REVIEW OF HEALTH AND EDUCATION PROGRESS IN SELECTED AFRICAN COUNTRIES (RHEP-SAC)

SYNTHESIS REPORT

Africa Policy Department,
DFID

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Preface

This report is the product of work initiated primarily for DFID internal purposes. It is being made available outside DFID to serve as a discussion paper and to contribute to the debate about how to help African countries make faster progress towards the Millennium Development Goals. This Synthesis Report draws from country level reports, which were drafted by DFID staff or by consultants in consultation with DFID staff. The views reflected are therefore not independent of DFID, but neither does the report represent DFID policy. The methodology used in the country level studies cannot test aid effectiveness hypotheses rigorously. Readers of the Synthesis Report should bear these limitations in mind.

The country level reports are also being prepared for release outside DFID in the hope that they will help to inform country level discussions. Again, these do not represent DFID policy.

REVIEW OF HEALTH AND EDUCATION PROGRESS IN SELECTED AFRICAN COUNTRIES (RHEP-SAC)

SYNTHESIS REPORT

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
APD	Africa Policy Department
CHF	Community Health Funds
DDP	Directors Delivery Plan
DFID	Department for International Development
DHS	Demographic and Health Survey
DPT3	Diptheria, Pertussis and Typhoid Immunisation (Third Dose)
EFA FTI	Education for All Fast Track Initiative
EFA GMR	Education for All Global Monitoring Report
EvD	Evaluation Department (DFID)
GAVI	Global Alliance for Vaccination and Immunisation
GBS (PRBS-G)	General Poverty Reduction Budget Support
GDP	Gross Domestic Product
GER	Gross Enrolment Rate
GETfund	Ghana Education Trust Fund
GFATM	Global Fund Against Tuberculosis and Malaria
GPI	Gender Parity Index
HIPC	Highly Indebted Poor Country
HIV	Human Immunodeficiency Virus
HR	Human Resources
IM	Infant Mortality Rate
IMF	International Monetary Fund
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
MoE	Ministry of Education
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NER	Net Enrolment Rate
OECD-DAC	Organisation for Economic Co-operation and Development - Development Assistance Committee
OPD	Outpatient Department Attendance per capita
PAF	Performance Assessment Framework

PCR	Primary Completion Rate
PER	Public Expenditure Review
PFM	Public Finance Management
PRBS	Poverty Reduction Budget Support
PRS	Poverty Reduction Strategy
PRSC	Poverty Reduction Support Credit
PSA	Public Service Agreement
PTR	Pupil Teacher Ratio
RHEP-SAC	Review of Health and Education Progress in Selected African Countries
SBA	Skilled Birth Attendance
SSP	Sector Strategic Plan
SWAp	Sector Wide Approach
TA	Technical Assistance
U5M	Under Five Mortality Rate
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Childrens Fund
WB	World Bank
WDI	World Development Indicators
WHO	World Health Organisation

Executive Summary

Introduction

1. The Review of Health and Education Progress in Selected African Countries (RHEP-SAC) was launched by the Director for Africa in August 2004, primarily to improve DFID understanding of recent developments in health and education sectors across some of our key African countries. The output will be useful centrally in meeting Ministerial and top management needs, and to feed into various 2005 processes, but is also expected to be of interest to other donor agencies.

2. Country and sector specific RHEP-SAC reports were produced for both health and education sectors in Ghana, Malawi, Mozambique, Uganda, Tanzania and Zambia and for education only in Ethiopia and Rwanda. Most reports were produced by consultants in consultation with DFID country staff [1] but with little involvement of partner governments or other donors in order to minimise transactions costs.

3. Working from a literature review and other sources, the country reports record changes in outputs and outcomes over the past 3 to 5 years, with a particular focus on primary level services. The RHEP-SAC reports reflect DFID views on reasons for the changes observed, including the role of aid, although attribution of elements of progress (or lack of it) to specific factors is difficult because typically a combination of factors have simultaneously been at work. Nonetheless, cross-country and cross-sector comparison provides some indications of which factors generally are associated with positive or negative trends in sector developments and in outputs and outcomes.

Key Findings: Recent Progress in Education

4. The key **education output** indicators used in the RHEP-SAC analysis are the Gross Enrolment Rate (GER), the Net Enrolment Rate (NER) and the Gender Parity Index (GPI) at the primary level of education. [2] The GER reflects total enrolment, the NER reflects correct age enrolment and the GPI reflects the gender balance in enrolment.

5. All countries in the sample had achieved significantly higher levels of enrolments by the end of the period, in many cases due to the implementation of a policy to remove tuition fees, and most of the sample countries are on track to meet the MDG target of 100% NER by 2015. [3] The second target for the MDG is the Primary Completion Rate; most of the sample countries still have a long way to go in increasing this to reach 100% by 2015.

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[1] The exceptions were that DFID country level Advisers produced the 2 Ghana reports and the Education reports for Rwanda and Ethiopia.

[2] In this report, we have reserved the label "outcome" for longer term effects of education (eg. on literacy) and of health (eg. on mortality) and we use the label "output" for service utilisation measures such as school enrolment and outpatient attendance. The indicators which we have called "output" are often referred to in other development literature as "intermediate outcomes" but our labelling approach avoids possible confusion between intermediate and final outcomes.

[3] Refer to Box 2.1 for graphical illustration of progress in key education outputs

6. GPI has been improving at the primary level in all countries, in some more quickly than in others. But only Malawi and Rwanda are likely to achieve the MDG target of gender parity in primary education by 2005.

7. Data is thin on long-term **education outcomes** such as literacy. There are a number of reasons for this, including the long time lags involved in translating education outputs into outcomes and the difficulty in measuring and comparing data on education outcomes.

8. Issues common to the education sector across the country reports include the policy trade-offs involved in increasing access to education often at the expense of quality, in improving the allocation of resources within the sector, and in increasing girls' access to education.

9. Removal of tuition fees appears to have stimulated demand for education, yet few countries have adequately planned for the supply requirements for increased enrolments, notably classrooms, textbooks and teachers. Pupil Teacher Ratios are in most cases at levels that have significant negative impact on quality.

10. With regards to intra-sectoral allocation, the competing needs of secondary and tertiary sub-sectors are in some cases leading to a lower share of resources for primary education. Whilst this may contribute to other (longer-term) national objectives it constrains the scope for simultaneously expanding access to and improving the quality of primary education.

11. Targeting of resources to vulnerable and needy groups – along geographical, socio-economic, special needs and gender lines – to improve equity in access is also a challenge. For example, national figures for education indicators discussed mask significant in-country variations, with poorer and more rural areas typically being doubly disadvantaged; they have proportionately fewer schools and the quality of education is also lower.

12. Whilst gender parity is slowly being attained at the primary level, higher levels of education remain significantly imbalanced. Improvements at the primary level are being seen typically as the result of an increasing focus on girls' education in policy and planning.

Key Findings: Recent Progress in Health

13. The key **health output** indicators used in the analysis are the DPT3 immunisation rate, the proportion of deliveries attended by a skilled birth attendant and the level of outpatient attendance per capita.[4] Progress in these outputs is generally positive in the six countries studied but there are exceptions, for example falls in skilled birth attendance in Zambia, and in Outpatient department attendance in Malawi.[5]

14. Key final **health outcome** indicators examined in the RHEP-SAC are those used to measure progress towards MDG targets – the infant, under-5 and maternal

[4] See footnote 2 for clarification of output / outcome terminology
[5] Refer to Boxes 2.2 for graphical illustration of progress in key health outputs

mortality rates. Data on health outcomes in the six countries is a little patchy, and does not show significant improvements in recent years (improvements in Zambian infant and under-5 mortality rates are a notable exception).[6] Most of the sample countries are far from achieving the MDG target of 67% reduction in infant and under-5 mortality rate by 2015 compared with 1990, given the reductions achieved by 2000.

15. Issues common to the health sector across the country reports include the human resource crisis, the impact of vertical programmes and user fees.

16. All of the health sectors looked at in this study are experiencing a human resource crisis – they are not managing to recruit, train, deploy and retain all the staff that are needed. Typically this is the result of a combination of factors; the loss of staff to non-governmental providers and other countries offering better terms and conditions, recruitment freezes, the inability to provide incentives, and HIV and AIDS.

17. Vertical Programmes, including global initiatives, may be having a positive impact on outputs, but their long-term sustainability is questionable in terms of the volume of resources provided and the pattern of expenditure supported. Additionally, the essentially project-type implementation arrangements are often not well integrated with national processes and may undermine the good work done in promoting harmonisation and alignment in these countries.

18. User fees for healthcare services represent a significant barrier to access, and raise serious equity issues since they tend to affect the poor disproportionately. The Ugandan experience shows a positive impact on Outpatient department attendance per capita as a result of abolishing user fees, and so far these gains appear to be sustained. However, it should be noted that removing health user fees in Uganda was part of a broader package of reforms, including increases in resources, in salaries for health workers and in drug availability. It is as yet too early to see from the data whether this package of reforms has resulted in a significant improvement in health outcomes in Uganda.

Key Findings: Cross-Cutting Issues

19. **Policy Environment:** Education and health sectors are both priorities within the Poverty Reduction Strategies of all of the sample countries. Sector strategic plans have in most cases been developed, linked with the PRS and agreed with the main stakeholders. Political commitment has been important in doing this. However, prioritisation and implementation of these plans are often weak.

20. **Sector Wide Approaches:** These are present in almost all of the sectors reported on and the process of developing these has helped in improving policy dialogue with donors as well as in promoting harmonisation and alignment.

21. **Medium Term Expenditure Frameworks and Budgets:** In most cases resources allocations to both health and education sectors have improved in recent years – in absolute terms and relative to GDP. Both domestic and external finances

[6] Refer to Boxes 2.3 for graphical illustration of progress in key health outcomes

have in most cases increased so aid appears to be additional to, rather than replacing, domestic commitments. However, in several countries budgets remain fragmented, budget execution remains weak and there are concerns about the rising aid dependency of the health and education sectors. But in Tanzania and Uganda, a growing share of the total resource envelope has been financed by government budget allocations, reflecting the high volumes of general budget support these countries receive.

22. **Aid Modalities and Effectiveness:** Pooled funding arrangements in support of SWAps operate in most of the sectors reviewed, but project funding remains significant. The country reports rehearse well known arguments for transition from project funding to budget support (sector or general) but also send out a strong message that both in-country donor teams and recipient governments feel it is necessary to maintain strong policy dialogue and technical support at sector levels. Technical assistance has played an important role in SWAp processes, for instance in developing sector plans.

23. **Data, Statistics and Monitoring:** There is a shortage of good quality reliable data which is needed to properly monitor and evaluate progress, and also better inform policy and planning in-country.

Conclusions

24. Enrolments in education are improving and most countries are on-track to meet the MDG target for this, but achieving the completion rate targets remains problematic.

25. Utilisation of health services is generally improving but not fast enough. Data on mortality rates is patchy and suggests improvements are modest at best; these countries are off-track in relation to the health MDG targets.

26. Improved service utilisation in both sectors reflect the combined effect of several factors including: policies to enhance access in some cases; increased resources in most countries (both domestic and external); and improved harmonisation and alignment.

27. In order to make further progress, the country reports argue that both sectors require: more resources – preferably delivered as either sector or general budget support rather than as projects; increased and more equitable access to quality services; action to address human resource constraints; stronger government led central and sectoral processes and strategic policy dialogue; and better data systems.

1 Introduction

Background to Review of Health and Education Progress in Selected African Countries

1.1. The Review of Health and Education Progress in Selected African Countries (RHEP-SAC) was launched by DFID's Director for Africa in August 2004, primarily to improve DFID understanding of recent developments in health and education sectors across some of DFID's African PSA countries where some progress might be evident[7]. It seeks to build a more coherent picture of what is happening than can be gleaned from information produced for corporate reporting (eg. for the DDP), and PQ answers, but using a quicker and lighter study process than classic EvD evaluations. The output will be useful centrally in meeting Ministerial and top management needs, and to feed into various 2005 processes. The exercise also has some value at country level as a snapshot assessment of performance and future challenges, and should be of interest to some other donor agencies too.

Methodology

1.2. Country and sector specific RHEP-SAC reports were produced for both health and education sectors in Ghana, Malawi, Mozambique, Uganda, Tanzania and Zambia and for education only in Ethiopia and Rwanda. Most reports were produced by consultants in consultation with DFID country staff[8] but with minimal involvement of partner governments or other donors.[9] The shortcomings of not using a more independent or more consultative review process were recognised, but this approach had the advantage of avoiding imposition of transactions costs on others participating in ongoing joint donor evaluations of budget support in most of the RHEP-SAC countries[10]. A standard set of questions (see Annex Two) was used to encourage consistency in approach across countries.

1.3. Working from a literature review and other sources, the country reports record changes in outputs and outcomes over the past 3 to 5 years, with a focus on primary level services. The RHEP-SAC reports reflect DFID views on reasons for the changes observed, including the role of aid, although attribution of elements of progress (or lack of it) to specific factors is difficult because typically a combination of factors have simultaneously been at work. Nonetheless, cross-country and cross-sector comparison provides some indications of which factors generally are

[7] The Director's commissioning minute for RHEP indicated our interest that Ghana, Ethiopa, Malawi, Mozambique, Rwanda, Tanzania, Uganda and Zambia should participate but left room for other country offices to take part also if they wished. However, in the event, other country offices judged that the study approach would not be appropriate for them.
[8] The exceptions were that DFID country level Advisers produced the 2 Ghana reports and the Education reports for Rwanda and Ethiopia.
[9] However, some reports were prepared in consultation with other donors (Mozambique Health and Education reports, Ghana Health sector report)
[10] The budget support evaluation in Tanzania was undertaken in 2004 for government and donors jointly. Evaluations of General Budget Support in Rwanda, Uganda, Malawi and Mozambique are being undertaken in 2005 as part of a multi-country joint donor exercise under DAC aegis.

associated with positive or negative trends in sector developments and in outputs and outcomes.

Purpose of RHEP-SAC Synthesis Report

1.4. This synthesis report draws upon data, evidence and discussion from the country reports. Section 2 summarises progress in terms of key education and health indicators. Section 3 discusses common trends and issues. Section 4 presents some possible operational conclusions. Section 5 looks at some wider lessons learned.

2 Recent Progress

2.0. To understand recent progress, this section reviews progress in terms of key output indicators, first in education, then in health. Progress in output indicators is assumed to be a leading indicator for improvements in longer-term outcomes, on which a limited amount of information in the health sector is also included.

2.1. The limitations of the data provided by the country reports are recognised. Data provided in the country reports often comes from different sources in different years. Different sources both within and across countries use different methodologies for data collection, and in some cases may even use different definitions of indicators. In most cases the output data comes from Education and Health Management Information Systems, whereas data on long-term outcomes where available is collected using instruments such as Demographic and Health Surveys.

2.2. To facilitate comparison across and within countries, the Synthesis Report analysis of progress uses international data sources as well as data contained in the country RHEP-SAC reports. For the education sector it makes use of data available in the Education for All Global Monitoring Reports (EFA GMR)[11] for the period 1998-2001, whilst the analysis for the health sector uses data from the World Development Indicators (WDI)[12] for the period 1998-2002. These sources are internationally recognised data sets, for which considerable effort is made to ensure the robustness and consistency of the data. The EFA GMR data is published by UNESCO but compiled using a variety of UNESCO and non-UNESCO sources, similarly the WDI database is published by the World Bank but compiled using a variety of World Bank and non-World Bank sources.

2.3. As expected, the country reports have in most cases captured data that is more up to date than the Education For All Global Monitoring Reports (EFA GMR), or the World Development Indicators (WDI) and this is used to supplement the EFA GMR and WDI data. However, because of differences in country level definitions and methodologies the country report data is better for indicating recent progress within countries, than for comparing across countries.

[11] Education for All Global Monitoring Reports 2002, 2003/4, 2005 (UNESCO)
[12] World Development Indicators Online Database

2.1 Education Sector

Trends in Key Education Output Indicators

2.1.1. Box 2.1 below shows how key education output indicators have evolved in Ethiopia, Ghana, Malawi, Mozambique, Rwanda, Tanzania, Uganda and Zambia over the period 1998-2004. The key education outputs used are the Gross Enrolment Rate (GER), the Net Enrolment Rate (NER) and the Primary Gender Parity Index.[13],[14]

2.1.2. The Primary Gross Enrolment Rate reflects the number of children enrolled in primary school as a proportion of the population of school-going age. As an indicator it is used to reflect access to and use of education services. The Primary Net Enrolment Rate reflects the number of children of primary-school going age enrolled in primary school as a proportion of the school-going age population. As an indicator it too reflects access, but also a dimension of efficiency by showing the number of children who gain access to education services at the time when they are supposed to.

2.1.3. All countries in the sample have a higher GER in 2004 [15] than in 1998, with the exception of Uganda. Combined with this all of the countries also have a higher NER by the end of the period.

2.1.4. The graphs illustrate some interesting trends with regards to the pattern and timing of increasing primary school enrolments. Ghana and Mozambique appear to be making steady progress in terms of both GER and NER, with gains being made more rapidly in Mozambique. In Ghana the GER has increased from 77% in 1998 to 87% by 2004; in Mozambique the GER increased from 81% in 1998 to 99% by 2001.

2.1.5. Uganda's very high GER of 143% in 1998 fell to 136% in 2000 according to the EFA Global Monitoring Reports. Between 2000 and 2004 data in the Uganda country RHEP-SAC report indicates that the GER fell more slowly from 128% to 124%, whilst the NER has increased from 85.5% to 88.7%. The fall in GER coupled with the increase in NER is indicative of the system educating more primary pupils at the correct age and is in fact what we would hope to see.

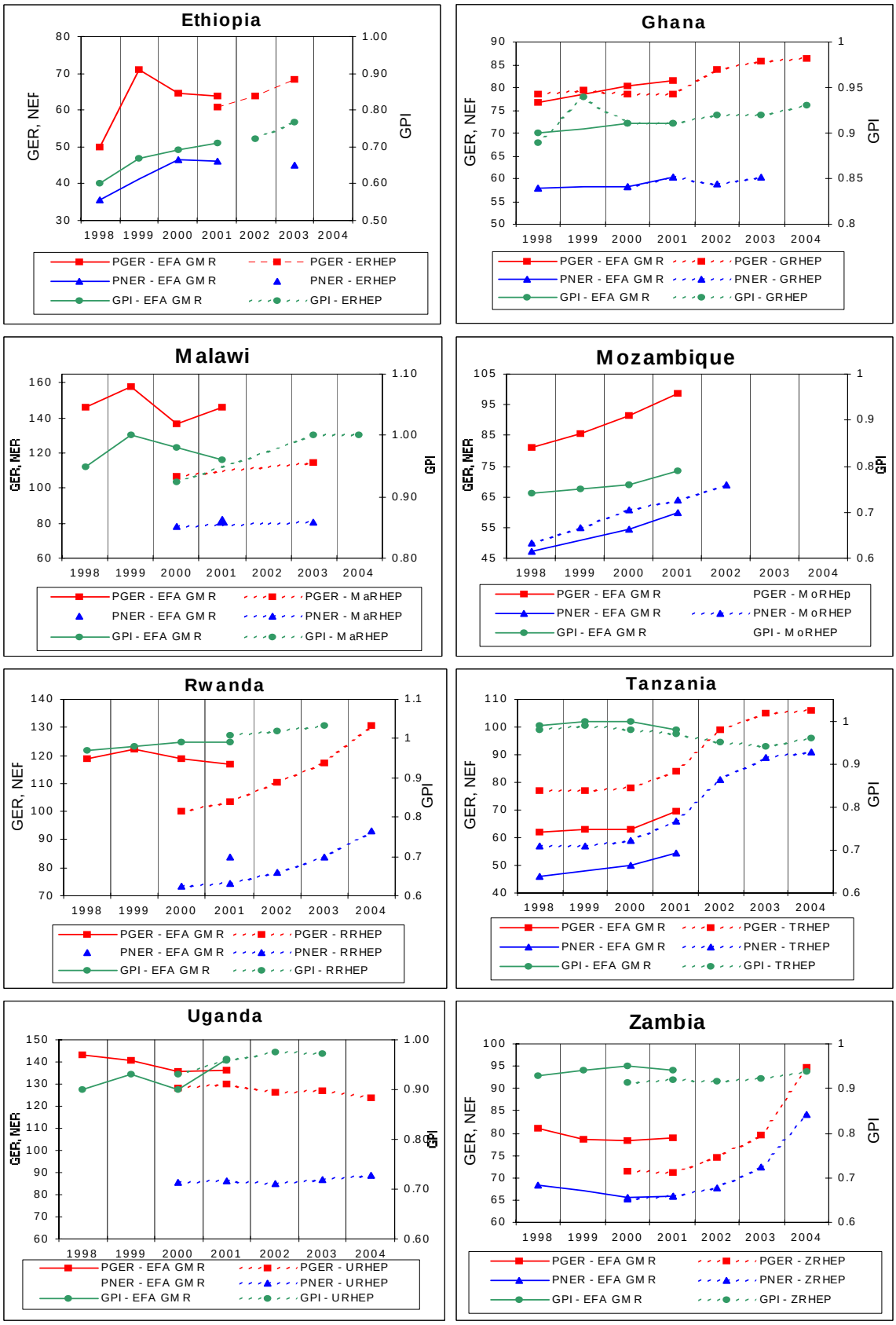
2.1.6. In Ethiopia, increases in GER appear to have been a little erratic, increasing from 50% in 1998 to 66% in 2003, but jumping to 71% in 1999 before dropping back to

[13] Annex One contains a full presentation of the data used to compile these graphs. Unfortunately differences across countries in the definitions and methodologies used for compiling statistics on primary completion and survival rates has meant that we are unable to use time series data on these statistics in the synthesis report. Individual country reports may contain data on additional indicators.

[14] In this report, we have reserved the label "outcome" for longer term effects of education (eg. on literacy) and of health (eg. on mortality) and we use the label "output" for service utilisation measures such as school enrolment and outpatient attendance. The indicators which we have called "output" are often referred to in other development literature as "intermediate outcomes" but our labelling approach avoids possible confusion between intermediate and final outcomes.

[15] 2003 for Ethiopia and Malawi and 2002 for Mozambique.

Box 2.1: Trends in Key Education Outputs (Enrolments): Evidence of Broad Progress



PGER – Primary Gross Enrolment Rate; PNER – Primary Net Enrolment Rate; GPI – Gender Parity Index; EFA GMR – Education for All Global Monitoring Report; xRHEP – Review of Health and Education Progress report for country x.

Note that for ease of presentation different scales are used on the axes of the different graphs

Zambia figures report on 9yrs basic education rather than primary education alone.

64 in 2000. Data from the country report suggests a steady increase since then, and Net Enrolment rates appear to be increasing steadily.

2.1.7. In Malawi the gross enrolment patterns also appear somewhat erratic according to EFA GMR data. However, the significant discrepancy between the EFA GMR data on GER and that in the country report should be noted - for example, the EFA GMR puts GER at 136.9% in 2000 whilst the country report quotes the MoE EMIS figure of 106.8%. A key contributor to the discrepancy is believed to be problems associated with population estimates; the Malawian National Statistics Office (NSO) estimates of population are apparently unreliable and so it is likely that the EFA GMR data does not use these. Net Enrolment Rates appear to be increasing more steadily in Malawi – and it appears that EFA GMR data and that quoted in the country report are less at variance with each other for NER than for GER.

2.1.8. The graphs for Rwanda, Tanzania and Zambia all demonstrate a surge in enrolments over the period 2001-2004. This coincides with the introduction of Tuition Free Primary Education in each of these countries in 2003, 2001 and 2002 respectively. In Tanzania, between 1998 and 2004, the GER grew from 77% to 106% and the NER grew from 57% to 91% according to the Tanzanian EMIS data reported in the country report. It should be noted that there is quite a large variation between EFA GMR and country report data on these figures.

2.1.9. Between 2001 and 2004, Rwanda saw the GER rise from 117% to 131% and the NER from 84% to 93%, while in Zambia the GER rose from 79% to 95% and the NER from 66% to 84%. What is interesting about the Rwandan and Zambian graphs in Box 2.1 is that in both countries the phenomenon of increasing enrolments appears to be gaining momentum; the shape of the graphs indicating that the annual increase is itself increasing each year. This appeared to be the case in Tanzania too between 2000 and 2002, but in recent years annual growth in enrolment has been much less pronounced.

2.1.10. The graphs, and the above discussion, highlight the importance of focusing on NER in addition to GER, especially when GER is close to or above 100%. And whilst a rising GER generally indicates more pupils are in schools, an increasing NER even when GER is stable or falling indicates improved efficiency and effectiveness of the education system in contributing to human development through the education of children at earlier (i.e. closer to the correct) ages.

2.1.11. The third indicator shown on the graphs (using the right hand axis) is the primary enrolment Gender Parity Index (GPI) – this reflects the relative number of boys and girls enrolled in schools and so the level of gender equity in access to education. A figure of 1.0 indicates gender parity has been achieved; below 1.0 girls are under represented and vice versa.

2.1.12. The GPI has increased in all of the sample countries over the period 1998-2003/4 with the exception of Tanzania. The introduction of tuition free primary education in Tanzania had however been expected to result in a larger deterioration in the GPI than that experienced and it is expected that it will begin to increase again from 2004 onwards. It is also interesting to note that the GPI in Zambia fell between 2000 and 2002, but has begun to recover coinciding with the introduction of tuition free primary education – somewhat the opposite of the Tanzania story. The EFA

GMR 2003/04 considers the removal of tuition fees to be extremely significant in reducing gender disparities, through significantly boosting both male and female enrolment.[16]

2.1.13. While not shown in the graphs, all of the country reports note that the gender parity index falls at each successive level of education.

Education Outcomes

2.1.14. Unfortunately the country reports provide little evidence on education outcomes. There are a number of reasons for this, including the long time lags involved in translating education outputs into outcomes and the difficulty in measuring and comparing data on long-term education outcomes. For example, data on learning outcomes is neither systematic nor robust because no national data collection system exists in many countries.

Key Education Financing Indicators

2.1.15. Table 2.1 below gives an indication as to the level of public expenditure on education and its composition. The indicators presented are: education expenditure as a proportion of GDP (where expenditure is both recurrent and development and includes domestic and external sources); expenditure on primary education as a proportion of total education expenditure (recurrent and development); and donor funding for education as a proportion of total education expenditure. [17]

Table 2.1: Indicators of Public Expenditure on Education

	GDP per capita, 2003 (Millions $US)[6]	Total Education expenditure as % GDP[1]	Primary Education as % total education expenditure	Donor Funding as % Total Expenditure[2]
Ethiopia 2003	102	(4.5) [3]	50	20
Ghana 2003	276	5.9	40	6
Malawi 2003	157	7.1	68	30
Mozambique 2001[5]	255	5.8	61 [4]	45
Rwanda 2001[5]	260	5.5	45	50
Tanzania 2003	309	5.1	71	53
Uganda 2003	277	4.5	68	10
Zambia 2003	354	(4.3) [3]	62	(26) [3]

Source: Country RHEP-SAC Reports, except GDP pc
Notes:
[1] Total expenditure: domestic + external; recurrent + development
[2] Excludes General Budget Support (GBS) which is generally counted as part of domestic funding via discretionary budget, due to fungible nature of GBS.
[3] (Estimated)
[4] Recurrent budget only
[5] GDP pc figures for 2003
[6] 2000 constant prices. Source : World Development Indicators.

[16] Education for All Global Monitoring Report (EFA GMR) 2003/04, UNESCO, 2004.

2.1.16. Education expenditure as a proportion of GDP varies quite considerably from an estimated 4.3% in Zambia to 7.1% in Malawi.[18]

2.1.17. Primary education expenditure as a proportion of total expenditure on education also varies considerably, from 40% in Ghana to 71% in Tanzania. The degree to which other sub-sectors of education are developed and the political interests vested within these will affect this allocation, as will the degree to which external support is earmarked for a particular sub-sector.

2.1.18. The figures on external funding as a proportion of total education expenditure must be treated carefully. Firstly, this measure does not include donor support for education provided as part of General Budget Support (GBS). Given the fungibility of GBS within the budget, meaning that once GBS is disbursed it cannot be distinguished from discretionary resources and it cannot be said exactly what proportion of GBS is used to finance any particular sector, support provided as GBS is generally reported as domestic expenditure. Secondly, the extent to which off-budget project-type support is captured in the above statistics is likely to vary across countries. This will generally lead to the figure reported in the table above understating the true extent to which the sector is dependent on external funds, which in some cases (Ethiopia and Tanzania for example) is very high – even before budget support is factored in.

2.1.19. Noting these caveats, the figures reported in the table show donor contribution to education expenditure as ranging from 6% in Ghana to 53% in Tanzania. The notably low figure in Ghana is due mainly to the provision of funds for education expenditure from domestic resources (including a statutory proportion of VAT receipts and a share of HIPC debt relief and General Budget Support inflows). The high volume of GBS is also the reason behind the low figure for Uganda of 10%.

On Track To Meet The Millennium Development Goals?

2.1.20. The MDG indicators and targets for education are: i) a primary Gender Parity Index of 1.0, preferably by 2005; ii) a Primary Net Enrolment Rate of 100% by 2015; and iii) a Primary Completion Rate of 100% by 2015.

2.1.21. Only Malawi, Rwanda, and perhaps Uganda look well placed to achieve the GPI target by 2005. The country reports generally send an upbeat message regarding the prospects of achieving the enrolment target; the general opinion in the country reports being that most of the countries are 'on-track'. However, some countries have much further to go than others. In 2004, both Rwanda and Tanzania had NERs in excess of 90%, but in Ethiopia the 2003 NER was only 45%.

2.1.22. Primary Completion Rates (PCR) are defined and measured differently across the sample of countries; for this reason statistics on this indicator were not included in the above analysis. However, Table 2.2 provides a snapshot view to demonstrate how far away the RHEP-SAC countries are from the primary

[17] For the most part these figures should be comparable across countries noting the year to which the statistic relates; and the exceptions pointed out in the table notes.
[18] The WDI online database gives the GDP pc (in constant 1995 $US) in 2003 for Uganda as $366, more than twice that of Malawi at $163.

completion target (according to their own definition of the indicator) – in 5 of the 8 countries, more than 50% of children fail to complete primary education.

2.1.23. It is interesting to note that despite the fact that gross and net enrolment levels in Uganda and Rwanda are amongst the highest reported in the sample of countries, their PCRs are amongst the lowest. Ghana on the other hand has the second lowest levels of gross and net enrolment in the sample, yet its PCR is high at 78%. This is related to efficiency, given that high repetition and drop-out rates lead to lower completion rates. Countries where high enrolments are exerting too much pressure upon the primary education system and negatively impacting upon quality will likely be experiencing higher repetition and drop-out rates and so lower primary completion rates. This question of the quantity-quality trade-off in education is addressed in Section 3.

Table 2.2: Primary Completion Rates

	PCR %
Ethiopia 2003 [1]	37
Ghana 2004 [2]	78
Malawi 2003 [3]	78
Mozambique 2003 [3]	43
Rwanda 2004 [2]	45
Tanzania 2003 [4]	72
Uganda 2003 [4]	22
Zambia 2004 [4]	72

Source: Country RHEP-SAC reports
Notes:
[1] over 8 yrs primary education
[2] over 6 yrs primary education
[3] over 5 yrs primary education
[4] over 7 yrs primary education

2.2 Health Sector

Trends in Key Health Output Indicators

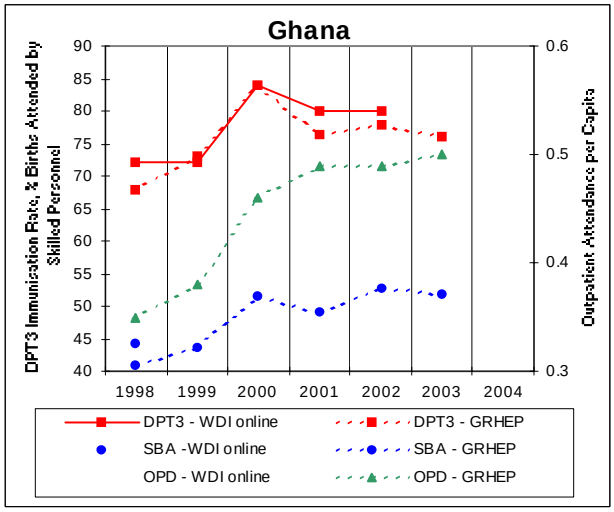
2.2.1. Box 2.2 below shows how key health output indicators have evolved in Ghana, Malawi, Mozambique, Tanzania, Uganda and Zambia over the period 1998-2004. The indicators used are the Diptheria, Pertussis and Tetanus 3rd dose (DPT3) immunisation rate, the % of births attended by skilled personnel (SBA), and outpatient department attendance per capita (OPD)[19][20].

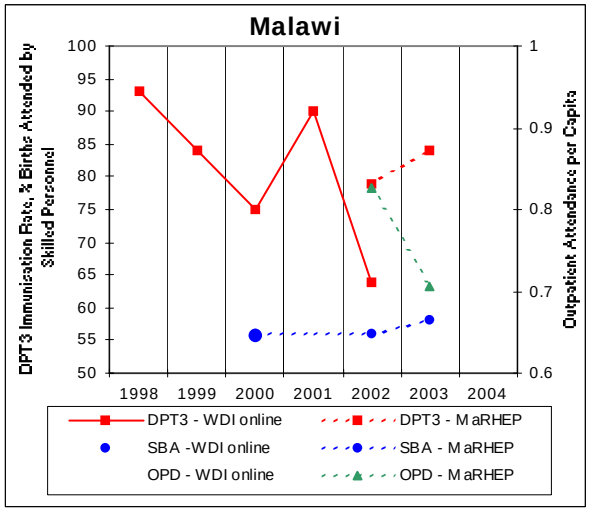
2.2.2. The DPT3 Immunisation rate is used as a proxy measure for assessing the health status of children less than one year – with an anticipated impact on infant and under-5 mortality rates. The DPT3 rate appears to be increasing in Ghana, Tanzania and Uganda, with 2002 levels at 80%, 89% and 72% respectively (as reported by WDI). In these countries the data reported in the country reports appears to correspond quite well with that reported by WDI.

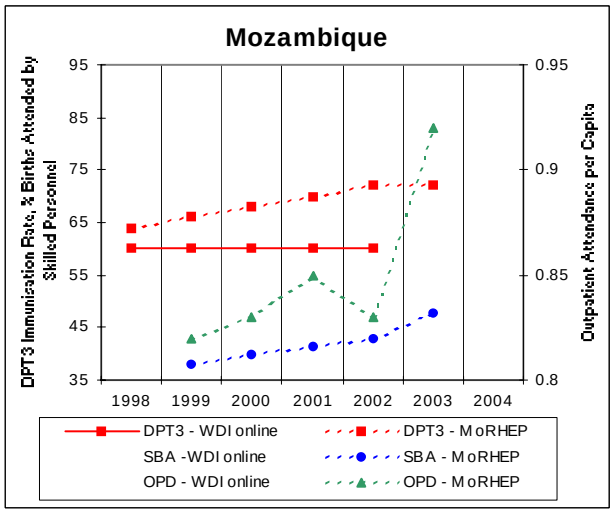
2.2.3. In Malawi and Zambia the DPT3 Immunisation rate reported by WDI fell between 1998 and 2002. In Malawi this drop is substantial - from 93% to 64% – whilst the drop in Zambia was only slight– 81% to 78%. However, it appears that the Malawi WDI figure may not have fully captured district data, a revised WHO/UNICEF estimate of 79% for 2002 is that shown in the MaRHEP line in Box 2.2 and the 2003 estimate shows an increase to 84%. The graph for Mozambique also

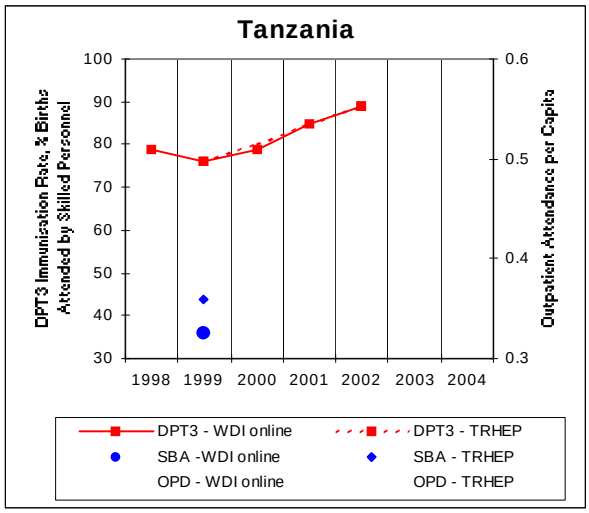
[19] Annex One contains a full presentation of the data used to compile these graphs. Individual country reports may contain data on additional indicators.
[20] See footnote 2 for clarification of output/outcome terminology

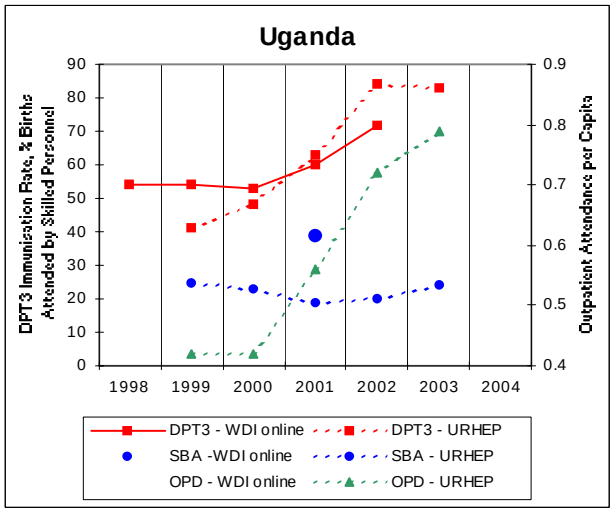
Box 2.2: Trends in Key Health Outputs (Service Use)– Most Countries Progressing

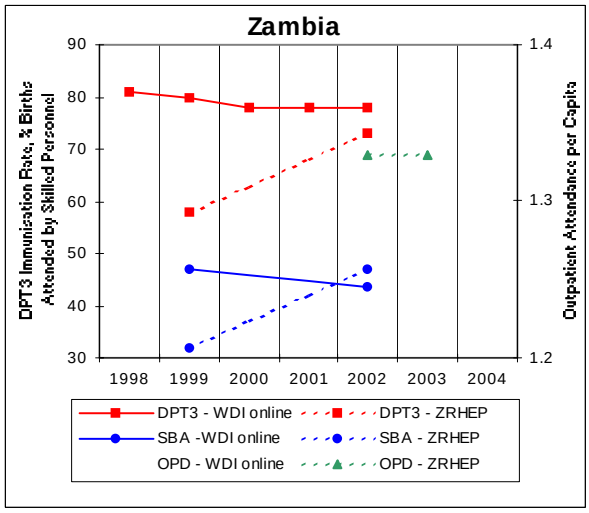












DPT3 – DPT3 Immunistion Rate; SBA - % of Births Attended by Skilled Personnel; OPD – Outpatient Department Attendance per capita

WDI online – Data available from the World Development Indicators Online Database; xRHEP – country RHEP report for country x

Note that for ease of presentation different scales are used on the axes of the different graphs

Mozambique RHEP reports institutional deliveries as a proxy for those attended by a Skilled Birth Attendant (SBA)

Uganda RHEP reports on deliveries in government and not-for-profit units as proxy for SBA

Zambia RHEP reports on EPI coverage rather than simply DPT3

appears to suggest a problem with the WDI data, which report a constant rate of 60% across the period – immunisation rates as reported in the country report are higher, and increasing.

2.2.4. Ensuring access to skilled delivery care is a key element to ensuring a safe pregnancy outcome for both mother and child, and improving infant and maternal mortality rates. The proportion of births supervised by a Skilled Birth Attendant is used as an indicator to measure progress in this area.

2.2.5. The WDI online database provides little information on this indicator – only one data point over the period 1998-2002 for most of the countries. The country reports however provide more detailed information. In Ghana and Mozambique the proportion of deliveries supervised by a skilled birth attendant is increasing. The figures however still seem to be relatively low at 52% and 48% respectively in 2003. There appears to have been little movement in this indicator in Malawi over the period; the level in 2003 was 58%.

2.2.6. In Uganda the indicator, as proxied by deliveries in government and not-for-profit units, has slightly fallen overall over the period, but is now on an upward trend. The value for Uganda is the lowest in the sample, but this is likely due to the use of a proxy indicator that does not sufficiently capture the total number of births attended by skilled personnel In Zambia the level of skilled birth attendance is also falling, from 47.1% in 1999 to 43.4% in 2002 according to WDI data.[21].

2.2.7. In Tanzania, WDI is only available for 1999, and reports a level of 36%, amongst the lowest in the sample. The country report quotes a figure of 43.8% for 1999 and no more recent data is available as yet, so the graph in Box 2.2 does not depict a trend. However, the country report does provide information prior to the review period – figures of 53.1% in 1992 and 46.6% in 1996, so it would appear that worryingly the proportion of births attended by skilled personnel declined during the 1990s.

2.2.8. The third indicator used to measure health progress is outpatient department attendance per capita (OPD) and this is used to provide an indication as to the level of access to, and uptake of, healthcare services. The values of this indicator are plotted against the right hand axes is each of the graphs in Box 2.2. Unfortunately WDI does not provide data on this indicator, and so all figures are taken from the country reports.

2.2.9. The level of outpatient department attendance has increased modestly in Ghana and Mozambique over the period 1999 to 2003. In Ghana OPD increased from a low base of 0.35 to 0.5, and in Mozambique it has increased from 0.82 to 0.92. It should be noted that improvements in data collection methods and more reliable population estimates are likely to have contributed to the improvement in the Ghana figure – but nonetheless the later figures should be more reliable.

2.2.10. Uganda has seen outpatient attendance per capita almost double, from 0.42 in 1999 to 0.79 in 2003. This can be linked to the removal of user fees for health care

[21] The Zambia country report data shows the indicator improving, but this includes births attended by traditional birth attendants who are not recognised as skilled birth attendants.

services in early 2001, as part of a range of health reforms. This is discussed in more detail in section 3.2.

2.2.11. There are only two data points available to look at OPD in both Malawi and Zambia. In Malawi these suggest a decline in OPD, from 0.83 in 2002 to 0.71 in 2003. In Zambia however the figure remains constant between 2002 and 2003 at 1.33 outpatient department visits per capita – by far the highest level amongst our sample of countries.

2.2.12. There is no available evidence on the OPD indicator in the Tanzania country report. The only available data on health utilisation in Tanzania reflects the proportion of those who when ill or injured did not seek any treatment, this fell slightly between 1993/4 and 2000/1 indicating a slight increase in the uptake of health services.[22]

2.2.13. The graphs only show national level data, but in all cases this masks disparities within countries, which point to substantial inequity in access to health services. For example, data for Ghana shows that in 1998, the figure for deliveries supervised by a skilled birth attendant was 73% in the Greater Accra Region compared with only 11% in the Northern region.[23]

Trends in Key Health Outcome Indicators

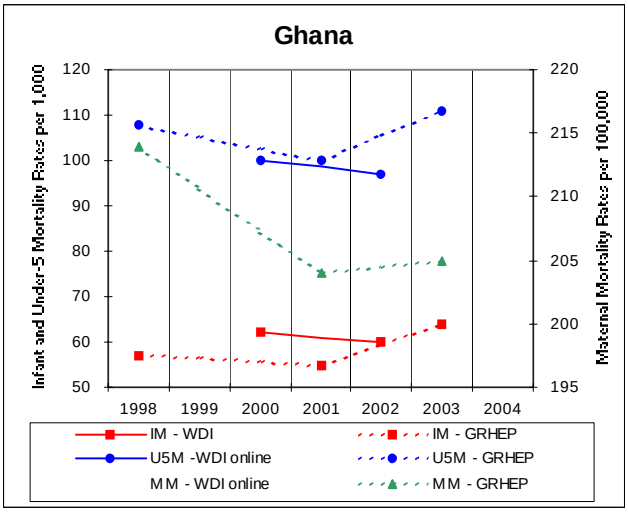
2.2.14. Box 2.3 presents available data on health outcomes as measured by infant, under-five and maternal mortality rates.[24] The most immediate observation to make is that there is much less data available to measure outcomes. This in effect makes it very difficult for us to say anything conclusive regarding progress in health outcomes – and is in itself an important point that will be discussed in Section 3.

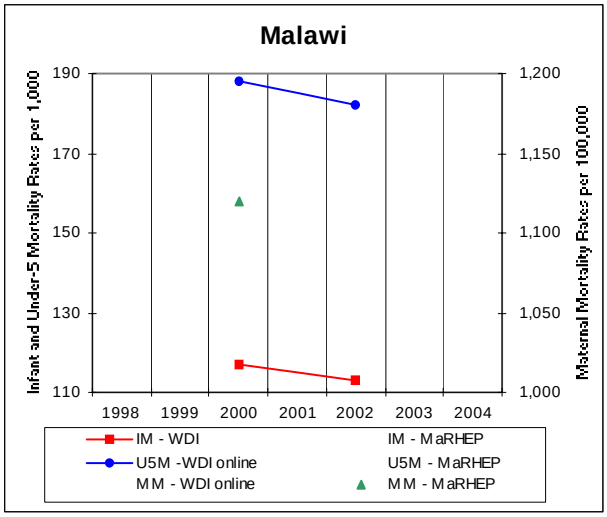
2.2.15. Exceptions to this are Ghana and Mozambique, for which a reasonable amount of data is available. In Mozambique, Infant Mortality rates have slightly improved with a fall in the indicator from 134 per 1,000 in 1997 to 128 per 1,000 in 2002. Under-five mortality rates have however deteriorated, with a slight increase in the indicator from 200 per 1,000 in 1997 to 205 per 1,000 in 2002. There appears to be a stark fall in maternal mortality rates reported between 2001 and 2002 – but this is due to the two estimates being made from different sources.[25] In either case the figure is high.

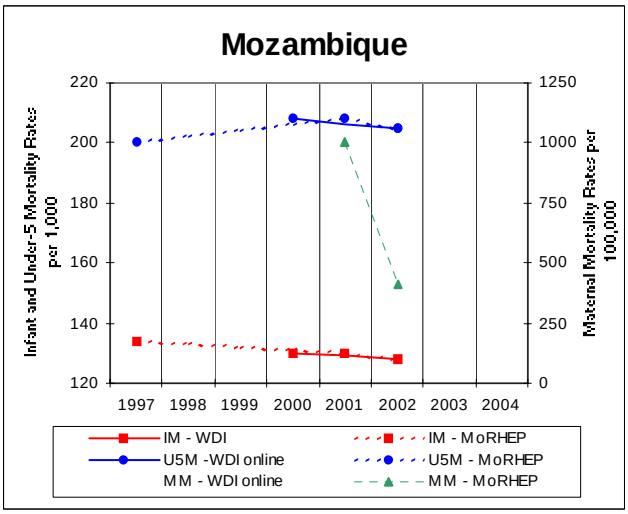
2.2.16. In Ghana, data presented in the country report suggests that both infant and under-five mortality rates are worsening, with the indicators increasing from 57 to 64 per 1,000 and 108 to 111 per 1,000 respectively between 1998 and 2003. Maternal

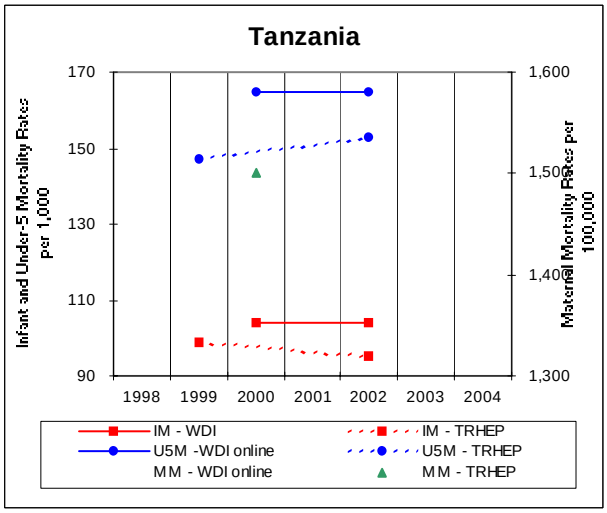
[22] Data as reported in the Tanzania Health RHEP, from the Human Resource Development Survey (1996) and the Household Budget Survey (2001).
[23] These figures come from the Ghana return for the *Achieving the Child and Maternal Mortality MDGs in Africa* study conducted by APD in May 2004.
[24] Annex One contains a full presentation of the data used to compile these graphs.
[25] The 2001 figure comes from the World Bank which uses model estimates, whilst the 2002 figure comes from the Demographic and Health Survey (DHS) which is a national stand alone survey.

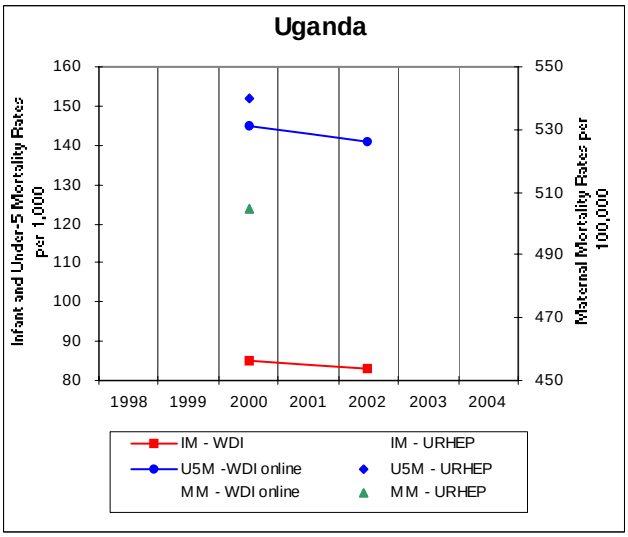
Box 2.3: Trends in Key Health Outcomes (Mortality Rates) – A Patchy Picture

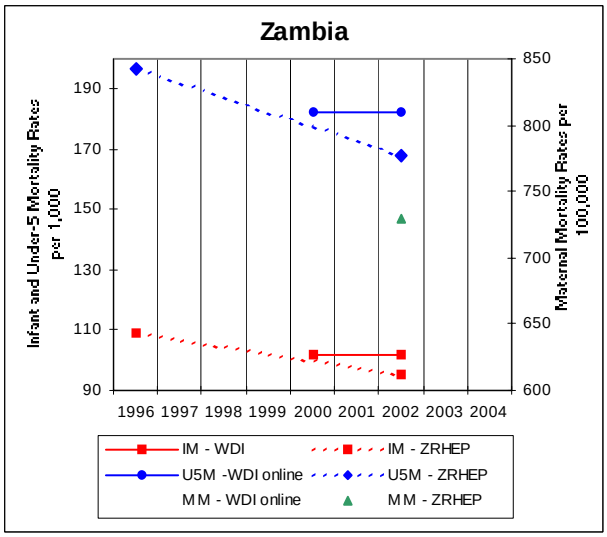












IM – Infant Mortality Rate per 1,000 live births; U5M – Under-5 Mortality Rate per 1,000 population 0-5; MM – Maternal Mortality Rate per 100,000

WDI online – Data available from the World Development Indicators Online Database; xRHEP – country RHEP report for country x

Note that for ease of presentation different scales are used on the axes of the different graphs

Mozambique MM - MoRHEP 2001 figure by World Bank, 2002 figure by DHS

mortality rates however have improved, with the indicator falling from 214 per 100,000 to 205 per 100,000 between 1998 and 2003.

2.2.17. Whilst not reflected in the graphs, it should be remembered that national indicators mask stark in-country variations, demonstrating substantial inequity in health status. Figures for 2000 indicate that the national Under-5 Mortality Rate in Ghana was 100 per 1,000; that of the Northern region was 171 per 1,000. Similarly the Maternal Mortality Rate of 214 per 100,000 nationally lay far below that of the Northern region at an estimated 600-800 per 100,000.[26] Figures available for Mozambique demonstrate the same pattern. The Infant Mortality Rate in Maputo City (the capital) is reported to be 51 per 1,000 compared with 182 per 1,000 in the far northern province of Cabo Delgado.[27]

2.2.18. Although there is not a vast amount of data for Zambia and it spans a wide period, the data source is felt to be very reliable (the Zambia DHS). Given this it appears that both Infant and Under-5 mortality rates in Zambia have been improving, falling to 95 and 168, per 1,000 respectively, in 2002.

2.2.19. For the remaining three countries little can be said regarding trends in outcome indicators, other than that more data is needed. The graphs do show that values for all these indicators are high, particularly for maternal mortality rates. Tentatively, one could surmise that the infant and under-five mortality rates in both Malawi and Uganda appear to have been slightly improving between 2000 and 2002.

On Track To Meet The Millennium Development Goals?

2.2.20. Despite improvements generally in health outputs, what little data we have suggests that any improvements in health outcomes are modest at best. The MDG indicators for health are those outcome indicators discussed above i.e. infant, under-5 and maternal mortality rates.

Table 2.3: Projected Reduction in Infant and Under-5 Mortality Rates by 2015 given 1990-2000 trend[1] (MDG target reduction 67%)

	Infant Mortality Rates	Under-5 Mortality Rates
Ghana	50%	51%
Malawi	55%	50%
Mozambique	61%	57%
Tanzania	-3%	-5%
Uganda	23%	22%
Zambia	-3%	-2%

[1] Using Millennium Indicators Database to obtain data for 1990 and 2000, the trend is applied to generate a projected level of reduction by 2015.

2.2.21. Although mortality rates are slow to change, the MDGs target significant improvements in these indicators by 2015. In these six countries, even where progress has been made, it is not nearly fast enough for the achievement of the MDG targets. This is illustrated in Table 2.3, which uses data from the Millennium Indicators database. None of the six countries are on-track to achieve the MDG targets of 67% reduction in both infant and under-5 mortality rates by

[26] These figures come from the Ghana return for the *Achieving the Child and Maternal Mortality MDGs in Africa* study conducted by APD in May 2004.
[27] These figures come from the Mozambique return for the *Achieving the Child and Maternal Mortality MDGs in Africa* study conducted by APD in May 2004.

2015, given their performance between 1990 and 2000.[28]

2.3 Recent Progress - Conclusions

2.3.1. It appears that there has been broad positive progress in terms of improving output indicators over the past 3-5 years in the 8 countries studied in education and the 6 countries studied in health. Primary school enrolments and gender equity, immunisation rates and outpatient department attendance have generally improved. However, national averages, even when exhibiting good progress, hide serious disparities within countries. A deeper understanding of the distributional and equity issues underlying average progress would enrich analyses of this kind.

2.3.2. However, even in these "good performer" countries, there is scant evidence that better outputs have been translated into improved long-term outcomes in recent years. We should not be too surprised by this. Outcome indicators change more slowly, with longer lead times, and the surveys on which outcome estimates are based do not occur every year. Nevertheless, in the context of the international debate about "scaling up resources to accelerate progress towards MDGs", we need to deepen our understanding of how different factors including outputs work together to enhance long-term outcomes.

[28] Unfortunately data held on the Millennium Indicators database on maternal mortality rates are modelled estimates for all of the countries – and significantly at variance with data in the RHEP-SAC country reports. Given this, projected reductions in maternal mortality rates are not included in Table 2.3.

3 Common Trends and Issues

3.0. This section of the synthesis report turns to a qualitative analysis of those factors identified in the country reports in order to explain the output trends described in Section 2. The synthesis report aims to identify those explanatory factors that are common to a number of the reports in order to take some useful lessons from the country experiences. The analysis first looks at a number of issues that are specific to the education sector, and secondly at issues specific to the health sector before considering issues that cut across both sectors.

3.1. Issues Common to the Education Sector

3.1.1. Issues raised that are specific to the education sector and recur as points of discussion across the education sector country reports relate to the trade-offs involved in policy, planning and resource allocation. Such policy trade-offs include the tension between quantity and quality, issues of intra-sectoral resource allocation, and how to improve gender equity.

Quantity versus Quality

Tuition Fees

3.1.2. Each of the eight countries for which education RHEP-SAC reports were prepared has a policy of tuition free primary education, which has come into effect in the different countries at different times. In Rwanda, Tanzania and Zambia the removal of tuition fees has occurred during the period of this review (in 2003,2001 and 2002 respectively). As we saw in section 2.1, access to primary education in all countries has been improving and the graphs for Rwanda, Tanzania and Zambia clearly illustrate the powerful impact that removal of tuition fees has had on primary school enrolment rates.

3.1.3. However, in introducing policies of free tuition very few countries have adequately planned for the supply requirements of accommodating increased enrolments. A dramatic increase in primary education enrolment requires an increased supply of qualified teachers, classrooms and essential teaching and learning materials such as textbooks. All of the country reports refer to the fact that demand is far outstripping supply, and that this is having an adverse impact on the quality of primary education delivered.

3.1.4. The perceived quality of education is an important factor in demand for education – sustaining increased levels of uptake as well as retention in and completion of primary education will require significant improvements in quality in these countries.

Inputs

3.1.5. Table 3.1 presents a snapshot view of two key input indicators in 2003 – Pupil Teacher Ratio (PTR) and Class Size. Primary Instruction is usually class based

with one teacher per classroom.[29] For both indicators a maximum average of 40 is usually taken to be desirable[30]; both PTR and class size above this level can negatively impact on quality. All countries in the sample with the exception of Ghana have PTR levels far above 40, and with the exception of Ghana and Zambia, all countries in the sample have class sizes far in excess of 40 – in Malawi at 108, the level is more than 2.5 times this maximum level.

Table 3.1: Key Input Indicators

	Pupil Teacher Ratio[1]	Average Class Size[2]
Ethiopia	63	74
Ghana[3]	34	37
Malawi[4]	68	107
Mozambique	68	n/a
Rwanda	67	55[5]
Tanzania	58[6]	n/a
Uganda	56	94
Zambia	52	35

Source: RHEP-SAC country reports
All figures 2003 unless stated otherwise
[1] Including unqualified teachers
[2] 'Class size' as an indicator here is reflecting the ratio of pupils per classroom
[3] Figures from Preliminary Education Sector Performance Report 2004
[4] Figure uses pupils per *permanent* classroom as a proxy
[5] Figure for 2001
[6] Figure for 2004

3.1.6. The disparity between PTR and average class size is also interesting. In most cases the average class size is considerably in excess of the PTR, notably in Malawi and Uganda. The extremely high GER's in these countries can help to explain this – where GER is so high it will eventually fall (as in Uganda) and using NER for planning requirements for long term investments such as classrooms makes more sense. To build to meet GER requirements would likely result in empty classrooms in the medium term.[31]

3.1.7. There are also large regional disparities within countries in both the PTR and class size indicators. For example, poorer and more remote areas generally have pupil teacher ratios far in excess of the national average, as teachers are reluctant to work in these areas. In countries such as Ghana and Mozambique, this has resulted in an increase in the use of unqualified teachers in such areas, which can further reduce quality and exacerbate the rural-urban disparities in quality of education.

Teacher Shortages

3.1.8. The country reports identify the shortage of teaching staff generally, and particularly qualified teaching staff, as a key component of the quantity-quality trade-off. The evidence in Table 3.1 supports this.

3.1.9. However, the scope for expanding teaching capacity and provide the correct incentives to attract good people, retain them and motivate them to work in disadvantaged and deprived areas is severely limited by the need to constrain expenditure on personal emoluments, which already absorb a large proportion of

[29] Primary instruction is usually class based i.e. a teacher stays with the one class group and teaches all subjects, whereas secondary education is more often subject based i.e. a teacher specialises in a particular subject and teaches this to different class groups.
[30] The Education for All Fast Track Initative benchmark for the PTR is 40.
[31] The Zambia figures show the opposite relationship– a higher PTR than class size. The country report does not explain why historically this is the case, but it does explain why this (inverse) disparity has increased – as enrolments have grown classroom construction has kept apace, but due to recruitment freezes expansion of the teaching force has not.

sector resources in these countries. The World Bank Public Expenditure Review (PER) of 2003 in Ethiopia puts the proportion of education sector recurrent expenditure on salaries at over 80% and the 2004 update of the 2000 Malawi PER puts the proportion of primary education expenditure going to Personnel Emoluments at 72% on average between 2000/01 and 2002/03. An appropriate input balance is needed to ensure good quality learning outcomes; it is unlikely to be cost-effective to increase expenditure on teachers, without also increasing expenditure on non-salary inputs, such as textbooks.

3.1.10. Coupled with this, salaries and other personnel issues typically fall under the responsibility of the Ministry of Finance, and not of the Ministry of Education. The ability of education ministries to then use salaries as a means of recruiting and motivating staff is heavily constrained. In Zambia for example, in 2003, the Ministry of Finance curtailed hiring of new staff in trying to control the budget deficit following a large public service wage increase announced earlier in the year. In 2004, recruitment was only permitted for replacement and for rural areas with serious teacher shortages. With enrolments in Zambia still rising but without recruitment of additional teachers the number of pupils per teacher is likely to increase rather than fall – further impacting on quality.

3.1.11. Improving the efficiency of service delivery – through lowering repetition and drop-out rates – would reduce the pressure on the system in terms of the number of pupils in primary schools. However, improving the quality of education is a key factor in reducing repetition and drop out rates.

Other Costs

3.1.12. Whilst the removal of tuition fees has positively impacted on enrolment, it should be noted that this is not a panacea – there are other costs, both direct and indirect, associated with education that act as a barrier to entry or retention. The opportunity cost of education due to the high incidence of child labour in Ethiopia is cited as a significant barrier, as are out-of-pocket expenses to cover items such as school uniform and travel. Other country reports also refer to the costs of textbooks, exercise books, registration fees, examination fees and school development funds as financial barriers to participation in education. On the other hand, the high politicisation of the policy of 'Free Primary Education' in Tanzania, has in some areas been taken to mean completely free education with parents reluctant to pick up any part of the cost.[32]

Intra-Sectoral Resource Allocation

3.1.13. The country reports confirm that primary education is a key priority of each country's Poverty Reduction Strategy (PRS) and that Education Sector Strategic Plans (where they exist) are consistent with commitments to international objectives such as the Millennium Development Goals and Education for All Goals. However, it is not always clear that this level of priority is reflected in sectoral Medium Term Expenditure Frameworks (MTEF) and budgets.

[32] A similar reaction has also occurred in Kenya.

3.1.14. The policy trade-offs between the competing needs of established and/or expanding secondary, tertiary and technical/vocational sub-sectors are affecting the intra-sectoral allocation of resources and there is some evidence of growth in resource shares to secondary and tertiary education amongst the RHEP-SAC countries. It is interesting to note that this shift in resources is not just within domestic discretionary expenditure, but is also reflected in other governmental resources (e.g. special trust funds and resources made available under the HIPC debt relief initiative) and in patterns of donor spending.

3.1.15. In Ethiopia policy decisions have led to an increase in both capital and recurrent funding for tertiary education. In Rwanda, the Genocide Survivors' Fund (FARG) and District Education Funds (DEF) are used mainly to support Secondary Education. In Ghana, the Ghana Education Trust Fund (GETFund) is increasing substantially and the majority of its resources are used to support secondary and tertiary education, although there are efforts being made to improve the alignment between GETfund allocations and sector plan priorities. In Malawi, the World Bank and African Development Bank have concentrated their lending on secondary education; donor funding has also increased for secondary and particularly tertiary education in Ghana. In fact the increase in the volume of GETfund resources, coupled with the new donor projects for tertiary education have seen tertiary education's share in expenditure increase from 14% in 2003 to an estimated 22% in 2004.

Box 3.1: Intra-Sectoral Resource Allocation and Equity

Ghana: Between 2003 and 2004 the share of public expenditure on education going to primary education fell from 40% to 35% whilst that going to tertiary education increased from 14% to 22%.

Recent reports have shown that the poorest 45% of the population have no access to higher education and derive no benefit from it, whilst the richest 1.5% of the population benefit from 55% of the public expenditure on tertiary education.

(For more information see the Ghana Education RHEP-SAC report.)

Rwanda: Between 1996 and 2001 the share of public expenditure on education going to primary education has fallen from 70% to 45%; the share going to higher education has increased from 15% to 37%.

Unit costs in Rwandan higher education are amongst the highest in the world, the ratio of primary to tertiary unit costs is currently 1:89. The best-educated 10% of an age cohort benefit from more than 70% of the total public spending on education received by that age group.

(For more information see the Rwanda

3.1.16. Expansion of primary enrolments will inevitably lead to increased demand for higher levels of education. Other national objectives, such as economic growth (in the longer term) and public sector capacity building, and political interests, may also increase demand for the further development of post-primary sub-sectors. However, increased *public* expenditure at higher levels of education is generally regressive. That is, the rich tend to benefit disproportionately more from the increase in expenditure at higher levels of the education system whereas the poor tend to be disadvantaged more than the rich by the shift in resources away from the lower levels. (See Box 3.1)

3.1.17. Level of education aside, the equity of resource allocation could still be improved in order to better respond to the needs of the poorest and most disadvantaged communities. Better targeting of resources to needy and vulnerable groups (identified along lines such as geographical location, socio-economic status,

gender and special needs for example) has positive implications for the equity of expenditure. In Ethiopia for example urban children are twice as well represented in primary schools as their rural counterparts, whilst it is noted in all reports that at post primary levels female participation in education is substantially below that of males.

Gender Parity in Education

3.1.18. As the graphs in Box 2.1 show, gender parity in primary education is improving in most of the countries under review, although more slowly in some than in others. Nevertheless, as the EFA GMR points out, the majority of countries with a GPI of below 0.9 are in Sub-Saharan Africa. At post primary levels of education, female participation is also gradually improving but remains substantially below that in primary education.

3.1.19. Many countries are now making an effort to focus more on issues of gender in policy and planning. In Ethiopia, improving the gender balance in education has been a priority in policy and planning in recent years, and such policy pressure from government can help to explain the relatively steep gradient of the Ethiopia graph for GPI in Box 2.1. Longer-term strategies include the use of quotas in teacher training colleges to increase the proportion of female teachers, which has been shown to have a positive 'role-model' effect on girls' education.

3.1.20. The opposite of this is highlighted by the relatively flat graphs for GPI in Ghana and Zambia. Both reports refer to the fact that with reasonably high levels of female participation historically, neither country has given sufficient attention to gender programming in developing policies and plans.

3.1.21. An important point to make with regards to the gender parity index however is that it is difficult to significantly increase it quickly. The GPI refers to female participation in the primary education cycle as a whole – the length of which ranges from 5-9yrs in the countries featured in this exercise. Policies introduced now, can affect enrolment in Grade 1, and retention and transition between subsequent grades. There can then be a substantial time lag between the introduction of gender-oriented policies and the realisation of their impact on the full primary cycle.

3.2. Issues Common to the Health Sector

3.2.1. Issues raised that are specific to the health sector and common points of discussion in a number of the health sector country reports again reflect the difficult policy choices and trade-offs involved in policy and planning. These include: how to attract, deploy and retain adequate human resources to run an efficient and equitable health service within a constrained resource envelope; how best to benefit from the large volume of resources made available through vertical programmes including global initiatives, yet improve their alignment with national processes; and the issue of revenue generation through user fees for health services in the context of inequitable access to quality service delivery.

The Human Resource Crisis

3.2.2. One of the biggest issues emerging from the country reports is the human resource crisis being faced in the health sectors of all six countries. It is clear that public health sectors are not managing to recruit, train, deploy – and crucially retain the staff that they require to run effective and equitable health services.

3.2.3. Public sector health personnel are being lost to non-governmental providers offering better terms and conditions, including to those agencies supported by vertical initiatives such as the global funds. Staff are also being lost through emigration to other countries. Beneficiaries of this are in some cases neighbouring African countries but more often non-African countries, notably the UK and the US. HIV and AIDS are further weakening health sector workforces.

3.2.4. Box 3.2 highlights the problem using Malawi as a case study drawing information from the Malawi health report.

3.2.5. Ghana, Mozambique, Uganda and Zambia all report similar stories. The Mozambique report also highlights the negative impact of low pay, poor motivation and inadequate supervision on productivity and accountability, further compounding the negative implications of low levels of staffing for health service delivery.

3.2.6. Inequitable access to health staff within countries is also referred to in many of the reports. High national population to health professional ratios mask even higher ratios in particular regions and districts. In Ghana for example the national average of 16,000:1 is much lower than the health professional to population ratio in the Northern region of 66,000:1. The northern region is identified as one of the deprived regions of Ghana, and as such is an undesirable part of the country in which to work.

Box 3.2: The Human Resource Crisis in the Malawi Health Sector

Since the late 1990s Malawi has experienced a serious exodus of health workers from government employment, largely due to the inability of the government to raise the real value of the salary of health professionals. (Salary costs are typically 30-40% of the Ministry of Health's budget compared with 60-70% on average in other African countries.)

Many staff have left to work either abroad or domestically, in the private sector or in the rapidly growing donor-funded NGO sector.

HIV and AIDS are growing problems – in 1990 only 8 MoH workers died; in 2000 this figure reached 200 – HIV and AIDS are thought to be key factors in this increase.

Combined, these factors have led to a population to doctor ratio of 106,397:1 in 2004, almost 12 times the recommended ratio of 9,000:1.

Vacancies amongst nursing cadres are over 60%. Ten of Malawi's 29 districts have no government doctor; 4 districts have no doctor at all. Vacancy rates are significantly higher in rural areas.

(See section 4.3 of the Malawi Health RHEP-SAC

3.2.7. At first glance the solution to this problem would appear to lie in increasing salaries and providing other material or cash incentives to motivate staff. However, payroll costs in many cases already represent a significant share of the health budget, as high as 91% of the discretionary budget for health in Ghana. Recruitment, or the provision of incentives, then involves costly tradeoffs. In some cases ceilings for expenditure on, or numbers of, personnel remove the possibility of this solution to

the problem. It is typically the case that human resource and payroll issues fall outside of the responsibility of the sector.

3.2.8. In addition to this, the distribution of health workers across the country is typically made according to a facility formula and not according to demand. The centralised nature of staff allocation in most cases means that there is not the flexibility to reallocate human resources and make savings that there would be in more decentralised environments.

3.2.9. Interestingly the Tanzania report states that Tanzania's health sector HR crisis is not stemming primarily from emigration or an inability to attract and retain staff. Specifically, the problem is the result of a restriction on public sector employment, procedural obstacles to filling existing vacancies and an absence of incentives to fill rural posts. In Zambia too the Ministry of Finance and National Planning is restricting personal emoluments and staffing levels, leaving the Ministry of Health unable to counteract staff attrition caused by the factors discussed above.

Vertical Programmes

3.2.10. Vertical programmes, notably global partnerships including GFATM and GAVI, are providing large volumes of resources to certain African countries to fund particular interventions – such as HIV and AIDS, Tuberculosis, Malaria and Polio.

3.2.11. The long-term sustainability of this is questionable – both in terms of the volume of resources and the overall pattern of spending. When vertical programmes such as the global funds have ended, the items that they are currently funding, such as anti-retroviral drugs or insecticide treated bed nets, will still be needed. The resources will have to be found in government budgets. The reports from Uganda and Tanzania voice concern that the impact of such funds on the total resource envelope does not reflect the governments' own priorities – in terms of allocations to and within the health sector. This concern is likely to be applicable to a number of other countries as well.

3.2.12. Although many vertical programmes are on-budget, the implementation arrangements are essentially project-type, with unique disbursement arrangements, often external to SWAps, that require intensive management arrangements and are not well integrated with existing systems. There is a general concern that this may undermine national processes and the good progress recently made in furthering the harmonisation and alignment agendas at sector and national levels. Sector Wide Approaches and Sector and General Poverty Reduction Budget Support have gone a long way in promoting alignment around national processes and donor harmonisation and co-ordination, even amongst some traditional project-type donors.[33]

3.2.13. But, as the Malawi report notes there have been output gains achieved as the result of vertically delivered interventions, particularly in the areas of tuberculosis, malaria and immunisation. A challenge will lie in sustaining and building upon such gains whilst encouraging agencies funding vertical programmes to harmonise

[33] A discussion of the progress made in harmonisation and alignment and in developing SWAps can be found in section 3.3.

with each other and align with national processes and plans, such as SWAp frameworks.

User Fees for Health Services

3.2.14. The issue of user fees for primary health care services is a controversial one. Table 3.2 below summarises the policy stance regarding user fees in the sample of countries.

3.2.15. There is little disputing the fact that user fees for healthcare services are acting as a substantial barrier to access. There are serious issues of inequity in access to health care services associated with this, since user fees tend to disproportionately discriminate against the poor as they represent a more significant part of their household expenditure. This situation is exacerbated by the fact that exemption and waiver schemes in Ghana, Mozambique, Tanzania and Zambia have not been successful.

Table 3.2: Summary of User Fee Policy in RHEP-SAC countries

	User Fees?	Comments
Ghana	YES	A complicated exemptions scheme is so far deemed unsuccessful – and is likely to get more complicated following the launch in 2004 of a National Health Insurance Programme
Mozambique	YES	Exemptions scheme is not applied equitably
Tanzania	YES	User fees in government hospitals and pilot districts introduced in 1994 – these have now been rolled out (at least informally) to all districts and health care facilities. The exemption and waiver system does not work. Additionally, the Community Health Funds (an alternative pre-payment insurance scheme) has also been unsuccessful in implementing exemptions and waiver systems.
Zambia	YES	Exemptions policy deemed unsuccessful
Malawi	NO	Officially no user fees for public health services but out-of-pocket expenses for households are high
Uganda	NO	See Case Study in Box 3.3 below

3.2.16. Exemption and waiver systems, which are intended to protect the poor, are typically difficult to manage and implement, meaning that the poor do not get the exemptions that they are supposed to. Problems exist in firstly identifying the poor to ensure that they benefit from exemption, and secondly in ensuring that money actually gets down to the level of the healthcare facility to enable them to implement the exemptions. Other forms of protection such as the Community Health Funds (CHF) insurance system in Tanzania have also been unsuccessful in managing this problem. The issue of inequitable access, and the problems associated with being unable to correctly implement exemption and waiver schemes apply in the same way to the CHF as they do to user fee arrangements.

3.2.17. In addition to this, other arguments can be used against user fees. These include: the fact that in most cases the revenue generated by user fees represents an insignificant part of the overall health resource envelope; that the fees themselves vary widely within countries raising further equity issues; and that they may

differentially affect the quality of service i.e. someone who can afford to pay more will receive better service. These arguments are generally believed to outweigh the arguments used for user fees, which relate to improved local capacity in accounting and management skills and the greater flexibility of locally generated resources.

3.2.18. Uganda provides an interesting case study, as the only country in the sample that has removed user fees for healthcare services during the period under review – and the impact on outpatient attendance per capita has been extremely positive as we saw in Box 2.2. Box 3.3 below summarises information from the Uganda country report, which uses one district as an example to show how outpatient attendance has improved following the abolition of user fees.

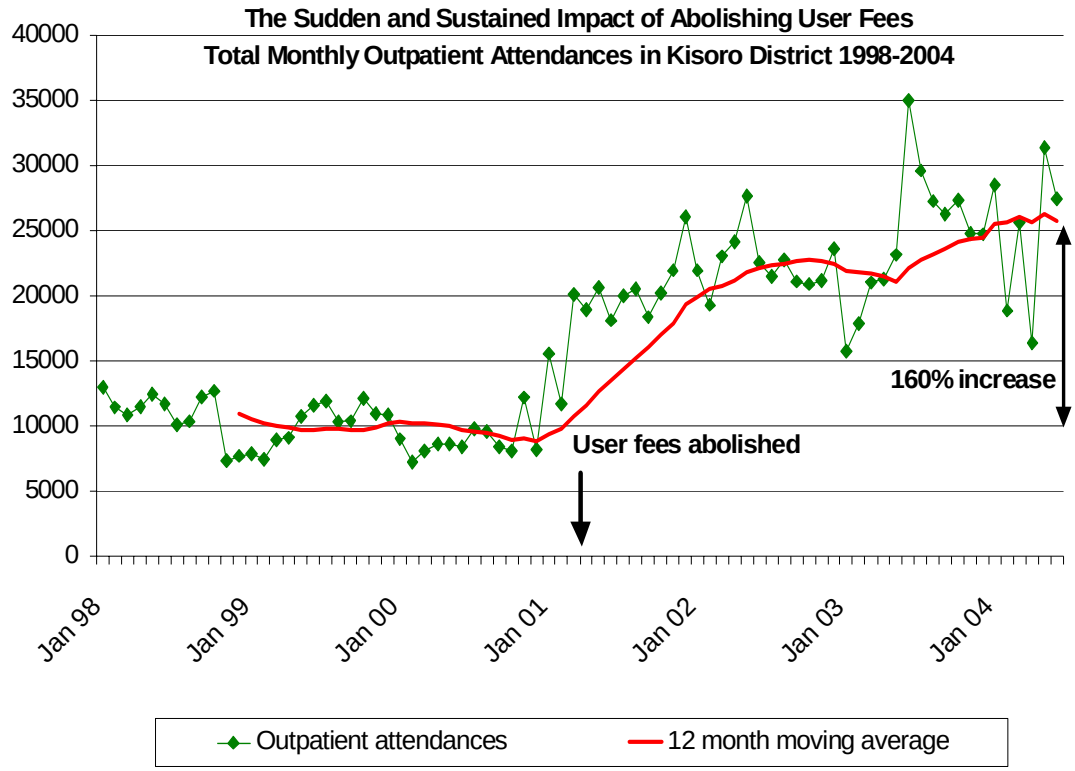
3.2.19. Whilst the case study illustrates possible positive implications of removing user fees for health services, it should be noted that the removal of user fees in Uganda was part of a broader package of health sector reforms. Increased resources, higher salaries for health workers, better deployment of human resources, and significant improvements in the availability of drugs at primary and secondary levels of care also contributed to the improved utilisation of health services. The sustainability of this increase has also yet to be demonstrated, and it should be remembered that at 0.8 outpatient visits per capita, Uganda is still far from the recommended target of 2.0.

3.2.20. As yet, there is no conclusive evidence of the impact on health outcomes as a result of removing user fees in Uganda (alongside complementary policy changes), although given the opportunity costs of attending clinics the strong increase in attendance suggest that people perceive that doing so will improve their health status. If the health outcomes data for Uganda begins to show significant improvement, then there may be a stronger argument for promoting this policy package in other countries. But in any case, the discussion around user fees in the country reports suggests that there is a strong need one way or another to improve access, and equity of access, to health care services.

Box 3.3: The Ugandan Experience in Abolishing Health User Fees

In early 2001, in response to public dissatisfaction with regards to cost-sharing and ten days prior to presidential elections, the Government of Uganda announced a policy to abolish all user fees in government health units. A range of important complementary health sector reforms to improve primary health service delivery was also being implemented at that time.

The impact on utilisation was striking and appears to have been sustained, as illustrated by this graph showing the evolution of outpatient attendance in the Kisoro district.



A World Bank PRSC mission (March 2004) noted that

> *"... the government policy to abolish user fees for health services resulted in a massive increase in the consumption of basic health services"*

The same mission also noted that the abolition of user fees had had a significant impact on the equity of access to health services:

> *"Of great significance for poverty alleviation strategies, poor people have benefited disproportionately, with the lowest income quintile capturing 50% of the benefits from this policy change."*

(For more information see the Uganda Health RHEP-SAC report)

3.3. Factors Underlying Trends In Both Education And Health Sectors

3.3.1. Given the large number of issues arising common to both the health and education sectors in the country reports, they have been grouped into four themes. These themes are:

- Environmental Factors
- The Institutional Environment
- The Policy Environment
- Process (including aid effectiveness)

Environmental Factors

3.3.2. Most country reports indicate that relatively stable macroeconomic performance has helped underpin positive sector developments, although disrupted periods were noted in Ethiopia (1998-2001, resulting from conflict with Eritrea) and in Malawi (2001-2003, due to fiscal management problems). Several reports note the impact of HIV and AIDS on human resources in both sectors. HIV and AIDS are also increasing the demand on health systems while the growing numbers of orphans and vulnerable children is posing extra challenges for education systems.

Institutional Environment

3.3.3. The country reports are showing an increasing trend of decentralisation of both responsibility for service delivery and of resources. Even in systems that are not decentralised there has been an increasing tendency to allocate more funds to districts (or equivalent) in an effort to shift more resources to the 'front line'.

3.3.4. The consensus from the country reports seems to be that this can increase local accountability and community participation, but that the full impact is constrained by a lack of capacity at the decentralised level in terms of planning, management, implementation and monitoring and evaluation functions. Power relations between local government ministries and central line ministries can also affect the impact of decentralisation. There is however some evidence (for example from Ethiopia and Rwanda) that decentralisation is having a positive impact on the local capacity to perform some of these functions.

3.3.5. A further implication of decentralisation is that it can make the role of donors more uncertain, particularly in terms of how and at what level they are expected to engage in policy dialogue, provide technical support and relate to other non-governmental providers – this situation is now becoming particularly complex in Ethiopia's federal system.

The Policy Environment

Positives:

3.3.6. Education and Health are identified in all of the country reports as being central to a country's Poverty Reduction Strategy (PRS) or equivalent. In many cases

a Sector Strategic Plan has been developed; where these do exist the plan has either informed or been informed by, and is consistent with the PRS.

3.3.7. Sector strategic plans are seen as positive developments. In almost all cases the country reports comment on the usefulness of the strategic plan as a common vision or joint programme for sector wide development agreed by all stakeholders in the sector including government, development partners and non-governmental organisations amongst others.

3.3.8. Positive comments have also been made where the strategic plan contains a comprehensive list of indicators for review purposes, where the plan is fully costed and can be used as the means of aligning external support to the sector, where the plan is supported by annual operational plans and sound institutional arrangements to support its implementation, and where the plan comprehensively looks at the sector as a whole.

3.3.9. Strong political commitment and leadership from senior management is identified as having played an important role in developing sector plans and putting them into operation. It is also important that this commitment and leadership is maintained even when changes of government or political reshuffles change key personalities in ministries.

Issues / Challenges:

3.3.10. Concerns raised regarding sector strategic plans include that they are not always properly prioritised in the light of the resources available, that key elements are often not implemented, that participation / involvement in implementation can be weak; and that they often lack clear strategies for capacity building.

3.3.11. Aggregating these comments points to a list of the 'essential ingredients' for any sector strategic plan. This is presented in Box 3.4.

Box 3.4: Ingredients for a Successful Sector Strategic Plan (SSP)

- A clear multi-year development framework that addresses the entire sector;
- Alignment with the PRS and national processes;
- Agreement by all stakeholders including Development Partners, Non-Governmental Organisations and Community Based Organisations;
- A clear set of indicators for review and monitoring and evaluation purposes;
- Implementation plans which are clearly prioritised and costed
- Political Commitment and leadership
- Capacity for implementation (or a plan for building it)

Process 1 – Sector Wide Approaches

Positives:

3.3.12. Sector Wide Approaches (SWAps) are present in almost all of the sectors covered in the country reports, and are seen to have been helpful as a means of developing joint responsibility with donors for implementation of sector strategic plans. They have improved donor harmonisation and co-ordination including with donors who provide traditional project-type support. In many cases the SWAps

include common funding modalities, such as sector budget support or pooled funding arrangements.

3.3.13. Other positive comments from the country reports include: that the process of developing a SWAp has improved the quantity and quality of policy dialogue (Malawi Education); improved alignment with national processes and arrangements such as those for procurement, accounting and auditing (Ghana Health); and the role that SWAps can play in generating more predictable funding (Zambia Health).

Issues / Challenges:

3.3.14. Concerns raised regarding SWAps tend to reflect on: weak implementation and institutional arrangements to support the SWAp and varying degrees of commitment amongst development partners (Mozambique Education); too heavy a focus on technical aspects of delivery rather than discussion of more strategic issues such as eliminating gender and geographical disparities (Zambia and Mozambique Education); strong relationships between sector specialists and line ministries limiting the ability of the sector to become fully engaged in broader national reform processes (Tanzania); and the extent to which performance of the sector can then become vulnerable to breakdowns in trust and communication (Ghana and Zambia Health sectors).

Box 3.5: Essential Ingredients for a Strong SWAp

- Strong domestic ownership and leadership
- But ... joint responsibility (government and donors)
- Commitment from all parties – in practice and not just on paper; project donors as well as programmatic donors
- Strong institutional and implementation arrangements (dialogue, delivery, M&E)
- Alignment with national processes (PRS, MTEF, PFM, procurement etc.)

3.3.15. Aggregating the discussions in the country reports reinforce the fact that all SWAps need a few essential elements. These are summarised in Box 3.5.

Process 2 –Medium Term Expenditure Frameworks and Budgets

Positives:

3.3.16. Medium Term Expenditure Frameworks and Annual Budgets need to reflect the priorities identified in the PRS and sector strategic plans. The country reports indicate that in most cases, budget allocations to health and education have significantly increased in recent years; Box 3.6 summarises the information they contain on sector financing.[34,35] Generally, it appears that domestic budget allocations have increased relative to both GDP and total government expenditure (exceptions

[34]Ghana Education data from the *Preliminary Education Sector Performance Report 2004,* MoEYS, Ghana, October 2004.

[35] Due to inconsistent ways of presenting information across different data sources – including WB and IMF country level reports – a more quantitative analysis of trends, involving tables and / or graphs proved to be less informative than expected. The information provided in Box 3.6 does allow us to look at progress within country, and also to reflect on the period since 2001, which tends to be the cut-off point for international data sources such as WDI.

Box 3.6: Expenditure on Education and Health (from RHEP-SAC country reports)

Education	GHANA	Health
• Total resource envelope increased from GHC 4.1 trillion in 2003 to an expected GHC 4.7 trillion in 2004 (15% increase) – due to increases in funding from both domestic (incl. GETfund and HIPC debt relief) and external sources • Aid contributes between 5 and 15% of the total resources available to education • Primary education share was 39.7% in 2003, falling to expected 35.1% in 2004		• Total expenditure increased from approx $122million to $233million between 1999 and 2003 (approx. 3% of GDP in 2003) • GoG share in expenditure fell from 56% in 1999 to 48% in 2003; external share increased from 25% to 27% (other increases via Internally Generated Funds, financial Credits and resources made available via HIPC debt relief) • In 2003, 58% of external resources flowed to the sector via the (Multi-Donor pooled) Health Fund

Education	MALAWI	Health
• Education expenditure by GoM increased from 2.8% of GDP to 5.0% between 2000/01 and 2003/04. • Also a significant increase in donor disbursements – from $25.9 million in 2000/01 to $35.4 million in 2003/04. • Share of total education expenditure on primary education increased from 25% to 54% over the same period. • Education sector has benefited from Pro-Poor Expenditures (i.e. protected from budget cuts; increased using HIPC debt relief).		• Total health expenditure increased from MK 4.7 billion in 2000/01 to MK 8.0 billion in 2003/04; equivalent to increase from 5.1% to 7.7% of GDP. • Externally funded share of total expenditure increased from 64% to 74% over the same period. • Expenditure on primary care increased from 24% to 34% between 2000/01 and 2003/04; expenditure on secondary care increased from 22% to 42%; expenditure on tertiary care fell from 19% to 16% of total.

Education	MOZAMBIQUE	Health
• Total education expenditure has increased by 50% in real terms between 1997 and 2001; equivalent to increase from 3.9% to 5.8% of GDP • Recent data not available but "no doubt that the past five years have been characterised by a substantial increase in spending on education" (MoRHEP, p7) • Intra-sectoral allocation stable; primary education consumes 61% of recurrent and 80% of capital expenditure		• GoM expenditure on health as a share of total government expenditure has increased from 7.7% to 8.8% between 1997 and 2001. • External support for the sector is estimated to be approx. $100 million per annum, and expected to increase. • Governments share in total health expenditure is 46.4%, with 51% coming from external sources

Education	TANZANIA	Health
• Total education expenditure increased from TSh 189.2 billion in 2000/01 to 464.4 billion in 2003/04; equivalent to increase from 3.3 to 5.1% of GDP • Recurrent spending has increased from 74 to 81% of total spending over the same period • Primary education share of expenditure has increased from 65% to 71%		• Total health sector expenditure has increased from TSh 118.8 billion in 2000/01 to 201.1billion in 2003/2004; equivalent to increase from 2.1 to 2.25 of GDP • GoT share in total health expenditure increased from 68% to 78% over same period • Basket funding accounted for 50% of total external funding in 2003/04

Education	UGANDA	Health
• In constant (1998) prices, real education expenditure increased by 38% between 1998/99 and 2003/04. • Education expenditure increased as a proportion of total discretionary expenditure from 30 to 32% over the same period. • Actual expenditure on primary education increased from 66% to 68% in same period		• In constant (2003) prices, real health expenditure increased by 19% between 2000/01 and 2003/04 • Composition of expenditure changed significantly due to big switch to GBS; GoU share of resource envelope (incl. GBS) rose from 37% to 48% over same period • Between 1999/2000 and 2003/04 the share of the GoU health budget allocated to primary health increased from 33% to 54%

Notes: In all cases external resources provided as General Budget Support are included as part of the domestic

Box 3.6 (continued)

Education	ZAMBIA	Health
• GRZ education expenditure has increased from 2.6% of GDP in 2001 to a budgeted 3.0% in 2003 • Total education expenditure is budgeted to increase from 3.7% of GDP in 2001 to 4.5% in 2004 • External share of this funding increased from 30% in 2001 to 34% in 2004 • Education share in total government expenditure increased from 15.4% in 2000 to 20.5% in 2003, and looks set to continue rising.		• GRZ health expenditure has declined from 2.5% of GDP in 1995 to 1.5% in 2000 and was budgeted at 1.9% in 2003 • Total health expenditure is budgeted to fall from 6.5% of GDP in 2001 to 6.2% in 2003. • Health sector's share in government expenditure declined from 12.5% in 2001 to 10% in 2002 and is estimated at 10% for 2003 • Approx. 60-65% of total health resources originate from donor sources – approx $100 million per annum projected 2001-2005

ETHIOPIA – Education	RWANDA – Education
• Finance for education has increased from 14% to 19% of total public expenditure between 2001 and 2005 • In absolute terms expenditure on education has increased from ETB 1.6 billion in 1997/98 to 3.9 billion in 2003/04 and is budgeted at ETB 5.3 billion in 2005 • 49% of public expenditure on education goes to primary education	• In 2001, government spending on education reached an all time high of 5.5% of GDP • Between 2001 and 2004 government spending on education decreased slightly from 30% to 24.2% of total public expenditure • Primary education share of recurrent expenditure has decreased from 70% in 1996 to 45% in 2001

Notes: In all cases external resources provided as General Budget Support are included as part of the domestic contribution to the sector resource envelope

are the health sector in Zambia and the education sector in Rwanda). It is also the case that external financing has increased, and in some cases now accounts for an increased share in the total resource envelope for the sector (e.g. Malawi Health, Zambia Education). The fact that domestic resources are increasing in the face of increasing external resources in most cases shows that in fact aid is additional and recipient governments are not simply reducing the allocation of domestic resources in response to higher aid inflows.[36]

Issues / Challenges:

3.3.17. However, it is not always the case that the PRS priorities are reflected in the patterns of budget spending. Budget execution is identified as weak in a number of the reports, with actual disbursements often being far from the provision made via annual budget ceilings, particularly so in Ghana, Malawi and Rwanda. Timing in the flow of funds is also poor in these countries. In Ghana in 2003, actual non-salary expenditures for education amounted to only 74% of the provision made in the budget. Within this delays in disbursements of funds meant that 61% of non-salary expenditure was made in the last quarter of the budget year.[37] This severely undermines the incentives for line ministries to prepare and present good sector budgets.

[36] HIPC Debt relief savings have also been a significant source of additional 'domestic' funding for most of the period under review

[37] Preliminary Education Sector Performance Report, 2004, MoEYS, Ghana

3.3.18. Fragmentation of budgets has emerged as a big issue in a number of the country reports – both in terms of external and domestic resources. On the domestic side, resources made available by HIPC debt relief and from special trust funds in particular in some cases (notably Ghana and Rwanda) are planned for, disbursed, executed, and reported on using arrangements quite separate from those used for appropriations to the sectors in the annual budget. With respect to external resources, significant volumes of project funds are not reported on budget, and in some cases grants and even loans are not fully reflected on budget.

3.3.19. This fragmentation of the total resource envelope available to a sector has significant implications for planning and budgeting. Co-ordination and harmonisation is made much more difficult, often leading to duplication of activities and excessive administrative and transactions costs.

3.3.20. Aid dependence on sector-earmarked external resources for health and education are high in some of these countries. For instance, in the Zambian health sector, it is estimated that 60-65% of resources are from external sources and in the Malawian health sector external resources accounted for 74% of expenditure in 2003. Government control over how resources are used tends to be lower for earmarked aid than for general budget support. In the figures provided in Box 3.6, aid provided as general budget support is not counted as external resources but is included within the domestic contribution. Tanzania and Uganda both receive large volumes of GBS and in both these countries the share of the health resource envelopes financed by the budget has increased, to 78% in Tanzania and to 48% in Uganda in 2003.

Process 3 – Aid Modalities and Effectiveness

3.3.21. Many of the country reports refer to pooled funding arrangements and/or sector budget support in support of SWAps (see Table 3.3). However, project funding is still an important part of donor support to the education sector and particularly to the health sector.

Table 3.3: Presence of Pooled Funding Arrangements in Health and Education Sectors

	Education Sector	Health Sector
Ethiopia	YES	
Ghana	NO	YES
Malawi	NO	YES
Mozambique	YES	YES
Rwanda	NO	
Tanzania	YES	YES
Uganda	YES	YES
Zambia	YES	YES

3.3.22. Traditional arguments used for the transition from project-type funding to sector programme and budget support recur throughout the reports. These include: reduced transactions costs; increased real resource transfer to the sector; improved co-ordination (reduced parallel and duplicative efforts); increased ownership of strategies and activities by recipient governments; better harmonisation and alignment with national plans, processes and priorities; and improved efficiency and effectiveness of public expenditure (in terms of levels of outputs achieved for given amounts of resources). The Uganda health sector report contains an interesting breakdown of project expenditure in 2003; revealing that 68% of project expenditures were made on items – such as Technical Assistance, Capacity

Building and overheads - that did not contribute directly to the achievement of Health Sector Strategic Plan objectives.

3.3.23. In some cases transactions costs have been reported to have increased as a result of moving to a SWAp and pooled funding arrangements, for example in the Zambia Health sector report, but this is argued to be a necessary 'start-up cost' on the Ministry's behalf in terms of investing in improved management and planning capacity. In this regard any initial increase should be followed by a sustained reduction in transactions costs.

3.3.24. All of the country reports suggest that good progress is being made on the harmonisation and alignment agenda, but that as yet it is insufficient and needs to go further both at national and sector levels. Indeed, in many of the sectors under review it would appear that certain processes are somewhat stronger at the sector level than at the national level, particularly in the presence of mature SWAp and sector budget support arrangements. For example, support to the Zambia Education SWAp is delivered through a pooled funding arrangement that is increasingly in line with budget support modalities, and as such is improving harmonisation and alignment. One reason given for this is that it is only by signing up to the joint MoU, which indicates a willingness to move to sector budget support, that external partners can gain access to the highest joint consultative body, the Joint Steering Committee.

3.3.25. Several country reports argue that aid to the education and health sectors, whether via sector level or general budget support, can be more effective when: it is aligned around strong sector plans which are consistent with the national poverty reduction strategy and clearly costed and prioritised; it is delivered within the context of a SWAp to which all partners are committed; and there are strong budgetary processes and financial management systems in both line and central ministries. Technical assistance (TA) has played an important role in supporting the development of sector plans, systems and capacities (e.g. Rwanda and Ghana), and also in supporting the development of improved systems for service delivery.

3.3.26. The low predictability of both domestic and external resource flows to the sectors in terms of both the timing and volume of disbursements is an issue raised in several of the country reports. Predictability needs to be improved, both within year and over the medium term, to facilitate better planning and implementation in both health and education sectors.

3.3.27. Many of the country reports recognise the concerns of line ministry officials and some donor personnel over the increasing use of General Poverty Reduction Budget Support (PRBS-G). This concern usually reflects fears that the sectors will not receive the same level of resources as they do under current sector support arrangements – however, there is also recognition that improving the negotiating power of line ministries with budget departments in Ministries of Finance and improving national processes such as Public Finance Management (PFM) and procurement should help in this regard. Increasing the extent to which central PRBS processes consider sector issues could also help – for example, the Tanzanian education sector is considering the use of a Sector Performance Assessment Framework (PAF) linked to the PRBS PAF.

3.3.28. Some sector ministry and donor staff also appear concerned that growing general budget support, if it leads to the phasing out of donor sector specialists, may weaken donor capacity to maintain healthy sector-level government-donor relationships and to engage helpfully in sector-level policy dialogue and harmonisation and alignment efforts. This could make it harder for sector ministries to argue strongly with central ministries for adequate budgetary funding and about intra-sectoral priorities.[38]

3.3.29. The country reports note that an increased volume of resources will be needed to assist these countries in meeting the MDGs and other international targets but that these additional resources will need to be delivered more efficiently and effectively.

3.3.30. The country reports generally argue that Poverty Reduction Budget Support (general or sector) will be the best way of delivering increased resources. Reasons given for this are that this will present the least problems in terms of absorption capacity, allows for a more flexible use of resources better aligned to national plans and processes and provides a better modality for translating resources into improved outputs.

3.3.31. Box 3.7 below on the Ugandan experience appears to support arguments for increased use of PRBS. As with the Ugandan experience of removing user fees presented in Box 3.3, it should be remembered that this increase in GoU budget expenditure on health is part of a broader package of health sector reforms. It is not simply the case that increased budget resources have led to increased OPD attendance; improved deployment of human resources, increased salaries for health workers, improvements in the availability of drugs at primary and secondary care levels and the abolition of user fees have all contributed to this improvement. However, budget support allows aid to be used to support national plans and priorities – in this case health sector reforms – and it is unlikely that project support would have provided such an enabling context within which these reforms could take place.

[38] This concern is referred to in a number of the country RHEP-SAC reports and the point was also strongly made in a presentation on the move from sector to budget support, given by Dr. Eddie Addai of the Ghana Ministry of Health at the Plenary meeting of the Strategic Partnership with Africa in Johannesburg, January 2005.

Box 3.7: Increasing Efficiency of Expenditure in Uganda

The graph below illustrates the correlation between the Government of Uganda (GoU) **budget for health** and outpatient attendance per capita. It is interesting to note that between 2000/1 and 2003/4 the **total resource envelope** available to the Ugandan Ministry of Health (MoH) (from all sources, including GoU budget and external support) increased only modestly by 19% in real terms. What has been significant is the change in the **composition** of the resource envelope – many donors have switched from using project support as their primary aid modality, to using Budget Support. As a result, the government budget for health has doubled, and the Government of Uganda (GoU) has become the largest contributor to the MoH resource envelope.

Figure 7 : GoU budget expenditure and total outpatient attendances

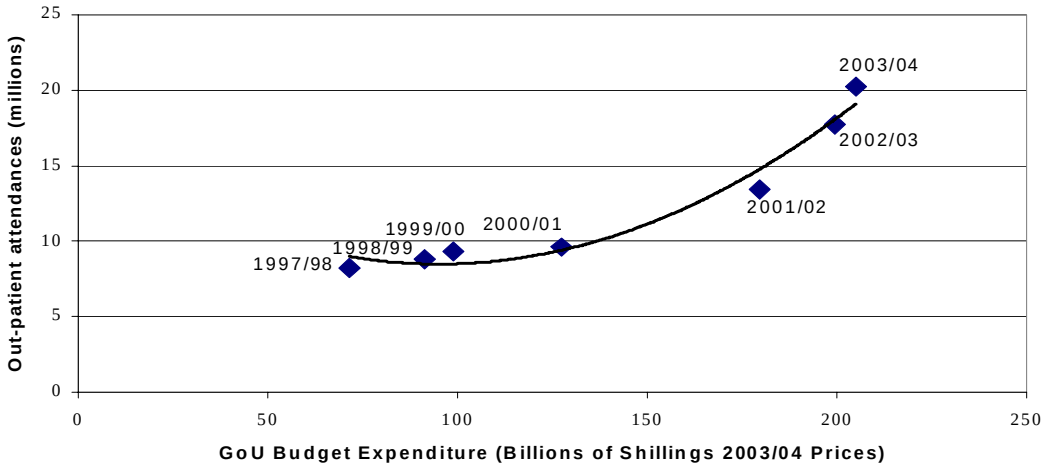


Figure 7 (above, taken from the Uganda health RHEP-SAC report) demonstrates a strong relationship between the volume of GoU budget resources and the level of outpatient attendance. What is interesting is that the sector is becoming increasingly efficient in turning its budget into outputs, as is indicated by the increasing gradient of the plotted line. Combining this with the information presented in Box 3.3 it would appear that increased GoU budget financing is proving both more efficient and more equitable than the previous combination of donor project and user fee financing.

Given that overall funding levels have not increased significantly, it would seem that the fact that an increasing proportion of resources are delivered in the form of budget support is arguably one of the key contributors to this improvement in the efficiency of expenditure.

Process 4 – Data, Statistics and Monitoring

3.3.32. As was highlighted in section two of this report there is a general problem regarding the shortage of good data and statistics to facilitate proper monitoring and evaluation, review and reporting in the countries studied.[39] This is particularly true for the health sector in terms of both output and outcome data, and for the education sector in terms of outcome data. This is becoming an increasingly important issue in the context of results orientated policies and processes – including aid modalities such as the World Bank's Poverty Reduction Support Credit (PRSC) and variable

[39] Note that these countries are regarded as 'good-performers' so problems of this nature in these 8 countries are likely to be hugely magnified in other African countries.

tranche components of general Poverty Reduction Budget Support (PRBS) mechanisms such as those used by the European Commission.

3.3.33. Aside from the demand from the donor side for improved data, there is an increased demand for data from the ministries themselves to inform the further development of poverty reduction strategies and sector strategic planning. However, the current use of data – in terms of analysis, reporting, dissemination and feedback into policy and strategy is weak.

3.3.34. A further problem is that data held on the same indicators, for the same year, for the same countries, differs from one source to another and often by a significant margin. Examples of this are the EFA GMR data on GER compared to the in-country EMIS data.

3.3.35. Access to good information on expenditure data is also problematic. Figures quoted for health and education expenditure data as reported in the country reports written for RHEP-SAC, various IMF Country Reports and the WDI online database are not consistent with each other. A major problem is the extent to which projects are on-budget and non-discretionary government expenditures are captured in sector expenditure plans. Another is related to the different methods used for reporting on wage expenditure and disaggregating recurrent and development expenditure.

3.3.36. Investments in Health and Education Management Information Systems should be a central part of technical and capacity building support to both sectors. Within this as well as looking at the traditional output indicators used to measure access, there will need to be an increasing focus on measuring equity in access, on measuring quality and particularly on measuring outcomes as a means of ensuring that improved outputs are having the anticipated impact.

4 Conclusions from the RHEP-SAC Synthesis

4.1. The preceding analysis and discussion, drawing on the country reports, points to the following conclusions:

4.2. Key outputs are improving in primary education in the eight countries under review. Generally these countries are on track to meet the enrolment targets of the MDGs, but there are not yet any grounds for confidence that the MDG completion targets will be attainable.

4.3. Utilisation of health services is generally improving but not fast enough to contribute to the reduction in mortality rates necessary to meet the MDG targets. Data on mortality rates is patchy and suggests improvements are modest at best; these countries are off-track in relation to the health MDG targets, and in most cases seriously so.

4.4. Improved service utilisation reflects the combined effect of several factors, including policies to enhance access in some cases, increased resources in most countries (both domestic and external), and improved harmonisation and alignment, typically through SWAps and budget support.

4.5. The consensus of the country reports is that:

- both sectors need more resources in order to accelerate progress;
- aid will be more easily absorbed if delivered as poverty reduction budget support - either sector or general - rather than projects;
- in both education and health there is need to:
  - improve access to services and equity in access (e.g. for the poor, for females and for rural populations)
  - ensure that those services are of good quality.

  This will require difficult trade-offs and choices (e.g. in the intra-sectoral allocation of resources) but there is scope for making more equitable, efficient and effective use of public expenditure. Addressing human resource constraints is a priority;
- a key challenge is to strengthen government led central and sectoral processes and strategic policy dialogue with key stakeholders (including donors);
- there is an urgent need for better data systems – this will provide a stronger basis for policy and planning, particularly where difficult trade-offs are involved, and will also help in better evaluating progress. Improved data systems must focus on outcomes for results-based performance monitoring, better disaggregation to allow analysis of equity and distributional issues, and better capture of quality measures.

5 Wider Lessons from the RHEP-SAC Exercise

5.1 The RHEP-SAC exercise has given a useful snapshot across some key PSA countries but does not give an Africa-wide picture.

5.2 The RHEP-SAC exercise highlights the fact that in a decentralised organisation like DFID, there exists more up to date and deeper knowledge of country level progress and processes in country offices than is routinely available to HQ. The difficulty DFID HQ experiences in accessing up to date country level information without specially asking DFID country offices demonstrates the importance of donor groups at country level jointly helping to strengthen government data systems and ensure that key data and sector review documents are placed online.

5.3 Most country teams involved in the RHEP-SAC appear to have found the process of developing the sector reports a useful stock-taking opportunity. Sharing the analysis with partner governments and with other donors may help central or sector level dialogue on how to make faster progress in the sectors.

5.4 An exercise of this depth does not need to be repeated every year, but a joint donor-government exercise of this sort every 2 or 3 years at country level may have value, not least to help maintain institutional memory.

5.5 In designing a multi-country review process, there is a tension between aiming for methodological consistency across countries, in order to facilitate cross-country analysis, and tailoring the design so as to add greatest value at country level by complementing other in-country processes (e.g annual sector reviews, public expenditure reviews etc) which differ between countries.

References

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World Development Indicators Online Data Base, http://devdata.worldbank.org/dataonline

Millennium Indicators Database, http://unstats.un.org/unsd/mi/mi_goals.asp

Annex One - Summary Of Data Used In Synthesis Report

Table A1.1: Summary Education Data
(Individual country reports may contain data on further education output indicators)

	1998	1999	2000	2001	2002	2003	2004	
Ethiopia[1]								
PGER - EFA GMR	49.9	70.8	64.4	63.9	…	…	…	+
PGER - ERHEP	…	…	…	61	64	68.5	…	
PNER - EFA GMR	35.8	…	46.7	46.2	…	…	…	+
PNER - ERHEP	…	…	…	…	…	45	…	
GPI - EFA GMR	0.6	0.67	0.69	0.71	…	…	…	+
GPI - ERHEP	…	…	…	…	0.72	0.77	…	+
Ghana[2]								
PGER - EFA GMR	76.8	…	80.2	81.4	…	…	…	+
PGER - GRHEP	78.4	79.4	78.6	78.6	83.8	85.7	86.3	+
PNER - EFA GMR	57.9	…	58.2	60.2	…	…	…	+
PNER - GRHEP	57.9	…	58.2	60.2	58.8	60.4	…	+
GPI - EFA GMR	0.9	…	0.91	0.91	…	…	…	+
GPI - GHEP	0.89	0.94	0.91	0.91	0.92	0.92	0.93	+
Malawi[3]								
PGER - EFA GMR	146.2	158.1	136.9	145.8	…	…	…	-
PGER - MaRHEP	…	…	106.8	…	…	114.6	…	
PNER - EFA GMR	…	…	…	81	…	…	…	
PNER - MaRHEP	…	…	78.2	…	…	80.9	…	
GPI - EFA GMR	0.95	1.00	0.98	0.96	…	…	…	+
GPI - MaHEP	…	…	0.92	…	…	1.0	1.0	
Mozambique								
PGER - EFA GMR	81	85	92	99	…	…	…	+
PGER - MoRHEP	…	…	…	…	…	…	…	
PNER - EFA GMR	47		54	60	…	…	…	+
PNER - MoRHEP	50	55	61	64	69	…	…	+
GPI - EFA GMR	0.74	0.75	0.76	0.79	…	…	…	+
GPI - MoRHEP	…	…	…	…	…	…	…	
Rwanda								
PGER - EFA GMR	118.6	122.4	118.6	117	…	…	…	-
PGER - RRHEP	…	…	99.9	103.7	110.2	117.3	130.8	+
PNER - EFA GMR	…	…		84	…	…	…	
PNER - RRHEP	…	…	73.3	74.5	78.2	84.0	93	+
GPI - EFA GMR	0.97	0.98	0.99	0.99	…	…	…	+
GPI - RHEP	…	…	…	1.01	1.02	1.03	…	+
Tanzania[4]								
PGER - EFA GMR	61.8	63	63	69.4	…	…	…	+
PGER - TRHEP	77	77	78	84	99	105	106	+
PNER - EFA GMR	45.8	…	49.8	54.4	…	…	…	+
PNER - TRHEP	57	57	59	66	81	89	91	+
GPI - EFA GMR	0.99	1.0	1.0	0.98	…	…	…	-
GPI – THEP	0.98	0.99	0.98	0.97	0.95	0.94	0.96	-

	1998	1999	2000	2001	2002	2003	2004	
Uganda[5]								
PGER - EFA GMR	143.3	140.9	135.8	136.4	…	…	…	-
PGER - URHEP	…	…	128	130	126.3	127	124	-
PNER - EFA GMR	…	…	…	…	…	…	…	
PNER - URHEP	…	…	85.5	86.5	84.8	86.7	88.7	+
GPI - EFA GMR	0.90	0.93	0.90	0.96	…	…	…	+
GPI - UHEP	…	…	0.93	0.96	0.98	0.97	…	+
Zambia								
PGER[6] - EFA GMR	81.2	78.7	78.2	78.8	…	…	…	-
PGER[6] - ZRHEP	…	…	71.4	71.3	74.7	79.4	94.8	+
PGER[6] - EFA GMR	68.5		65.5	66.0	…	…	…	-
PGER[6] - ZRHEP	…	…	65.3	65.8	67.9	72.3	84.3	+
GPI - EFA GMR	0.93	0.94	0.95	0.94	…	…	…	+
GPI - ZHEP	…	…	0.91	0.92	0.92	0.92	0.94	+

Notes:

Indicators -

PGER – Primary Gross Enrolment Rate

PNER – Primary Net Enrolment Rate

GPI – Gender Parity Index (Inferred from GER / enrolment data if not explicit in country RHEP report)

Sources -

EFA GMR – Education for All Global Monitoring Report (UNESCO; 2002, 2004, 2005)

xRHEP – Country report for country x (where E – Ethiopia, G – Ghana, Ma – Malawi, Mo – Mozambique, R – Rwanda, T – Tanzania, U – Uganda, Z – Zambia)

… data not given in either source for particular year

+/- indicates positive / negative progress over the period

[1] 2000 refers to budget year 2000 / 01 etc. (Ethiopia)

[2] 2000 refers to academic year 1999 / 00 etc (corresponds with 2000 financial year) (Ghana)

[3] 2000 refers to budget year 1999 / 00 (Malawi)

[4] 2000 refers to budget year 2000 / 01 (Tanznaia)

[5] 2000 refers to budget year 2000 / 01 (Uganda)

[6] Zambia figures refer to 9 years of basic education

Table A1.2: Summary Health Data
(Individual Country reports may contain data on further health output indicators)

	1996	1997	1998	1999	2000	2001	2002	2003	2004	
Ghana										
DPT3 - WDI online	…	…	72	72	84	80	80	…	…	+
DPT3 - GRHEP	…	…	68	73	83.9	76.3	77.9	76	…	+
SBA -WDI online	…	…	44.3	…	…	…	…	…	…	
SBA - GRHEP	…	…	41	43.5	51.6	49.2	52.6	51.9	…	+
OPD - WDI online	…	…	…	…	…	…	…	…	…	
OPD - GRHEP	…	…	0.35	0.38	0.46	0.49	0.49	0.5	…	+
IM - WDI online	…	…	…	…	62	…	60	…	…	+
IM - GRHEP	…	…	57	…	…	55	…	64	…	-
U5M -WDI online	…	…	…	…	100	…	97	…	…	+
U5M - GRHEP	…	…	108	…	…	100	…	111	…	-
MM - WDI online	…	…	…	…	…	…	…	…	…	
MM - GRHEP	…	…	214	…	…	204	…	205	…	+
Malawi[1]										
DPT3 - WDI online	…	…	93	84	75	90	64	…	…	-
DPT3 – MaRHEP	…	…	…	…	…	…	…	…	…	
SBA -WDI online	…	…	…	…	55.6	…	…	…	…	
SBA - GMaHEP	…	…	…	…	56	…	56	58	…	+
OPD – WDI online	…	…	…	…	…	…	…	…	…	
OPD - MaRHEP	…	…	…	…	…	…	0.83	0.71	…	-
IM - WDI online	…	…	…	…	117	…	113	…	…	+
IM - MaRHEP	…	…	…	…	…	…	…	…	…	
U5M -WDI online	…	…	…	…	188	…	182	…	…	+
U5M - MaRHEP	…	…	…	…	189	…	…	…	…	
MM - WDI online	…	…	…	…	…	…	…	…	…	
MM - MaRHEP	…	…	…	…	1120	…	…	…	…	
Mozambique										
DPT3 - WDI online	…	…	60	60	60	60	60	…	…	
DPT3 - MoRHEP	…	…	64	66	68	70	72	72	…	+
SBA -WDI online	…	…	…	…	…	…	…	…	…	
SBA[2] - MoRHEP	…	…	…	38	39.7	41.2	43	47.6	…	+
OPD - WDI online	…	…	…	…	…	…	…	…	…	
OPD - MoRHEP	…	…	…	0.82	0.83	0.85	0.83	0.92	…	+
IM - WDI online	…	…	…	…	130	…	128	…	…	+
IM - MoRHEP	…	134	…	…	…	130	128	…	…	+
U5M -WDI online	…	…	…	…	208	0	205	…	…	+
U5M - MoRHEP	…	200	…	…	…	208	205	…	…	+
MM - WDI online	…	…	…	…	…	…	…	…	…	
MM – MoRHEP	…	…	…	…	…	1000	408	…	…	+

	1996	1997	1998	1999	2000	2001	2002	2003	2004	
Tanzania[2]										
DPT3 - WDI online	…	…	79	76	79	85	89	…	…	+
DPT3 - TRHEP	…	…	…	76	…	…	89	…	…	+
SBA -WDI online	…	…	…	35.8	…	…	…	…	…	
SBA - TRHEP	…	…	…	43.8	…	…	…	…	…	
OPD - WDI online	…	…	…	…	…	…	…	…	…	
OPD - TRHEP	…	…	…	…	…	…	…	…	…	
IM - WDI online	…	…	…	…	104	…	104	…	…	
IM - TRHEP	…	…	…	99	…	…	95	…	…	+
U5M -WDI online	…	…	…	…	165	…	165	…	…	
U5M - TRHEP	…	…	…	147	…	…	153	…	…	-
MM - WDI online	…	…	…	…	…	…	…	…	…	
MM - TRHEP	…	…	…	…	1500	…	…	…	…	
Uganda[3]										
DPT3 - WDI online	…	…	54	54	53	60	72	…	…	+
DPT3 - URHEP	…	…	…	41	48	63	84	83	…	+
SBA -WDI online	…	…	…	…	…	39	…	…	…	
SBA[3] - URHEP	…	…	…	25	23	19	20	24	…	-
OPD - WDI online	…	…	…	…	…	…	…	…	…	
OPD - URHEP	…	…	…	0.42	0.42	0.56	0.72	0.79	…	+
IM - WDI online	…	…	…	…	85	…	83	…	…	+
IM - URHEP	…	…	…	…	88	…	…	…	…	
U5M -WDI online	…	…	…	…	145	…	141	…	…	+
U5M - URHEP	…	…	…	…	152[4]	…	…	…	…	
MM - WDI online	…	…	…	…	…	…	…	…	…	
MM - URHEP	…	…	…	…	505	…	…	…	…	
Zambia										
DPT3 - WDI online	…	…	81	80	78	78	78	…	…	-
DPT3[1] - ZRHEP	…	…	…	58	…	…	73	…	…	+
SBA -WDI online	…	…	…	47.1	…	…	43.4	…	…	-
SBA - ZRHEP	…	…	…	32	…	…	47	…	…	+
OPD - WDI online	…	…	…	…	…	…	…	…	…	
OPD - ZRHEP	…	…	…	…	…	…	1.33	1.33	…	
IM - WDI online	…	…	…	…	102	…	102	…	…	
IM - ZRHEP	109	…	…	…	…	…	95	…	…	+
U5M -WDI online	…	…	…	…	182	…	182	…	…	
U5M - ZRHEP	197	…	…	…	…	…	168	…	…	+
MM - WDI online	…	…	…	…	…	…	…	…	…	
MM - ZRHEP	…	…	…	…	…	…	729	…	…	

Notes:

Indicators -

DPT3 – DPT3 Immunisation Rate
SBA - % of Births Attended by Skilled Personnel
OPD – Outpatient Attendance per Capita
IM – Infant Mortality per 1,000 births
U5M – Under-5 Mortality per 1,000
MM – Maternal Mortality per 100,000

Sources -

WDI online – World Development Indicators Database 2003
xRHEP – Country report for country x (where E – Ethiopia, G – Ghana, Ma – Malawi, Mo – Mozambique, R – Rwanda, T – Tanzania, U – Uganda, Z – Zambia)

… data not given in either source for particular year
+/- indicates positive/negative progress over the period (note for health outcome indicators a fall in the value of the indicator is positive progress)

[1] EPI coverage
[2] proxied by institutional deliveries
[3] proxied by deliveries in government and private not for profit units
[4] Figure from the Uganda return to *Achieving the Child and Maternal Mortality MDGs in Africa*, APD, May 2004

[1] 2000 refers to budget year 1999/00 (Malawi)
[2] 2000 refers to budget year 2000/01 (Tanzania)
[3] 2000 refers to budget year 2000/01 (Uganda)

Annex Two – ToR for Country Reports

Review of Health and Education Progress : Scope of Each Sector Report

Format
10 page maximum length (Arial 12 font), excluding tables and graphs and including 1 page summary.

Summary Description of the Sector Report
A well-informed, up-to-date, balanced assessment by the DFID country team (even if the report was drafted by a consultant after consulting DFID staff) of what changes in outputs and outcomes have been occurring in the sector and why, what the prospects for further improvements might be, and what could (and could not) reasonably be claimed about the contribution that aid has made to these changes. It is important to be honest about the risks and challenges in achieving related outcome improvements.

Key Questions for the Report to Cover
The report needs to answer the following questions :

1. What changes in outputs and outcomes have occurred?[40] [Provisional list of output indicators to focus on are : for education : gross and net enrolment rates and survival to Grade 5, by gender; for health : childhood immunization, skilled attendance at birth and outpatient attendance rates]
2. What factors lie behind these changes? including :
   (a) Changes in inputs (especially in real terms) : public spending (recurrent, investment, staff, non-staff). [NB. The literature suggests public expenditure is poorly correlated with social sector outcomes, at least in cross country and panel studies. Demand side factors are often a more binding constraint than supply side ones. ie. poor people are restrained from using facilities because they are poor.]
   (b) Changes in intermediate indicators related to service delivery eg. % of resources reaching frontline providers; better quality data; more accessible data; increased access to services; more accountability (how measured?) between providers, citizens and state.
   (c) Changes in policy (eg abolition of user fees).
   (d) Changes in aid instruments by (each of?) the major donors (sector baskets, sector budget support, pooled TA, delegated cooperation modalities, other SWAp aid mechanisms, general budget support, capacity building).
   (e) What role did strong leadership play? (political level, official level, central level, sector level)

[40] In the RHEP-SAC country reports, we have reserved the label "outcome" for longer term effects of education (eg. on literacy) and of health (eg. on mortality) and we use the label "output" for service utilisation measures such as school enrolment and outpatient attendance. The indicators which we have called "output" are often referred to in other development literature as "intermediate outcomes" but our labelling approach avoids possible confusion between intermediate and final outcomes.

(f) What role have institutions (in the broadest sense) played?
   (i) Which institutions were important?
   (ii) Which features of these institutions were key?
   (iii) How were these good institutions built? {How far was this government-led?]
   (iv) How significant has been the donor contribution to institution-building?
   (v) What was the donor entry point?
   (vi) What role did improved donor behaviour play in allowing shaping the better institutional performance? (improved donor coordination, harmonisation, alignment, predictability, donor-government dialogue – either at central or sector level)
   (vii) What role did SWAp processes play?
   (viii) What role was played by the PRS process ? (eg through participation; by giving clearer focus on poverty reduction)
   (ix) What role was played by the MTEF and clearer prioritisation and PRS-to-budget links?
   (x) What role was played by improved working between government ministries?

3. How strongly are the changes in outputs linked to aid? What is the evidence for this? (Try to make explicit the assumptions being made about what might have happened otherwise – although the RHEP is not expected to invest the same level of effort in describing the counterfactual as would a full-scale evaluation.) Provide data on changes in aid flows, by instrument, if possible. Recognise the difficulties of attribution.
4. How far are the changes that have been occurring those which we expect to be reinforced by general budget support (PRBS-G)? {eg. at the centre of government. Refer to DAC GBS Evaluation Framework)
5. What evidence is there for (or against) expecting the changes in outputs will lead to changes in outcomes? What are the key challenges and risks to this link? Can anything be said about sustainability?