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Beyond 'The Answer' to Flexible Solutions in Managing Health in Africa

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BEYOND 'THE ANSWER' TO FLEXIBLE SOLUTIONS IN MANAGING HEALTH IN AFRICA

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ABSTRACT

The critical issues facing public administration manifest in droves in developing countries. I focus here on problems of administering the health sector in Africa, characterized by dire conditions and woeful results. I contrast two approaches to fostering administrative solutions in Africa's health sector. The first is reflected in an older regime of development interventions in the 1990s focused on introducing a decentralization blueprint. The second is a newer regime centered on performance-based funding that incites more flexible, context-specific administrative solutions. I label the first approach a misguided example of experts proposing "THE ANSWER" and suggest the second accommodates dynamic solutions "appropriate to circumstance". I show that the development community may be moving toward the second approach through a comparison of newer Global Fund projects that look different to older World Bank projects. I also show that the newer projects appear to be better implemented, with more tangible results. I don't suppose to say the evidence is conclusive but do think that it suggests African administrations need space to find themselves rather than prefabricated answers to who they should be. Administrative systems in places like the United States developed in just this kind of space. The same space should be afforded those now trying to develop.

INTRODUCTION

Development always has a major administrative component. Whether one is considering creating a new macro-forecasting unit in Haiti or fostering expansive regulatory reform in Guinea, administrative details have to be considered and solved: "*How* do we do *what* we want to do?" This question has typically been addressed within the context of sponsored projects and interventions in developing countries; often under the auspices of funding agencies like the World Bank and, more recently, new players including the Global Fund. The projects center on vital social issues. This paper focuses on one sub-set of such issues, in the health domain, and one region, Sub-Saharan Africa.

The administrative challenge posed by administrative issues in Africa's health sector is both urgent and complex. Basic statistics show the continent way behind the rest of the world, and facing seemingly insurmountable problems—no skilled people, limited resources, and infrastructure constraints being the most basic. Recent critique of the development community's response to these administrative issues in the 1990s suggests that organizations like the World Bank fostered one-best-way administrative solutions characterized by strong policy-oriented central government units and decentralized service providers; with standardized processes, basic care packages and new buildings, cars and drugs thrown in as crucial inputs to producing health outcomes. If the critique is correct, such approach resembles a health sector version of "THE ANSWER" to development (much like the Washington Consensus for macroeconomics). It would contrast with a different approach to address administrative problems, allowing the emergence of administrative solutions "appropriate to circumstances" (Brown and Stillman, 1985, 466), which I believe seems to be reflected in new Global Fund interventions that provide performance-based flexibility for contingently-shaped administrative solutions. The Global Fund allocates money to the treatment and prevention of specific diseases, funding multi-actor initiatives in their efforts to reach particular performance targets, with minimal prescription on 'how' but with

institutionalized feedback to allow flexible adjustment and learning, given the circumstance.

This paper looks at whether the development community has indeed gone from "THE ANSWER" to methods "appropriate to circumstances" in its approach to solving administrative problems in Africa's health sector. It goes one step further to question whether the new approach is superior to its predecessor. In so doing it essentially asks if African health administrations need prefabricated answers to who they should be, or space to find themselves. The first section introduces the situation more clearly and poses some research hypotheses based on the following questions: Did the development community really have a one-best-way prescription to health administration in the 1990s? Is the new Global Fund approach really different, accommodating more flexibility and variation in administrative approach? Is there any evidence that the new approach is 'better' than the old? The second section discusses the qualitative method used to address these issues, essentially involving a disciplined analysis of project documents in a set of ten African countries. The final section presents evidence from this research and argues that there is no THE ANSWER to Africa's health administration challenge but that solutions must be appropriate to circumstances.

BACKGROUND AND CORE ARGUMENT

Administrative processes are generally weak in Africa. They are even weak in projects conceptualized and funded by international agencies, which therefore have to address questions of what to do *and* how to do it. This paper concentrates on the 'how to' administrative challenges in the health domain. Projects in this area—and the 'how' administrative solutions they address—are set in context of the lowest life expectancy rate in the world (51 in 2001, compared with 78 in high income countries like the United States) and highest infant mortality and under 5 mortality rates (92 and 151 per 1,000 births, compared with 6 and 6 in high income countries). Inequality in service provision is another fact of life, as is a debilitating lack of service providers (vacancy rates for nurses and doctors were

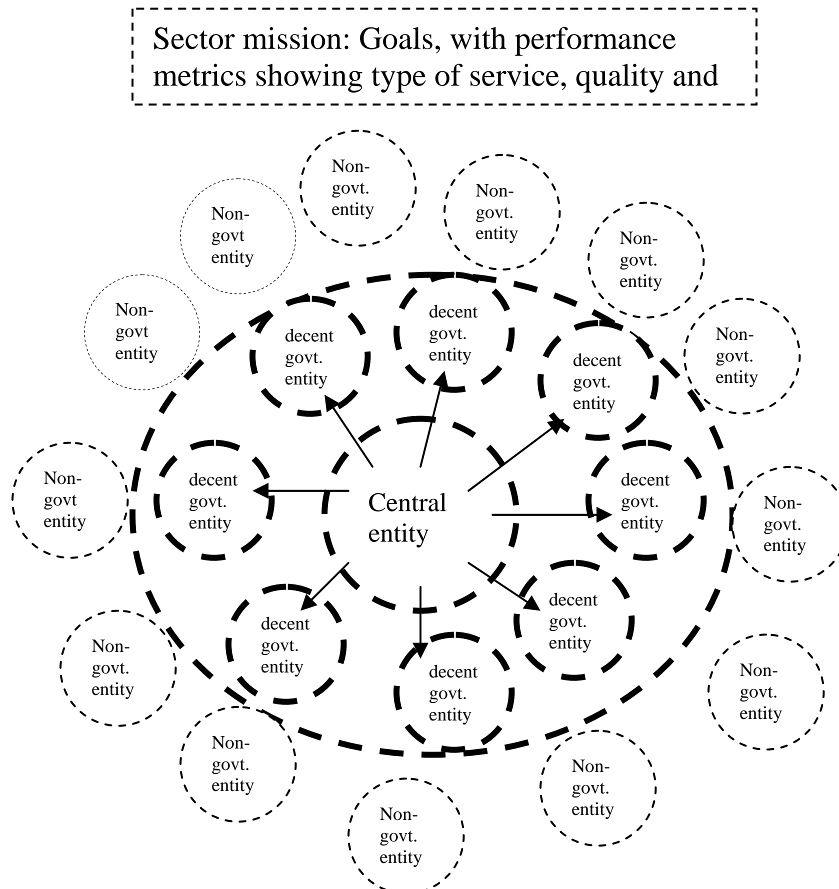
57% and 47% respectively in Ghana in 2000, and 40% and 55% in Zimbabwe in 2004). Many of the countries are socially and politically unstable, and most have very weak economies. But the countries are also really different, with varying languages, traditions, government types, and geographic and social profiles.

The importance of working in these domains cannot be overstated. The complexity of doing so also needs no mention. It is hard enough to think about 'what' should be done, but arguably harder to think about 'how'. From my reading, I think many management and administrative legends (including people like Dwight Waldo) would have resisted giving formalistic solutions, preferring to "raise provocative questions [rather] than to offer "hard answers"" especially holding back from "providing THE ANSWER" (Brown and Stillman 1985, 459). In contrast, the development community is commonly criticized as focused on producing THE ANSWER and then replicating it as best or better or good practice. The notorious one-size-fits-all Washington Consensus stood as THE ANSWER to development economics for much of the late 1980s and 1990s, for example (Rodrik 2005). Now, governance indicators underlie one-best-way models of effective government (Andrews 2008).

Commentators note that a similar 'blueprint' Health Sector Reform (HSR) approach dominated initiatives in the 1990s, manifest in numerous projects that looked very similar in "technical content and process" (Green 2004, 292). Observers suggest that this one-best-way blueprint fostered a standard administrative solution for health sectors based on a decentralization model characterized by: (i) Strong central entities making policy; (ii) Decentralized government service providers with clearly defined structures; (iii) Service provision dictated by centrally defined essential service packages; (iv) Inter-organizational connections effected through strong central management control systems (including financial management and monitoring and evaluation); (v) With centrally administered resource management mechanisms (drug procurement, infrastructure and motor vehicle maintenance) (Green 2004).

Figure 1 illustrates the emphasis of this approach, on the structures of the government sector (the large, bolded oval), structures of individual government organizations within the sector (the individual bolded circles) and the structures connecting these (within the sector, from the center outwards, through rules about what can be provided, resource management systems and control mechanisms). One should note the rigid focus on the 'structures' as THE ANSWER, the lack of emphasis on mission and performance issues or of connection between the structural interventions and the mission, and the limitation of 'sector' perspective to 'government' (no NGOs, civil society, etc.). The essential idea is to institutionalize the structures—not necessarily the objectives. Put another way, process is tightly defined but goals are loose.

Figure 1. Stylized presentation of the 'older' approach to health administration



While the idea of setting in place decentralization structures with a strong backbone of institutionalized management control may be attractive and seem universal, I believe many would have called their routine replication 'faddy'. Dwight Waldo, for example, would have faulted the development community for viewing itself as many consider medicine, "Rather self-assured and stable" to believe this was THE ANSWER when in fact "A close look" at both the medical field and development administration community "reveals an apparently unending succession of changing opinions and therapies" (Brown and Stillman 1985, 465). He would not have advocated reproducing one administrative approach throughout Africa's many health systems (even one based on seemingly sensible characteristics), but would rather have fostered approaches "appropriate to circumstances" (Brown and Stillman, 1985, 466). I believe he would have pointed to evidence of "circumstantial appropriateness" in health sectors of the world's better performing nations. As I have argued previously (Andrews 2008), "Top scoring governments [on governance indicators] all produce highest-level health, education and infrastructure services ... [but] … There is less consistency in the way the different governments produce these services…

> Government in the USA plays a relatively smaller role in both sectors than in other countries, actually contributing less to health care than the private sector. Countries like Sweden and Denmark (and even the UK and Canada) stand in contrast, with relatively small private sector contributions. Structural approaches to delivery also vary greatly with some governments (like Sweden) engaged in more quasi-private activities than others ... Public private partnership engagements in health, education, infrastructure and other sectors also vary across the sample as do levels of decentralization (with the UK, Belgium and the Netherlands more centralized in health care than Sweden, Denmark and Germany)."

The management literature (especially on learning organizations but also on contingency) would probably have suggested a more flexible approach accommodating differences across Africa (just as these differences are accommodated by differences in structure in Sweden, the USA and Canada). Such approach, especially influenced by the performance movement, might center on

the issues to be addressed, the people to be reached, and the people involved in providing the administrative solution. The complexity of different situations, manifest in the different profiles of issues and people, would 'contingently influence the administrative solution' in different places.

One could imagine this different approach pointing administrators in the right direction (based on mission and reach), affording them flexibility in getting there, and allowing frequent feedback to assess progress and allow learning and adjustment. Figure 2 is a modified version of Figure 1, to show how I think this alternative approach might look. It focuses tightly on goals, but is loose on process.

Figure 2. Stylized presentation of the 'newer' approach to health administration

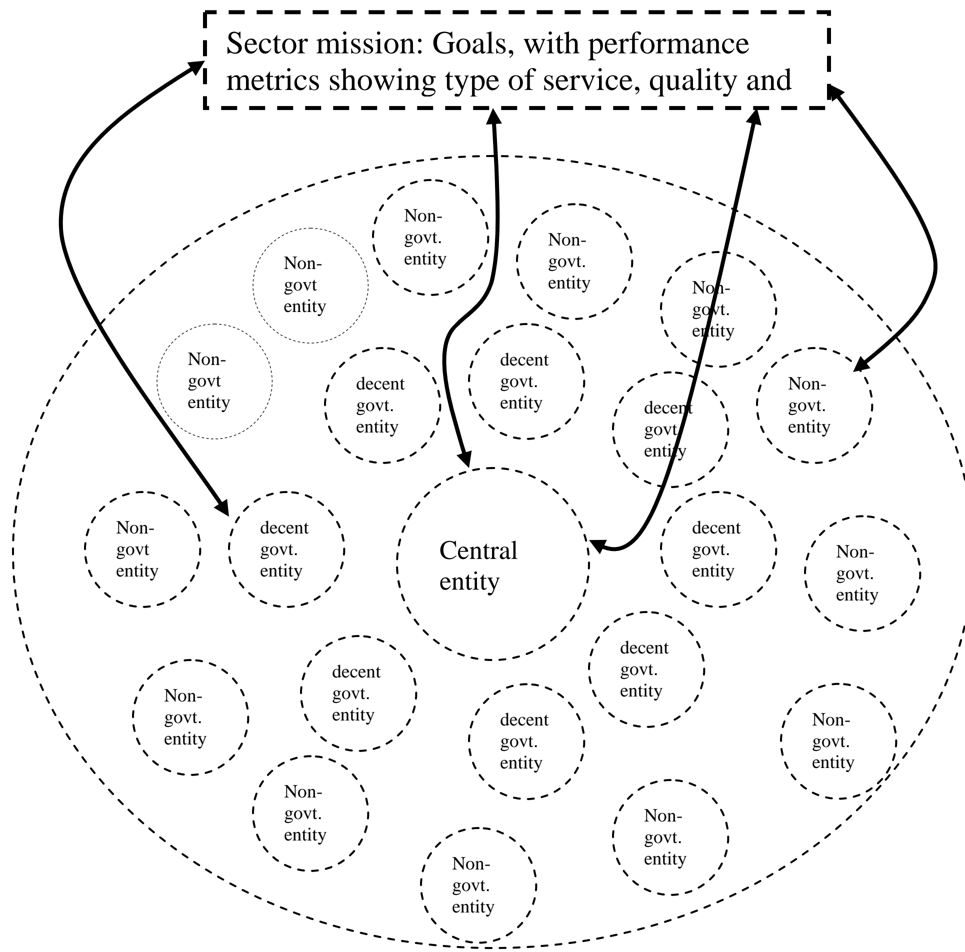


Figure 2 emphasizes defining and pursuing the mission (shown in bold), through a broad set of actors (government and non, with the sector border no longer rigidly defined). The actors in this sector would be encouraged to determine their own contextually appropriate structures (for the sector, for organizations within the sector, and also for inter-organizational connections—all non-bolded or not even shown, denoting that they are not prescribed or only loosely identified). Feedback loops would be purposefully structured into the system, with some shown in bold connecting organizations to and through each other to information pertaining to sectoral performance. The information loops would go both ways, allowing organizations to learn about the implications of mission for their own structures (facilitating adjustments) and to learn about complications with the mission (also facilitating adjustments). The adjustments would essentially, over time, ensure a dynamic administrative solution to dynamic problems, 'appropriate to circumstances'. The essential idea is to institutionalize an active focus on objectives, and allow flexibility in structural administrative response.

In many senses this is the approach the Global Fund (GF) claims to take. It involves providing money against performance commitments in specific disease areas (clear mission and clear reach) to projects initiated through multi-actor Country Coordination Mechanisms (CCMs) (acknowledging the multiplicity of policy and administrative actors), to be implemented by multiple agents in coordination with each other, and with regular reviews that accommodate flexibility and the continual shaping of administrative solutions to circumstances. This approach is itself the product of most recent better practice thinking in public and even private management theory. Consider commentary on the Fund's descriptions of its approach (in parentheses, from the Global Fund website, http://www.theglobalfund.org/en/funds_raised/principles):

- "The Fund will base its work on programs that reflect national ownership and respect country-led formulation and implementation processes" reflects directly on ideas that solutions come from inside organizations (a

key tenet of theory on learning organizations, and recent literature on organizational change).

- "The Fund will support proposals which focus on performance by linking resources to the achievement of clear, measurable and sustainable results" draws directly from the past two decades' emphasis on introducing performance into the public domain.
- "The Fund will support proposals which focus on the creation, development and expansion of government/private/NGO partnerships" links to the public administration emphasis on networks, distributed and collaborative governance structures and inter-organizational complexity.
- "The Fund will support proposals which strengthen the participation of communities and people, particularly those infected and directly affected by the three diseases, in the development of proposals" ties to the growing public administration literature on civic engagement and direct democracy.
- "Once awards are made, Local Fund Agents assess local capacity to implement programs. Specific and measurable intended results are incorporated into grant agreements, and ongoing grant disbursements are tied to progress, as reported and independently verified at regular intervals." This resonates again with the language of performance management and particularly with recent work on performance-based accountability and performance-based dialog, and the opportunities such creates for single and double loop learning (especially when the Local Fund Agents Assessments are used to facilitate program improvement).

The interesting thing about the Global Fund's approach to using these kinds of better practice ideas is that it blends them together in a fairly postmodern way, to create space for solution rather than as the solution (as critics claim the 1990s projects did—in more of a modernist tradition). I liken this to my reading of recent work by development economists Dani Rodrik and Ricardo Hausmann—on the totally unrelated topic of industrial policy. They decry the one end of

growth literature that argues for hard technical industrial policy intervention by governments in 'picking winners'—industries on which to focus, for instance. They also criticize those calling for no government involvement at all. Their work suggests an alternative solution focused on government's policy and administrative role in fostering growth-enhancing decisions by business. In discussing his ideas for effective "institutional arrangements for industrial policy" Rodrik (2004, 16) emphasizes creating administrative structures that stimulate coordination, information sharing and learning, primarily between firms in industries but also at the interface between firms and government. He and Hausmann (2006, 31) call this proposed framework an "open architecture" in which government's role is less about making a technical choice about how growth should be achieved and more about allowing "potential areas of attention [to] evolve" by "creating [a] space" for such.

I have developed a similar focus on 'space' creation as the key to development in my research on public sector reform. In observing government attempts to solve management problems with standard technical mechanisms I find that the same mechanisms have vastly different results in different settings. I also observe that the technical solution can become the problem itself. In trying to explain these different experiences I find that those cases where reform progresses furthest seem to have an organizing logic facilitating change, creativity, open thought and new ideas much like Rodrik and Hausmann's open architecture would. On the basis of these observations I developed a simple model in which 'reform' or 'change' space is the crucial ingredient for public sector adjustment and implementation. This space does not seem random to me, but rather a real organizational quality that emerges where three factors align—administrative acceptance of a particular mission and its implications, administrative authority to tackle the mission, and administrative ability to tackle the mission (Andrews 2004). This kind of space is highly circumstance-specific and will probably come in different shapes and sizes, is not about formulas but rather about mission driven

and inspired problem-solving management—adaptive rather than technical in nature.

Proponents of the new Global Fund approach seem to argue that it is a significant improvement on the project approach of the past, ostensibly because it fosters this kind of locally owned, performance driven, dynamic administrative form—or ‘space’ for administrative solution. Green (2004, 292) hails it as a departure from Health Sector Reforms (HSR) of old and an example of interventions “focused on health system performance and development (HSD).” McCarthy (2007, 307) quotes William Easterly’s praise for its mission focus, comparing this to prior experience: “One of the curses of foreign aid is that each agency tries to do everything; and when you try to do everything, you tend to do a mediocre or bad job.” McCarthy (2007, 307) also cites Joanne Carter, “associate director of RESULTS, an advocacy group” who “says that the Global Fund has “fundamentally transformed” the fight against tuberculosis. “It is like night and day”, she said. “We knew what to do; we had systems in place; now with Global Fund support we can actually do what we know we can do.””

Carter lends strong support to the idea that the Global Fund approach solves the administrative question of ‘how’ to do the things ‘what’ development experts knew were needed. Her comment seems to answer conclusively ‘yes’, ‘yes’ and ‘yes’ to the following three questions I still have in reviewing the story to date:

- Did the development community really have a one-best-way blueprint prescription to health administration in the 1990s?
- Is the new Global Fund approach really different, accommodating more flexibility and variation in administrative approach?
- Is there any evidence that the new approach is ‘better’ than the old?

Carter’s answers allow the formulation of research hypotheses related to the questions:

H1: The development community had a one-best-way, rigid model of health administration in the 1990s, reflected in strong similarities in

administrative elements of health sector interventions across countries (focused on creating strong singular central entities and planning protocols and decentralized service delivery entities, and providing inputs for the sector, with very little focus on mission and performance and/or on flexible organizational learning).

H2: The Global Fund method offers a new, flexible approach to health administration "appropriate to circumstances" reflected in relatively high levels of variation in administrative elements of cross-country health sector interventions (the approaches, while varying, are expected to accommodate organizational opportunities—space—for learning and innovation, for multiple organizations, driven by mission and performance concerns).

H3: The Global Fund method has been more successful than the old approach, evidenced in higher levels of policy and program implementation and greater impact of interventions.

RESEARCH METHOD AND DATA SOURCES

The kind of information required to investigate these hypotheses is not readily available in a database. It is, however, buried in many records on projects and interventions in African countries. This is largely because transparency in the development community has improved remarkably in the past two decades. I began my search of these records by accessing publicly available documents related to over 50 World Bank and World Health Organization (WHO) interventions in Africa during the 1980s and 1990s. These were the basis of background reading on the topic and the initial hypothesis—emerging from casual reading, not rigorous study—that projects from the era appeared similar in content (technical and administrative).

The quality and content of the documents varied significantly, however, posing reliability and validity problems for more rigorous research. I thus decided to

concentrate such research on projects where similar content was available, in the form of project descriptions (at conception) and project assessments (at completion) in one of the two organizations. I chose the World Bank because of the greater availability of publicly available information, and settled on a set of ten projects (in different countries) with the requisite ‘thick’ documentation. They were all in sub-Saharan Africa and all introduced during the 1990s, albeit at different times (see Table 1). Given that I am assuming these all came from the same ‘era’ the fact that they were introduced over a fairly long ten year period constitutes a problem for comparison. Are projects developed in 1998 really from the same era as those developed in 1992? The issue is not trivial but is easily resolved by controlling for dates of project conception in discussing the sample’s characteristics.

I identified these characteristics (to assess whether a one-best-way model was in place in the era) by initially collecting and coding all information on project components—recording exactly what administrative issues individual projects addressed. Information was coded and recorded using a rigid-flexible approach whereby I first matched text with characteristics of the ‘blueprint’ characteristics implied by Green (2004) as central to THE ANSWER: Building strong central entities making policy; Creating decentralized government service providers with clearly defined structures; Fostering service provision dictated by centrally defined essential service packages; Creating inter-organizational connections effected through strong centrally managed management control systems (including financial management and monitoring and evaluation), and; Promoting centrally administered resource management mechanisms (drug procurement, infrastructure and motor vehicle maintenance). After matching with these rigid categories (where I expected to find most of the attention in all countries) I recorded project characteristics that looked different under headings that emerged through the analysis.

Table 1. Countries and project analyzed[2]

Country	World Bank project, duration	Global Fund project, duration
Comoros	Health Project, 1998-2004	Prevention of Sexually Transmitted Infections and HIV/AIDS Among Youths and Adolescents, 2005-2007
Cote d'Ivoire	Integrated Health Services Development, 1996-2004	Prevention of the spread of the HIV/AIDS epidemic in the context of severe political and military crisis, 2004-2006
Eritrea	Health Project, 1998-2004	National AIDS Control Program, 2004-2006
Ethiopia	Health Sector Development Program, 1999-2006	HIV/AIDS Prevention and Control, 2003-2004
Ghana	Health Sector Support, 1998-2004	Accelerating access to prevention, care, support and treatment of all persons affected by HIV/AIDS, 2002-2003
Guinea	Health and Nutrition Sector Project, 1994-2002.	Project to Strengthen the Fight Against HIV/AIDS, 2004-2008.
Niger	Health Sector development Program, 1997-2003	Contribution to the Fight Against Sexually Transmitted Diseases and HIV/AIDS, 2004-2006
Sierra Leone	Health Sector Investment Project, 1996-2003	Development of a comprehensive national response to HIV/AIDS that includes adequate prevention, treatment, care and support for those affected, 2005-2007
Uganda	District Health Project, 1995-2002.	Comprehensive Country Proposal for Scaling up the National Response to HIV/AIDS, 2003-2005
Zambia	Health Sector Support Project, 1995-2000.	Churches Health Association of Zambia's Program to Combat HIV/AIDS, 2003-2005

The resulting spreadsheet allowed me to note exactly how many of the ten projects adopted the THE ANSWER reform elements and how alike the projects actually were. I was able to compare this information with a similar spreadsheet of characteristics of Global Fund HIV/AIDS projects in the same ten countries, all initiated after 2002 (See Table 1). As will be seen, the Global Fund project information did not allow a very rigid coding approach—given the high levels of variation they exhibited. A more flexible method was thus adopted, to analyze the publicly available documents I accessed on project proposal and grant performance (written to decide second tranche awards on existing projects).[3] As with the World Bank documents, these all had similar structures that allowed for

[2] In the case of World Bank projects, documents accessed were typically the Project Appraisal Document (or equivalent) and Implementation Completion Report (or equivalent). Global Fund documents accessed were the Original Proposal and Grant Score card.
[3] Or similar performance reports for projects not yet at this stage.

easy comparison. The structures are different to the World Bank documents but essentially capture similar information—especially as is required for the current study.

One could question the comparison of the two samples because the Global Fund projects are focused on HIV/AIDS only while the World Bank projects cover a wide variety of issues. I do not think this is a problem given how the documentary derived data is used: To check whether World Bank project characteristics are more rigidly defined and therefore more similar across countries than Global Fund project characteristics. If this is indeed reflected in the evidence, even with more variation in World Bank projects, support for the hypothesis would only be stronger.

The two data sources—World Bank and Global Fund documents—were then used as the basis for analyzing the final hypothesis, that new-era Global Fund interventions are more effective than old-era World Bank projects. I based this assessment on information in the World Bank Implementation Completion Reports (ICR) and Global Fund Grant Score Cards. These documents record a mixture of written descriptions and numeric or symbol-based 'performance' metrics. Metrics used differ between the two organizations. Given observations about these differences, I focus my discussion as much on the nature of the performance dialog in the two sets of documents (and what it says about how performance was framed) as I do on the actual evidence of performance.

EVIDENCE AND DISCUSSION

I believe the research method is well suited to study the hypotheses at hand, accommodating both descriptive reflections on the qualitative evidence reviewed (through references to actual words used) as well as a more quantitative presentation of patterns in this evidence (through references to frequencies of words used or of topic discussion). The research method was systematically

developed to allow analysis of the three hypotheses presented earlier. This is how I discuss the evidence as well.

Did 1990s projects follow a 'THE ANSWER' administrative blueprint?

Did the ten World Bank projects look similar, reflecting an administrative blueprint focused on developing structures specific to a one-best-way decentralization model? If so, then one would find the following characteristics dominating all projects: (i) Strong central entities making policy; (ii) Decentralized government service providers with clearly defined structures; (iii) Service provision dictated by centrally defined essential service packages; (iv) Inter-organizational connections effected through strong centrally managed management control systems; (v) Centrally administered resource management mechanisms. One would also find other characteristics, "appropriate to circumstances" introduced only at the margins of projects, limited emphasis on non-governmental actor involvement, and little attention to objectives and mission.

I will start by noting that documents certainly pay limited attention to objectives and mission, apart from the most recent—Ghana's 1998-2002 Health Sector Project and Ethiopia's 1999-2006 Health Sector Development Project (and Sierra Leone's project after a 2000 adjustment). Ghana's completion report includes a prominent page 3 table showing output and outcome data for seven performance areas, with 2001 estimates standing shoulder-to-shoulder with 1996 baselines. The similar Ethiopian document opens with a six page section on development objectives and indicators, as well as a list of dated "Ratings of Project Performance". The Ethiopian project is the only one which seems to have introduced performance metrics with baseline measures at project initiation. These metrics also serve as the primary basis of communicating project effectiveness and appear to have driven regular learning loops (via regular Implementation Status Reports, tied to disbursements).

In contrast, other projects note “objectives” in vague written descriptions with limited evidence of measures, baselines and attempts at institutionalized evaluation. Sierra Leone’s Health Sector Investment Project (1996-2003) notes one objective as “improve key health status indicators” and its Implementation Completion Report provides some metrics associated with such in an annex—but the baseline is 2000. This timing anomaly is partly due to the project’s stops-and-starts (given unrest in the country) but also arises because the metrics were not evident at the project’s start (apparently added as it progressed, or maybe even at conclusion). This is the pattern across the eight other projects, where the emphasis on mission/objectives/performance is quite low:

- The Comoros Implementation Completion Report has little reference to objectives and results in its main text. It does, however, have a table in Annex 1 that shows aggregated performance against indicators identified at appraisal. These are not discussed in any detail and questions of attribution are significant.
- Cote d’Ivoire has a similar Annex 1 table, with extremely little discussion of objectives in the main text. Its annex does not suggest that indicators were identified at appraisal, however, and there is no evidence of indicators and baselines identified in appraisal documents.
- Eritrea’s Implementation Completion Report provides a table of key performance indicators only in Annex 1, but this table is not in initial project preparation documents.
- Guinea’s Completion document provides (again in an annex) a list of indicators and “actual/latest estimates”, where it compares mid-term and end of project statistics. Similar data is missing from the project preparation documents reviewed.
- Niger’s completion document has metrics like those in Sierra Leone (also in an annex), which candidly indicate that baselines were “not defined in PAD (Project Appraisal Document)”.

- Uganda’s Implementation Completion Report shows (in annexes) various tables of data on health care utilization etc. but with no direct reference to project objectives.
- Zambia’s completion document opens with a small paragraph that suggests problems with attributing project impact on outcomes, and then only shows key indicators in Annex 1. Much like Guinea, indicators and baselines seem to have been introduced along the way as they were not in place at project initiation.

All of the project documents apart from those pertaining to Ethiopia and Ghana lead with sections describing “components” rather than objectives. These components tend to emphasize structural interventions, not performance (as hypothesized) and also emphasize government role players above others (again as hypothesized). Central government entities are the borrower/implementing agency in all ten cases (a biased finding because these are the only entities allowed to borrow from the World Bank). Furthermore, non-government engagement is rather low in most cases. Six of the ten sets of project documents did suggest some intended engagement with civil society and NGOs, but mostly at the margin of a minor component. The Comoros project, for example, indicated that the Ministry of Health created a small project fund for sub-project financing (and notes nothing more, other than that there was some corruption in the process). The Sierra Leonean project indicates fostering some communication between the Ministry of Health and NGOs. The Zambian reports speak of community institutions created and then abolished, ostensibly important to the decentralization initiative but not discussed very much. Once again, the most recent Ethiopian project stands apart, incorporating elements aimed at increasing private sector participation in health care (especially through the provision of technical advisory services), training staff in health NGOs, creating accreditation mechanisms for NGOs and private sector health professionals, and establishing broad communication programs for social awareness.

The Ethiopian project thus has some characteristics that run counter to the hypothesis that all 1990s projects lacked mission focus and were predominantly focused on establishing certain structures in government organizations only. The other nine project documents generally support the hypothesis, however, with (as argued) limited mission focus and limited discussion of non-governmental players. All ten projects are similar in their focus on decentralization, however, and on the kinds of structural interventions critics suggest constituted the blueprint administrative decentralization model of the 1990s. This focus (which I will discuss momentarily) drowns out any project elements that appear different or "appropriate to circumstances". These are evident in all ten projects but at the margins, accounting for less than 25 percent of project funding in all cases. Eritrea developed a blood bank that has proved vital in addressing the HIV crisis, for example, accounting for about $2 million of a $21.1 million project. Guinea's sub-component 3 (of 6) emphasized "strengthening key technical programs" and included some specific interventions like an iodine deficiency intervention to address the circumstantial manifestation of goiters in one region. Sierra Leone's project included a component aimed at addressing major health issues which also emphasizes some technical and administrative solutions for the country's peculiar post conflict setting. However, even this component ended up being revised and overlapping with objectives to "reform the health system" through a series of 'usual suspect' structural interventions.

These 'usual suspect interventions' center on establishing the kinds of characteristics noted at the start of this section and implicit in the earlier hypothesis: a specific model of decentralization. They account for at least two thirds of all project focus in all ten cases, wrapped in an emphasis on decentralization explicit in all documents:

- The Comoros project sought to strengthen decentralization, noting that "Support for decentralization was already firmly established."
- Ideas in the Cote d'Ivoire project were "pressed in favor of … decentralization."

- The main component in Eritrea's project sought "to enhance decentralization"
- Ethiopia's project had as a major objective, "Strengthening the Borrower's health sector management and information systems with a view to establishing a well-managed, decentralized, and participatory health system"
- The Ghanaian project sought explicitly to enhance "decentralization of decision-making to regional and district management teams…"
- Guinea's project explicitly mentions the goal of "Rehabilitation and strengthening of decentralization process"
- Niger's project aimed to "ensure continued improvement of the population's health through" … [primarily] … "decentralization of basic health services."
- The Sierra Leone project mentions its goal of "decentralization of management and decision-making."
- The Zambian project notes that, "decentralization was the earliest reform to be initiated."

The Ugandan project describes its decentralization intentions in a way that explicitly shows parts of the 'blueprint' approach evident across the projects:

> The project aimed to "Support the MoH at the center in realigning its role to be compatible with the decentralization policy and to strengthen the Ministry in order to provide the necessary leadership/stewardship of the sector in the new policy environment … The project was to support the MoH in formulating and executing action plans for health services decentralization."

As with the others, the Ugandan project had multiple components: Pilot Activities, Demonstration Activities, Capacity Building for District Health Administration and Restructuring and Capacity Building for the Ministry of Health. I examined each component separately to assess the degree of focus on the 'blueprint' characteristics named earlier. As with all the projects, I found these characteristics implicit in all components:

- The Pilot Activities centered on a number of districts implementing an Essential Health Services Package.
- Demonstration Activities emphasized implementing the Essential Health Services Package in another seven.
- Capacity Building for District Health Administrations aimed to provide equipment, infrastructure, and such to district offices. There is some discussion of working with NGOs but the emphasis is on enhancing the autonomy and effectiveness of government health units.
- Restructuring and Capacity Building for the Ministry of Health aims to assist the MoH in realigning its role to be compatible with the new decentralized structure. It included helping the MoH play a greater policy planning role, exercise oversight, develop management and control mechanisms and strengthen procurement and logistics management.

As discussed in the section on research method, I conducted a similar study of all ten projects, and constructed Table 2 to summarize evidence of 'blueprint' characteristics. Uganda's column reflects characteristics drawn even from the basic descriptions above. The underlying evidence is of course much more detailed, for Uganda and all the other countries' projects. The bottom line is that the ten projects focused predominantly on packages of these characteristics, with some (like Uganda's project) addressing all at once and others (like Comoros and Eritrea) incorporating three or four.

Table 2.Which 'blueprint' administration characteristics appear in which projects?

Characteristic	Cote d'Ivoire	Comoros	Eritrea	Ethiopia	Guinea	Ghana	Niger	Sierra Leone	Uganda	Zambia
Support for central entities making policy.	X	X	X	X	X	X		X	X	X
Support for decentralized government service providers.	X	X	X	X	X	X	X	X	X	X
Service provision dictated by centrally defined essential service	X	X	X	X		X	X	X	X	

packages.										
Inter-organizational connections effected through strong centrally managed management control systems.	X			X	X	X	X	X	X	X
Centrally administered resource management mechanisms (including procurement)	X	X		X	X	X		X	X	X

Table 2 and the related discussion certainly do not prove that health projects across Africa in the 1990s all looked the same. The evidence does, however, lend support to the hypothesis that the administrative approach fostered in these projects reflected a common blueprint. I am not trying to evaluate whether the blueprint was good or bad, just to assess whether evidence supports the idea critics have had for years, that a one-best-way, rigid model of health administration existed. And I think the evidence does show this, with major similarities in administrative approach across this admittedly small but also diverse sample of projects and countries. They generally focused little on mission, much on government organizations, and predominantly on introducing common structural change. This change model, one could argue, was an example of the development community having "THE ANSWER" to Africa's health sector administration problems—much like the Washington Consensus solved all the world's macroeconomic problems.

Are newer projects more flexible, 'Appropriate to Circumstances?'

Some say that the only thing that stays the same is change. Others argue that the more things change the more they stay the same. Put the two together and we have the question driving a second part of this analysis: Is the new, changed, Global Fund approach *really* different, accommodating more flexibility and variation in administrative approach to health administration in Africa? Of course

I imply a positive answer in my earlier hypothesis, convinced by Joanne Carter's words that the Global Fund has "fundamentally transformed" health administrative solutions, allowing her and her fellow health care professionals to finally "do what we know we can do." But does the evidence support the hypothesis? Does it show that the Global Fund fosters an approach focused on mission and results rather than structure, accommodating multiple actors, allowing multiple administrative solutions, and encouraging dynamic learning and shaping of administrative solutions "appropriate to circumstance"?

I believe the answer is a repetitive yes, yes, and yes.

My first observation from the ten grant proposal and score card combinations was the emphasis on performance. Whereas the World Bank project documents (apart from Kenya and to a lesser extent Ghana) had very little information on mission, objectives, and results, Global Fund projects are largely about exactly these things. If sixty or seventy percent of the World Bank documents focus on structure and process, the Global Fund documents spend the same proportion of pages on the topic of mission, objective and results. Within two pages of the start of each proposal one finds a box or loose text about overall goals, activities and main activities in each component. The Grant Scorecards similarly begin the leading "Rationale for Recommendation" section with a discussion on program performance, generally in the form of concise bullet pointed metrics. The two documents routinely allocate most of their pages to discussion of mission, results metrics, baseline indicators and activities needed to meet targets. The objectives tend to be extremely operational as a result of this attention, and are obviously and explicitly the basis of project evaluation.

My second observation was the variation in objectives across the ten projects. One should remember that they are all focused on HIV/AIDS and should thus be more similar in substance than the World Bank projects, which were of a wide variety covering the entire health sector. But consider examples of the differences:

- Cote d'Ivoire's intervention has a stated goal (or mission statement) of "Reduc[ing] the spread and the effects of HIV/AIDS in the rebel-controlled zones as well as in the refugee-hosting areas adjacent to the front lines (buffer zone) over a period of 18 months." The objectives it identifies to achieve this include: Reorganizing the condom-distribution network and ensuring regular distribution of condoms; Initiating or strengthening general and local awareness campaigns tailored to the situation and involving community peer educators; Strengthening the intervention capabilities of the local NGOs or associations in the field; and coordinating or strengthening the HIV/AIDS interventions of international and non-governmental agencies active in the field in the rebel-controlled zones, including the healthcare centres under their authority.
- The Eritrean project has as the ultimate goal (akin to a mission statement), "To reduce sexual, blood and mother-to-child- HIV transmission, and mitigate the personal, social and economic impact of HIV/AIDS". Its objectives include: Scaling-up and expanding effective HIV prevention activities with target populations; Increasing the number of people who know their HIV status by improving availability and quality of voluntary counselling and testing (VCT); Increasing the number of infected mothers who receive effective counselling and medical intervention to decrease the likelihood of HIV transmission (PMTCT); Improving the availability and the quality of health care and psychosocial and economic support for people with HIV/AIDS (PLHAs) and those affected by the epidemic; Expanding blood transfusion safety (HIV, Hepatitis B and C and Syphilis) to regional blood banks, and establishing procedures to ensure adherence to Universal Precautions in the health care setting; Strengthening and expanding epidemiological and behavioural surveillance for evidence-based planning.
- Niger's project's end goal (mission) statement is: "To reduce the developing tendencies of the HIV/AIDS epidemic and reduce its negative

effects throughout the population." The objectives include: Intensifying STI/HIV/AIDS prevention and treatment efforts in at least 90% of the population of Niger by 2006, placing specific emphasis on young people between 10 and 24 year's old, groups at risk and vulnerable groups; Ensuring correct STI/HIV/AIDS treatment and access to ARVs for 3500 PLH, including psychosocial and physical support.

Just in these three examples we find different goals focused on tackling the spread of AIDS in remote conflict areas, reducing the transmission of AIDS from mother to child, and addressing HIV/AIDS in young people and groups at risk, with Anti-Retroviral treatment. The objectives differ even more, from improving condom distribution networks and mobilizing local and international NGOs in rebel areas to scaling up testing and counseling of mothers and ensuring safe blood transfusion capacities, to providing anti-retroviral drugs.

My third observation is embedded in the descriptions of objectives: Global Fund projects accommodate multiple actors, in number and type. The different actor combinations appear to arise as "appropriate to circumstance" (as do the goals and objectives). The project in Cote d'Ivoire, for example, stressed the role of local NGOs and community groups in addressing HIV issues in rebel controlled areas, partly because government entities were not functional in such areas. The Principal Recipient managing this project was also a non-governmental agency, the local office of CARE international. The project intended to draw in support from international NGOs, local NGOs, local "clubs", and a network of local peer educators. This assortment differs substantially from the government-centered perspective on who is included in the health sector evident in 1990s World Bank projects. (Actually, the Cote d'Ivoire case turns the relational blueprint on its head, with the NGO Principal Recipient managing the Central Ministry of Health as a Sub-Recipient).

The actor mix in the Cote d'Ivoire project also differs from that in other projects, however. Two of the remaining nine projects were also managed by non-

governmental Principal Recipients (The Association Comorienne pour le Bien-Etre de la Famille (ASCOBEF) in Comoros and The Churches Health Association in Zambia), three were managed by specially created coordination bodies in government (Ethiopia's HIV/AIDS Directorate, Niger's Multiscetoral Unit for the Fight Against HIV/AIDS and Sierra Leone's National HIV/AIDS Secretariat) and four were managed by single, central government entities (Eritrea's Ministry of Health, Ghana's Ministry of Health, Guinea's Ministry of Public Health, and Uganda's Ministry of Finance). One could contrast even this with the fact that singular central government ministries were main partners for all 1990s projects reviewed.

Beyond the managing entity one also finds a broader set of actors—in different mixes—across the projects. Uganda's 2003-2005 project notes that, "The partners who will be involved in the implementation of the CCP will include Government sectors, civil society organizations (CSO's), private sector, and groups of PHA [people living with HIV/AIDS]." The actual implementation approach adopted involved the Central Ministry of Finance leading and coordinating the broader engagement, which was dominated by government entities in most respects. This is similar to Ghana's experience, where the Global Fund proposal noted the aim of catalyzing governmental attempts to deal with HIV/AIDS. District governments were the main sub-recipients in this case, and private/public partnerships were forged for specific reasons (mostly to mobilize extra human resources and facilitate service delivery). In Guinea, however, the Global Fund project was managed by a central government entity but implemented by a broad variety of players—local prefectures, the national reference library, district facilities and a wide range of NGOs who received contracts to provide key services. The Guinea project is similar to that in Cote d'Ivoire in that it also included performance metrics related to the number of community centers and NGOs created, engaged and/or strengthened—reflecting an obvious awareness of the multi-actor nature of the health sector. The two experiences are also similarly

characterized by conflict, which undermines the ability of government to access many areas and makes NGO engagement "appropriate to circumstance."

Eritrea has also been plagued by conflict and thus also found non-governmental entities circumstantially better-positioned to intervene than government. It also found these entities lacking capacity for action, however, so introduced a time-sensitive approach that had government leading initially but also building other entities to lead in future:

> "At the moment, the greatest capacity for implementation outside of the Government is in the FBOs. However, the implementation capacity of the FBOs is limited due to the nature of the personnel available, the nature of the institutions and primarily the lack of financial resources. The religious organisations in Eritrea do not provide any significant amount of preventive or curative services unlike the situation in many African countries. Our implementation strategy, therefore, focuses on Government implementation of activities and interventions in the first years of the project. We have attempted to increase the allocation of funding to our potential partners in order to build their capacity and to enable them to become more operational in the future."

I also observed broad, contextually driven, varying actor engagements in the membership and structure of Country Coordination Mechanisms (CCM). The Global Fund requires that all proposals flow through this entity, created in most cases especially for such purpose. It is one of what I see as three administrative pre-requisites for Global Fund engagement (the others being the need for a Principal Recipient (PR) to manage the program and for Local Fund Agents to facilitate on-going monitoring of project performance). As I have already suggested with the variation in PR identity, the CCMs look very different. The variation is not just about membership, however, but also about administrative structure and operation:

- Guinea's CCM has over 50 members from a broad spectrum and is chaired by the local representative of the World Health Organization. The General Meeting convenes twice a year to make major decisions, but an executive committee and technical working groups meet more

often to provide oversight to projects. It has elaborate coordination and communication mechanisms in place to facilitate its own engagement.

- Eritrea's CCM emerged from a Steering Committee created to oversee implementation of a 1990s World Bank project (called HAMSET). It has only eleven members and is Chaired by a Government Minister. It meets bi-annually to facilitate reporting to the Global Fund but also meets on an ad-hoc basis, as a full CCM. It met multiple times in a three week period running run-up to project approval in August and September 2002, for example, but then only again the next May. The organization seems more inter-personal than formal and there is no evidence of the need or function of any elaborate coordinating mechanism.

These are just two examples. The variation in membership size should give an indication of how much difference there is across all ten countries: The Comoros CCM has 27 members, Cote d'Ivoire's CCM has 25 members, Ethiopia's CCM has 14 members, Ghana's CCM has 39 members, Niger's CCM has 19 members, Sierra Leone's CCM has 25 members, Uganda's CCM has over 50 members, and Zambia's CCM has 22 members. The variation in administrative structure and implementation approach extends beyond the CCM as well. I have already mentioned differences in the organizational identities of PRs, as well as the different assortments of collaborators engaged in projects. The differences show the lack of an administrative blueprint in Global Fund engagements. Even where the interventions explicitly mention links to decentralization initiatives (as in Ghana) their contents cannot be neatly and consistently coded into categories like those in Table 2. Ghana's intervention, for example, did include steps to strengthen HIV/AIDS prevention capacities in district-level facilities, but these facilities were "public, private and mission" facilities—not just public. Facility strengthening was also one of twenty activities focused on reaching objectives, which implied different administrative relationships, control structures and such

(including mechanisms to coordinate community groups and NGOs, to disburse money directly to people living with HIV/AIDS, etc.).

One can see differences in administrative ‘solutions’ in the way project proposals describe core processes (The Global Fund requires that all proposals specify their solutions to management issues like CCM/PR relationships, Monitoring and Evaluation, Financial Management and Procurement/Supply Chain Management). Monitoring and Evaluation in Ghana was done through pre-existing government mechanisms. Project finances in Ghana flowed through the national treasury and the Ministry of Health, treated as earmarked funds. Financial management procedures were thus defined by the national standards and mechanisms (much like they would have been done in 1990s World Bank projects). In contrast, the Zambia CCM took up a special role in monitoring, committing to establish partnerships to access information needed at appropriate times. The CCM indicated, for example, that it would introduce a new special annual report on activities of NGO sub-recipients. The Zambian CCM allowed sub-recipients to use their own financial management systems and even reporting mechanisms, but did preserve the right to require some standardization of reports, as needed. Cote d’Ivoire and the Comoros had another totally different administrative approach to financial management, defined most prominently by the fact that money flowed through the NGOs and not government. The relevant NGOs (CARE in Cote d’Ivoire) signed agreements with local NGOs and then worked with these NGOs to (in CARE’s case) “design a programme of activities and an operational budget.” It thus took the responsibility of creating financial management systems in recipients appropriate to the recipient and the Global Fund intervention. This differs significantly from the 1990s model of creating standardized Management Control Systems in central Ministries of Health to accommodate management of decentralized government units.

The different administrative structures also manifest in different administrative problems, identified through the Global Fund’s regular monitoring mechanisms

(mostly by Local Fund Agents at times of disbursement). And interestingly, there is also variation in administrative solutions! In Ethiopia's case the PR is lauded as doing a good job, but weak monitoring and evaluation systems are identified as a problem, partly related to sub-par engagement of the CCM. The 'solution' involves strengthening the CCM's oversight activities and engaging the World Bank and PEPFAR project teams in supporting technical assistance for better monitoring. The non-governmental Zambian PR is commended for its good management as well: "CHAZ [Churches Health Association of Zambia] is marked by strong leadership, close coordination with their network of mission hospitals and rural health centers, and the spirit of a learning organization that accepts and embraces constructive feedback on performance." Monitoring and evaluation concerns are also raised in regard to the Zambian project, however, but they are quite different to those in Ethiopia: While CHAZ had a solid system it lacked the capacity to effectively cover all sub-recipients and ensure quality control of data. The solution was also different, involving the Local Fund Agent conducting ad hoc quality checks on data and seeking to reinforce CHAZ's monitoring and evaluation capacity by hiring an extra person.

The Zambian project also suffered some procurement problems, stemming from CHAZ's dependence on government procurement systems (through a tender board). The solution, identified through the ongoing dialog about performance and problems, was to start procuring products through an independent procurement agent. Procurement weaknesses in Guinea were one part of a general management failure, implicating the PR, CCM and strategic partners (notably UNICEF, the procurement agent). The problems were so significant that the UNDP was asked to finance technical assistance to create and run a central management unit, which worked closely with a WHO technical team to save the grant. The Comoros faced a similar management breakdown that was tackled by strengthening the capacity of the original PR, not introducing another unit. Much of its struggle is in coordinating and managing NGOs (with multiple reporting practices), and part of the solution involved standardizing the NGO processes.

Cote d'Ivoire's project was also heavy on NGO engagement (in rebel-controlled areas) but coordination and control of these entities did not pose a major problem. The complication peculiar to this circumstance centered on tensions between the Principal Recipient NGO (CARE) and the Sub Recipient Ministry of Health (and some other agencies).[4] The solution was better coordination between the two, something contextually relevant.

I am not suggesting that these were all 'solutions' in a final sense (of achieving improved administration). I am just pointing them out as further evidence of the lack of a blueprint in the newer Global Fund type health sector interventions in Africa. I believe this evidence supports the hypothesis that these interventions are in fact different in their approach to dealing with the administrative question of 'how' in Africa's health sector. They are focused on mission and results rather than structure, do not rigidly define sectoral boundaries and allow for broad and different collaborative engagements. They accommodate many different administrative structures—and indeed evolving ones (based on learning). They thus do not provide "THE ANSWER" but allow approaches that are "Appropriate to Circumstances."

Is the new approach better than the old one?

This is not an evaluation of old versus new. It is rather a comparison of a set of projects in one era and another set in a new era. Thus far I have tested two hypotheses that combine to say, "The newer projects look very different to the old." I have presented evidence that I believe lends considerable support to these hypotheses and the conclusion that the shift from old to new projects presents a move away from prescribing "THE ANSWER" to administrative problems in African health care to allowing organic emergence of answers "appropriate to circumstances."

[4] The Grant Performance Report notes that, " There has been some resistance from other agencies to be coordinated by CARE.."

The third hypothesis introduced earlier proposed that the newer projects would be better than the old—yielding greater levels of implementation and impact. This section reviews the evidence to assess if such hypothesis is also supported by the current study. The review is complicated by the fact that the two types of documents referenced for information for old and new project types provide quite different perspectives on 'performance.' Table 3 shows the metrics they use, for example, with the 'old' World Bank projects assessing project outcomes on an ordinal basis with three options (Unsatisfactory, Satisfactory and Highly Satisfactory) as well as scoring the likelihood of sustainability and institutional development impact (like administrative strengthening). The Global Fund performance reports and Grant Scorecards use an ordinal scale as well, with four options, to indicate if the project's overall performance is excellent, adequate, inadequate or unacceptable (A, B1, B2 and C).

Table 3. How the projects were 'rated' in respective documents

	'Old' World Bank projects			New Global Fund Projects
	Outcome	Sustainability	Institutional development impact	Performance rating
Comoros	Unsatisfactory (1 of 3)	Unlikely (1 of 3)	Modest (2 of 3)	A (1 of 4)[5]
Cote d'Ivoire	Unsatisfactory (1 of 3)	Unlikely (1 of 3)	Negligible (1 of 3)	A (1 of 4)
Eritrea	Unsatisfactory (1 of 3)	Likely (2 of 3)	Substantial (3 of 3)	B1 (2 of 4)
Ethiopia[6]	Moderately Satisfactory (2 of 3)			B1 (2 of 4)
Ghana	Satisfactory (2 of 3)	Likely (2 of 3)	Substantial (3 of 3)	A (1 of 4)
Guinea	Satisfactory (2 of 3)	Likely (2 of 3)	Substantial (3 of 3)	B1 (2 of 4)
Niger	Unsatisfactory (1 of 3)	Unlikely (1 of 3)	Modest (2 of 3)	B2 (3 of 4)
Sierra Leone	Satisfactory (2 of 3)	Unlikely (1 of 3)	Substantial (3 of 3)	A (1 of 4)
Uganda	Unsatisfactory (1 of 3)	Likely (2 of 3)	Substantial (3 of 3)	B1 (2 of 4)
Zambia	Unsatisfactory (1 of 3)	Likely (2 of 3)	Modest (2 of 3)	A (1 of 4)

One useful observation drawn from the table is that there is variation in results in both old and new projects! Another is that the worst performer on the new projects (Niger, the only one to get a B2 in the sample) was also a poor performer in the old project regime (producing unsatisfactory outcomes, unlikely sustainability and only modest institutional development impact). Two of the

[5] This score was taken from the Global Fund's summary of projects, not the Scorecard, which suggests a B1 outcome instead.
[6] World Bank assessment approach changed for this, the most recent project.

three countries with ‘satisfactory’ 1990s projects also scored A’s on the new Global Fund projects (Ghana and Sierra Leone). Three of the countries in which 1990s projects were marked ‘unsatisfactory’ managed to get highest rated ‘A’ Global Fund project results, however (Comoros, Cote d’Ivoire and Zambia).

One should note that the older World Bank projects in these three countries were adjudged as achieving only ‘modest’, ‘negligible’ and ‘modest’ improvements in institutional (essentially administrative) development. This undermines any thoughts readers might have of suggesting that strong Global Fund project performance now was facilitated by the older projects in the past (at least in these projects). Experience in the Comoros suggests a lack of acceptance of the blueprint decentralization approach, especially with the strong role of the central Ministry of Health (and the national planning mechanism at its disposal):

> “The project had a moderate impact on the institutional development of the sector. Support for decentralization was already firmly established… [but] … Health sector support and the project’s own initial objectives for implementing a national poverty reduction strategy were far less broadly accepted … Conflicts between the central and island authorities contributed to the underutilization of documents offering options for strengthening the sector…”

The World Bank project in Cote d’Ivoire was judged as having “positive but negligible” institutional impact, largely because of a lack of incentives to actually implement the new administrative ‘tools’:

> “The project has developed a series of structures, tools and procedures … [but] … a major effort is likely needed to establish incentives that encourage effective utilization of the tools.”

Zambia’s Implementation Completion Report suggests limited success in strengthening the health sector, which it explains at various points in terms of low capacity in local entities and varying levels of buy-in across actors and over time. It concludes that, at project conclusion,

> “Financial management, procurement planning and logistics management, monitoring and evaluation, and human resource capacity are still considered to fall short of what is required for an effectively functioning decentralized system.”

One should note further that the institutional approach taken in the three more successful Global Fund projects was significantly different to the 1990s World Bank projects. The biggest difference was management by non-governmental organizations. Did the fact that the new project type allows different administrative leadership accommodate better results? The Global Fund would probably argue so, and cite its finding that projects managed by civil society organizations perform better on average than those managed by government organizations.[7] It could also point to the fact that NGO leadership—while not easy—was contextually appropriate in Cote d'Ivoire given the lack of government reach into rebel-controlled areas: "CARE is doing a good job trying to bring together agencies working in the northern part of the country which is under the control of the 'New Forces' and thus somewhat out of touch with HIV efforts of the government in Abidjan." It could also cite the potential its Zambian project tapped in the faith-based community, which allowed a contextually appropriate and accepted form of health sector decentralization different to the blueprint type the 1990s project failed to institute:

> "[The] Program … enables the expansion of a comprehensive response to HIV/AIDS, ranging from prevention to mitigation to treatment activities. It concentrates on mobilizing the faith-based community and strengthening delivery of services at health facilities run by religious institutions."

This kind of argument can only get one so far, however, in trying to suggest that newer projects have better implementation and impact than old ones. More focused evidence is required, allowing active comparison between results in the two types of projects in the same country setting. Arguably, this evidence is available, through qualitative descriptions and quantitative data. Consider what documents say about Cote d'Ivoire's older and newer projects (as well as what some of the numbers show):

The older project **The newer project**

[7] Referencing the Global Fund's report on Civil Society Organizations (undated, at http://www.theglobalfund.org/ru/partners/ngo/introduction/): "Year-end figures from 2006 show that 83 percent of civil society PRs were A or B1-rated. Civil society as an entity received the largest percentage of A and B1-ratings (28 percent A-rated and 55 percent B1-rated) in comparison to the other entities involved in grant implementation."

The 1996-2004 project	The 2006-2008 project
The 1996-2004 project is rated "unsatisfactory" and "no data can be made available to support any significant improvement for the period … with regard to overall performance of the health system … with the exception of the General Census."	The 2006-2008 project is given an "A", as "Most of the intended results have been achieved or largely exceeded"
Key results (related to Project Development Objectives (PSOs)) include: • The main 'achievement' noted is the completion of a General Census of the population (including publication). • Percentage of deliveries correctly assisted has increased from 44 to 63. • Number of curative consultations per annum per 100 inhabitants has dropped form 24 to 21. • One functional unit has been created for the MoH to support districts. • 95 Health facilities were equipped to provide family planning services (compared with the goal of 106). • 4 programs were resuscitated in the context of addressing 'post conflict needs' (short of the targeted 8). • Five other PDOs were not addressed at all.	*Key results include:* • By period 6, 169 wholesalers and sub-wholesalers have a regular supply of condoms available (compared with baseline of 10 and target of 70 by this period) • 85 local NGOs/Community Associations and International Organizations regularly distributing condoms (minimum of 500 per month) (compared with baseline of 2 and target of 30 by this period) • 5,645,019 condoms sold (compared with target of 4,600,000). • 20 departments in the target areas with HIV prevention activities (compared with baseline of 1 and target of 20 by this period) • 119 Military camps have HIV prevention activities (compared with baseline of 0 and target of 20 by this period) • 85 Local NGOs strengthened and supported (compared with baseline of 0 and target of 20 by this period) • 33 additional Anti-AIDS clubs developed (compared with baseline of 0 and target of 30 by this period) • And five other similar references.

The side-by-side comparison should show that the newer project performance information is more tangible and 'sharper' than the older one. It is also arguably easier to attribute results to the intervention. The newer project is obviously more effectively implemented than the older one, but it is difficult to assess impact of either (the first project has no information on this and the latter is too new for the data—measures of such are slated for two and three years out in the project monitoring and evaluation plan). One can do this kind of comparison on all ten projects. In most cases one will find a clearer focus on performance and tighter attribution of project activities to performance in the new projects and hence the appearance of better implementation and potential impact. This is even the case when one compares Ghana's Satisfactory World Bank project with its "A" Global Fund Project.

The completion report from Ghana's 1998-2000 project provides a table of outputs and outcomes according to which the project was judged. The outputs include "outpatient visits per capita", "births attended by skilled health staff", "TB cure rate", "proportion of children using bed nets" and others. Four out of seven fell short of achieving projected rates (one—the proportion of children using bed nets, actually showed lower end numbers than the 1996 baseline). The outcomes include "percentage of government recurrent budget spent on health", "infant mortality rate", "life expectancy years" and "percent under-fives underweight". Six of seven achieved outcomes were below projected goals. The completion report also asks whether the project should be credited with such outcomes: "The question remains as to whether or not these gains were influenced by [the project]." Even with this evidence and qualification, the project was considered effective, based largely on the qualitative statement that "the overall sector program is on track and the implementation is successful [yielding] the specific details of activities … less important."

Compare this with the opening paragraph in Ghana's Global Fund project scorecard:

> "The program's overall performance is good, and it has exceeded targets for key indicators. In particular, 6,698 people completed the voluntary testing and counseling process (135% of target), an additional 4,399 pregnant women completed the testing and counseling process as part of the prevention of mother-to-child transmission pilot program (146% of target), 884 HIV-infected women received a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission (98% of target), and 6,404 people received prophylaxis and treatment for opportunistic infections (101% of target)."

I cannot vouch for these or any other numbers in the documents analyzed. I can say, however, that what they communicate is a clear level of project implementation, with direct outputs one could well see connected to significant outcomes and impacts. My tendency to believe the numbers is supported by the up-front discussion of project shortcomings as well:

> “The grant was less successful reaching people in its prophylaxis and treatment for people with opportunistic infections, antiretroviral therapy (ARV) and monitoring, and care and support service delivery areas. This poorer performance was primarily due to program management issues, particularly in procurement.”

Inherent in this statement is the idea that performance information is not just provided to show good versus bad performance but, perhaps more importantly, to facilitate dialog and action to improve performance in the future. This kind of comment is present in all ten Global Fund projects and is a major reason why I do believe the projects end up with higher levels of implementation and potential impact than their predecessors (even if they start slowly, as was the case in six of the ten analyzed).

Interestingly, this performance-based learning characteristic is evident in the discussion of both the Ethiopian and Sierra Leonean World Bank projects. As discussed, the Ethiopian project also shares the general performance emphasis with Global Fund projects, and is in many ways a peer (produced in late 1999 and running to 2006). The Sierra Leonean project, though initially conceived in 1996 and closed in 2003, was also in many ways alike the Global Fund type projects. This was because the project was largely derailed until 2000 by civil war and unrest. It was then re-defined in 2000 when it incorporated performance metrics and largely adjusted its focus to “address priority health needs … taking appropriate … measures.” The ability to re-draw the project is attributed to “built-in flexibility in the project design” which, like Global Fund projects, allowed adjustments on the basis of regular performance assessments (in this case annual planning processes). The Implementation Completion Report credits the flexible adjustment and emerging performance approach with a positive result in which “a number of accomplishments materialized.” It is important to note that results were stronger and more tangible in the objective area that emphasized major public health issues (like maternal and child health and HIV/AIDS) than in the more dominant “Reform the Health system” objective area (which continued to promote a blueprint decentralization model): while a central store and 12 district

offices were created, the $3 million rehabilitation of district hospitals was completely shelved because it not was no longer a priority, "appropriate to the circumstances."

I would argue that the Sierra Leonean project exhibits within itself the transition from older approaches to providing an administrative blueprint to the newer approach of accommodating flexibility in administrative solution. I would argue further that qualitative evidence exists suggesting the superiority of the 'newer' approach in Sierra Leone. I have also tried to present such evidence in comparing most of the older World Bank projects with newer Global Fund projects. I believe this evidence too suggests superiority of the new approach, supporting the hypothesis that the newer approach is better than the older one.

CONCLUSION

African health outcomes are way behind the rest of the world. The continent has no time to waste in rectifying the problem. But this will require generating solutions to major administrative weaknesses in the continent's health sector. I look at two approaches to this challenge, implied in projects in the development community in the 1990s and more recently via the Global Fund. The former projects present a routine solution or THE ANSWER in the form of a specific blueprint for organizing government. The second set of projects allows much more flexibility of administrative solution, centered on allowing sectors to work out how they will meet tightly defined objectives. This approach accommodates solutions that are "appropriate to circumstances" which emphasize creating 'space' in which management solutions can be appropriately fashioned rather than forcing square peg models into round peg countries.

The approach implies thinking by many giants of management. I see hints of Tom Peters' loose-tight model here (with tightly defined objectives and regular

monitoring, but loose accommodation of innovative solutions and ideas). I also see Hirschmann's Hiding Hand principle—of not over-planning and over-specifying solutions but rather allowing creativity. I also think Lindblom's "Muddling Through" ideas are relevant—emphasizing the importance of managers (especially in political settings) working through problems in a dynamic and creative fashion. While development approaches often recommend one-size-fits-all models of management (and more recently governance) these giants emphasize experimentation, differential fit and learning by doing.

I think that these thinkers would have approved of this approach, and the Global Fund model, even though it has its weaknesses (reflected in critiques of vertical funds, the lack of direct technical assistance, sustainability, etc.). I sense they would approve that the new approach acknowledges (i) the importance of administration being about service (and mission), (ii) the messiness of administrative tasks and settings, (iii) the multiplicity of actors potentially involved, and (iv) the importance of administrative creativity. The approval could reflect this paper's evidence that the new approaches are different to the old approaches, and seem to yield higher levels of implementation and impact. It could also be more focused, relating that the new approach seems to work even in conflict environments like Cote d'Ivoire, where other interventions failed miserably; or that strong results were recorded in countries like Sierra Leone regardless of near-to-no human resource capacity in the health sector.

The most positive aspect of the new approach, in my own opinion, is that these sectors were, possibly for the first time, starting to define themselves and set a path for their future development. There is growing evidence that administrative systems develop over time, along dynamic paths, and not in moments where blueprint best practices are imported for use. Administrative solutions should emerge as appropriate to circumstance, reflecting a path determined by context. Much like teenagers need structured space to find themselves rather than prefabricated answers to who they should be. I believe the new Global Fund

approach to fostering mission driven solutions to Africa's health care administration problems can create such structured space, and is much preferred to the old approaches based on THE ANSWER. Future research would be well-placed to test this belief further.

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