid coordination in Zambia. Archival records (budgets) and documentation were used in study III to account for the contribution of the SWAp on administrative, technical and allocative efficiency. Finally in study IV, district financial data were analysed.

In all situations where documentation is used it is important to reflect critically upon the quality of the data: are the documents used authentic and is the information contained in them correct? (Merriam, 1994; p.119). The authenticity of official documents was not a major concern since such documents are scrutinized by the different stakeholders and forgeries are rare. Generally, the quality and availability of public documents and archival records was perceived to be good, although findings from study II showed that interviewees criticised the quality of the annual action plan. That said, most documents used have undergone several review and consultation processes conducted by the Ministry of Health and by donors. The fact that many district plans were missing from central archives presented some logistical challenges to obtaining documentation before conducting interviews for study IV. Furthermore, reliability of financial data at the district level was a concern in study IV. Information gathered from documents and archives was therefore verified by additional data sources. For example, information on financial flows in district plans was cross-checked with bank statements, but almost no discrepancies between the two were found.

4.4 Analysis

4.4.1 Categorical aggregation and direct interpretation

The analysis of data has been an ongoing activity, without a clear start or end-point. This issue is discussed by Stake (1995; p.75), who argues that the analysis of a case study is a matter of giving meaning to first impressions as well as final results. He presents two strategic ways in which researchers can give meaning to a case study: direct interpretation and categorical aggregation. Direct interpretation is an instant reading of a particular observation, a spontaneous reaction to the information collected. Categorical aggregation, on the other hand, is when different instances are compiled to make a collective statement. The studies in this thesis have relied on both the above-mentioned strategies.

The early analyses were characterised by a greater degree of direct interpretation. In study I, differences were observed in how actors defined the SWAp model. This realisation was an instant interpretation of the observations and interviews conducted and it shaped how data collection was conducted. The subsequent analysis in study I was based more on categorical aggregation. On the assumption that different actors had different definitions of SWAp, additional data collected for study I were compiled giving special attention to such differences. The data were used to answer questions such as: "How is SWAp defined in different policies and strategic documents?"; "How different are these definitions from each other?"; and "What are the differences between actors in terms of how SWAp is defined?"

The different perceptions observed among actors in study I shaped much of the enquiry in studies II–IV. These subsequent studies were based on the assumption that actors carry different definitions of aid coordination and that these definitions are likely to sometimes influence coordination activities. A second assumption that was derived from the results from study I and that was followed-up in studies III and IV was that the introduction of aid coordination alone is not likely to change practice significantly. Thus, to properly analyse health-sector aid coordination in Zambia, the contextual factors must be carefully considered.

4.4.2 An inductive/deductive approach to analysis

This thesis has relied on what can best be described as a mix of an inductive and deductive approach to analysis. Qualitative research often follows an inductive logic, from the ground up rather than being guided by theory (Creswell, 2007). In study I, the formation of themes and categories emerged from the interviews and observations conducted. At the same time, the design of interview guides in the later studies was guided by previous research; the construction of the interview instruments was influenced by the results of study I as well as by the approaches to aid coordination as used by other researchers.

Researchers commonly have some degree of theoretical predisposition. Patton (2002) argues that conducting a holistic inductive analysis is always a matter of degree as the enquiry is shaped by people's previous ideas and understandings. The interview guides in studies II and III constituted the basis for the initial analysis and thus the analysis does not follow an exclusively inductive logic, as categories were

initially predetermined. During the analysis of interview data, however, the initial categories were challenged and, in study II, were consequently changed.

4.5 Coordination indicators

Studies III and IV used indicators in their analysis of coordination. In study III, effects were studied in terms of developments in efficiency. Efficiency in allocation and use of resources was measured using seven different indicators, as illustrated in Table 1.

Table 1: Indicators of efficiency in allocation and utilisation of resources and data sources used in study III

Indicator of efficiency	Data sources
Administrative efficiency	
• Number of meetings • Time spent in meetings • Number of donors using joint systems of reporting and financing	Key informant interviews, group interview, government reports and policies, meeting minutes
Technical efficiency	
• Hospital bed occupancy rate • Spending on drugs versus total public health budget	Key informant interviews, group interview, official statistics, government reports and policies
Allocative efficiency	
• Spending at different levels of health care • Budget execution (actual releases against budgeted amounts)	Key informant interviews group interview, official statistics, government reports and policies

Administrative efficiency was defined in study III as "reduced transaction costs". When the study was conducted, however, no established methods for how to measure transaction costs were found. Bigsten (2006) made a similar observation and highlighted the need for more empirical work on how to estimate transaction cost. Brown et al. (2000) defined transaction costs of aid as those arising from preparation, negotiation, monitoring, and enforcement of agreements for the delivery of ODA. A significant part of this work is conducted in meetings and thus it was deemed appropriate to estimate the number of meetings conducted and time spent in these gatherings. Furthermore, to make donors use a joint system for reporting is seen as way to decrease transaction costs. Thus, the number of donors using joint systems gives an indication of the transaction costs involved.

Technical efficiency was measured by looking at hospital-bed occupancy rates and spending on drugs. Hospital-bed occupancy was selected since it is one of the

indicators used by the Ministry of Health to assess productivity of hospitals (Ministry of Health, 2006a). Expenditure on drugs is used as drugs are a major cost item in the health system and level of expenditure is seen as a good proxy indicator of the quality of health care provided (Ugalde and Homedes, 1998; Attridge and Preker, 2005).

Allocative efficiency refers to resources being allocated to where they are put to best use (McPake and Kutzin, 1997). A central goal of health reforms in Zambia is to increase allocations to districts. Therefore, the indicators applied looked at budgetary allocations by level of health care (central, province and district level). Furthermore, budget execution was explored to determine timeliness/predictability of funds.

The indicators used were quantitative in character but were complemented with qualitative information to provide a better understanding of how actors involved perceived the performance of the health-care system.

Signatories of the Paris Declaration have agreed on a set of indicators to monitor the progress of joint efforts to improve aid effectiveness. Study IV assessed the effects of aid coordination on aid effectiveness in the health sector at the district level in Zambia according to selected Paris-Declaration indicators (Table 2).

Table 2: Selected indicators agreed upon by the Paris Declaration and used in study IV
Source: (Paris Declaration, 2005a)

Paris –Declaration indicator		**Paris –Declaration target**	**Application to study IV**
No.	**Description**		
3	Aid flows are aligned on national priorities	Halve the gap – halve the proportion of aid that flows to government sector not reported on government's budget(s)	Actual financial resources at district level as a percentage of total resources budgeted for
6	Avoiding parallel programme implementation units (PIU)	Reduce by two-thirds the stock of parallel PIUs	Number of district level partners and their involvement in planning
7	Aid is more predictable	Halve the gap – halve the proportion of aid not disbursed within the fiscal year for which it was scheduled	Regularity of district disbursement to health centres
9	Use of common arrangements	66% of aid flows are provided in the context of programme-based approaches	Share of resources to districts provided as programme-based support

As seen in Table 2, four indicators from the Paris Declaration were selected and adapted to fit the district context in Zambia. In total, the Paris Declaration comprises twelve indicators that are used for follow-up; the four selected represent those that

were deemed most appropriate and for which data were available at the district level in Zambia. The quantitative information collected during study IV was also complemented with data from qualitative interviews to explore the reasons for progress or lack thereof.

4.6 Validity

The validity of qualitative enquiry differs from the traditional, quantitative, interpretation of a concept. In quantitative studies, validity is a means for verification of results. Based on such reasoning, qualitative studies are bound to lack validity in a quantitative sense. Creswell (2007), however, argues that qualitative research is based on assumptions that are different from those of quantitative research and validity should thus be based on other criteria. Below, I discuss the validity of the findings of this thesis based on strategies presented by Creswell, including triangulation, member checking, prolonged engagement, "thick" descriptions and researcher bias (Creswell, 2007; pp 207–209).

Triangulation

In triangulation, researchers make use of multiple and different sources, methods, investigators or theories to strengthen validity (Creswell, 2007). This thesis used triangulation of data sources, as all studies relied on a combination of data sources. Using multiple methods of data collection may be a challenge, but is very much worthwhile, as it increases the reliability of the results (Lincoln and Guba, 1985; p.306). As I assume that there is no single interpretation of aid coordination among actors, the use of multiple methods is valuable to get different perspectives of the phenomenon. In study II, for example, I did not rely only on the respondents' accounts of coordination, I also personally observed a number of coordination meetings to get my own understanding of how coordination was applied in practice.

Member checking

Member checking is a technique whereby participants are allowed to provide feedback on data, analyses, interpretations and conclusions (Lincoln and Guba, 1985; p.314). In the studies described in this thesis, findings were continuously tested on the interview respondents; that is, the respondents were given the opportunity to comment on the results of the study. In study I, for example, debriefing sessions were held with a selection of respondents from each of the countries where data were collected. During these sessions, the interview respondents were presented with the preliminary interview results and their interpretation and were given the chance to provide feedback. The feedback from the debriefing session was subsequently used to sharpen the enquiry in the subsequent interviews. Member checking can also be used, using the terminology of Yin (2003; pp 35–36), to increase the construct validity of a case study, i.e. to ensure that the appropriate operational variables are used to capture what the study was supposed to cover.

Prolonged engagement

Prolonged engagement is useful for validity purposes as it allows for persistent observations in the field (Creswell, 2007). It also gives more room to become

familiar with the local culture, build trust with participants and check for misinformation. During the course of the research described in this thesis, I have spent nearly two years in Zambia, over a six-year period. The extended period and the close relationships that I have developed with my colleagues have helped me to better understand the Zambian context. Such prolonged engagement has also allowed for the use of a flexible study design; in study II, for example, follow-up interviews were conducted with a selection of respondents one year after the original interview. These interviews were not initially planned, but were included to increase the validity of the observations.

Thick descriptions

"Thick" descriptions are referred to by Lincoln and Guba (1985) as a tool that allows the reader to determine whether the findings are also true for other contexts, or even in the same context at a different time – so-called "transferability" of results. In order to make such a judgement, the researcher should provide "thick descriptions" of not only the data, but also the context. The individual studies in this thesis are limited in their description of the Zambian context, and one of the aims of this cover story is therefore to provide the reader with a more in-depth understanding of the Zambian context. Another way of increasing transferability is to use multiple cases, which gives more room for analytical generalisation of the findings. For example, in study I it was observed that actors from the same donor agency seem to have fairly similar understanding of the SWAp model, regardless of if they worked in Bangladesh, Uganda or Zambia. This led to the assumption that the institutional affiliation of a donor is more important for their understanding of SWAp than is the context in which they are currently working, a finding which allows us to make some generalisations about likely donor behaviour in other countries. Cross-country comparisons can assist in separating context-specific issues from issues that are more easily to generalise (Walt, Shiffman et al., 2008). That said, findings naturally have to be interpreted in relation to their contextual background.

Researcher bias

According to Creswell (2007), accounting for researcher bias is important to help the reader understand the researcher's position. This includes commenting on past experiences, biases, prejudices that could have shaped the study. Similarly, Angen (2000) talks about "reflexivity", i.e. how knowledge is shaped by the researcher. Contrary to quantitative research, qualitative enquiry does not set out to be objective or neutral. The researcher is herself/himself the instrument in the research and pure objectivity is therefore neither attainable nor desirable. While the skills of the researcher are imperative for successful data collection, they also constitute a source of potential bias. However, as expressed by Fochsen (2007), such subjectivity becomes a problem only if the researcher is oblivious to this fact. Therefore it is critical that the researcher clarifies his/her position and reflects upon it critically. Below I describe some sources of potential bias.

Being a foreigner: All studies were financed by the Swedish agency Sida, one of the largest donors in the health sector in Zambia – a fact that was well known by most interview respondents. Although I made it very clear that I did not in any respect represent Sida, nor did Sida have any influence whatsoever on the study design, it is

not unreasonable to assume that some respondents saw me as a representative for this aid agency, which could have had an impact on the study results. For example, interview respondents from the government might have been more cautious in their responses. Other donors could also have avoided raising sensitive topics for political or tactical reasons. The long-standing relationship between myself and many of the respondents can therefore be seen as a strength of this work; it has allowed trust to develop and dialogue to become more frank and open over time.

Understanding the context in which events takes place is important to be able to interpret the data. According to Thurén (2005; p.109) one's knowledge has to be complemented by empathy; so called "hermeneutic interpretation". The ample time I spent in Zambia during the course of this thesis has allowed me to better understand the political, social and cultural context in which aid coordination is being implemented and its implications for my findings.

Being an observer: The research spanned over a long period of time and as personal relationships evolved it became more difficult to distance myself from the research objects. As I shared findings from the early studies with respondents in latter studies, I was engaged in informal discussions and communication. I was also occasionally asked to provide advice based on experiences from my own work. Given my longstanding involvement, it is possible that the behaviour of some meeting participants was influenced by my presence. At the same time, the direct significance of my work for the individual participants should not be overestimated and it is probably more likely that my presence did not have any marked impact on people's behaviour.

Being a young economist: Staff based in the field offices of donor agencies commonly have vast experience of aid and development work in numerous countries and have worked in the field for many years. Thus coming in as a relatively young research student was both a challenge and an advantage. It was a challenge in the sense that it was sometimes difficult for me to gain access to busy individuals. On the other hand, it was an advantage as I could ask basic questions without being challenged. This is an advantage of being a "stranger" in a specific setting (Thurén, 2005; p.42). On some occasions I also found my lack of experience to be disarming: respondents did not feel threatened in their expertise. During the course of the research I was regarded more and more as a member rather than a stranger, allowing for a better understanding of the events under study. Moreover, I was an economist entering the field of health, a realm that is heavily dominated by medical staff, particularly doctors. This led some people to assume that I did not possess certain competences and thus I could allow myself to pose more naïve questions, which often yielded valuable information.

4.7 Ethics

Interviewee dependency was thoroughly discussed during the preparations for all studies. No respondents in studies I–III were dependent on the researcher in any direct way. The interviewees were senior officials within the government and aid agencies and all were informed of the purpose of the study. No respondents refused to participate.

Overall risks for the respondents were seen to be low. However, information about stakeholders' views and perceptions of aid coordination could potentially be sensitive. Such issues are closely coupled with issues of corruption, governance and regulation of development aid. Respondents were therefore offered early versions of manuscripts to read to ensure that they had not been misinterpreted. No respondent had any objections as to how or which data were presented. In study IV, since the district-level managers and staff interviewed would be highly dependent on the Ministry of Health, it was considered important to preserve the anonymity of the individual respondents: individual respondents are therefore not disclosed.

The Ministry of Health in Zambia sanctioned all four studies. Study I was also approved by the Ministry of Health of Uganda and the Ministry of Health and Welfare, Bangladesh. Studies II, III and IV were also granted ethical clearance by the research ethics committee of the University of Zambia. Informed consent was obtained from all respondents before starting an interview.

4.8 Research collaboration

Studies II–IV were conducted in collaboration with staff at the Department of Economics, University of Zambia (UNZA) and at the Ministry of Health. In study II, a researcher from UNZA participated in planning, analysis and manuscript-writing. In studies III and IV, a staff member from the Ministry of Health was deeply involved in the work. The collaboration with UNZA and the Ministry of Health was established during 2004–2005 when I worked as a research affiliate at the Department of Economics. Apart from participating in the studies, these collaborators have also acted as a continuous quality-assurance mechanism. My colleagues have been given regular opportunities to critique my work to ascertain that my understanding of events and context-specific issues is correct.

The objectives, methods, study population and period of studies I–IV are summarised in Table 3.

Table 3: Summary of the objectives, methods, study population and period of studies described in this thesis

Study No.	Abbreviated title of study	Objective	Methods	Study population	Study period
I	Translations of health-sector SWAps	Analyse how a model for coordination is translated when adopted in different contexts and to what extent these translations trigger changed practice.	Interviews, observations and document review	64 donors and policymakers interviewed; 18 meetings observed. Global and country policies reviewed	2002–2003
II	Stakeholder perceptions of aid coordination implementation	Explore donor and government stakeholders' perceptions of the process of implementing coordination of health sector aid in Zambia. .	Interviews, observations and document review	22 donors and policymakers interviewed, 7 meetings observed. National plans and agreements reviewed	2006–2007
III	Exploring SWAp's contribution to the efficient allocation and use of resources in the health sector in Zambia	Explore if the envisaged improvements with implementation of coordination, in terms of allocation and use of resources, have been achieved using the Zambian health sector SWAp as a case.	Interviews, secondary data, document review	21 interviews, 1 group interview. Secondary data from 1990–2006. Literature on SWAp reviewed.	2005–2007
IV	The Paris Declaration in practice	Analyse implementation of health-sector aid coordination at district level in Zambia in relation to global and national indicators for progress.	Interviews, secondary data, document review	22 interviews with health workers, district managers and government officials. Cash books and ledger cards for three districts and six health centres reviewed.	2007–2008

SWAp, sector-wide approach

5 KEY RESULTS

5.1 How is health-sector aid coordination implemented?

Studies I and II were mainly concerned with how aid is coordinated. The results represent both stated practice, i.e. stakeholders' perceptions of coordination, as well as actual practice, e.g. how stakeholders participate in coordination processes. Study I was a three-country comparative study in which SWAp was analysed at three levels: as a model, in country policies and in action. The aim was to understand how a model for health-sector aid is coordinated had been defined in different contexts and how these definitions trigger changed practice.

Results revealed that several definitions of SWAp exist among the stakeholders interviewed, but they are general and vague in character. However, three central themes were identified in the model namely: *sector-wide*, *ownership* and *coordination*. The sector boundary in the concept "sector-wide" is commonly defined as activities under the Ministry of Health or simply as the health sector. Ownership in the model is described as putting the government in charge of health-sector development. Finally, coordination under SWAp defines a government-led process in which actors, resources and activities are all in line with overall health-sector strategies.

When analysing country policies, it was observed that the definitions of SWAp and its core features are, to some extent, more specific than in the model. Country policies have defined the sector according to the mandate of one ministry. Ownership and coordination are less clearly defined and still leaves plenty of room for interpretation. That said, all three countries have an agreed framework for how to work with a SWAp. And although the definitions of key concepts appear vague, there is a programme of work agreed upon by all the largest stakeholders.

Finally, the way in which theoretical definitions of SWAp was translated into practice varied for each individual actor. There were disagreements about where to draw the sector boundary, how to work with the government and what should be coordinated under the SWAp framework. From the interviews it seemed that the variations in understanding were more closely linked to the institutional affiliation of each individual than to the country in which they worked.

The study revealed a multitude of different "translations" of the definition of the SWAp model, these differences being summarised in Table 4.

Study II built on the findings from the first paper (study I), recognizing that different actors have different perceptions of coordination. The aim was to investigate donor and government stakeholders' perceptions of the process of implementing the coordination of health-sector aid in Zambia to understand whether the coordination of such aid is in line with agreed plans for implementation. In particular, we explored differences in stakeholders' view on how aid is coordinated. The goal was to move beyond describing and analysing the concept of coordination and make an attempt at analysing its practical application.

Table 4: Overview of how the sector-wide approach (SWAp) is defined at different levels

Aspect of SWAp	Characteristic		
	Sector-wide	**Ownership**	**Coordination**
The model	A single, sector-wide policy and strategy Sector boundary defined as activities under the ministry of health, or simply as the "health sector"	Government in the lead of a sustained partnership Government in the "driver's seat" Government responsible for developing policies and strategies	Moving from projects to programme, including a larger number of stakeholders Coordinating funds, resources and activities under a common expenditure framework
Country policies	SWAp is limited to one ministry with the major responsibility for health care All partners should consider the entire health sector In all three countries, the sector boundary has been defined according to the existing administrative structure	Ownership rarely addressed in policies Government should provide overall leadership over planning, administration and monitoring Government should assume a larger responsibility for planning and budgeting	Common frameworks for reporting, budgeting and monitoring In Uganda and Zambia, the goal is to make all funding available for any activity in the strategic plan. In Bangladesh, funding modalities are flexible
SWAp in action	Different opinions about which providers that should be included in the SWAp Different opinions about whether or not institutional reforms are expected under a SWAp	Different opinions about whether the government must be in control over the funds or not to achieve strong ownership The level of government ownership over strategic policy documents is questioned	Coordination reduces the risk of duplicating activities Different opinions about whether increased coordination reduces the administrative workload Disagreement on whether funds or activities should be coordinated under a SWAp

The study suggested that all the interview respondents representing government and non-governmental and donor organisations were fairly satisfied with the implementation of coordination of health-sector aid in Zambia. However, these stakeholders did not share a common view of the framework for health-sector coordination. This was highlighted by the contrast in their perception of the degree of coordination of strategic plans and agreements: while all the donors interviewed

claimed that their support was in line with the National Health Strategic Plan, the government representatives declared that not all donor support conformed to this plan.

We found that one of the main concerns of the interviewees was the potential effect of parallel funding on coordination. A large proportion of resources in the health sector are not channelled via the Ministry of Health systems since the large amounts of funding and activities devoted to HIV/AIDS in Zambia are coordinated via a separate structure – the National AIDS Council. The government interviewees stressed the importance of getting all external funds "on-budget", i.e. channelled through the accounts of the Ministry of Health, since the existence of parallel processes is perceived as negative for government ownership.

Interviewees proposed the relatively long history of aid coordination in Zambia as an explanation for the reported increase in trust and good relationships between donors and the government. The efforts of the Zambian government to achieve consensus among stakeholders was also seen as positive. However, although most donors are willing to implement aid coordination as agreed in national plans, they are also restricted by the rules and regulations of their own organisations and by the mandate on which they operate. Despite the fact that the respondents all declared that aid coordination was working well, interviews with several key actors suggested that issues of trust and conflicting agendas still persist.

The study shows that there are formal processes for aid coordination in place that stakeholders' perceive to have evolved over time. At the national level, there are joint mechanisms for funding and all partners endorse activities, strategic plans and agreements. Formal meetings and committees have been established. Therefore, the development of aid coordination in Zambia appears to be in line with the aims of the Paris Declaration on Aid Effectiveness

5.2 What have been the effects of health-sector aid coordination?

The overall aim for studies III and IV was to analyse the effects of aid coordination implementation. Study III examined the effects of coordination at the national level using the SWAp model in the health sector in Zambia as an illustrative case. The paper analysed developments in administrative, technical and allocative efficiency to see if the envisaged improvements with the SWAp model had been achieved.

Overall, the results showed that there has been little improvement in efficiency. Administrative efficiency, measured as time spent in meetings and number of donors using separate systems, indicated that transaction costs are still high in the Zambian health SWAp. For example, in 1993 there were a total of 59 multilateral and bilateral projects in the health sector. In 2004, one donor alone was funding 73 sub-projects on HIV/AIDS. Furthermore, the number of meetings organized under the SWAp was remarkably high (Table 5).

Table 5: Number and average duration of meetings on the sector-wide approach (SWAp)

Type of meeting	No. of Meetings per year	Average duration per meeting (hours)	Average No. of participants
Annual consultative meeting	1	6	130
Sector advisory group meeting	2	6	133
Policy consultative meeting	9	4	35
Monitoring and evaluation meeting	48	2	20
Technical working group meetings (various)	96	1.5	15
Total	156	294	Not applicable

Technical efficiency was calculated using indicators for hospital-bed occupancy and drug financing; no improvements were observed in these indicators. Hospital-bed occupancy rate had dropped by more than 20% (from 71% to 50%) from 1991 to 2004. The share of government funding for drugs decreased dramatically from 1990 to 2005, from 21.1% to 2.7%. The few improvements that were found were in allocative efficiency. Allocative efficiency was estimated by studying budgetary allocations by level of health care and budget performance and timing of disbursements. Findings showed that the share of funds distributed to the district level increased from 31% (pre SWAp, 1981–1992) to 55% (post-SWAp, 1996–2005), which was in line with the objective of the health-sector reforms. However, budget performance did not improve; the percentage of the budgeted amount that was actually disbursed from donors fell from 91% (1990–1992) to 65% (1995–2005) (Table 6).

The aim of study IV was to analyse implementation of aid coordination at the district level in Zambia in order to see if efforts at the national level are trickling down to lower levels of the system. For this purpose, four indicators of aid coordination were selected from the Paris Declaration and adapted to fit the district context in Zambia. The findings revealed that, so far, aid coordination efforts at the national level are yielding limited results at the district level in Zambia, because coordination at the district level is weak.

The first indicator, the number of partners and their involvement in planning, showed that in all three districts the number of partners has increased over the past four years in one district (Kabwe) with as much as seven partners (Figure 7). The sharp increase observed in Kabwe is mainly due to the appearance of new partners working in the area of care and treatment for people with HIV/AIDS. At the same time, partner involvement in the district planning process is limited. According to interviews, it was difficult to include partners in planning as their activities were often predetermined and districts had little power over the priority-setting for the

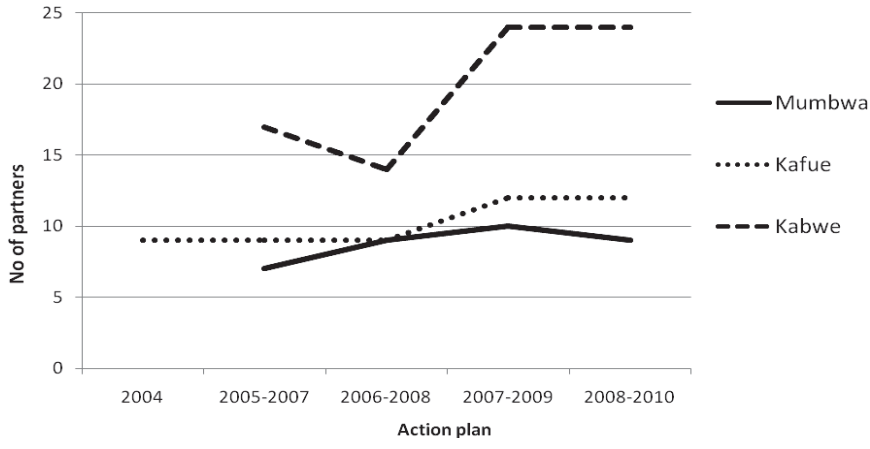
partners' funds and activities of the partners. This is one explanation for the fact that these resources are not reflected in the district budgets. According to interviews, HIV/AIDS partners seemed to be more integrated with respect to planning and provision, although their involvement was still limited.

Table 6: Budgeted versus actual donor funding (district basket and other funds channelled through the public system)

Period	Annual planned budget (million US$)	Amount actually disbursed (million US$)	Amount disbursed as a percentage of annual budget
Pre-SWAp			
1990	13.0	13.6	105
1991	13.4	11.9	89
1992	15.7	12.6	80
Total 1990–1992	42.1	38.1	—
Average	**14.0**	**12.7**	**91**
Post-SWAp			
1995	46.1	33.2	72
1996	44.7	42.2	94
1997	64.5	49.2	76
1998	53.6	30.3	57
1999	35.9	41.3	115
2000	32.1	19.4	60
2001	49.7	17.7	36
2002	63.4	28.5	45
2003	114.8	52.9	46
2004	134.5	68.4	51
2005	113.3	69.4	61
Total 1995–2005	752.6	452.5	—
Average	**68.4**	**41.1**	**65**

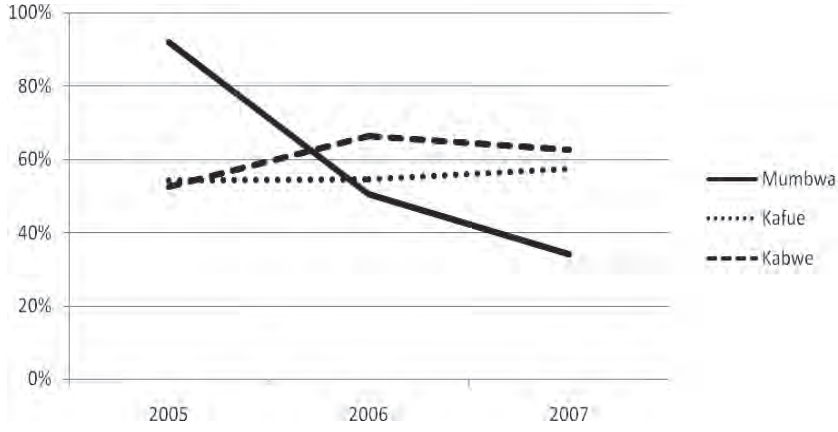
SWAp, sector-wide approach

Figure 7: Number of donors, non-governmental organisations and civil-society organisations listed as partners in three districts in Zambia, according to district health-sector action plans for 2004–2008



The second indicator, share of resources provided as programme-based support (PBS), showed a slight increase in two districts, but a marked decline in one (Figure 8). The sharp decline in PBS in Mumbwa is attributable mainly to a large increase in "other" income, including considerable contributions for the construction of a new district hospital that were disbursed in 2006 and 2007.

Figure 8: Share of resources provided as programme-based support at the district level in three districts of Zambia, 2005–2007



Indicators three and four relate to predictability of resources. Overall, resources are still highly unpredictable; however, there were differences between resources coming through the Ministry of Health district basket compared with other resources. Interviewees claimed that the predictability of district grants was often good, although extraordinary events such as the appreciation of the *kwacha* (the currency of Zambia) in late 2005 rapidly reduced the true value of the grant. Other resources were, however, more unpredictable. Predictability of resources distributed from districts to health centres (indicator 4) was low; it was observed that health centres received their supposedly monthly payments only four to eight times in 2006.

6 DISCUSSION

My findings suggest that there has been a change in practice. I found that the coordination of health-sector aid in Zambia has been implemented in line with global models. Plans and agreements that were initiated in the 1990s have become established as a framework for how aid should be coordinated and have been developed through a consultative process led by the aid recipient. There are several established coordination structures in the form of meetings and technical committees that are formally controlled and led by the government. Mechanisms for joint funding of the health sector were established in the early 1990s and appear to be working well.

In spite of this change in practice, however, evidence for the effects of implementation of aid coordination, as defined by the indicators used in this thesis, is difficult to demonstrate. Coordination as a tool to increase efficiency in use and allocation of resources was questioned by the findings, which showed little measurable improvement when comparing the aims of the Zambian health SWAp with actual outcomes. The indicators for aid effectiveness also showed limited progress. The results highlighted the difficulty associated with measuring the effects of health-sector aid coordination; there are no established models for how such coordination should be assessed.

It was observed that while actors are generally content with the processes for coordination, there is disagreement about to what extent the government leads, or has ownership, over the implementation process. Actors questioned the ownership of country strategic plans and collaboration agreements. It was also seen that government control over funds is limited, since many donor resources are channelled outside government systems.

This thesis illustrates that policies for aid coordination follow both top-down and bottom-up patterns of implementation, which has had an impact on the effects of coordination. On the one hand, a top-down approach, following standardized and broadly agreed but vaguely defined models, can be an enabling factor. I observed general and widespread support for coordination from all actors although they had very different perceptions of what coordination implied in practice. On the other hand, generic models often run the risk of becoming too general. As a result I found decouplings between policy and practice at all levels studied, which in turn could explain the limited effects noted. In the following sections I discuss these and other key results from my thesis in more detail.

6.1 Translations of aid coordination

A top-down perspective on policy implementation suggests that lower levels put into practice policies formulated at higher levels (Hill and Hupe, 2002; p.44). Results show that coordination was formulated as a global idea, which has diffused to low-income countries around the world. This appears to be logical as coordination was formulated in response to the perceived inefficiencies of the previous, more project-dominated, approach. When the idea was translated into local practice, however,

significant differences between actors were observed. It was found that translations of coordination differed between countries but even more between different actors within each country (study I). Although the concept was translated differently, all actors seemed satisfied with the functioning of formal structures for aid coordination. However, they did not share a common view of the framework for health-sector aid coordination, which was manifested by their very different perceptions of the degree of coordination of jointly defined plans and agreements (study II).

Previous research tells us that global models and ideas are likely to be translated differently. Global models are often vaguely defined, in order to be applicable in different contexts (Strang and Meyer, 1993; Sahlin-Andersson and Engwall, 2002). Thus, when they are implemented in a specific setting they have to be translated to fit the local context (Czarniawska and Joerges, 1996). Thus it seems that the broad manner in which coordination was defined left room for each actor in the Zambian health sector to adapt the definition according to their own interests. Implementation of coordination thereby has the character of a more bottom-up process. Those responsible for implementation, the "street-level bureaucrats", effectively change policies to meet their own ends. Although the ideas and models for how aid should be coordinated are prescribed at the global level, donor agencies' staff and civil servants at the national level translate them to fit the local context. Similarly, although the district-level staff is supposed to coordinate efforts of external partners at the district level, they struggle to do so to the extent necessary because of the limited predictability of donor support.

Results also showed that, in some instances, translations did not vary between actors. For example, all stakeholders agreed that all aid should be in line with Zambia's National Health Strategic Plan. This joint understanding, however, did not mean that they acted in a similar fashion, as there were different understandings of what this actually implied in practice. A common conception among actors was that *all our support is aligned with the strategic plan – but others' support is not* (study II). This corresponds with previous research, which has observed that translation does not only take place between different levels, it also refers to the process of turning the abstract into concrete action (Czarniawska, 2005; p.56). Generally, it is argued that the greater the number of organisations and government departments that must cooperate, the more likely it is that the implementation process will fail (Pressman and Wildawsky, 1984; p.xxiv). Similarly, the case of Zambia shows that it is possible to agree on the formal content of aid coordination, but reaching a common understanding of what it implies in terms of changed practice appears to be more difficult.

6.2 Decoupling as a means to mitigate demands posed by different translations

This thesis has shown that decoupling occurs to mitigate the different translations of aid coordination. When implementing aid coordination, several organisations reported constraints to their efforts to coordinate aid (studies I and II). Yet few aid organisations or governments would today argue against the fact that aid should be coordinated and all actors involved in the health sector in Zambia are supportive of coordination. This can be seen as a sign of organisations responding to normative

(e.g. cultural expectations) and mimetic (e.g. the desire to look like other organisations) institutional pressures (DiMaggio and Powell, 1983). Over time, coordination has developed more and more into a "standard of appropriate behaviour" (Finnemore and Sikkink, 1998) in development aid. Actors in development are likely to adjust according to this collective norm. This was observed in the results (studies I and II). Despite the fact that domestic policies of bilateral aid agencies and mandates of multilateral institutions restrict to what extent different actors can harmonize and align their procedures, all major financial stakeholders are supportive of aid coordination. However, the results showed that important actors and large amounts of funds remain uncoordinated. Large donors in the HIV/AIDS area do not participate in health-sector coordination processes (study II) and there is a significant inflow of funds at the district level, which is not reflected in budgets or plans (study IV).

In a study set in Cambodia, Lanjouw et al. (1999) illustrated the importance of political context for aid coordination. The study showed that coordination was undermined because the processes lacked both internal and external political credibility. Political factions within Cambodia did not allow for the mechanism to function effectively and donors were unwilling to work through the public system, as they feared losing ability to manoeuvre. Donors instead delegated technical implementation to NGOs and the authors conclude that this led to resource allocation being decided by donor priorities. A further contextual factor concerns trust. Mutual trust and accountability has been defined as necessary for government ownership and this involves confronting issues of power (Hydén, 2008). The importance of relationships and trust was observed in study II and respondents highlighted the view that relationships are generally good, although some questions were raised about the agendas and motives of different actors and also the ability of stakeholders to deliver as promised.

The above examples of differences between talk and action, between policy and practice, can be seen as examples of decoupling. As stated earlier, decoupling occurs when informal norms and formal rules disagree. In this case, the norm is that aid to the health sector should be coordinated, which means that all actors should adhere to jointly agreed plans. At the same time, the actors involved are bound by the formal rules and informal norms of their own institutions, which might not allow donors to behave in the agreed fashion. Or, as astutely formulated by Whittington and Calhoun (1988), "everybody wants to coordinate, but no one wants to be coordinated" (p.307).

Similar experiences were documented by Buse (1999), who showed that donors in Bangladesh were unwilling to enter joint coordination arrangements. Donor unwillingness was based on both political motives (e.g. that the visibility of their own institutions and autonomy over decision-making would be reduced) and also uncertainty about the capacity and willingness of the government to take leadership over a coordination process. This thesis suggests that, in Zambia, decoupling occurs in order for donors to mitigate the demands for performing practically desirable activities, i.e. support coordination of health-sector aid, and maintaining organisational legitimacy, i.e. conforming to contextual rules and norms.

6.3 Power over policy translation and implementation

Coordination is high on the agenda in the global aid discourse. It is as a "high-politics" matter. High-politics issues are macro and systemic policies and are usually the domain of the government (Walt, 1994; p.42). Through more coordination and moving from project support to SWAps and budget support, donors have moved upstream in the policy process (Hydén, 2008). The findings from studies I and II lend support to this. All donors in the health sector in Zambia are included in discussions and negotiations of overall plans and agreements, which means that they can influence not only how policy is formulated but also how it is implemented. Therefore it could be argued that increased coordination has led to donors having more influence over policy implementation as they are now highly involved in a domain commonly seen as a realm exclusive to the government.

Findings suggest that donors have a varying degree of power over implementation of coordination (study II). All actors in Zambia are supportive of the general principle of aid coordination, but have their own understanding of what it implies in practice. One such example is the different understandings of ownership (studies I and II). Ownership is an important issue for all actors involved – donors and the Zambian government – but there are different views on what it actually entails.

The importance of recipient ownership over aid coordination was stressed early on by Clift (1988), who argued that there was no substitute for effective leadership; the recipient must guide donor activities in support of agreed development plans. Although most donors subscribe to the notion of recipient ownership, there are several examples of situations in which actors outside the government influence implementation of policies in low-income settings. Okuonzi and Macrae (1995) show in an analysis of Uganda how donors influenced user-charge and drug policies that threatened national sovereignty and weakened accountability mechanisms. Finally, Woods (2005) claims that major donors (i.e. the World Bank, the USA, Japan, the UK and the EU) are failing to coordinate aid and are not allowing recipient countries to define their own priorities.

Having different understandings does not automatically create conflict when implementing policies, but it raises questions as to who finally decides on how to move forward. In a study of aid to Rwanda, Hayman (2006) argued that a pure country-led development policy and practice was difficult to envisage as there is a limit as to how much control donors are willing to relinquish (p.195). My findings from studies I and II seem to support this statement, showing that donors question the need for the Zambian government to have full control over resources. Jönsson (2002) argues that donors do not only directly influence policy but they may also, by introducing ideas and policies, shape the interests of recipients and thereby eventually policymaking. This is particularly true in aid-dependent countries where donors often have access to high-level policymakers in government (p.63). Hydén (2005) has argued that, in Tanzania, donors have replaced the government as the hegemonic actor deciding not only which policies to pursue but also how. Similarly, I observed that the Zambian Ministry of Health rarely challenges donor priorities (study II).

In a study of coordination and ownership in Bangladesh (Sundewall, Forsberg et al., 2006), conducted outside this thesis, I found that different understandings can become a source of conflict in some instances. The study followed a process in which the Ministry of Health and Family Welfare decided unilaterally to reverse one of the outlined reforms in the national health programme. The Government of Bangladesh saw it as their exclusive right to change the content of the national health programme. Some donors, however, argued that such decisions should be taken in consultation with the donors. The outcome was that the World Bank-led donor consortium tried to influence the government by temporarily suspending aid payments.

The above suggests that the power relationship must be taken into account when analysing how donors translate and implement coordination. It has been established that the implementation of policy is influenced by the relative power of actors (Hill and Hupe, 2002; p.76). The power of the individual actors is determined by several factors, but the most obvious is the size of their financial contributions to the sector. For example, the US government is the largest donor in the health sector in Zambia, and is also often criticised for poor coordination (study II). It is reasonable to assume that a smaller donor would have less opportunity to avoid coordinating resources. Furthermore, the Zambian case showed that some donors are more prominent and active than others in implementing coordination. For example, Sweden and the UK were both acknowledged by other donors as providing strong leadership in their role as chair of the donor group (study II). These two countries are also strong proponents of the Paris Agenda and government ownership and thus it can be expected that under their leadership, issues of ownership, harmonisation and alignment were high on the agenda.

6.4 From policy to practice: the effects of aid coordination efforts

So far the discussion has focused on how aid coordination is implemented in Zambia. I have shown that implementation has the character of both a top-down and a bottom-up process. In this process, actors have defined and re-defined the idea of aid coordination. I have also shown that there are several challenges in implementing coordination as priorities disagree between actors, and this creates decoupling between policy and practice. In light of these challenges, I will now elaborate on what the effects of coordination have been.

6.4.1 Formal structures for coordination

A formal structure for health-sector aid coordination exists in Zambia. Results revealed that formal meetings are held between donors and between donors and the government in Zambia. Coordination is also conducted by joint activities and plans and agreements (studies I and II). My findings conform the structures identified by Lake and Musumali (1999), who described a number of mechanisms for aid coordination that had been deployed in the health sector in Zambia, including joint planning and budgeting procedures, pooled financing of district-level health services, regular meetings between donors and the Ministry of Health, dedicated "coordination staff" within the Ministry of Health and the development of a National Health Strategic Plan. However, this thesis also identified additional structures.

Funds for HIV/AIDS, the area for which resources have increased the most, are coordinated through a separate structure under the National Aids Council (study II). This is similar to experiences in the Democratic Republic of Congo, Malawi, Tanzania and Uganda. In all these countries, the HIV/AIDS crisis led to the establishment of parallel structures for coordination (Biesma, Brugha et al., 2009).

The structures identified in Zambia are similar to those for the coordination of aid in the health sectors in Bangladesh, Ghana, Mozambique and Uganda (Pavignani and Durao, 1999; Independent Evaluation Group, 2007; Örtendahl, 2007; White, 2007). Although the specific details vary from country to country, health-sector aid coordination in all these countries is based on formal and jointly agreed plans and meetings where these plans are negotiated, reviewed and evaluated.

Based on the fact that several mechanisms had been established to coordinate aid, Pavignani and Durao (1999) have argued that coordination efforts in Mozambique seemed to have been rewarded. However, as I illustrated earlier, the mere existence of mechanisms for coordination says very little about to what extent this actually leads to a change in practice. And the fact that a policy can be interpreted as being implemented gives little indication about what effects the policy has led to. In order to obtain a comprehensive understanding of the effects of aid coordination, efforts must therefore be related to more concrete outcomes.

6.4.2 Indicators of the effects of coordination

Analysis of the effects of health-sector aid coordination in Zambia indicated limited results both at the national and at the district level. At the national level, the indicators used to measure efficiency showed no sign of decreasing transaction costs and technical performance did not improve (study III). Indicators for allocative efficiency showed mixed results, with improvements in fund allocations but a decline in the predictability of resources. These findings correspond well with other evaluations. A comprehensive review of the World Bank's Health, Nutrition and Population support from 1997 concluded that experiences with SWAp have yielded little evidence of improvements in efficiency or reduced transaction costs (Independent Evaluation Group, 2009) The World Bank evaluation emphasised that the reason for lack of demonstrable improvements was that these aspects have not been monitored, a fact that reinforces the assertion that there are very limited data available on the effects of aid-coordination efforts. Another evaluation (McKinsey & Company, 2005) has suggested that lack of coordination increases transaction costs; this report describes how GHIs establish parallel systems and processes, bypassing country systems, and resulting in transaction costs that could have been avoided, although no estimate of how high these costs are is given. Finally, Oomman et al. (2007) have reported that government officials found the complex reporting systems and requirements of the World Bank Multi-country HIV/AIDS Program (MAP) to be a burden.

Results of the district-level assessment of Paris-Declaration indicators (study IV) showed that, on average, the share of support that is programme-based has fallen from 66% to 51% in the three selected districts of Zambia. On a global and national level, the share of PBS has remained constant from 2006 to 2008, but at levels below the Paris-Declaration target of 66% for 2010. When looking at the number of parallel

implementation units (PIU), we can see that overall in countries receiving aid the average number of PIUs has decreased from 61 to 49. At both the national and the district level in Zambia, the number of partners has increased. The trend towards increasing partner activity at the district level in Zambia and less resources provided as PBS is contrary to national objectives and those of the Paris Declaration, and is evident in Paris-Declaration indicators for 2005–2008 (Table 7).

Table 7: Trends in Paris-Declaration indicators of partner activity and resources provided as programme-based support: comparison of findings from OECD surveys and from study IV

Paris-Declaration indicator	OECD surveys						Study IV			Paris-Declaration target
	All countries			Zambia			Three districts in Zambia			All countries
	2006	2008	% change	2006	2008	% change	2005	2007	% change	2010
6. Partner activity (average No. of parallel implementation units)	61	49	–20%	24	34	+50%	11	15	+36%	–66%
9. Share of support that is programme-based (average %)	35%	35%	—	47%	47%	—	66%	51%	–15%	66%

Source: OECD (2007); OECD (2008a).

OECD, Organisation for Economic Cooperation and Development

The two OECD surveys used in the comparison above arguably represent the most thorough reviews of the effects of aid coordination in relation to the agreed Paris-Declaration indicators. Both surveys concluded that much more has to be done if the 2010 targets of the declaration are to be met and urged donors to reduce the transaction costs of managing and delivering aid and to improve aid predictability (OECD, 2007; OECD, 2008a). Although the surveys used national-level data that were not disaggregated at lower levels or by sectors, they still constitute a useful benchmark.

6.4.3 Reasons for limited effects

In study I it was concluded that the introduction of models in isolation is of limited utility in the restructuring of development cooperation. A model in itself will not lead to changes in practice and attention must be devoted to influencing the context

in which it is introduced. Indeed, Mosse (2004) goes as far as to say that policy is a less important driver of aid practices than the complex relationships and organisational cultures of the different actors involved. Based on the overall findings of this thesis, however, I would not venture thus far. Implementing ideas for coordinating health-sector aid in Zambia has undoubtedly led to changed practice; there are today formal agreements and structures in place and there is a continuous dialogue between donors and the Zambian government. Thus the policies seem to have generated some of their intended outcomes.

It is difficult to determine the reasons for the limited effects of implementing health-sector aid coordination in Zambia, which were observed in studies III and IV. The success or failure of policy is largely judged by the expectations held by those introducing it. While sufficient time is also a necessary factor for the success of implementation (Howlett and Ramesh, 2003; pp 208–209), time constraint is not a likely reason for the limited effects observed in Zambia, where aid coordination has been on the agenda since the 1990s, and thus an explanation must be sought elsewhere.

Critics have argued that that the new aid agenda is not based on solid empirical evidence. More coordinated aid efforts (e.g. SWAp) are deemed to be superior on the basis of arguments of efficiency, for example, that coordination reduces transaction costs. According to Killick (2004), the arguments for decreased transaction costs remain merely a hypothesis, which has not been empirically proven, and my findings support this notion. Another reason could be that aid coordination has been introduced by donors and in a fairly standardized manner; SWAp was an idea promoted by WHO, DFID, the EU and DANIDA; the IHP was an initiative launched by the British government; and the OECD Development Assistance Committee has led the establishment of the Paris Declaration. The limited ownership of the Zambian Ministry of Health as to which models have been introduced and also how they are implemented could contribute to the lack of effects.

In a study of governance in South Africa, Frödin (2008) argued that policies have to be applied by a critical mass of people to be broadly accepted and standardized; models imposed from the outside should therefore always be questioned (p.225). Buse and Mays (2005; pp 121–122) argue that there are several instances where donor-driven policies have shown less than positive results. The authors did not attribute the limited to poor ideas, but rather that the idea did not consider the broader context in which it was implemented. The present thesis seems to support this statement as the idea of coordination in the Zambian health sector was fairly uncontested. The explanation for the limited effects is therefore more likely be found in the fact that the policies for coordination did not agree with how the actors implemented them, owing to regulatory and institutional constraints. Using the terms of Walt and Gilson framework (1994) for health-policy analysis, it seems that actors, processes and context are all important in the implementation of aid coordination in Zambia. However, the identities of the actors and the context in which each actor operates seem to be more important than the processes through which coordination policies are implemented.

6.5 Methodological considerations

One of the goals of this thesis was to add to the limited body of empirical evidence on the implementation of aid coordination. Much of the research on the implementation of health aid is not published in the scientific literature. A recent review article on "the effects of global health initiatives on country health systems" (Biesma, Brugha et al., 2009) provides an illustrative example. Of the 31 publications matching the inclusion criteria, only 2 were published in peer-reviewed scientific journals.

Thus, my main ambition was not to make a theoretical contribution. That said, using the concepts of decoupling and translation helped me to analyse and explain why coordination is not always undertaken in line with intended practice. This allowed for a discussion about whether the findings from Zambia are unique to that particular context or are likely to be found elsewhere. The analytical framework thereby proved useful to understand how aid coordination is implemented, but could be further developed to better capture the power relationships between different actors.

Different approaches are used in the different studies described in this thesis. The possibility to consider and account for the context is one of the strongest arguments for conducting a case study, although this at the same time is seen as limiting for empirical generalisation. Studies I and IV are comparative studies looking at several cases using the same methods. Study III (and to some extent study IV) has a more longitudinal character, studying the effects of coordination over time. One common difficulty, however, is the lack of reliable data. Future studies could aim at combining the two approaches – designing longitudinal studies in which a large number of cases are included.

6.5.1 Indicators and measurements of the effects of aid coordination

Indicators were used to measure effects of aid coordination implementation. General criteria for useful indicators are that they should be relevant, easily generated, easily measured, reliable and action-oriented (Chalker, 2003). There is no established standard for how to measure the effects of health-sector aid coordination, though the Paris Declaration has contributed to a movement towards a consensus around such a standard. Thus it is particularly important to reflect on the indicators used in this thesis.

Study III used a selection of indicators for administrative, technical and allocative efficiency. For each of these aspects of efficiency, alternative indicators could have been used. A more careful estimation of administrative efficiency could have been conducted through a careful costing of all activities associated with aid delivery to determine total transaction costs. However, such an undertaking is both cumbersome and costly and was not deemed feasible within the scope of this thesis. A costing activity would also have encountered the difficulty of determining both how to classify and cost the different elements involved (UNDP and DFID, 2000). Indicators for technical and allocative efficiency were selected to reflect the goals of the health-sector reform and represent fairly standard indicators for performance. Other Zambia Ministry-of-Health indicators for technical efficiency, for example

health-centre utilisation and average duration of hospitalisation were not seen as feasible to determine productivity of the health system.

There seems to be a national–local disconnection in analyses of coordination; policymakers should take an interest in exploring how aid is coordinated at lower levels of the system. The coordination structures identified in study II are a national-level concern and involvement of stakeholders at lower levels is limited. Study IV made a first attempt to assess the effects of coordination at the district level in Zambia. Although significant effort has been put into developing the Paris-Declaration indicators that were adapted for study IV, they still suffer from ambiguity in the terminology used, and could be understood differently in different contexts. That said, the indicators provide a standardized approach, which, despite its flaws, allows for cross-country comparison of progress towards the agreed targets.

To my knowledge, study IV is the first study to use Paris-Declaration indicators for evaluations below the national level. The results showed that Paris-Declaration indicators could be used at the district level, although some modification of the indicators was required to make them appropriate for the local context. So what is lacking is neither data nor useful indicators but rather a mechanism to routinely collect and compare data in an efficient manner. Such a mechanism would allow quantitative assessments of a large number of districts in Zambia to be conducted.

All studies trying to determine the effects of policy implementation suffer from the difficulty of establishing causal links between the policy in question and the outcome. This thesis does not claim to have established such causal links; we know that implementation of policy is influenced by several factors that are beyond the control of those in charge of implementation. The indicators used, however, do show that implementation of aid coordination has not achieved its intended effects, neither at the national nor at the district level.

6.5.2 Additional considerations

This thesis does not deal specifically with issues of corruption and misappropriation of public funds. Civil service in Zambia has always been surrounded with rumours of corruption and the country was in 2008 ranked 115th (out of 180 countries ranked) on Transparency International's corruption perceptions index (Transparency International, 2009). The previous president, Fredrick Chiluba, and his wife are both under investigation for large-scale fraud perpetrated during his time in office.

Corrupt practices among public servants have implications for how development aid is channelled, as illustrated by recent events in Zambia. In May 2009, two of the largest donors to the health sector, Sweden and the Netherlands, decided to delay disbursement of their support to the health sector. The suspension came as a reaction to the revelation by the Anti Corruption Commission of a case of corruption in which more than 27 billion Zambian *kwacha* (about US$ 5.5 million) had been fraudulently obtained from the Ministry of Health. After the fraud was revealed, the Anti Corruption Commission seized property and assets that they suspected were connected with dishonest practices. More than 30 members of staff at the Ministry of Health, including the former Permanent Secretary, were suspended from work until a

thorough investigation had been conducted (Anti Corruption Commission, 2009; Lusaka Times, 2009b; Lusaka Times, 2009a).

The discovery of this fraud does not have direct implications for the findings of this thesis, as the sums involved are relatively small compared with total donor funds. However, even the suspicion of corrupt practices is likely to have implications for how health-sector aid in Zambia is coordinated in the future. As illustrated by the findings of this thesis, the issue of trust is important in order for donors to be willing to pool funds and support a joint sector plan. Thus, suspicion of corruption could lead to donors becoming less willing to move towards the targets of the Paris Declaration. On the other hand, the story in Zambia shows that existing systems are able to discover corrupt practices. It is impossible to safeguard completely against the illicit practices of individuals and an important goal of health-sector development aid in Zambia is to strengthen national systems for financial management. Thus the recent events in Zambia could be interpreted as a sign that necessary systems needed for donors to be willing to pool funds exist, which could strengthen trust in the capacity of the government to deal with irregularities.

Another consideration relates to how aid is channelled. Two donors, DFID and the EC, have recently shifted to providing budget support. The adoption of budget support by donors complicates the analysis of coordination for the health sector alone, as coordination of resources is not limited to one sector but also becomes part of negotiations with other ministries. The study of coordination has been further complicated by the inflow of funds from GHIs; while much of these funds are targeted specifically for health, the donors are not necessarily involved in dialogue in the health sector. That said, the Ministry of Health remains the natural counterpart and the government agency responsible for fulfilling the goals of the National Health Strategic Plan.

This thesis is limited to a consideration of the coordination of health-sector aid between the Ministry of Health and the largest external donors (in financial terms) and primary data were collected between 2002 and 2008. The main focus has been on the bilateral and multilateral agencies and organisations providing most of the external resources for health. Consequently, it does not cover all actors or resources in the Zambian health sector; private-sector actors, e.g. hospitals, clinics, corporate health care and insurance companies, are not considered. Furthermore, NGOs involved mainly in service delivery have not been analysed in detail. Other stakeholders in the health sector, such as professional bodies and civil society organisations, also fall outside the scope of this thesis. Thus, the analysis to a large extent represents policymakers' view of coordination.

7 CONCLUSIONS

In this thesis, I have set out to contribute to the limited body of empirical evidence on aid coordination. I have explored how aid is defined as a global policy and how it is implemented at the national and district level in Zambia and argued for the importance of actors, processes and context in the implementation process. Furthermore, I have used indicators for efficiency and aid effectiveness to analyse the effects of aid coordination on agreed targets of progress. My findings identify a number of challenges to aid coordination, from which some overall conclusions and policy implications emerge.

Coordination of health-sector aid in Zambia has not yielded the anticipated effects on indicators for efficiency and aid effectiveness

Coordination has led to changes in practice with regard to how development aid is managed in Zambia. A number of structures and processes have been introduced, which now appear to be institutionalised in the Zambian health sector. Donors and government have formal forums where they can discuss and negotiate. Joint planning and review processes have been established. These mechanisms have led to an increase in trust, although fragile, between partners who seem content with their functioning. However, the findings of this thesis lend support to the notion that aid is still fragmenting; there are a large number of donors with multiple funding mechanisms and donor-specific procedures. Despite having been on the agenda for some 20 years, evidence demonstrating the effects of coordination remains scarce at both the national and the district level in Zambia.

Achieving desired effects requires donors to give up control over resources

In order to achieve the desired effects and reach the internationally agreed targets of the Paris Declaration, donors must change their practices at the country level. Coordination is a process that is meant to be led by the recipient government. In Zambia, however, government control over resources remains limited since large amounts of funding remain only partially coordinated. As long as governments and ministries of health do not have full control over funds and activities, government ownership, a key feature of coordination, is bound to be compromised. For donors to give up control over resources, mechanisms that meet donor requirements for follow-up, and can be combined with the ambitions of the Paris Declaration, must be designed. The power to change how aid is managed and delivered lies first and foremost with donors. The Zambian government can provide reliable and transparent mechanisms for financial management and follow-up, but it is up to the donors to decide to what extent resources are aligned and harmonised with these systems.

Coordination efforts must consider both the local and the international context

The effects of coordination are dependent not only on the context in which it is introduced, but also on the specific contexts influencing each donor. If the rules and regulations of donor agencies prohibit them from channelling resources in a particular way, new Zambian policies for how to coordinate resources are likely to

have a limited impact on donor behaviour. Thus, a wider scope for aid coordination models, beyond the current national-level focus, is suggested, which takes into account the institutional context of all stakeholders involved.

Challenges remain in assessing the effects of coordination

Existing tools for evaluating the effects of aid coordination have proved useful, although they still suffer from ambiguity with regard to how variables should be defined. Furthermore, this thesis has highlighted a weakness of aid coordination – a lack of follow-up of progress at the district level. It is expected that coordination of national-level aid efforts will generate effects at the district level. At present, however, indicators for evaluation are not applied at the district level. More sensitive tools, developed specifically for the Zambian context, could be derived based on the Paris-Declaration indicators.

EPILOGUE

This thesis has come to a close, but the discourse on aid coordination continues to thrive, particularly at the global level. This summer a UN taskforce on Innovative Financing for Health Systems Strengthening recommended a sharp increase in resources for improving the capacity of health systems in low-income countries, in order to attain the Millennium Development Goals. The taskforce's proposal to create a joint funding mechanism for the World Bank, The Global Fund and GAVI is very much in line with the aim of the Paris Declaration to reduce the number of funding agencies involved at country level.

The creation of a joint mechanism used by these three agencies could be seen as a positive move towards better coordination of aid. At the same time, however, it also highlights the importance of the overall aid architecture to the means by which aid is implemented at country level. Although all actors agree on the need for development to be country-led, the fact is that countries often simply have to adjust to the situation with which they are presented.

The importance of global aid architecture highlights a question that this thesis has merely touched upon. Is more coordination by default a good thing? I have argued that coordination has led to some donors actually gaining more power over the policy process. If that is indeed the case, then more coordination could actually be counter-productive to achieving national ownership and making development aid more country-led.

ACKNOWLEDGMENTS

A very big “thank-you” goes to my supervisors, Göran and Kristina. We have arrived at this point after an extended struggle to merge our worldviews: I think we did a pretty good job!

This work would never have been completed had it not been for the wonderful people at the Department of Economics, University of Zambia, whom I have got to know over the years: Professor Ndulo, Professor Seshamani, Webby, Dale, Lutangu, Felix M., Pamela, Chrispin, Sylvia, Bonah, Mrs Chanda, Sharon, Mavis, Nyambe, Gabriel and Mundia. Justin and Felix S., who left us far too early – M.Y.S.R.I.P. Caesar: you deserve special thanks for tolerating all the hours I spent squatting in your office; thanks for your support and for being a great friend. I would also like to extend my gratitude to the Ministry of Health, Zambia, for being so accommodating and allowing me to rummage around their archives and placing such trust in me. Collins and all the others at the SWAp secretariat – I owe you one. Thank-you Vincent Musowe, for sharing your immense knowledge about Zambia with me; our numerous discussions have been extremely informative and enjoyable.

There are a number of people who deserve a special mention. Kerstin Sahlin: you were the one who put me on the research track and down the aid path and I certainly would not have ended up here had it not been for you. Pär Eriksson: for thinking it was a good idea to employ a complete novice to conduct a very complicated study all by himself in three countries to which he had never been; I hope you’re happy with the outcome. Birger: for you there are no words – we have used them already; I have to thank you for so much so I won’t even try to do it in just a line or two. Karin and Jaran: for sharing work angst, but more importantly, for sharing our spare time and fond travel memories. Special thanks go to: Göran Elinder for guidance and help in muddling through the KI bureaucracy. To Gill Walt for valuable input at the early stages of this work; Anders Anell for being my mentor; Anastasia Pharris, Anders Molin, Birgitta Rubenson, Grethe Fochsen, Rolf Wahlström and Sarah Wamala for critically reviewing manuscripts and research proposals.

There are so many people at KI with whom I have had the benefit of working and socializing with over the last few years. Lots of love is sent to all my dear friends and colleagues at IHCAR – you are the reason I enjoy coming to work.

And thanks to all my great friends, in Stockholm and elsewhere, and to my cycling buddies in Zambia and Stockholm for sharing all those hours on the road. It kept me (somewhat) sane during this crazy undertaking. To Adam: for always being willing to listen to my academic whining and teaching me how to run a marathon using “ant steps”; I did it! And to my family, of course: this thesis is dedicated to you. That says it all.

And finally, Sara, you were not in my life when I wrote the first version of this acknowledgement – yes, I started early – but now you are number one. I’ll follow you anywhere.

REFERENCES

Adams, M. E. (1989). "Aid coordination in Africa: a review." Development Policy Review **7**(1989): 185-192.

Alexander, D. (2007). "The International Health Partnership." Lancet **370**(9590): 803-4.

Angen, M. J. (2000). "Evaluating interpretive inquiry: reviewing the validity debate and opening the dialogue." Qual Health Res **10**(3): 378-95.

Anti Corruption Commission (2009). "K 10 billion scam at Ministry of Health exposed." Retrieved 6 July 2009, from http://acc.gov.zm/acc/AX_Articles.aspx?id=102

Atkinson, S. (1997). "From vision to reality: implementing health reforms in Lusaka." Journal of International Development **9**(4): 631-639.

Attridge, J. C. and A. Preker (2005). Improving access to medicines in developing countries: application of new institutional economics to the analysis of manufacturing and distribution issues. HNP Discussion Paper, World Bank.

Banda, Y., V. Chapman, et al. (2007). "Use of traditional medicine among pregnant women in Lusaka, Zambia." The Journal of alternative and complementary medicine **13**(1): 123-127.

Barrett, S. M. and C. Fudge (1981). Reconstructing the field of analysis. Policy and action: essays on the implementation of public policy. S. M. Barrett and C. Fudge. London, Methuen**:** 249-278.

Biesma, R. G., R. Brugha, et al. (2009). "The effects of global health initiatives on country health systems: a review of the evidence from HIV/AIDS control." Health Policy Plan **24**(4): 239-52.

Bigsten, A. (2006). Donor coordination and the uses of aid, Department of Economics, Göteborg University.

Bloom, G. and H. Standing (2008). "Future health systems: Why future? Why now?" Soc Sci Med **66**(10): 2067-75.

Bossert, T., M. B. Chitah, et al. (2003). "Decentralization in Zambia: resource allocation and district performance." Health Policy and Planning **18**(4): 357-369.

Brewer, G. D. and P. D. Leon (1983). The Policy Process. The Science of Public Policy: Essential readings in policy sciences II. T. Miyakawa. London and New York, Routledge.

Brown, A., M. Foster, et al. (2001). The status of sector-wide approaches. Working Paper 142, Centre for Aid and Public Expenditure. Overseas Development Institute.

Brown, A., F. Naschol, et al. (2000). Aid Transaction Costs in Vietnam, Centre for Aid and Public Expenditure London, Overseas Development Institute.

Brown, L. A. (1981). Innovation diffusion: a new perspective. New York, Methuen & Co.

Brugha, R., M. Donoghue, et al. (2004). "The Global Fund: managing great expectations." Lancet **364**(9428): 95-100.

Brugha, R. and G. Walt (2001). "A global health fund: a leap of faith?" BMJ **2001**(323): 152-154.

Brunsson, N. (2003). Organized Hypocrisy. The Northern lights: organization theory in Scandinavia. B. Czarniawska and G. Sevon. Copenhagen, Liber/Abstract/Copenhagen Business School Press**:** 201-22.

Buse, K. (1999). "Keeping a tight grip on the reins: donor control over aid coordination and management in Bangladesh." Health Policy and Planning **14**(3): 219-228.

Buse, K. and C. Gwin (1998). "The World Bank and global cooperation in health: the case of Bangladesh." The Lancet **351**: 665-669.

Buse, K., N. Mays, et al. (2005). Making Health Policy. Berkshire, Open University Press.

Buse, K. and G. Walt (1996). "Aid coordination for health sector reform: a conceptual framework for analysis and assessment." Health Policy **38**(3): 173-87.

Buse, K. and G. Walt (1997). "An unruly melange? Coordinating external resources to the health sector: a review." Soc Sci Med **45**(3): 449-63.

Cassels, A. (1997). A guide to sector-wide approaches for health development - concepts, issues and working arrangements, World Health Organization.

Cassels, A. and K. Janovsky (1998). "Better health in developing countries: are sector-wide approaches the way of the future?" The Lancet **352**: 1777-1779.

Central Board of Health (2002). Health Institutions in Zambia: A listing of facilities according to levels and location for 2002.

Chalker, J. (2003). Interventions for improved prescribing and dispensing of medicines in Nepal, Thailand and Vietnam. Stockholm, Karolinska Institutet.

CIA (2009). "CIA World Factbook." Retrieved 24 June 2009, from https://www.cia.gov/library/publications/the-world-factbook/geos/ZA.html

Clift, C. (1988). "Aid Co-ordination: are there any lessons to be learnt from Kenya?" Development Policy Review **6**(1988): 115-137.

Creswell, J. (2007). Qualitative inquiry and research design - choosing among five approaches. Thousand Oaks, Sage.

Czarniawska, B. (2005). En teori om organisering. Lund, Studentlitteratur.

Czarniawska, B. and B. Joerges (1996). Travel of ideas. Translating organizational change. B. Czarniawska and G. Sévon. Berlin, DeGruyter**:** 13-48.

Dahlgren, L., M. Emmelin, et al. (2004). Qualitative methodology for international public health. Umeå, Umeå University.

Dante, I. (2003). Aid Coordination and Donor Reform. Africa Report, Assessing the new partnerships. R. Schmidt, R. Beamish and D. Shadid. Ottawa, The North-South Institute.

DiMaggio, P. J. and W. W. Powell (1983). "The iron cage revisited: institutional isomorphism and collective rationality in organizational fields." American Sociological Review **48**: 147-160.

Eisenhardt, K. M. (1989). "Building Theories from Case Study Research." Academy of Management Review **14**(4): 532-550.

EuropeAid (2007). Support to sector programmes. Covering the three financing modalities: sector budget support, pool funding and EC supported project procedures, European Commission.

Finnemore, M. and K. Sikkink (1998). "International norm dynamics and political change." International Organization **52**(4): 487-511.

Fochsen, G. (2007). Encounters with power: health care seeking and medical encounters in Tuberculosis care: experiences from Ujjain District, India. Stockholm, Karolinska University Press.

Fontana, A. and J. H. Frey (2005). The Interview: from neutral stance to political involvement. The Sage handbook of qualitative research. N. K. Denzin and Y. S. Lincoln. Thousand Oaks, Sage Publications.

Foster, M. (2000). What can we learn from experience with implementing sector-wide approaches? Working Paper 140, Overseas Development Institute.

Foster, M., A. Brown, et al. (2000). Sector-wide approaches for health development: a review of experience, Overseas Development Institute. World Health Organization.

Frödin, O. (2008). Synergies, stalemates and social dilemmas: governance in South Africa in a comparative perspective. Lund, Lund University.

Frontiers Development and Research Group, Royal College of Surgeons in Ireland, et al. (2008). Global HIV/AIDS initiatives in Zambia: issues of scale up and health systems capacity. London, Open Society Institute.

Führer, H. (1994). The story of official development assistance: A history of the development assistance committee and the development co-operation directorate in dates, names and figures, OECD.

Garner, P., W. Flores, et al. (2000). "Sector-wide approaches in developing countries. The aid given must make the most impact." Bmj **321**(7254): 129-30.

Gilson, L. and N. Raphaely (2008). "The terrain of health policy analysis in low and middle income countries: a review of published literature 1994-2007." Health Policy Plan **23**(5): 294-307.

Gleneagles G8 meeting (2005). "Africa." Retrieved 2008-10-27, from http://www.g7.utoronto.ca/summit/2005gleneagles/africa.pdf.

Harrold, P. and associates (1995). The broad approach to investment lending. Sector investment programs. World Bank Discussion Papers 302, World Bank.

Hayman, R. (2006). The complexity of aid: government strategies, donor agendas and the coordination of development assistance in Rwanda 1994-2004. Edinburgh, The University of Edinburgh. **PhD**.

Hill, M. and P. Hupe (2002). Implementing public policy. London, Sage publications.

Hill, P. S. (2002). "The rhetoric of sector-wide approaches for health development." Soc Sci Med **54**(11): 1725-37.

Hjertholm, P. and H. White (2000). Survey of foreign aid: history, trends and allocation, Department of Economics, University of Copenhagen.

Howlett, M. and M. Ramesh (2003). Studying public policy: policy cycles and policy subsystems. Ontario, Oxford University Press.

Hutton, G. (2004). Case study of a 'successful' sector-wide approach: the Uganda health sector SWAp. Basel, Swiss Tropical Institute.

Hutton, G. and M. Tanner (2004). "The sector-wide approach: a blessing for public health?" Bull World Health Organ **82**(12): 893.

Hydén, G. (2005). Why do things happen the way they do? a power analysis of Tanzania, Report to the Swedish Embassy in Tanzania.

Hydén, G. (2008). "After the Paris Declaration: taking on the issue of power." Development Policy Review **26**(3): 259-274.

Independent Evaluation Group (2006). Project performance assessment report Bangladesh. Fourth population and health project. Health and population program project., The World Bank.

Independent Evaluation Group (2007). Project performance assessment report Ghana. Second health and population project. Health sector support project., The World Bank.

Independent Evaluation Group (2009). Improving effectiveness and outcomes for the poor in health, nutrition and population: an evaluation of the World Bank group support since 1997, The International Bank for Reconstruction and Development / The World Bank.

International Development Association (2007). Aid architecture: an overview of the main trends in official development assistance flows. Washington.

Jeppsson, A. (2002). "SWAp dynamics in a decentralized context: experiences from Uganda." Social Science & Medicine **55**(2002): 2053-2060.

Jönsson, K. (2002). Translating foreign ideas into domestic practice. Pharmaceutical policies in Laos and Vietnam. Department of Political Science. Lund, Lund University.

Kalumba, K. and V. Musowe (1997). Sustainable partnerships for health. Paper presented at a consultative meeting on sector support programmes in Kafue Gorge, Zambia.

Kalumba, K. and V. Musowe (1998). Effective Coordination and Use of Donor Funding in Zambia. Sustainable Health Care Financing in Southern Africa. B. Allison, J. Doherty, L. Gilson, E. Lambo and P. Shaw. Washington DC, The World Bank.

Kapur, D., J. P. Lewis, et al. (1997). The World Bank - Its first half century: Vol 1 History. Washington DC, Brookings Institution Press.

Kasumba, G. and A. Land (2003). Sector-wide approaches and decentralisation - strategies pulling in opposite directions? A case study from Uganda.

Kaunda, K. D. (1966). A humanist in Africa. London, Longmans, Green and Company Limited.

Killick, T. (2004). "Politics, evidence and the new aid agenda." Development Policy Review **22**(1): 5-29.

Koeberle, S. and Z. Stavreski (2006). Budget support: concept and issues. Budget support as more effective aid? recent experiences and emerging lessons. S. Koeberle, Z. Stavreski and J. Walliser. Washington DC, The World Bank.

Kombe, G., D. Galaty, et al. (2005). Human resource crisis in Zambia's health system: A call for urgent action. Bethesda MD, The partners for health reform plus project, Abt Associates Inc.

Kvale, S. and S. Brinkmann (2009). Interviews - learning the craft of qualitative research interviewing. Thousand Oaks, Sage Publications.

Lake, S. and C. Musumali (1999). "Zambia: the role of aid management in sustaining visionary reform." Health Policy Plan **14**(3): 254-63.

Lanjouw, S., J. Macrae, et al. (1999). "Rehabilitating health services in Cambodia: the challenge of coordination in chronic political emergencies." Health Policy and Planning **14**(3): 229-242.

Latour, B. (1986). The powers of association. Power, action and belief. J. Law. London, Routledge and Keagan Paul**:** 196-233.

Lincoln, Y. S. and E. G. Guba (1985). Naturalistic Inquiry. Beverly Hills, Sage Publications.

Lipsky, M. (1980). Street-Level Bureaucracy: Dilemmas of the individual in public services. New York, Russell Sage Foundation.

Lumsdaine, D. H. (1993). Moral Vision in international politics: the foreign aid regime 1949-1989. Princeton, Princeton University Press.

Lusaka Times (2009a). "Be patient, Dr Simon Miti told." Retrieved 6 July 2009, from http://www.lusakatimes.com/?p=13658

Lusaka Times (2009b). "Police pick up Dr. Simon Miti." Retrieved 6 July 2009, from http://www.lusakatimes.com/?p=13190

Mayhew, S. H., G. Walt, et al. (2005). "Donor agencies' involvement in reproductive health: saying one thing and doing another?" Int J Health Serv **35**(3): 579-601.

McKinsey & Company (2005). Global health partnerships: assessing country consequences, McKinsey & Company.

McPake, B. and J. Kutzin (1997). Methods for evaluating health system performance and the effects of reform. Current Concerns ARA paper no. 13. Geneva, World Health Organization.

Merriam, S. B. (1994). Fallstudien som forskningsmetod (Original title: Case study research in education). Lund, Studentlitteratur.

Meyer, J. W. and B. Rowan (1977). "Institutionalized organizations: Formal structures as myth and ceremony." American Journal of Sociology **83**(1): 340-363.

Ministry of Health (1991). National Health Policies and Strategies (Health Reforms), Ministry of Health.

Ministry of Health (2005a). Human resources for health strategic plan 2006-2010, Ministry of Health.

Ministry of Health (2005b). National health strategic plan 2006-2010, Ministry of Health.

Ministry of Health (2006a). 2005 Annual Report, Ministry of Health Zambia.

Ministry of Health (2006b). Memorandum of Understanding between the Government of the Republic of Zambia/Ministry of Health and Cooperating Partners, Government of the Republic of Zambia.

Ministry of Health (2007). Action Plan 2007 (Draft version 29 January 2007), Ministry of Health.

Ministry of Health (2008a). Report of the mid-term review of the Zambia National Health Strategic Plan 2006-2010 (Draft 13th October 2008). Lusaka, Ministry of Health.

Ministry of Health (2008b). Towards scaling up for better health: stock-taking report for Zambia; Report to Lusaka meeting of the International Health Partnership and Related Initiative (IHP+) and Harmonisation for health in Africa (HHA). Lusaka, Ministry of Health.

Ministry of Health (2009). Zambia national health accounts 2003 to 2006: general accounts with HIV/AIDS, TB and Malaria sub-accounts. Final Report. Lusaka, Ministry of Health.

Mosse, D. (2004). "Is good policy unimplementable? reflections on the etnography of aid policy and practice." Development and Change **35**(4): 639-671.

Mosse, D. (2005). Cultivating Development. An Ethnography of Aid Policy and Practice. London, Ann Arbor, Pluto Press.

Murray, C. J., J. Frenk, et al. (2007). "The Global Campaign for the Health MDGs: challenges, opportunities, and the imperative of shared learning." Lancet **370**(9592): 1018-20.

Nakamba-Kabaso, P., C. Cheelo, et al. (2006). The Zambian costs of a basic health care package. Policy Lessons and Emerging Challenges in the Zambian Health Sector 2000-2005. C. Cheelo, M. Ndulo and K. Ödegaard. Lund and Lusaka, Department of Economics, University of Zambia and The Swedish Institute for Health Economics.

Nee, V. and P. Ingram (1998). Embeddedness and beyond: institutions, exchange and social structure. The new institutionalism in sociology. M. C. Brinton and V. Nee. New York, Russell Sage Foundation.

OECD (1992). DAC Principles for effective aid. Paris, OECD.

OECD (2007). Aid effectiveness: 2006 survey on monitoring the Paris Declaration. Overview of the results, Organisation for economic co-operation and development.

OECD (2008a). 2008 survey on monitoring the Paris Declaration. Effective aid by 2010? What will it take. **Volume 1: overview**.

OECD (2008b). Better Aid: 2008 Survey on monitoring the Paris Declaration. Making aid more effective by 2010. Paris, Organization for Economic Cooperation and Development.

OECD (2008c). Measuring Aid to Health, October 2008, OECD.

Okuonzi, S. A. and J. Macrae (1995). "Whose policy is it anyway? International and national influences on health policy development in Uganda." Health Policy Plan **10**(2): 122-32.

Oomman, N., M. Bernstein, et al. (2007). Following the funding for HIV/AIDS: a comparative analysis of the funding practices of PEPFAR, the Global Fund and World Bank MAP in Mozambique, Uganda and Zambia. Washington, Center for Global Development.

Ooms, G., W. Van Damme, et al. (2008). "The 'diagonal' approach to Global Fund financing: a cure for the broader malaise of health systems?" Global Health **4**: 6.

Örtendahl, C. (2007). The Uganda health SWAp: new approaches for a more balanced aid architecture. Technical Approach Paper. London, HLSP Institute.

Paris Declaration (2005a). "Baseline and suggested targets for the 12 indicators of progress - Paris Declaration on Aid Effectiveness." Retrieved 28 July, 2009, from http://www.oecd.org/dataoecd/45/46/35230756.pdf.

Paris Declaration (2005b). "Paris Declaration on Aid Effectiveness." Retrieved June 3, 2009, from http://www.oecd.org/dataoecd/11/41/34428351.pdf.

Patton, M. (2002). Qualitative research & evaluation methods. London, Sage Publications.

Pavignani, E. and J. R. Durao (1999). "Managing external resources in Mozambique: building new aid relationships on shifting sands?" Health Policy Plan **14**(3): 243-53.

Peters, D. and S. Chao (1998). "The sector-wide approach in health: what is it? where is it leading?" International Journal of Health Planning and Management **13**: 177-190.

Pressman, J. L. and A. Wildawsky (1984). Implementation Berkeley, University of California Press.

Ravishankar, N., P. Gubbins, et al. (2009). "Financing of global health: tracking development assistance for health from 1990 to 2007." Lancet **373**(9681): 2113-24.

Robson, C. (2002). Real world research. Malden, MA, Blackwell Publishing.

Rogers, E. M. (1983). Diffusion of innovations. New York, The Free Press.

Ross, D. J. (1990). "Aid co-ordination." Public administration and development **10**: 331-342.

Sahlin-Andersson, K. (1989). Oklarhetens strategi. Lund, Studentlitteratur.

Sahlin-Andersson, K. and L. Engwall (2002). The expansion of management knowledge. Stanford, Stanford University Press.

Shiffman, J. and Y. Wu (2003). "Norms in tension: democracy and efficiency in Bangladeshi health and population sector reform." Social Science & Medicine **57**(2003): 1547-1557.

Stake, R. E. (1995). The art of case study research. Thousand Oaks, Sage Publications.

Stake, R. E. (2005). Qualitative Case Studies. The sage handbook of qualitative research. N. K. Denzin and Y. S. Lincoln. Thousand Oaks, Sage Publications.

Strang, D. and J. Meyer (1993). "Institutional Conditions for Diffusion." Theory and Society **22**: 487-511.

Sundewall, J., B. C. Forsberg, et al. (2006). "Theory and practice - a case study of coordination and ownership in the Bangladesh health SWAp." Health Res Policy Syst **4**: 5.

Task Force on Health Systems Research (2004). "Informed choices for attaining the Millennium Development Goals: towards an international cooperative agenda for health-systems research." Lancet **364**(9438): 997-1003.

The Economist (2008). "A scramble in Africa." The Economist. Retrieved 23 July 2009, from http://www.economist.com/world/international/displaystory.cfm?story_id=12060397

Thurén, T. (2005). Källkritik. Stockholm, Liber AB.

Transparency International (2009). "Corruption perceptions index." Retrieved 26 June 2009, from http://www.transparency.org/policy_research/surveys_indices/cpi/2008

Ugalde, A. and N. Homedes (1998). Medicines and rural health services: An experiment in the Dominican Republic. The context of medicines in developing countries: Studies in pharmaceutical anthropology. S. V. Geest and S. R. Whyte, Springer**:** 57-80.

UNDP (2007). Human Development Report 2007/2008. New York, United Nations Development Programme.

UNDP and DFID (2000). Aid transaction costs in Viet Nam.

Uplekar, M. and M. C. Raviglione (2007). "The "vertical-horizontal" debates: time for the pendulum to rest (in peace)?" Bull World Health Organ **85**(5): 413-4.

Van Meter, D. and C. E. Van Horn (1975). "The policy implementation process: a conceptual framework." Administration and Society **6**(4): 445-488.

Wake, W., J. Sundewall, et al. (2008). Private health care in Zambia: findings from provider and client surveys in two districts.

Walford, V. (2003). Defining and evaluating SWAps, Institute for Health Sector Development.

Walt, G. (1994). Health Policy: an introduction to process and power. London/Johannesburg, Zed Books/Witwatersrand University Press.

Walt, G. and L. Gilson (1994). "Reforming the health sector in developing countries: the central role of policy analysis." Health Policy Plan **9**(4): 353-70.

Walt, G., E. Pavignani, et al. (1999a). "Health sector development: from aid coordination to resource management." Health Policy Plan **14**(3): 207-18.

Walt, G., E. Pavignani, et al. (1999b). "Managing external resources in the health sector: are there lessons for SWAps (sector-wide approaches)?" Health Policy Plan **14**(3): 273-84.

Walt, G., J. Shiffman, et al. (2008). "'Doing' health policy analysis: methodological and conceptual reflections and challenges." Health Policy Plan **23**(5): 308-17.

White, H. (2007). "The Bangladesh health SWAp: experience of a new aid instrument in practice." Development Policy Review **25**(4): 451-472.

Whittington, D. and C. Calhoun (1988). "Who really want donor co-ordination?" Development Policy Review **6**: 295-309.

WHO (2000). 2000 World Health Report: Health systems - improving performance. Geneva, World Health Organization.

Woods, N. (2005). "The shifting politics of foreign aid." International Affairs **81**(2): 393-409.

World Bank (1993). Investing in Health, World Development Report 1993. Washington, Oxford University Press.

World Bank (2007). World Development Report. Washington, World Bank.

World Bank, OECD, et al. (2008). Effective Aid: Better Health: report prepared for the Accra High Level Forum on aid effectiveness 2-4 September 2008.

Yin, R. (2003). Case study research design and methods. Thousand Oaks, Sage Publications.