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# STRENGTHENING HEALTH SYSTEMS – IMPORTANT BUT CHALLENGING FOR SWEDISH HEALTH AID

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The Expert Group for Aid Studies (EBA)

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# Foreword by EBA

Health systems strengthening (HSS) has long been a central focus of Swedish health aid. The purpose of this evaluation is to contribute to a better understanding of how Swedish bilateral aid supports HSS and what effects this support has. To answer the evaluation questions, an initial descriptive mapping of Swedish HSS interventions in six countries (Democratic Republic of Congo, Somalia, Zambia, Uganda, Bangladesh and Myanmar) was performed. The evaluation focuses on the effects, efficiency, and coherence of Sweden's support to HSS in two of those countries – Bangladesh and Uganda – between 2013 and 2023.

The evaluation is intended to inform policymakers, managers, aid practitioners, and researchers at the Ministry for Foreign Affairs, embassies, Sida, and other government agencies engaged in international cooperation and global health. It is also relevant for to civil society organizations and stakeholders within Team Sweden, Team Europe, the UN system, and other multilateral organizations.

The study has been guided by a reference group chaired by Andreas Wladis, member of EBA. The authors bear sole responsibility for the content of their respective chapters.

Stockholm, March 2026

Torbjörn Becker,
EBA Chair

Andreas Wladis,
Chair of the Reference group

# Sammanfattning

Under de senaste decennierna har många låg- och medelinkomstländer gjort betydande framsteg när det gäller att förbättra befolkningens hälsa. Mödradödlighet och barnadödlighet har minskat, vaccinationstäckningen har ökat och tillgången till kvalificerad förlossningsvård har förbättrats. Samtidigt står många länders hälso- och sjukvårdssystem fortfarande inför betydande utmaningar, bland annat begränsat finansiellt skydd, brist på personal och svag styrning. Dessa utmaningar har bidragit till en ökad uppmärksamhet på vikten av att stärka länders hälso- och sjukvårdssystem (health system strengthening, HSS) inom internationellt utvecklingssamarbete.

Denna utvärdering analyserar Sveriges bilaterala hälsobistånd under perioden 2014–2023 i sex länder – Uganda, Bangladesh, Zambia, Somalia, Myanmar och Demokratiska republiken Kongo – med särskilt fokus på Bangladesh och Uganda. Syftet är att bedöma i vilken utsträckning svenskt stöd har bidragit till långsiktiga och hållbara förbättringar i hur hälso- och sjukvårdssystemen fungerar, samt att identifiera faktorer som har möjliggjort eller begränsat sådana bidrag.

## Resultat

Utvärderingen visar att stärkta hälso- och sjukvårdssystem inte har varit ett uttryckligt mål i Sveriges bilaterala samarbetsstrategier under den studerade perioden. De flesta insatser har i stället fokuserat på att förbättra tillgången till vård, öka utbudet av vård eller stötta utbildning av vårdpersonal. Dessa insatser har bidragit till viktiga hälsovinster, men har i begränsad utsträckning syftat till att förändra de strukturer och incitament som påverkar hälsosystemens långsiktiga funktion och prestation.

Samtidigt identifierar utvärderingen några exempel där svenskt stöd har bidragit till mer långsiktiga systemförändringar. Sveriges långvariga stöd till utvecklingen av en professionell barnmorskekår i Bangladesh har bidragit till att institutionalisera barnmorskor inom det of-

fentliga hälsosystemet och till att förbättra mödra- och neonatalhälsan. I Uganda har svenskt stöd till ett program för resultatbaserad finansiering bidragit till förändringar i hur primärvården finansieras och styrs.

## Slutsatser

Sveriges bidrag till starkare hälsosystem har gett bäst resultat när stödet varit långsiktigt, samordnat med nationella prioriteringar och genomförts i nära samarbete med regeringar och institutionella partners. Samtidigt har fragmenterade programportföljer, begränsningar kring i vilken utsträckning biståndet stöttar arbete genom offentliga system och brist på tydlig vägledning kring HSS begränsat möjligheterna till mer genomgripande systemförändringar.

Utvärderingen pekar på behovet av ett mer strategiskt och samordnat arbetssätt om Sverige i högre grad ska kunna bidra till att stärka hälso- och sjukvårdssystem i partnerländer. Detta inkluderar att tydligare formulera HSS som ett strategiskt mål, stärka samarbetet med partnerländernas regeringar samt utveckla vägledning och kompetens för utformning och uppföljning av systeminriktade insatser.

Våra resultat ligger i linje med bredare diskussioner inom globalt utvecklingssamarbete inom hälsa. Nya initiativ såsom Lusaka-agendan och Accra Reset betonar behovet av mer samordnade, landsledda och systemorienterade arbetssätt. Dessa initiativ understryker också vikten av ökad inhemsk finansiering för hälsa, starkare primärvård och bättre samordning mellan utvecklingspartners. Vi menar att dessa globala förändringar ger Sverige en möjlighet att ompröva hur bilateralt hälsobistånd mer effektivt kan bidra till att stärka nationella hälso- och sjukvårdssystem.

# Summary

Over the past twenty-five years or so, many low- and middle-income countries have made significant progress in improving population health. Rates of maternal, neonatal and child mortality have declined, vaccination coverage has expanded, and access to skilled birth attendance has increased. Progress toward universal health coverage has improved, although unevenly. At the same time, health systems in many countries continue to face substantial constraints. Financial protection remains weak and a large share of households in many countries still risk catastrophic health expenditure when using medical services. Health systems are also challenged by limited domestic financing, human resource shortages, and governance and accountability problems. These persistent challenges have contributed to a growing recognition of the importance of health system strengthening (HSS) in international development cooperation, including within Swedish development assistance for health.

Sweden's development cooperation policy emphasizes improved health for the most vulnerable and recognizes that stronger health systems are key for achieving this objective. Although health system strengthening is referenced in policy documents, it has been unclear to what extent Swedish bilateral development assistance for health contributes to long-term health system strengthening in partner countries. This evaluation has reviewed Sweden's bilateral health aid during the period 2014 to 2023 in six countries (Uganda, Bangladesh, Zambia, Somalia, Myanmar and the Democratic Republic of Congo), with particular attention to Bangladesh and Uganda. The purpose has been to assess whether Swedish support has contributed to sustainable improvements in how health systems function and perform in these countries, and to identify factors that have enabled or limited such contributions.

## What is health systems strengthening?

A clear conceptual understanding of health system strengthening is essential for assessing the performance of health systems. In the general health policy literature, HSS refers to efforts that lead to lasting improvements in the functioning of the health system. Such efforts target the core functions of the system, including stewardship, financing, service delivery, and resource generation. They also address the underlying performance drivers, including policies, regulations, and organizational structures across the entire health system, that influence whether the system can deliver equitable, quality and efficient care.

HSS is therefore different from health system support. Health system support focuses on short-term inputs such as training, commodities or equipment that help the health system maintain, or even increase, operations but do not improve how the system performs over time. Many interventions that are described as strengthening the health system do not meet this definition. While such health system support programmes can produce valuable short-term improvements, they do not alter the underlying rules, incentives or capacities that shape long-term system performance.

## Findings from the evaluation

Based on the generally accepted definition of health system strengthening, several overarching conclusions emerge from the evaluation. The first is that **health system strengthening is not an explicit objective in Sweden's bilateral country cooperation strategies** during the evaluation period. Although the strategies often acknowledge the importance of strong health systems in the description of country challenges, the goals and sub-goals are formulated in terms of improved basic health, increased access to health care, or enhanced access to sexual and reproductive health and rights. These formulations do not necessarily imply a focus on health system strengthening. Since Sida is expected to structure and report its re-

sults in relation to these strategic goals, the absence of HSS as an explicit objective has influenced both programme design and expected results.

This is reflected in the portfolio of bilateral health programmes reviewed in Bangladesh and Uganda. **Out of the twenty-three programmes reviewed, only a small number had objectives that could be interpreted as targeting health system strengthening explicitly,** as HSS is defined in this evaluation. Most of the programmes focused on expanding service provision, improving access, providing training, or supporting specific service delivery functions. These activities produced important health gains and were valued by partners. However, they did not generally aim to change the performance drivers of the system. As a result, these programmes could not lead to sustained improvements in system performance once external support concludes.

Despite this overall pattern, **the evaluation identified a few cases where Sweden has contributed meaningfully to health system strengthening.** Out of the contributions evaluated, the most prominent example is Sweden's long-standing support to the midwifery reform in Bangladesh. Over a period of more than a decade, Sweden has supported UNFPA and the Government of Bangladesh in developing and consolidating a professional midwifery cadre. This has included support to regulatory systems, midwifery education, deployment and supervision structures, and the introduction of midwife-led models of delivery care. These interventions relate to several core functions of the health system and have helped to institutionalize midwives within the public health system and contributed to improved maternal and neonatal health outcomes. Importantly, the Government of Bangladesh now finances salaries for midwives, which indicates national ownership and enhances sustainability. The Bangladesh example demonstrates how sustained and coordinated engagement over time can contribute to system transformation.

A second example is Sweden's support to the World Bank-led "Uganda Reproductive, Maternal and Child Health Services Im-

provement Project" (URMCHIP). This programme introduced new financial incentives, strengthened reporting and verification systems, and created greater accountability for service delivery performance. The Ugandan Government subsequently adopted and integrated a modified results-based financing (RBF) model into its national health financing system. Although the mainstreamed version differs from the original programme and provides more limited autonomy at facility level, the decision to institutionalize RBF represents a significant shift in the financing and governance of primary health care. Sweden's contribution to the programme helped to enable this policy development.

**These two case studies illustrate characteristics that have supported Sweden's contribution to HSS. In both Bangladesh and Uganda, Sweden's engagement was long term, coordinated with government priorities, and implemented through partners with strong technical and institutional mandates.** Respondents emphasized that Sweden's approach, including its predictability, flexibility, emphasis on equity and long-term commitment, allowed for constructive dialogue and contributed to an enabling environment for reform. These ways of working do not, in themselves, constitute HSS, but they facilitate HSS when combined with programmes that target underlying system performance drivers.

At the same time, several constraints have limited Sweden's overall contribution to health system strengthening. The bilateral portfolios in Bangladesh and Uganda have often been fragmented, and it was difficult to identify a coherent strategy aimed at system transformation. A very small share of Swedish bilateral health aid has been channelled through recipient governments, and this share has decreased over time. Since governments are the main actors responsible for system reform, limited engagement with government systems reduces the scope for influencing core health system functions such as financing, governance and resource generation. Further, Sida's internal capacity to design and monitor HSS-focused programmes is uneven, and there is no institutionalised guidance on what consti-

tutes HSS or how to track it. In addition, country-level political, economic and institutional constraints limit the feasibility and sustainability of system reforms, regardless of donor intent.

Our findings are consistent with broader discussions in global development cooperation. Recent initiatives such as the Lusaka Agenda and the Accra Reset highlight the need for more coherent, country led and system-oriented approaches. These initiatives also stress the importance of domestic financing, stronger primary health care, and improved coordination among development partners. We argue that the current global shifts provide an opportunity for Sweden to reassess how bilateral health assistance can more effectively support system strengthening.

## Conclusions and implications

Based on the findings of this evaluation, several implications follow. If Sweden aims to contribute more consistently to health system strengthening, HSS needs to be articulated as an explicit strategic objective in the government's bilateral cooperation strategies. Without such direction, HSS will likely remain incidental. Working more closely with partner governments is essential for system reform, as is strengthening Sida's internal competence and developing clearer guidance on HSS oriented programme design. **Future programmes would benefit from focusing more directly on performance drivers rather than short-term outputs.** Greater coherence and coordination between Swedish bilateral, regional and global engagements could also enhance effectiveness.

In conclusion, **Sweden has demonstrated that it can contribute to health system strengthening when support is long term, coherent, and aligned with government led reforms.** The contributions to midwifery reform in Bangladesh and financing reform in Uganda are clear examples of this. However, such contributions have been the exception rather than the norm during the evaluation period. A more strategic, institutionally supported and government

aligned approach would enable Sweden to more effectively support partner countries in strengthening their health systems and advancing progress toward universal health coverage.

# Abbreviations

| | |
|---|---|
| BMS | Bangladesh Midwifery Society |
| BNMC | Bangladesh Nursing and Midwifery Council |
| CBO | Community-based organization |
| DAH | Development assistance for health |
| DRC | Democratic Republic of Congo |
| DPT3 | 3rd dose of the diphtheria, tetanus and pertussis vaccine |
| Gavi | The Vaccine Alliance |
| GNI | Gross national income |
| HRH | Human resources for health |
| HPNSP | Health, population and nutrition sector programmes |
| HSS | Health systems strengthening |
| IOM | International Organization for Migration |
| LMICs | Low- and middle-income countries |
| MDGs | Millenium development goals |
| MoH | Ministry of Health |
| MoHFW | Ministry of Health and Family Welfare |
| NGO | Non-governmental organization |
| ODA | Official development assistance |
| OECD CRS | Organisation for Economic Co-operation and Development - Creditor Reporting System |
| OECD DAC | Organisation for Economic Co-operation and Development - Development Assistance Committee |

| | |
|---|---|
| OOPE | Out-of-pocket expenditure |
| PHC | Primary health care |
| RBF | Results-based financing |
| SDGs | Sustainable development goals |
| SEK | Swedish Krona |
| SRHR | Sexual and reproductive health and rights |
| UHC | Universal health coverage |
| UN | United Nations |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| UN Women | The United Nations Entity for Gender Equality and the Empowerment of Women |
| URMCHIP | Uganda Reproductive, Maternal and Child Health Services Improvement Project |
| USD | United States Dollar |
| WASH | Water, sanitation and hygiene |
| WHO | World Health Organization |
| WB | World Bank |

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# Introduction

Over the past 25 years, the world has witnessed unprecedented improvements in health in low- and middle-income countries (LMICs). Key health indicators have improved across the globe, including significant improvements in maternal-, under five- and neonatal mortality. Other indicators show that access to care has also improved. More births are attended by skilled health personnel, more women are receiving antenatal care, and more children are vaccinated. More people also have access to essential health care services, as indicated by the composite Universal Health Coverage (UHC) service coverage index which the World Health Organization (WHO) use to monitor UHC progress.

However, despite this progress, significant health challenges remain and are being further exacerbated by recent global aid cuts. The COVID -19 pandemic also contributed to major setbacks for global health in multiple ways (Ahrne & Sundewall, ed., 2024). Mortality indicators in LMICs are still much higher than the Sustainable Development Goals (SDG) targets and most countries are not on track to reach the Agenda 2030 goals. Many people also remain at risk of financial hardship due to seeking healthcare as mechanisms for ensuring financial protection are weak.

## Strengthening health systems

The health system is the backbone for effective, equitable, and sustainable healthcare delivery in any country. In LMICs, however, health systems often face significant challenges, including limited financial resources, workforce shortages, weak governance, and insufficient infrastructure. These constraints not only impede the capacity to deliver essential health services but also hinder progress towards UHC and the SDGs.

Given these challenges, strengthening health systems in LMICs has been a policy priority of development cooperation globally and for

Sweden for a long time. As an example, one of the thematic priorities of the current Swedish government's aid policy is "improved health for the most vulnerable" and one of three objectives under this thematic priority is to contribute to stronger health systems (Regeringskansliet, 2023).

Stronger health systems can be understood as an enhanced capacity to achieve the core goals of all health systems: improving population health, expanding access to quality care, and ensuring financial protection against high out-of-pocket health expenditures. Consequently, health systems strengthening (HSS) has become an objective of many international development partners and aid programs. HSS represents a broader approach in health aid and includes effects beyond more disease specific programs. That is why both the Global Fund[1] and Gavi[2], organizations mostly providing disease or intervention specific health aid, also emphasize health systems strengthening in their programs. Furthermore, the interest in HSS reflects a recognition that unless development assistance for health also contributes to stronger health systems, efforts are unlikely to be sustained beyond the duration of the aid program. Focusing on HSS has also been a way for aid agencies to mitigate the concern that aid focusing on specific diseases or discrete interventions create inefficiencies and contribute to fragmenting or even weakening country health systems (Hafner & Shiffman, 2012).

[1] The Global Fund is a worldwide partnership to defeat AIDS, tuberculosis (TB) and malaria and ensure a healthier, safer and more equitable future for all (www.theglobalfund.org).

[2] Gavi, the Vaccine Alliance is a public-private partnership that helps vaccinate more than half the world's children against some of the world's deadliest diseases (www.gavi.org).

# This assignment

The overall objective of our work has been to

- evaluate the effectiveness of Swedish bilateral development assistance for health in contributing to health systems strengthening and to
- identify the underlying factors that have influenced both success and limitations of HSS support.

The assignment was to evaluate Swedish bilateral development assistance for health (DAH) during the period 2014-2023. The terms of reference further specified that the evaluation should cover six countries: Uganda, Bangladesh, Zambia, Somalia, Myanmar and the Democratic Republic of Congo (DRC), with a particular focus on support to Uganda and Bangladesh. During the evaluation it became evident that Sweden's support to HSS in the focus countries, Uganda and Bangladesh, must be understood in a historical context and our case studies and country descriptions therefore consider developments also before 2014.

## Evaluation questions

1. How much bilateral DAH has Sweden disbursed and what areas has it focused on?
2. How and to what extent is HSS reflected in Swedish bilateral strategies and policies for development cooperation?
3. To what extent has Swedish bilateral DAH to Bangladesh and Uganda targeted HSS?
4. What are the effects of Sweden's bilateral DAH to HSS in Bangladesh and Uganda during the evaluation period and are the effects sustainable?
5. Overall, does Swedish bilateral DAH contribute to health system strengthening?

6. What are the main lessons and recommendations from the evaluation?

For evaluation questions 1 and 2 we cover all six countries (Uganda, Zambia, Somalia, Myanmar, DRC and Bangladesh). For evaluation questions 3–5 we focus on Uganda and Bangladesh. For evaluation question 6, we use all the material collected to discuss the implications of our findings and make suggestions for how Swedish support for HSS could be improved.

## Outline of the report

The report is structured as follows. First, we provide important background information for the evaluation, including a section on Swedish health aid and a brief review of the literature on health system strengthening. We briefly describe the methods used. Finally, we present the results of the evaluation, structured around the evaluation questions. We conclude with a set of recommendations aimed at the Swedish government and Sida for how to improve support for HSS in the future.

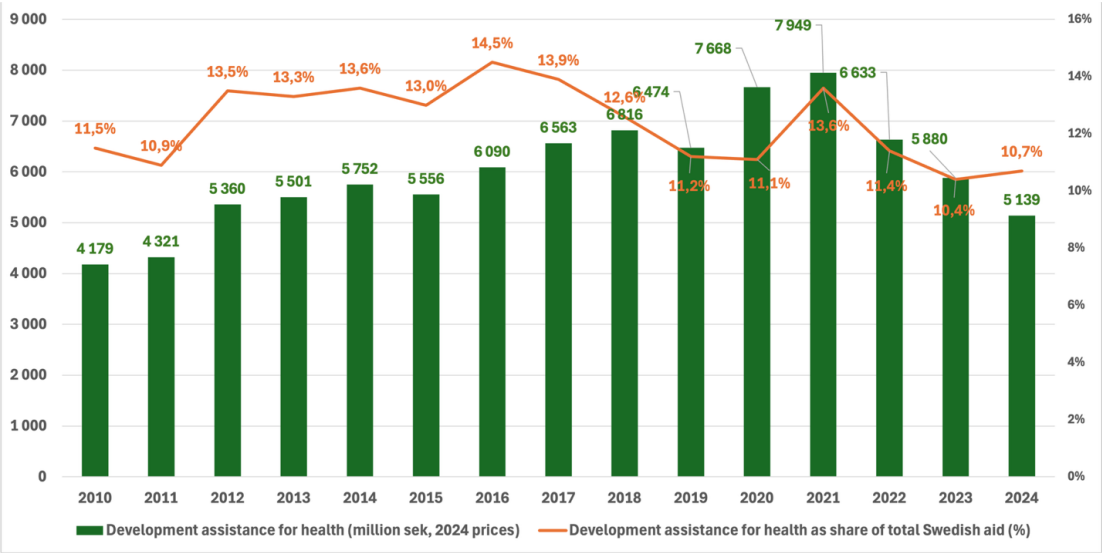
# Background

## General overview of Swedish development assistance for health

Health and sexual and reproductive health and rights (SRHR) remain priorities in Sweden's international development cooperation. These areas are part of the current government's aid policy: *Development assistance for a new era – freedom, empowerment and sustainable growth,* which emphasizes long-term, transparent, and effective aid that reaches the most vulnerable populations (Regeringskansliet, 2023).

In 2024, Sweden's total development assistance for health amounted to SEK 5.1 billion, and for SRHR SEK 2.7 billion, representing slightly higher shares of overall aid compared to 2023. DAH has constituted between 10.4–14.5% of total Swedish aid during the period 2010–2024 (Regeringskansliet, 2025). From 2022, there has been a sharp decline in both the level and the share of DAH. This is partly explained by the overall decrease in development assistance. The current government abandoned the target of spending 1% of the gross national income on official development assistance (ODA). It is also a consequence of Swedish aid being increasingly focused to Ukraine after Russia's full-scale invasion in 2022.

**Figure 1. Development assistance for health, share and amount, 2010–2024**




Sources: Official reports on Swedish health aid from 2012, 2016, 2018, 2021, 2024 and 2025. (Amounts are adjusted for inflation using consumer price index from Statistics Sweden and reported in 2024 prices.)

Swedish development assistance for health is channelled both through the Ministry for Foreign Affairs (primarily as core support to multilateral organisations) and through Sida (via bilateral, regional and global programmes). Swedish development assistance is governed by strategies (bilateral, regional and thematic strategies). The different strategies set goals and commit resources over a defined period (normally 3-5 years). For example, in December 2024 the government decided on a new health and SRHR strategy: Strategy for Sweden's development cooperation for health and sexual and reproductive health and rights, 2025–2029, together with an indicative commitment of resources of SEK 4.3 billion. There is also a regional SRHR strategy for Africa and several bilateral strategies where health is one of the overall goals. SRHR goals are also found in the Strategy for gender equality and women's and girls' freedom and empowerment 2025–2028.

The current government has announced their intention to reduce the number of strategies and the number of countries Sweden work with using the argument that this will make aid less fragmented and thereby more effective. According to Sida's annual report for 2024, 46 strategies where in force: 26 country strategies, 12 thematic strategies and 8 regional strategies (Sida, 2025).

Swedish development assistance for health channelled through the Ministry for Foreign Affairs mainly consist of core contributions to the UN and other international organizations. Substantial support is provided to organizations such as UNFPA, UNICEF, The Global Fund and Gavi. These contributions are normally announced on an annual basis as part of the regular government budget process for Sweden's international aid. In addition to financial support, Sweden also play a role in global health governance, holding board seats in Gavi, UNFPA, the World Bank (WB), UNICEF, and UN Women, and serving as an alternate on the Global Fund board (Regeringskansliet, 2025).

In summary, Swedish development assistance for health is implemented across several different strategies, partners and focus areas. In this report, we focus on Swedish bilateral development assistance for health, i.e. DAH that is provided under a specific country strategy. In the results section we describe the trends for bilateral DAH in the six focus countries where health has been part of the strategies' goals. The total number of country strategies where health and SRHR is a priority sector varies from year to year, as bilateral aid is being phased out from many countries and priorities change. In 2023, health and SRHR were targeted in nine bilateral strategies (Afghanistan, Bangladesh, Democratic Republic of Congo, Myanmar, Somalia, South Sudan, Uganda, Zambia and Ukraine)[3].

[3] Sida Portfolio Overview Health 2023 https://cdn.sida.se/app/uploads/2024/06/14091150/62702_Portfolio_Overview_Health_2023_WEB.pdf

# Definitions of key concepts

In this section we give a brief description of what constitutes a health system. We then explain what health system strengthening is and how HSS differs from health systems support. Lastly, we present an analytical framework outlining how we have approached evaluating if and how Sweden's bilateral DAH has contributed to health systems strengthening.

## What is a health system?

A health system is often described as having four key functions (service provision, stewardship, financing and resource generation). *Service provision* involves providing effective, safe, and quality health services to the population. *Stewardship (governance)* refers to leadership, regulation, and policymaking to guide and oversee the entire health system. Financing includes raising funds, pooling resources, and purchasing services to ensure people can access care without financial hardship. *Resource generation* focuses on producing essential inputs like trained health workers, medicines, technologies, and infrastructure. The four functions all contribute to three overall goals (health improvements, financial protection and responsiveness) (Murray & Frenk, 2000).

A careful analysis of any health system should therefore start with identifying performance and underperformance in the system and its' causes, which can guide health system reforms and improvements. For those interested in a more elaborated description of health systems and how thinking around health system has evolved over time we refer to Appendix 1.

## What is health system strengthening?

With this simple, functional, view on health systems established, we move over to describe what is meant by *health system strengthening*. A health system analysis is focused on how the health system performs

in terms of delivering on the final goals. If we argue along these lines, *health system strengthening* is concerned with the performance of the health system and how efforts undertaken contribute to improving performance.

Chee et al. (Chee et al., 2013) define health system strengthening as *"permanently making the system function better"*. This means not just increasing short-term outputs. With this definition, HSS refers to improved intermediate objectives like health services coverage, quality, or efficiency, through comprehensiveness across health system building blocks[4]. Improvements should be made in ways that lead to and have lasting impact on final health system goals beyond the life of the project. This definition emphasizes that HSS is about lasting, systemic change. It modifies how the system itself functions so that it can deliver better health outcomes sustainably, even after external funding or projects end.

HSS refers to comprehensive changes to health system performance drivers to make the system perform better over time. In this study, we define health system performance as countries' progress towards achieving Universal Health Coverage for improved health outcomes. This includes that all people should have access to the quality health services they need, without experiencing catastrophic health spending due to health care costs (World Health Organization & World Bank, 2023). Moreover, it assumes that progress towards UHC contributes to improved health outcomes, which is the overarching goal of every health system. It is through this lens that we evaluate Swedish bilateral DAH for HSS.

[4] A framework used by WHO to describe health systems, disaggregating them into six core components: 1) leadership and governance; 2) service delivery; 3) health system financing; 4) health workforce; 5) medical products, vaccines and technologies and 6) health information systems. Ref: https://www.who.int/publications/i/item/everybody-s-business----strengthening-health-systems-to-improve-health-outcomes

## Health systems strengthening vs. health system support

Having defined health systems strengthening we can see that HSS is distinctly different from health system support. HSS is about transforming the system, changing rules, incentives, information flows, and capacities to make it perform better in addressing its four functions, in the long term. Health system support on the other hand is about helping the system function in the short term, providing resources or operational assistance without necessarily improving how the system performs in the long term (Table 1).

Distinguishing the two is important because only strengthening efforts lead to sustainable system resilience and improved population health. Health system support alone, while being merited from other perspectives, risks creating dependency and short-lived gains.

Distinguishing between *strengthening* of health systems and *support* to health systems becomes important as much of what is described as HSS in development programs would, according to the definition by Chee et.al., perhaps be better described as health system support.

To be clear, this does not mean that *strengthening* is always better than *support*. From the perspective of a development agency, both supporting and strengthening the health system are important. The choices must be made strategically based on the country context and specific need at the time. In fragile and conflict settings, health system support is often a priority, as health services might not even be available at all. However, if health system support is incorrectly or carelessly described as HSS, there is a risk for disappointment and unmet expectations when improvements are not sustained over time.

Health system support can also be detrimental to HSS, or undermine development of the health system, if unwisely designed. For example, if health care infrastructure is funded externally to meet a temporary need, this may contribute to ineffective long term domestic allocations for infrastructure.

**Table 1. Health systems strengthening vs. health system support**

| | Health System Strengthening | Health System Support |
|---|---|---|
| Question | Does the system *perform better* today than how it performed before? | Are *more services* provided today than compared to before? |
| Focus | Affect the *interactions* of the health systems building blocks to improve performance across health services and outcomes. | Affect the quantity and quality *within* the health system building blocks. |
| Goal | Long-term, sustainable improvements in system functioning and outcomes. | Short-term increase in a function's activity such as output of services. |
| Example | National health financing reforms or building health information systems that improve decision-making. | Buying medicines, funding salaries, or providing training for a specific disease program. |
| Outcome | System is better able to deliver quality, equitable, and efficient care independently. | Services may improve temporarily, but gains disappear once support is withdrawn. |
| Change mechanism | Acts on *root causes* of poor performance (e.g. governance, financing, service delivery integration). | Addresses *symptoms* of system weakness (e.g. lack of supplies or staff). |

Source: Developed by the authors based on Chee et al. (2013)

## Definition of HSS in this evaluation

In this analysis, we rely on the definition of HSS by Chee et al. who argue that health systems strengthening encompasses:

> *"more comprehensive changes to (the performance drivers of) policies and regulations, organizational structures, and relationships across the health system building blocks that motivate changes in behaviour, and/or allow for more effective use of resources to improve multiple health services" (Chee, Pielemeier, Lion, & Connor, 2013).*

This definition has a clear focus on performance drivers and emphasizes changes and reforms to these drivers across the health system. However, what HSS means in the context of development cooperation is less clear. While objectives of development cooperation policies and programs articulate goals and ambitions for strengthening health systems, the contents of these programs are not necessarily targeting systemic changes, i.e., transforming the performance drivers (for example how the health system is governed or financed) to improve how the health system performs. Or in other words, many development programs that are labelled as "health system strengthening" programs are rather health system support programmes if analysed according to the definition by Chee et al.

In this study we thereby take an approach that differs from most other HSS evaluations. Instead of evaluating programs that are labelled as HSS programs, we looked at all Swedish bilateral development assistance for health to a set of countries and assessed, program by program, the extent to which they can be understood as health systems strengthening, i.e., aims to change or reform the performance drivers of the countries' health systems. The main reason for choosing this approach is that the ambition of our work is to be forward looking and contribute to a discussion about how Sweden's development cooperation can better support health system strengthening in the future. The analytical framework for this evaluation,

guided by this definition of HSS, is described below. (For a review of HSS evaluations by other organisations we refer to Appendix 2.)

# Methods and material

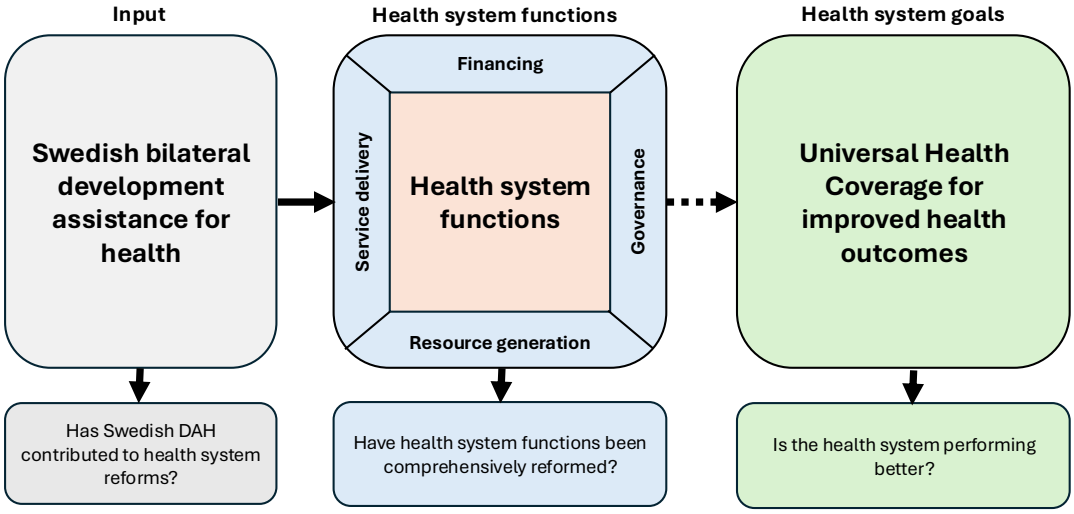
This evaluation applies a theory-based, mixed-methods design. The aim was to assess Sweden's support for health systems strengthening combining a portfolio-level review with in-depth case studies. The assignment specified that the evaluation should cover six countries: Uganda, Bangladesh, Zambia, Somalia, Myanmar and DRC, with in-depth case studies of support to Uganda and Bangladesh. The selection of Uganda and Bangladesh as cases was made by the commissioning agency EBA, based on an assessment of the overall bilateral Swedish DAH and collaboration with partner countries.

## Analytical framework

In this evaluation, our assessment is guided by the definition of HSS described above, combined with a function-based health systems framework. Our starting point is the core functions and goals of health systems. This allows us to assess whether Sweden's support has addressed documented health system performance challenges, and if it was designed with a programmatic logic toward improvement.

Based on this functional view on health systems we have developed an analytical framework (Figure 2.). This framework illustrates how we have analysed if Sweden's bilateral development assistance for health has contributed to substantive and long-term changes in health system functions that contributes to improved performance of health systems. We ask: 1) Is the health system performing better? If yes: 2) Have health systems functions been comprehensively reformed? And if so: 3) Has Swedish bilateral DAH contributed to the health system reforms?

**Figure 2. Analytical framework for the evaluation**




Source: Developed by the authors.

# Material

We used multiple data sources to assess the plausibility and nature of Sweden's impact on HSS outcomes. The evaluation is based on data on health aid disbursements (from the OECD Creditor Reporting System (CRS) Database[5]; CRS purpose codes 120 and 130), interviews with current and former Sida staff and partner representatives, project documentation country-specific international development cooperation strategies ("country strategies"), and strategy reports from 2014-2023.

For evaluation questions 1 and 2 (p. 16), quantitative analysis of disbursement data was conducted in Stata, while qualitative thematic analysis examined key informants' perceptions of how Swedish bilateral DAH contribute to HSS.

[5] OECD Data Explorer CRS: Creditor Reporting System Ref. https://data-explorer.oecd.org/?lc=en

For the evaluation questions that focus on Bangladesh and Uganda (questions 3–5) multiple data sources were used: CRS data, project documentation, and interviews with Sida staff, partners, and government counterparts. Programmes relevant to HSS were identified through a comprehensive mapping with input from Sida. This produced a final sample of 23 programmes (14 in Bangladesh and 9 in Uganda). Extensive documentation was collected from embassies, and semi-structured interviews were conducted both remotely and during field visits in 2025. Interview data were transcribed and thematically analysed. Project documentation was reviewed to assess whether objectives and indicators targeted systemic performance drivers aligned with HSS goals. Two illustrative cases were developed to highlight examples of effective Swedish HSS support in Uganda and Bangladesh.

The evaluation is formative in that a primary purpose is to provide feedback to improve HSS in ongoing initiatives (Green & South, 2006). While most of the projects we have reviewed are completed, the Swedish government emphasizes HSS as a priority in ongoing and future development cooperation in health. We therefore argue that the findings from this study are relevant for other bilateral Swedish health programs, and also for informing Sweden's dialogue and investments in the Global Fund and Gavi, and for core support to UN organizations working with HSS.

The methodological approach in this study does not allow for establishing a causal link between Sweden's support and actual changes in the health system performance indicators. Causality, in the current context, refers to the question of whether any change in the health system outcomes can be directly or indirectly attributed to the Swedish support.

A comprehensive description of methods and material and how causality can be understood in this study is available in Appendix 3. Interview guides are available in Appendix 5 and 6.

## Limitations

This evaluation has focused exclusively on Swedish bilateral development assistance for health. Bilateral DAH is defined as support provided directly to the evaluation countries, financed through country cooperation strategies and reported under health-related OECD-DAC sector codes. While this definition captures most of Sweden's health support to Bangladesh and Uganda, it excludes development assistance channelled through core support to multilateral organizations such as the UN system, development banks (e.g., the World Bank), Gavi, and the Global Fund. Many of these organizations claim to contribute to health systems strengthening in the evaluated countries.

Despite the delimitations and focus on bilateral programs, we note that Sweden's implementing partners at country level are often the same actors that receive core support globally. So although we have not assessed HSS through Sweden's core funding to UNFPA, our Bangladesh case study examines a UNFPA-led program. Similarly, while Sweden's core support to the World Bank were not included in the evaluation scope, our Uganda case focuses on a World Bank-led initiative that is also financed through Sweden's bilateral cooperation strategy with Uganda.

Our intentional focus on bilateral DAH also means that development cooperation initiatives falling outside this definition have not been assessed. For example, Sweden's bilateral research cooperation with Makerere University in Uganda, despite its relevance to health research and potential indirect links to HSS, was excluded as it does not fall within our definition of bilateral DAH.

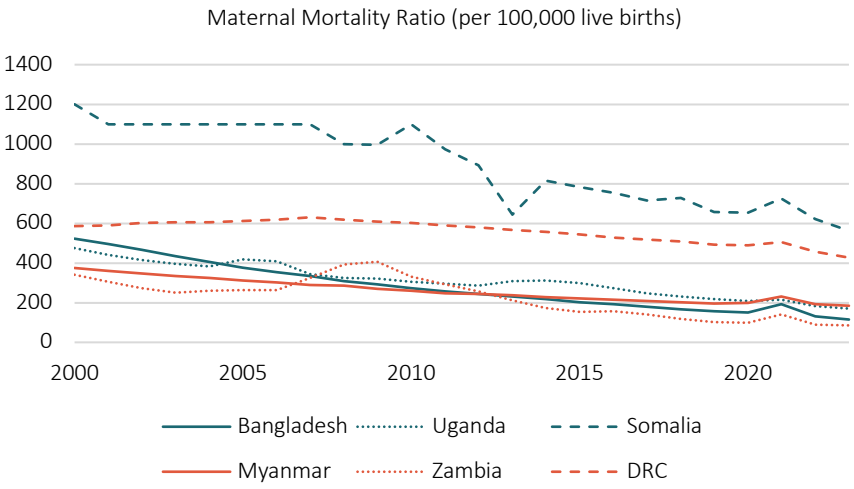
# Health in the selected countries

To set the scene for our analysis, this section provides a brief overview over how health and key health systems indicators have developed in the six countries covered in this evaluation: Uganda, Bangladesh, Somalia, DRC, Zambia and Myanmar. The health sector in Uganda and Bangladesh, and the Swedish support to health in Uganda and Bangladesh over time is described in more detail in Appendix 4.

All six countries have experienced positive health developments over the past two decades. There have been substantial improvements in maternal and neonatal mortality (Figure 3–4), although countries are not on course to meet the SDG targets of maternal mortality of less than 70 per 100,000 live births and neonatal mortality of less than 12 per 1,000 live births.

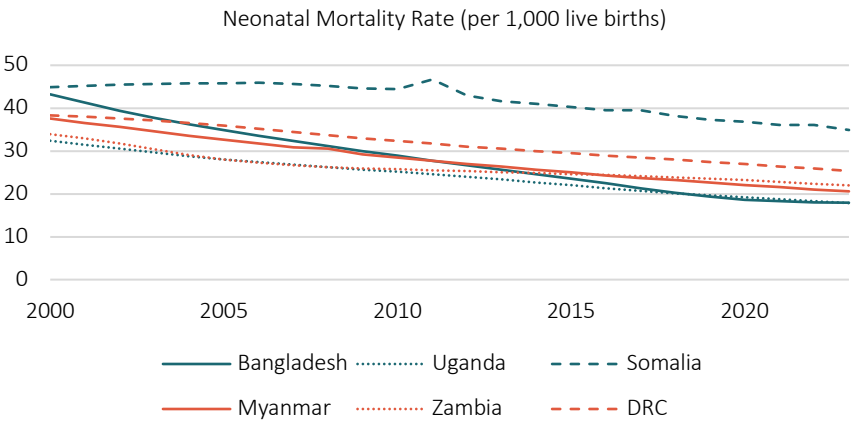
Except for DRC and Myanmar, where data are very limited, the countries have also seen an improvement in the share of births attended by skilled health personnel (Figure 5) and child vaccination coverage (Figure 6).

## Figure 3. Maternal mortality in the six evaluation countries, 2000–2023



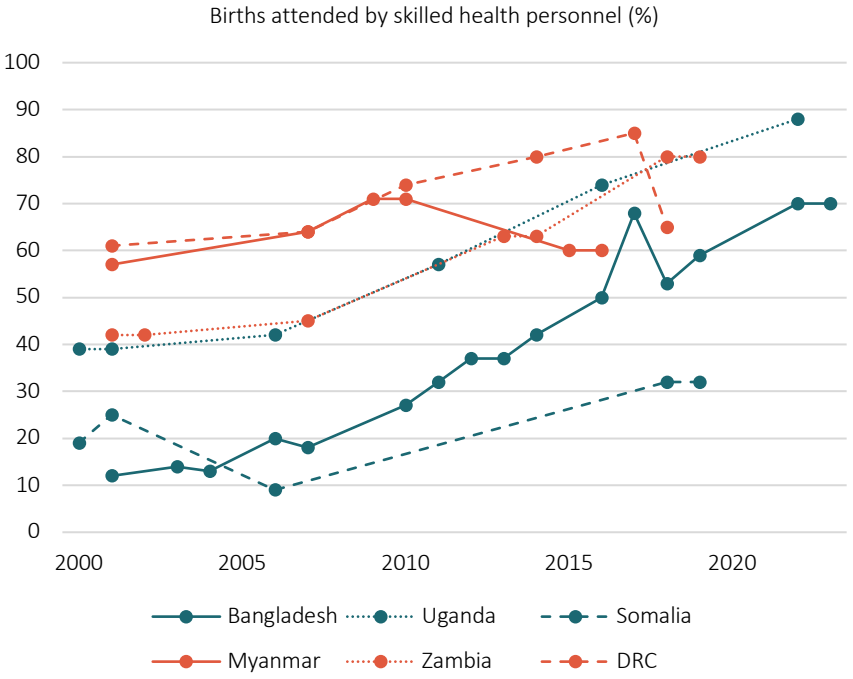

Source: World Health Organization Data https://data.who.int/indicators/i/C071DCB/AC597B1

## Figure 4. Neonatal mortality rate (median) in the six evaluation countries, 2000–2023



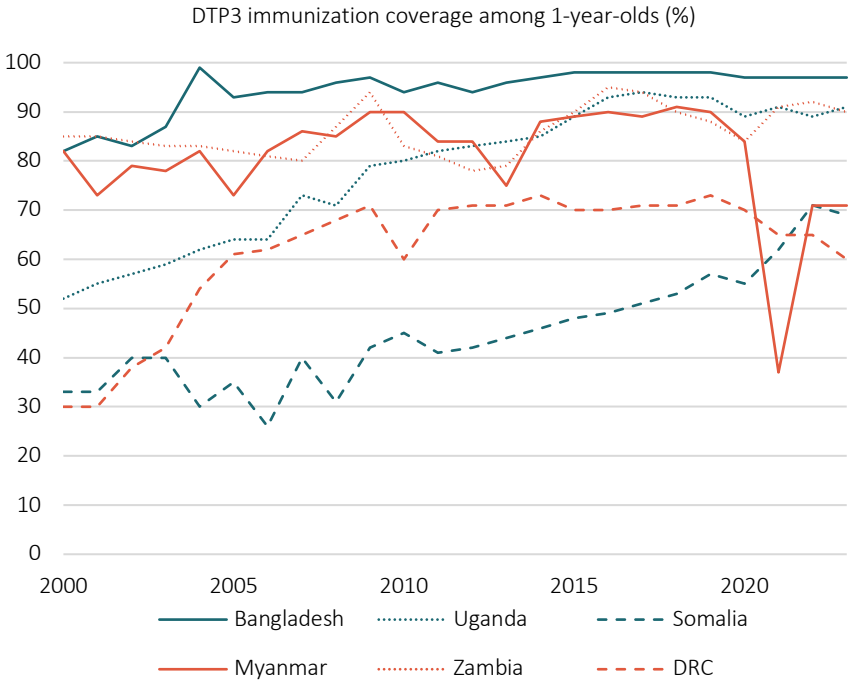

Source: UNICEF Data

**Figure 5. Share of births attended by skilled health personnel in the six evaluation countries, 2000–2023**




Source: The Global Health Observatory

**Figure 6. DPT3 immunization6 coverage in the six evaluation countries, 2000–2023**

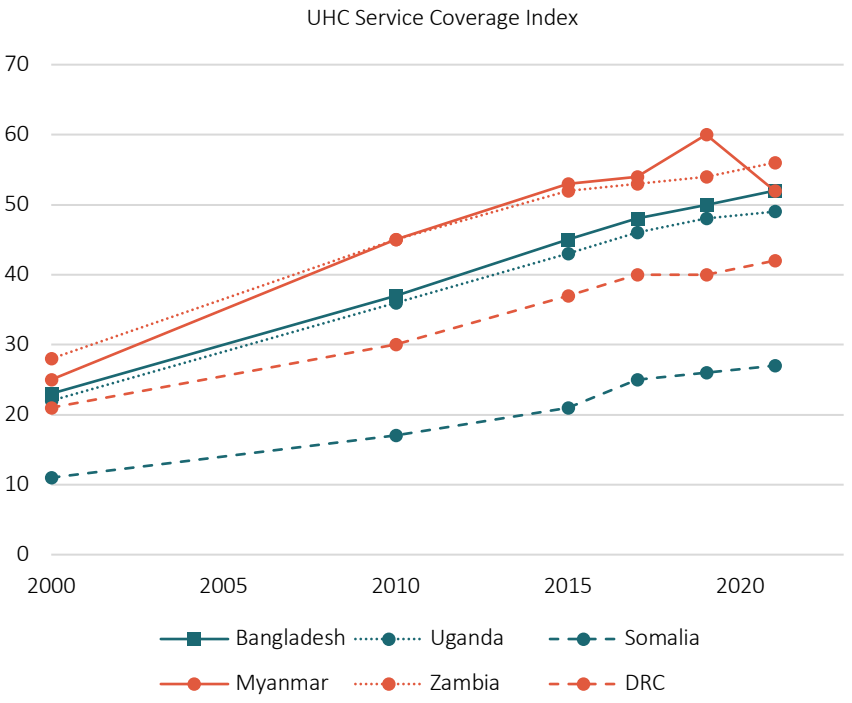



Source: The Global Health Observatory

The UHC service coverage index by WHO indicates that all six countries have improved in providing essential health services to their populations in 2023, compared to in 2000 (Figure 7.). However, data before 2014 are limited and the index is a complex composite measure which runs the risk of hiding important country developments.

[6] DPT3 (or DTP3) is the third dose of the diphtheria, tetanus toxoid, and pertussis vaccine, a critical measure of child immunization coverage and health system performance. It is typically given to infants at 14 weeks of age as part of a 3-dose series starting at 6 weeks. High DPT3 coverage indicates effective routine immunization programs (www.who.org).

**Figure 7. Health care service coverage in the six evaluation countries, 2000–2023**




Source: The Global Health Observatory

## Out-of-pocket expenditure

Regarding trends in financial protection against catastrophic health expenditure, (for exemple financial hardship caused by high health care costs), data are even more limited and of varying quality. There are large differences in out-of-pocket expenditure on health (OOPE). OOPE is an important proxy indicator for the systems ability to offer financial protection. High OOPE figures indicate an increased risk of financial hardship when seeking or needing health care. In Bangladesh, out-of-pocket expenditure constitutes 73% of total health expenditure, which is one of the highest shares in the world. OOPE in Bangladesh has also continued to increase, indicat-

ing that the government is not doing enough to address this, and to increase it's contribution of domestic resources to the health system. In Uganda and Zambia, out-of-pocket expenditure is much lower, 34% and 10% respectively. OOPE in the other countries range from 47% (DRC) to 65% (Myanmar).

In summary, the trend in all six countries is generally towards lower maternal and neonatal mortality and increased access to health services, although there are large differences in absolute numbers. In Uganda and Bangladesh, the two countries in focus of this evaluation, the share of births attended by a skilled health worker has increased but maternal and neonatal mortality is still much higher than the SDG targets.

All countries still grapple with poor financial protection. Bangladesh and Myanmar in particular have extremely high levels of OOPE as share of total health expenditure. In low- and lower-middle income countries the average OOPE share is much higher than in high-income countries. In low- and lower-middle income countries the average OOEP is 44% and 47% respectively, compared to high-income countries where OOPE on average is about 12%.

# Portfolio overview of Swedish bilateral health aid to six countries

In this section, we respond to the first two evaluation questions that include all six countries (Uganda, Bangladesh, Somalia, DRC, Zambia and Myanmar) during the period 2014-2023:

1. How much bilateral DAH has Sweden disbursed and what areas has it focused on?
2. How and to what extent is HSS reflected in Swedish bilateral strategies and policies for development cooperation?

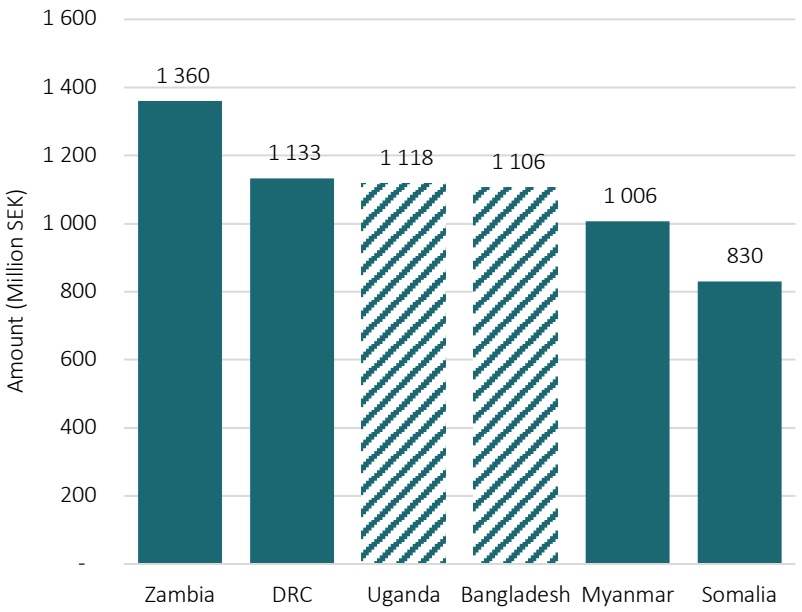
It is important to note that much of development assistance for health, about half, is multilateral and disbursed directly from the Ministry for Foreign Affairs[7]. To what extent these funds, which for example include core funding and support to global organizations like Gavi, the Global Fund and the WHO has targeted and succeeded in strengthening health systems is not covered by this evaluation.

## Volumes of bilateral health aid

In total, Sweden has disbursed 6 553 million SEK in bilateral development assistance for health during the period 2014–2023 to the six countries in this evaluation. Disaggregated by country, disbursements range from 830 million SEK in Somalia to 1 360 million SEK in Zambia (Figure 8. Total Swedish development assistance for health, by country, 2014-2023 (million SEK).

[7] Sveriges bistånd till hälsa och SRHR 2024 https://www.regeringen.se/rapporter/2025/10/sveriges-bistand-till-halsa-och-srhr-2024/

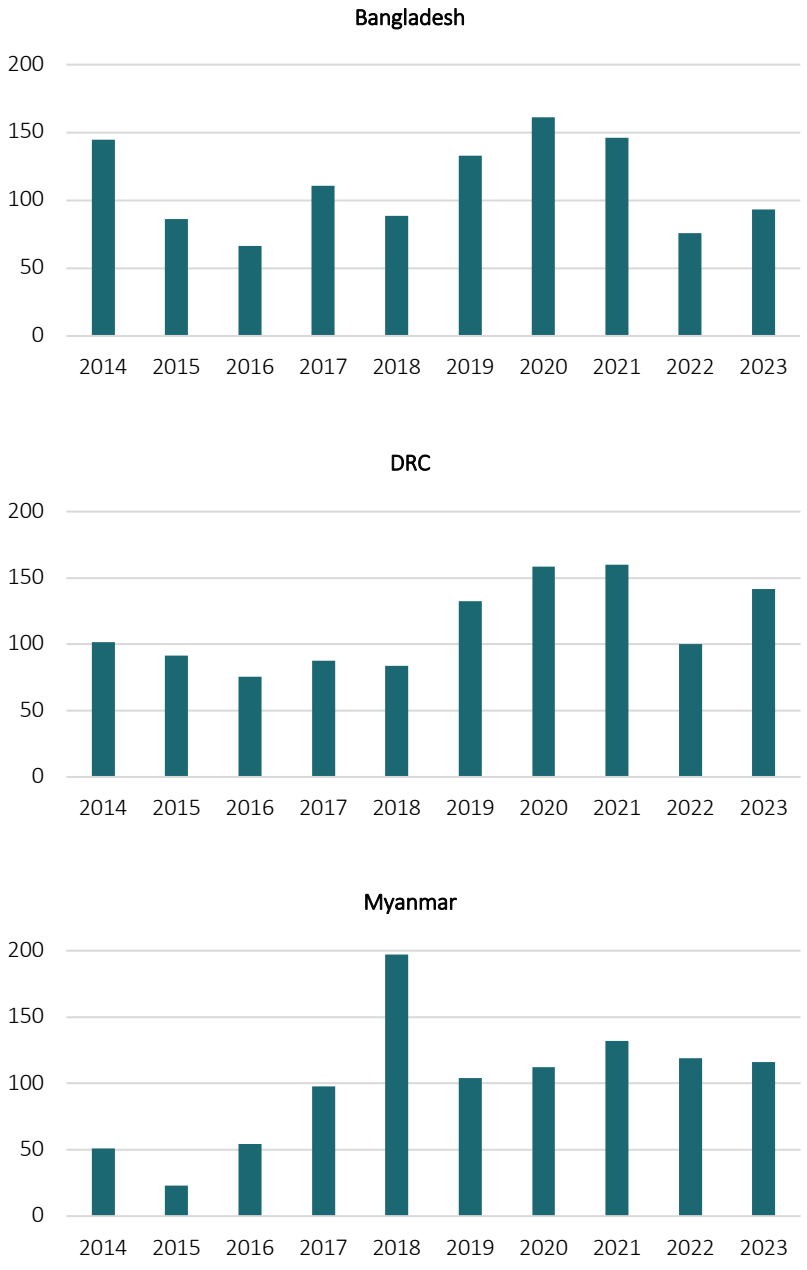
**Figure 8. Total Swedish development assistance for health, by country, 2014–2023 (MSEK)**

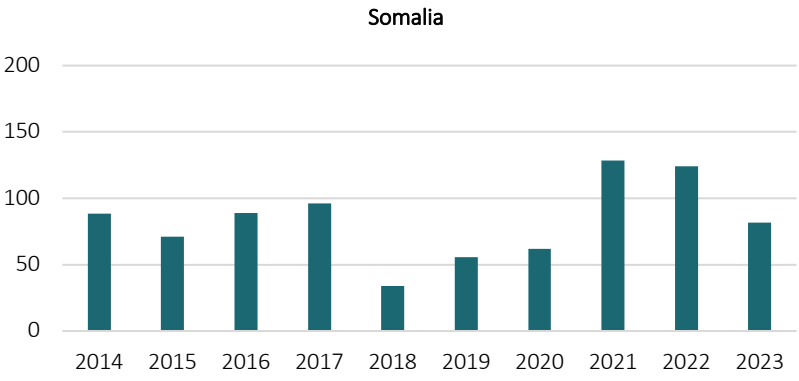


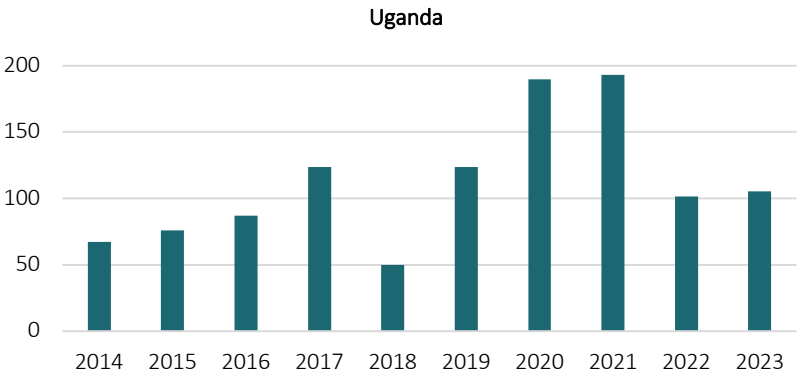

Source: Disbursement data from Sida statistics unit.

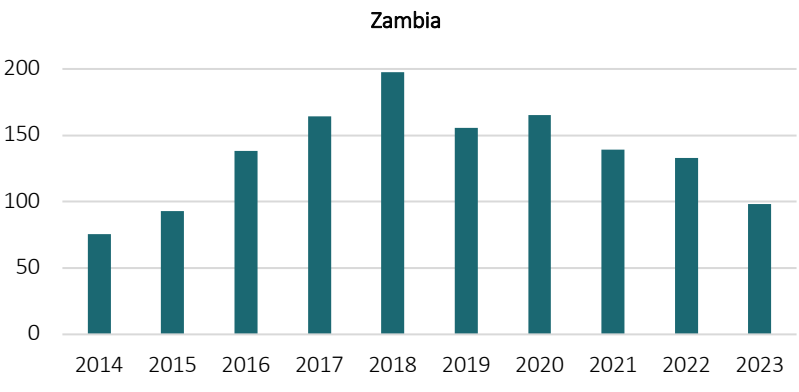
On average, the countries have received annual bilateral disbursements of about 80-140 million SEK. However, as Figure 9 shows, there have been large annual variations in disbursements over the period.

**Figure 9. Annual disbursement of health aid per year, 2014–2023 (MSEK)**






Source: Aid disbursement data from Sida's statistics unit.

## “Basic health care” is the largest sector

In the OECD-DAC reporting system where ODA disbursements are reported, aid is categorized according to sectors and sub-sectors. *“Basic health care”* and *“reproductive health care”* are two sectors that cover many different types of health sector support.

When looking at Swedish disbursements during the period 2014–2023, and disaggregate by OECD-DAC sector codes, we see that in four of the six countries, “basic health care”[8] is the largest sector in, followed by “reproductive health care”[9].

This reflects the goals and priorities within the health sector, as articulated in Swedish strategies for development cooperation. In Uganda, reproductive health care is by far the largest sector. In Zambia there is a more even distribution across multiple sector codes.

There is no specific OECD-DAC sector code for “health system strengthening”. Health system strengthening is mentioned as one area under sector code 12110, *Health policy and administrative management,* which has constituted a relatively large share of the support to Bangladesh. However, sector code 12110 is also used for other types of programmes such as public health administration, aid to health ministries and unspecified health activities that are not obviously relevant for HSS. Because of the limitations of the database, our assessment is that it is not possible to estimate the amount of funding that has targeted HSS using Sida’s disbursement data, without going into detail of the content of specific programmes.

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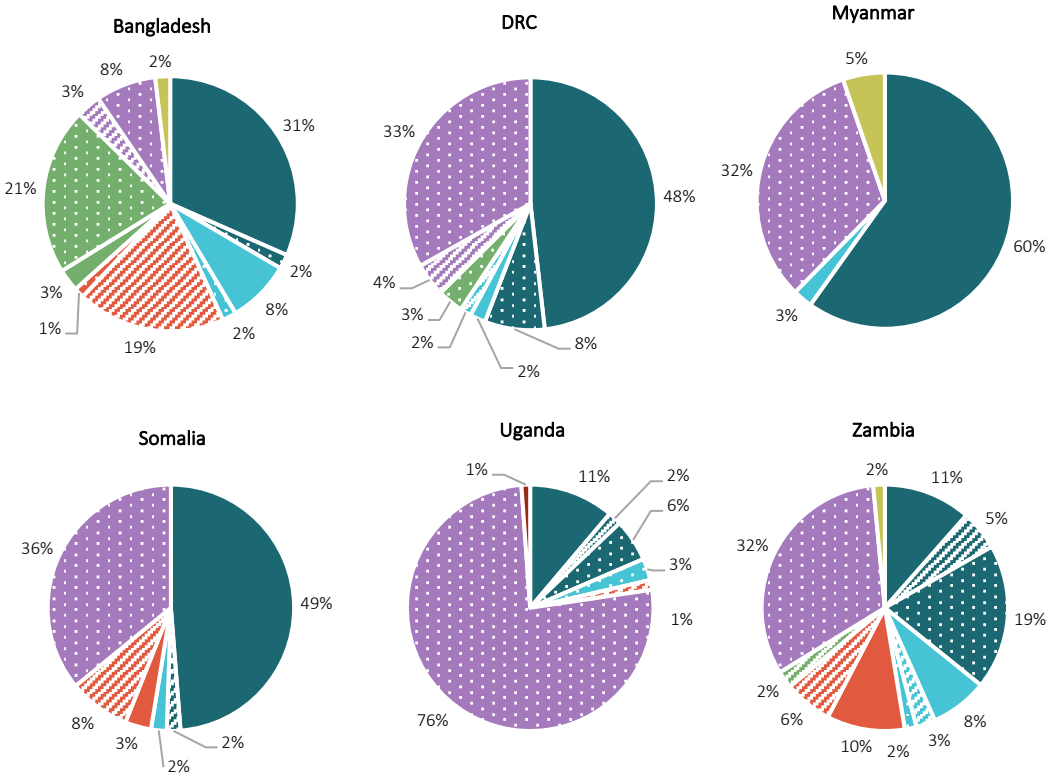
[8] Defined by OECD-DAC as: Basic and primary health care programmes; paramedical and nursing care programmes; supply of drugs, medicines and vaccines related to basic health care; activities aimed at achieving universal health coverage. https://development-finance-codelists.oecd.org/CodesList.aspx

[9] Defined by OECD-DAC as: Promotion of reproductive health; prenatal and postnatal care including delivery; prevention and treatment of infertility; prevention and management of consequences of abortion; safe motherhood activities. https://development-finance-codelists.oecd.org/CodesList.aspx

## Figure 10. Share of total disbursements by country and sector code, 2014–2023



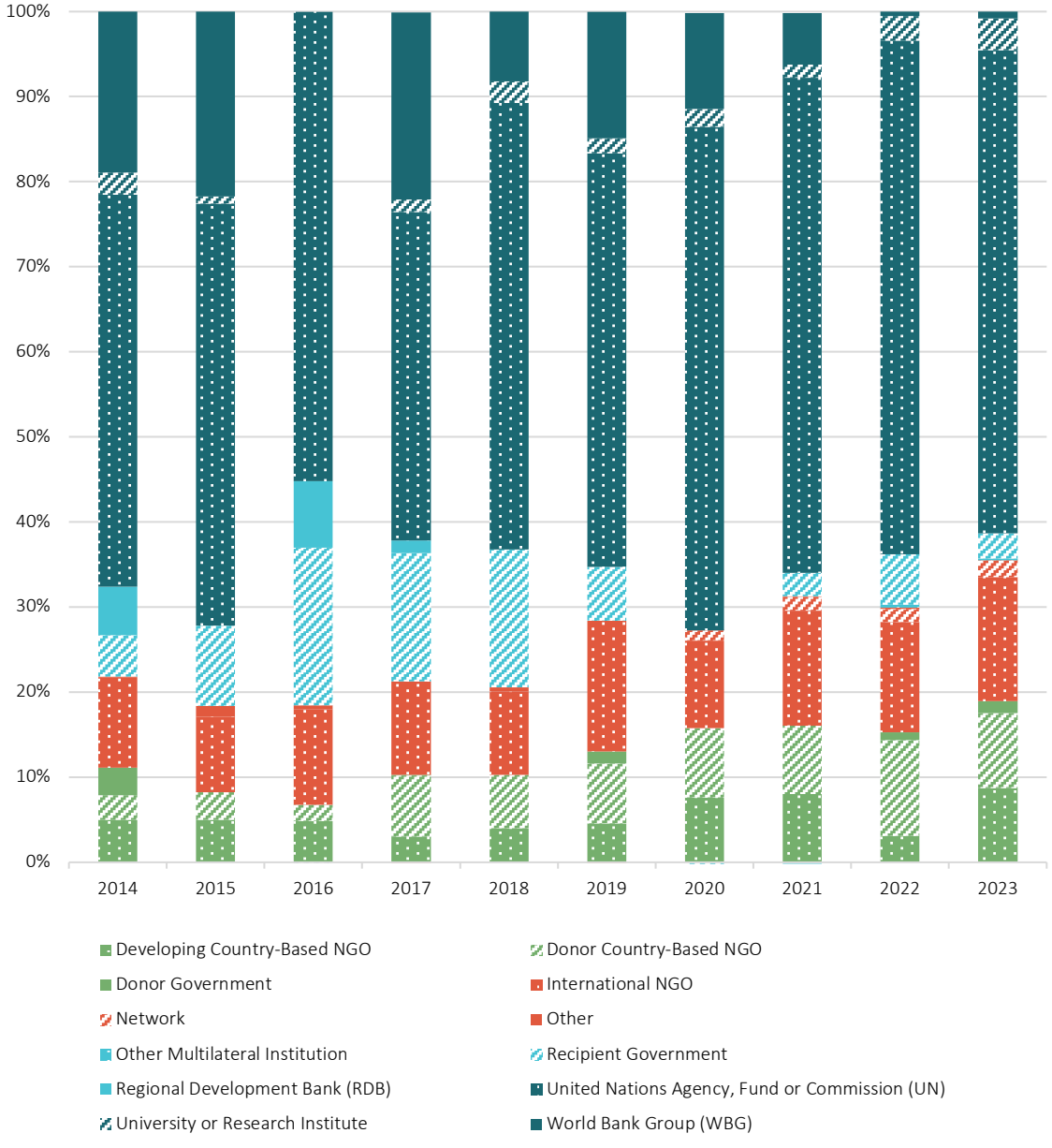

Note: Sector codes with total disbursements of <10 MSEK during the period have been excluded to make figures clearer.
Source: Aid disbursement data from Sida.

## UN agencies major recipient of Swedish health aid

When exploring health systems strengthening, it is important to look at who the recipients of health ODA are. Sida is not an implementing agency. Sida funded projects, called "contributions", are channelled through different implementing partners. Successful efforts to strengthen health systems require strong government leadership and commitment. Reforming health system functions necessitates support from national and sub-national governments and authorities, not least the "Stewardship" and "Financing" functions of the health system (see p. 21). We have therefore estimated the share of Swedish bilateral development assistance for health by type of recipient. Over the period 2014–2023, the largest recipients of Swedish bilateral DAH were different UN agencies. The share disbursed to UN agencies has also increased over time. Zambia is the only country where the government has been a recipient of Swedish bilateral DAH during the period (Figure 11).

Our estimates show that funding directly to "recipient government" only constitutes a small share of total bilateral DAH. Funding through the World Bank Group, which is closely linked to governments, has decreased over time and is almost zero towards the end of the period. Total funds disbursed either to recipient governments or the World Bank, on average, make up less than 20% of total bilateral DAH disbursed by Sweden during the period, and the share has decreased over time.

**Figure 11. Share of total annual disbursements by type of recipient (organisation sub-category), 2014–2023**




Source: Aid disbursement data from Sida

In summary, Swedish bilateral DAH to the six countries has primarily targeted basic health care and reproductive health care which, at an overall level, resonates with priorities of Swedish development assistance. Only a small share of bilateral DAH has been disbursed to recipient governments or intermediaries such as the World Bank, and the share has decreased over the period. The small share of funding to partner governments indicates limited direct collaboration with recipient governments. DAH for HSS is not reported separately in Sida's and OECD-DACs statistics and consequently it is not possible to estimate the amount of aid for HSS using Sida's disbursement data.

## Health systems strengthening is a priority, but weakly embedded in goals

Health systems strengthening is articulated as an overall priority for Swedish development assistance for health, as stated before. But how is HSS reflected in the context analyses and objectives of bilateral cooperation strategies and policies? To understand how and to what extent health systems strengthening is reflected in Swedish strategies and policies for development cooperation, we analysed all country strategies and strategy reports from 2014-2023 for the six countries included in the study.

Our analysis shows that, at a general level, most country strategies emphasize the importance of a strong health system in the description of the challenges and context in the country. However, HSS is not clearly reflected and articulated in goals and subgoals. None of the strategies reviewed have had a goal or sub-goal that specifically address HSS. Strategy goals are often formulated broadly, for example *"Improved basic health" or "Equal health, including sexual and reproductive health and rights"*. Sub-goals are in turn formulated along the lines of *"increased access to quality health care" or "increased access to sexual and reproductive health and rights"* (see Table 2.)

**Table 2. Examples of goals and sub-goals from the Swedish bilateral cooperation strategies for Zambia and Bangladesh**

Strategy for Swedish development cooperation with Zambia 2018-2022

| Goal | Sub-goals |
|---|---|
| 2. Equal health, sexual and reproductive health and rights, and nutrition. | 2.1 Increased and equal access to health and medical care with a focus on women, youth, and children.<br>2.2 Increased access to and respect for sexual and reproductive health and rights.<br>2.3 Improved nutritional intake for women, youth, and children. |

Strategy for Swedish Development Cooperation with Bangladesh 2021–2025

| Goal | Sub-goals |
|---|---|
| 4. Health including sexual and reproductive rights. | 4.1 Strengthened capacity to provide good quality healthcare.<br>4.2 Increased conditions for access and respect for sexual and reproductive health and rights. |

The fact that HSS is not an explicitly articulated goal of Swedish country cooperation strategies is an interesting observation, and we have identified this as a weakness. Results of contributions are reported directly in relation to the goals formulated in the strategies. Consequently, as there are no goals formulated, Sida is not required nor expected to report results in relation to HSS to the Swedish government. A comprehensive presentation of the goals, sub-goals and results from all strategies and strategy reports related to health systems strengthening are available as supplementary material.

**Box 1. To what extent has Swedish bilateral DAH to Bangladesh and Uganda targeted HSS?**

To find out to what extent health systems strengthening has been targeted, we selected 23 Swedish health aid contributions to different implementing partners in Bangladesh (14 contributions) and Uganda (9 contributions) during 2014–2023. The contributions were selected based on a qualitative assessment of the HSS relevance in the overall project description of all contributions to Uganda and Bangladesh during the period. All project descriptions were reviewed independently by at least two team members and assessed for relevance. The HSS relevance was based on an assessment of overall goals, objectives and indicators of the contributions. For details on the selection of contributions we refer to Appendix 3.

We then analysed if the project's overall objective was formulated in a way that targets health system strengthening (i.e. contributing to more comprehensive changes or reforms of health system functions). Furthermore, we assessed if the overall objective of the contribution was monitored and followed up using relevant HSS indicators (for example health outcomes and financial protection).

If the overall objective targets performance drivers of health systems AND imply change or reform to these drivers – that contribution is assessed as targeting HSS (YES). If the overall objective targets performance drivers OR imply change or reform to these drivers - that contribution is assessed as partly targeting HSS (PARTLY). If the overall objective does not target performance drivers NOR imply any change or reform to these drivers - that contribution is assessed as not targeting HSS (NO). The results are presented in Table 3. and Table 4.

## Table 3. Bangladesh – Assessment of overall objectives or goals and indicators for follow-up for selected contributions funded under the Bangladesh country strategies, 2014–2023[10]

| | Bangladesh contributions (number and name) | Overall objective | Targeting health system strengthening? | Use of relevant health systems performance indicators? |
|---|---|---|---|---|
| 1 | 11123: WASH (Water, sanitation and hygiene) for Urban Poor 2017-2023 | Improved environmental health and resilience of WASH deprived urban poor living in slums and low-income settlements. | No | Partly |
| 2 | 14914: WASH (Water, sanitation and hygiene) for Urban Poor Phase II 2023-2027 | Improved environmental health and resilience of WASH deprived urban poor living in slums and low-income settlements. | No | Partly |
| 3 | 12966: IOM (International Organization for Migration) Mental Health Cox's Bazar 2019-2022 | Scale-up Mental Health and Psychosocial Support (MHPSS) to increase outreach capacity and improve service provision towards achieving a more holistic, comprehensive and inclusive mental health and psychosocial response for both refugees and host population. | Partly | No |
| 4 | 13393: Midwifery UNFPA (United Nations Population Fund) 2022-2025 | Improve SRHR and reduce maternal- and neonatal mortality by strengthening midwifery-led care, including SRHR services. A particular focus to reach the most vulnerable and hard to reach women and girls. | Yes | Yes |
| 5 | 14200: WHO Strengthening health systems 2021-2027 | Health System Strengthening in Bangladesh: Invigorating Health Financing for Universal Health Coverage, Amplifying the Capacity for Detection and Containment of Antimicrobial Resistance, Improving Mental Health Care, and Upholding Health Services Quality in Cox's Bazar. | Yes | No |
| 6 | 5160023: Promoting Environmental Health for the Urban Poor 2011-2018 | To contribute to the national goal and millennium development goal (MDG) related to environmental health through ensuring access to safe drinking water, improved sanitation and desired hygiene practices. | Partly | No |

[10] Results strategy for Bangladesh 2014–2020 and Strategy for Sweden's Development Cooperation in Bangladesh 2021–2025.

| | Bangladesh contributions (number and name) | Overall objective | Targeting health system strengthening? | Use of relevant health systems performance indicators? |
|---|---|---|---|---|
| 7 | 51060001: Bangladesh Health, Population and Nutrition Sector Development Programme 2011-2016 | Ensure quality and equitable health care for all citizens of Bangladesh. | No | Yes |
| 8 | 51960002: Urban Primary Health Care (PHC) Services Delivery Project 2012-2017 | Impact: improved health of the urban population in Bangladesh, particularly the poor, women, and children Outcome: sustainable good quality urban PHC services provided in project areas that target the poor and the needs of women and children. | No | Yes |
| 9 | 51060044: Reproductive Health Services Training and Education Program (RHSTEP) 2014-2016 | Contribute in reduction of Maternal Mortality, morbidity from unsafe abortion and improve the sexual and reproductive health and rights situation of women and adolescents in the project areas. | No | No |
| 10 | 52170010: Health Sector Programme 2017-2022 | Overall goal: All citizens of Bangladesh enjoy health and well-being. Program objective: To ensure quality and equitable healthcare for all citizens of Bangladesh by gradually achieving Universal Health Coverage (UHC). | No | Yes |
| 11 | 52170012: UNFPA Midwifery 2017-2021 | Improved health of mothers and adolescents in select districts of Bangladesh. | No | Yes |
| 12 | 52170014: Midwifery 2016 UNFPA - Technical Assistance to Strengthen the Quality of Maternal Health Services 2015-2018 | Increased access to effective, qualitative and non-discriminatory health care for people living in poverty, with a focus on maternal health care. | No | No |
| 13 | 52170025: Urban Primary Health Care Project 2018-2023 | By 2023, sustainable improvement in the health status of the Bangladeshi population in urban areas is achieved, particularly for the poorest and most vulnerable groups. | No | Partly |
| 14 | 52170040: Systems strengthening and scaling up Drinking Water Safety in Bangladesh 2017-2025 | Secure citizens' right to safe water by enabling accountable national and sub-national governments to operationalize a drinking water safety risk management framework. | No | No |

## Table 4. Uganda – Assessment of overall objectives or goals and indicators for follow-up for contributions funded under the Uganda country strategies, 2014–2023

| | Uganda contributions (number and name) | Overall objective | Targeting health system strengthening? | Use of relevant health systems performance indicators? |
|---|---|---|---|---|
| 1 | 10191: World Bank Reproductive, Maternal and Child Health Services 2017-2021 | 1) Improve utilization of essential health services with a focus on reproductive, maternal, newborn child and adolescent health services in target districts, 2) scale-up birth and death registration services. 3)Provide immediate and effective response to an eligible crisis or emergency. | Partly | Yes |
| 2 | 10717: UNICEF maternal and newborn health west Nile 2017-2021 | Decline in maternal, newborn and child mortality and improvement in the nutritional status of young children. | No | Yes |
| 3 | 11739: World Food Program (WFP) - UNICEF Joint Programme on Social Protection in Uganda 2019-2023 | Improved community and household resilience among refugees and host populations (out of UNICEF control). | No | Yes |
| 4 | 14600: UNICEF Uganda – country programme support 2021-2025 | Five outcomes related to 1) maternal and newborn health, 2) immunization, 3) malnutrition, 4) HIV prevention, and 5) water. | Partly | Yes |
| 5 | 51180046: UNFPA SRHR 2013-2014 | 1) To increase coverage for selected sexual & reproductive health services in the 8 UNFPA/Government of Uganda country programme focus districts and 5 HIV thematic districts. 2) To strengthen capacity of leaderships of 9 cultural and 3 religious institutions for their (re)engagement in HIV prevention and promotion of family planning (FP), menstrual health (MH) and gender-based violence (GBV) services. | No | No |
| 6 | 51180056: UNFPA SRHR 2015-2017 | 1) To increase coverage for selected sexual & reproductive health services in the 8 UNFPA/Government of Uganda country programme focus districts and 5 HIV thematic districts. 2) To strengthen capacity of leaderships of 9 cultural and 3 religious institutions for their (re)engagement in HIV prevention and promotion of FP/MH and GBV services. | No | No |

| | Uganda contributions (number and name) | Overall objective | Targeting health system strengthening? | Use of relevant health systems performance indicators? |
|---|---|---|---|---|
| 7 | 51180075: Naguru Teenage Centre extension 2014-2015 | To work together with other partners to contribute to the reduction of the incidence of unwanted pregnancy, sexual and gender-based violence (SGBV), HIV and other sexually transmitted diseases (STIs) among young people. | No | No |
| 8 | 51180095: Naguru Teenage Health & Info Centre 2015-2020 | Increased understanding of SRH rights and access to appropriate youth-friendly services for young people. | No | No |
| 9 | 51180090: Umbrella fund, SRHR & HIV prevention Uganda 2016-2021 | Outcomes: 1) Expanded access and increased use of quality, inclusive and integrated SRHR and HIV services among vulnerable and key populations, 2) increased adoption of safer sexual practices among vulnerable and key populations, 3 )an enabling SRHR and HIV environment for vulnerable and key populations, and 4) Strengthened institutional capacity of implementing organisations (NGOs/ CBOs) to deliver quality and inclusive SRHR and HIV programmes in Uganda. | Partly | No |

# Health systems strengthening in Bangladesh

Few project descriptions clearly targeted health systems strengthening, based on our analysis. Out of all the contributions reviewed, only two (9%) contributions to Bangladesh had an overall goal or objective that could be understood as directly targeting health systems strengthening (Table 3). These "HSS contributions" that were identified are analysed in detail in the next section.

## Case study 1: Sweden's support to the midwifery reform in Bangladesh

This case study summarizes Sweden's support to the strengthening of midwifery care in Bangladesh. We selected Sweden's support to UNFPA focusing on midwifery in Bangladesh. This program spans over three contribution periods, from 2016–today (contributions 4, 11 and 12 in Table 3).

### Background and context

Bangladesh's efforts to establish a dedicated midwifery profession gained momentum in 2008, following a 2007 stakeholder meeting convened by WHO. In 2010, Bangladesh's midwifery reform was formally launched when the Government of Bangladesh pledged to train and deploy 3,000 professional midwives during the "Every Woman, Every Child" initiative at the UN General Assembly. This commitment came after years of advocacy from WHO, UNFPA, and other partners who highlighted persistent maternal mortality (194 per 100,000 live births in 2010) and low coverage of skilled birth attendance.

The early phase of the midwifery reform focused on establishing policy, regulatory, and educational structures. Key steps included the development of "Strategic Directions for Enhancing Nurse-Mid-

wives' Contributions to Millenium Development Goals (MDGs) 4 and 5" (2008), the Nursing and Midwifery Act, and the creation of the Bangladesh Nursing and Midwifery Council, Directorate General of Nursing and Midwifery, and Bangladesh Midwifery Society (BMS). The three-year midwifery diploma programme launched in 2013 produced its first graduates in 2016, deployed to public facilities from 2018.

By the time Sweden entered as a donor through UNFPA in 2016, the policy and institutional architecture was largely established. The need was to operationalize midwifery at scale, through workforce deployment, supervision, and service integration.

## Swedish support through UNFPA (2016-2025)

Sweden's engagement with Bangladesh's midwifery reform has unfolded over three phases within the framework of the national Health, Population and Nutrition Sector Programmes (HPNSP). Sweden's support has been implemented by UNFPA in collaboration with the Ministry of Health and Family Welfare (MoHFW) (contributions 4, 11 and 12 in Table 3).

### Technical assistance (2016)

Sweden provided SEK 9.5 million for short-term technical assistance to strengthen midwifery governance and regulation. Funding supported national and international midwifery specialists placed within MoHFW and UNFPA, who helped develop job descriptions, professional standards, and supervision mechanisms. This period also coincided with the consolidation of the Directorate General of Nursing and Midwifery and the development of licensing and accreditation systems under the Bangladesh Nursing and Midwifery Council.

## Strengthening the midwifery-led continuum of care (2017-2022)

With SEK 100 million in support, Sweden and UNFPA implemented the Strengthening Midwifery-Led Continuum of Care project. The project focused on three interrelated areas:

1. Policy and institutional development: technical support to MoHFW and the development of national standard operating procedures.
2. Education and professionalization: midwifery faculty training, mentorship, and support to the Bangladesh Midwifery Society as a professional body.
3. Service delivery: piloting midwife-led care models in four districts and Dhaka City Corporation.

According to Sida's 2022 appraisal for the 3rd contribution, deployment of government midwives increased substantially and skilled birth attendance rose by an average of 282% in project districts. However, systemic challenges persisted including weak supervision, underutilization of midwives' competencies, and frequent reassignment to nursing or COVID-19 duties.

## Strengthening midwifery-led and SRHR care (2022–2025)

The current phase (SEK 100 million) aims to consolidate earlier gains while integrating midwifery into broader SRHR and climate-resilience agendas. It covers 35 upazilas across four districts and Dhaka City Corporation. Priorities include:

1. Continuing professional development for midwives.
2. Strengthening emergency obstetric and newborn care.
3. Expanding integrated SRHR services; and
4. Introducing digital and outreach models to reach underserved and climate-vulnerable populations.

The Bangladeshi government now finances midwives' salaries, while Swedish funding supports supervision, training, and system strengthening.

## Health impact and system effects in Bangladesh

An evaluation conducted by Johns Hopkins university in 2024 found that professional midwives trained and deployed since 2016 contributed to reductions in maternal and neonatal deaths in Bangladesh. The evaluation modelled the impact of midwives in eight districts from 2019 and 2023 and estimated that midwifes had contributed to an additional 892 neonatal lives saved and 151 maternal lives saved. The evaluation also conducted prospective modelling of lives saved from a national scale-up of midwifery care in the period 2024-2030, and under the most conservative estimate indicated an additional 11,052 neonatal and 995 maternal lives saved Inagaki et. al., 2024.

These improvements occurred alongside a national decline in maternal mortality from 318 (2000) to 153 (2022) and reduced neonatal mortality from 39 to 16 per 1,000 live births. Strengthening of midwifery has become a core element of Bangladesh's broader maternal health gains. Our interviews and analyses of project documentation support the notion that Swedish support has contributed to this reform.

Yet implementation challenges remain. Many midwives still work under restrictive clinical hierarchies, facility readiness varies, and generating demand for midwifery services has been difficult. Sustainability depends on continued domestic financing and managerial recognition of midwives' autonomous roles.

## Has Sweden's support contributed to health system strengthening in Bangladesh?

The overall objectives of the UNFPA programmes supported by Sweden have increasingly over time been formulated in a way that is aligned with the definition of health system strengthening. During

the first programme in 2016, the goal was to increase access to care. Even though that is a goal of a health system, access to care in itself is not clearly a health system strengthening goal. However, over time the project objectives became more systems strengthening oriented. During the 2022-2025 period, the programme objective targeted health improvements (a final health system goals) and provided a direction for how that should be achieved (strengthening midwifery led care).

To understand if Sweden's support has contributed to health system strengthening, we assessed the support to UNFPA in relation to our analytical framework of the core functions of health systems (Figure 2).

**Governance:** Swedish-funded technical assistance supported the establishment of governance structures for enhanced midwifery practices in Bangladesh, including the development of the Nursing and Midwifery Act (2016), professional standards, and standard operating procedures. Coordination across different directorates of the Ministry of Health and Family Welfare improved but remains fragmented. Facility, district and Upazila[11] level managers have limited authority to enforce midwifery practice guidelines.

**Resource generation:** Human resource development was the primary focus of Sweden's support. Support covered midwifery education, faculty development (through Swedish universities), and in-service mentorship. A professional association (Bangladesh Midwifery Society) and a regulatory council (The Bangladesh Nursing and Midwifery Council) were strengthened, institutionalizing the cadre. Deployment and career progression, however, continue to lag.

**Financing:** Swedish funding served as a catalytic investment. The Government now finances salaries for over 2,500 midwives, indicating fiscal absorption and show government ownership. Supervision,

[11] Upazila is an administrative sub-unit of a district in Bangladesh.

continuing education, and facility readiness remains largely dependent on external funding.

**Service delivery:** Pilots of midwife-led care at sub-district and urban facilities improved quality of maternity and SRHR services and established referral pathways. Scale-up beyond project areas has been slow, constrained by infrastructure challenges, supply chain weaknesses, and inter-professional hierarchies.

## Health systems strengthening vs. support

Health systems strengthening entails more than just supporting the system. Strengthening the system includes some additional dimensions. Chee et.al. (2013) formulates a set of questions that can facilitate how health systems strengthening can be distinguished from health systems support. These questions are applied to Sweden's support to UNFPA and the Bangladesh midwifery reform below, to support the analyses.

**Does the intervention address system constraints rather than a specific disease or facility?** Yes. Swedish support targeted the regulation, education, and management of midwives which are core health system functions, rather than specific service outputs.

**Does it have cross-cutting benefits?** Yes. Strengthening midwifery governance, workforce education, and data systems has benefitted maternal, newborn, and reproductive health services broadly and informed human resources for health (HRH) reforms[12].

**Are improvements sustainable?** Partly. Integration of midwifery within public service structures and government payrolls suggests institutional sustainability. However, external support is still required for supervision and quality assurance.

[12] Read more on HRH: https://www.who.int/teams/health-workforce/human-resources-for-health-observer

**Does it enhance system adaptability?** The 2022-2025 phase's additional focus on digital health, SRHR and climate links, and community resilience indicates an ambition to increase capacity to respond to emerging challenges.

## Discussion and conclusion

Our assessment is that Sweden's support to UNFPA and Bangladesh's midwifery reform is a good example of when Swedish development assistance for health has contributed to health system strengthening. Our analysis suggests that Sweden's support strengthened health system functions, not merely supporting the system to increase service volumes.

The midwifery reform addressed key organizational and workforce constraints, supported regulatory and financing structural reform, and enhanced the system's adaptability beyond maternal health. Nonetheless, some challenges remain related to domestic financing, quality assurance, and facility readiness. Sweden's engagement can thus be viewed as health system strengthening through targeted support to a government-led reform with lasting institutional effects.

Some of the key enablers identified were:

- Broad consensus around the problem and a shared goal facilitated collaboration among stakeholders.
- Strong political backing by the government of Bangladesh.
- Long-term international donor advocacy, technical support and funding.

The enabling factors resonates with our overall conclusion that health system strengthening takes time and must have support of, and be led and owned by, the government. Changes and reforms in health system performance drivers are unlikely (impossible) without strong political support.

Over fifteen years, Bangladesh has progressed from having no professional midwives to an established public-sector cadre. Sweden's decade of collaboration with UNFPA reinforced regulation, education, and midwife-led service models, working through government systems and avoiding parallel structures. The result is a sustained, system-oriented support that has helped integrate midwifery within Bangladesh's health system.

# Health systems strengthening in Uganda

In Uganda we selected the World Bank led "Uganda Reproductive, Maternal and Child Health Services Improvement Project" (URMCHIP; contribution 1 in Table 4) and more specifically, Sweden's contribution to this project, for an in-depth review regarding health systems strengthening. The project started in 2017 and was initially supposed to end in 2021 but was extended to the end of 2023. According to our assessment, this contribution target health systems strengthening.

## Case study 2: Uganda Reproductive, Maternal and Child Health Services Improvement Project

### Background and context

In Uganda, various health projects with results-based financing mechanisms have been implemented over the last 20 years (Ministry of Health, 2024). With a maternal mortality rate of 246 and a neonatal mortality rate of 21 in 2017, improving reproductive health has been a priority in Uganda. A project with a total value of USD 180 million was therefore started in 2016 financed by World Bank/IDA, but with contributions of SEK 250 million from Sweden and USD 15 million from the Global Financing Facility – the World Bank Reproductive, Maternal and Child Health Services 2017-21.

The overall project objectives were to: (a) improve utilization of essential health services with a focus on reproductive, maternal, newborn, child and adolescent health services in target districts, and (b) scale-up birth and death registration services. Result indicators in the project appraisal document covered several service delivery out-

comes, for example: births attended by skilled health personnel; child immunization and birth and death registration.

## The concept of results-based financing (RBF)

Originally the project included components on results-based financing for primary health care services, reproductive, maternal, child and adolescent health services and scale-up of births and deaths registration services. Additional components were added during the project, including operational research and financing of emergency interventions, with the emergence of the COVID-19 pandemic.

The concept of results-based financing has been integrated in World Bank financed projects in several sectors (health, education, solid waste etc.). The concept links payments to actual achieved results, and the idea is to create financial incentives for service providers to extend basic services specifically to low-income communities.

According to the Global Partnership for Results-Based Approaches, the concept also includes components like creating incentives for consumers to access services[13] - for over 20 years and in over 30 countries[14]. In health, the RBF schemes are diverse, but with some general features, including (i) "the introduction of a pay-for-performance scheme at some level of health provision" and/or (ii) "demand side financing for health" (Friedman et al., no date).

The RBF component in the Uganda World Bank Reproductive, Maternal and Child Health Services 2017-21 introduced several changes in remuneration- and disbursement procedures. The main features were:

**Disbursements based on performance reporting:** Apart from the first quarter of year 1, disbursements were based on reports of performance in relation to a selection of 11 maternal and child health/

[13] https://www.gprba.org/who-we-are

[14] https://www.worldbank.org/en/news/feature/2019/06/28/banking-on-impact-what-you-need-to-know-about-results-based-financing

reproductive health indicators, during the previous quarter. The performance reports were submitted from the health facilities to the district level but were validated by an independent external organisation.

**Financing directly to the targeted health facilities:** Funds were paid directly to the health facilities from the national level and allocated through a management board/group at the health facility which determined how to use the money, but within a framework of guidelines for the project. The district level health office was only reimbursed for its role of compilation of reports and for supervisory functions.

**Staff incentives:** In line with the RBF guidelines, the facilities spent nearly 40% of the funds on staff incentives. Principles and criteria for determining the individual bonus were decided by the facilities. Generally, the reimbursement based on individual staff performance was considered "more fair" than reimbursement to groups (Ministry of Health, 2022).

## Swedish support to URMCHIP

Initially, the cooperation between the World Bank and Sweden was suggested to be a "meeting of minds". Joint, coordinated efforts would have a greater impact, compared to if every partner developed their own programme. As with other programmes in Uganda, and in line with Swedish strategic priorities, Swedish support to the overall programme focused primarily on reproductive health. Additionally, support also included targeted contributions to governance-related aspects.

Findings from the field visits suggest that Sweden actively participated in both the design and the supervision of the RBF component, particularly in defining the 11 indicators to be monitored and rewarded.

In addition, Sweden also contributed to interventions during the COVID-19 pandemic in Uganda. More explicitly, Sweden provided

support into three of four of the original project components, but with most of the funding going through the results-based financing component. It was noted that the flexibility in using Swedish funding for different areas as need arose was seen as commendable, especially in terms of issues at the national level and in relation to the COVID-19 pandemic.

## Health system strengthening effects

In this case, focus is on the health system strengthening effects of URMCHIP. The project has been evaluated jointly by the Uganda Ministry of Health, World Bank and Thinkwell, through a quasi-experimental study (using difference-in-differences design), which concluded that "significantly positive effects" were achieved for several indicators including for first and fourth antenatal care visit, uptake of modern contraceptives, postnatal care and outpatient visit for children under 5 (Ministry of Health, 2024).

Based on the experiences of the World Bank/Sida financed project, a process for the Government to adapt and adjust the results-based financing started in 2019. The process led to a strategic decision in 2020 to mainstream RBF into the national financing mechanisms of the Ministry of Health. After this decision, the work to adapt the scheme to Government financial management requirements while preserving the effects of the project took off. Figure 12 illustrates the process of mainstreaming RBF, from the inceptions of the externally financed project up to and including the mainstreaming (Ministry of Health, 2025).

This process led to the integration of the results-based financing mechanism into the already existing Primary Health Care Conditional Grant.

**Figure 12. Main actors and roles within the design process for mainstreaming results-based financing**


Source: Ministry of Health, 2025.

In summary, the contextualized format changed the RBF component to a model closer to an annual planning framework. Performance indicators were changed from quarterly assessments to be linked to performance the previous year. Freedom for facilities to allocate funds was curtailed as funds had to be spent according to the annual plan. Cash incentives for staff were not allowed. Through the integration with the general primary health care reporting framework, the number of indicators were expanded. From only focusing on reproductive, maternal and child health, the reporting was widened to a more comprehensive format with 31 indicators in total, covering five different outcome areas (quality, utilization/coverage, efficiency, financing equity, primary health care financing). Finally, fiscal constraints meant that the RBF funds were limited to USD 9 million compared with USD 16 million during the WB/Sida financed project.

## Has Sweden's support contributed to health system strengthening in Uganda?

To understand if the URMCHIP programme more broadly, and the RBF component specifically (and thereby the Swedish support), contributed to health system strengthening, we assessed the support in relation to our analytical framework (see p. 27).

**Governance:** The intervention introduced several novelties into the Ugandan health sector, mainly by linking performance (both individual and organisational) to remuneration. In doing this, the information collected and how it was validated was strengthened. A participatory approach to the planning for utilisation of funds received was also introduced (Ministry of Health, 2022).

**Resource generation:** No additional sources of internal funding were introduced. In the utilisation of funds received, however, it was noted that they were used to fill gaps in areas of drugs, in maintenance of and supplies (20%), infrastructure (10%), community engagement (6%), management (6%), and equipment (5%).

**Financing:** Swedish funding functioned as catalytic investment to introduce RBF into the Government financial management structure. The results of the project led the Government to continue with RBF albeit on a lower level than previously and with changes in both how the funds may be used and in the autonomy of the health facilities. Additionally, no staff incentives were allowed. Thus, the project led to a sustained change in financial resources allocation mechanisms.

**Service delivery:** Improvements in access to and (to some extent) satisfaction with care were noted, and there is some evidence of other improvement in quality of care (Ministry of Health, 2024). After the finalisation of the project, however, the improvements in the targeted areas have deteriorated somewhat, not the least as the allocation within the Government system is about half of the allocation under the WB/Sida project.

As in Case study 1 from Bangladesh, we have applied a set of questions proposed by Chee et.al. (2013) to the Swedish support to URMCHIP. These questions can be used to distinguish between health systems strengthening and health systems support.

**Does the intervention address system constraints rather than a specific disease or facility?** The intervention targeted facilities providing primary health care but focusing on maternal and child health/sexual and reproductive health. The mechanism used was addressing general system constraints, however.

**Does it have cross-cutting benefits?** Yes. Even if the RBF mechanism was mainly targeted towards resource allocation, the program has addressed issues related to other areas including logistics, information systems and staff welfare.

**Are improvements sustainable?** As the Government has made RBF a part of their allocation mechanisms, it appears sustainable. As regards the improved results, however, these will largely depend on the fiscal space that is allocated to health. Whether the revised scheme will be able to maintain the level of staff motivation remains an issue.

**Does it enhance system adaptability?** The introduction of other financing and management mechanisms apart from the traditional incremental approach does make larger flexibility possible also in the future. There is, however, a limit to what can be achieved without additional resources. The mainstreaming of the RBF concept into the overall governance structure of the health system during the later stages of the project meant that some of the initial flexibility and autonomy for the health facilities was reduced. As the financial allocation is related to the previous year's performance and the operational targets are set in an annual plan, the possibilities for operational changes during the year are limited. Local influence through the facility management board was weakened as part of the process to align with general government procedures.

Additionally, the interviews that were conducted points at; (i) communication and orientation challenges at inception; (ii) problems with emergency medicine procurement; (iii) gaps and weaknesses in performance reporting; (iv) less motivated staff; (v) inequitable geographic and demographic effects on outcomes, and (vi) stock-outs of essential medicines (Ministry of Health, 2025).

## Discussion and conclusion

The WB/Sida project was externally financed and limited in time. Additionally, the project was managed by the Ministry of Health, but the Ministry had external consultancy support for validation and for disbursements.

The situation changed as the government decided to integrate RBF into the national financial framework and to develop and implement its own version of results-based financing. Thus, the government added one more tool into its governance structure.

In the transition into the government structure, however, the financial allocation to RBF was nearly halved. Additionally, the principles for reporting and controlling changed and were internalized into government structures. Even so, the principles behind the financing mechanisms were maintained and contributed to strengthen the system.

HSS was not clearly articulated as the main objective of this project, however. The main project objective focused on improving utilization of health services. This is an important performance indicator for a health system, but perhaps it would have been valuable to include health systems strengthening explicitly as a project goal and reflected in the results matrix.

# Overall assessment of HSS in Uganda and Bangladesh

In this section we attempt to make an overall assessment of Sweden's effort to support health system strengthening in these two long term partner countries, Uganda and Bangladesh.

Out of the 23 aid contributions that were selected for an in-depth review (see Box 1. p.47), five were assessed as "partly" targeting HSS and the remaining 16 were assessed as not targeting HSS. We also assessed if relevant health systems performance indicators are used to follow up the projects overall goal. Relevant performance indicators refer to metrics that track changes in relation to health systems goals, for example health improvements, equity and financial protection. Nine projects had indicators of relevance for health system performance, three were assessed as partly measuring health system performance and the remaining 11 did not have relevant indicators. Interestingly, seven projects had no indicators for follow-up in relation to the overall objective or goal.

In summary, based on the definition of HSS used in this evaluation, only seven of the 23 contributions reviewed had goals and/or objectives that clearly reflected an ambition to strengthen health systems.

The case studies in Bangladesh and Uganda provide a complex picture of Sweden's contribution to health systems strengthening. A recurrent theme across interviews is that Sweden's way of working based on long-term engagement, flexibility, and close dialogue with national partners, has created favourable conditions for system-oriented reforms. In both Bangladesh and Uganda, respondents emphasized that Sweden's long-term presence enabled constructive contributions to policy processes, national planning, and institutional development. This mode of engagement does not in itself constitute HSS, but it has been an important foundation for Sweden's more systemic contributions.

In the interviews, the respondents argue that Sweden has, in selected areas, supported changes that align with the definition of HSS as articulated by Chee et al. (2013), namely efforts that modify performance drivers and enable the health system to function better over time.

In terms of concrete effects, some of the selected initiatives supported by Sweden illustrate contributions to strengthening key performance drivers of the health system. In Uganda, Sweden's co-financing of the World Bank's results-based financing programme is widely perceived as having introduced changes to the national financing and accountability architecture and has contributed to improved health outcomes. Interviewees highlighted the institutionalization of performance-based grants, strengthened verification systems, and improved use of routine data for decision-making. These changes influenced incentives and governance arrangements at multiple levels of the system, suggesting effects that go beyond increased service delivery and instead target core system functions.

Another area where Sweden has played a role in contributing to health system changes is in adolescent health in Uganda, where Sweden has successfully supported integration of adolescent health services in the standard set of health services provided. At the same time, contributions in both Uganda and Bangladesh have been uneven, and many programs have delivered health system support rather than systemic strengthening. The interviews therefore suggests that Sweden has contributed to HSS primarily through focused, long-term engagement in specific system functions rather than through a coherent, organization-wide HSS strategy.

Similarly, in Bangladesh, Sweden's long-term support to midwifery through UNFPA is cited as one of the most significant system-strengthening contributions. Respondents emphasized that Sweden's role extended beyond financing training to supporting the development of a professional cadre, strengthening regulatory structures, and improving the institutional environment for midwifery education and deployment. Such efforts represent changes to work-

force governance and quality assurance mechanisms, consistent with HSS as defined in this evaluation. Sweden has also contributed to health financing reform processes in Bangladesh through support to the World Health Organization, the Health Economics Unit and UHC-related policy development, although these efforts remain at an early stage and what effects it will have on how Bangladesh health system remain to be seen.

In both countries, Sweden has also supported improvements in governance and institutional capacity at sub-national level. In Uganda, Swedish-supported programmes helped strengthen district planning, data use, and accountability structures. In Bangladesh, pilots such as the "Aalo urban primary health-care clinics" demonstrated how to improve health service delivery and offer models for future system reform. While these initiatives remain limited, they illustrate how Sweden's contributions have at times extended beyond inputs to push for changes in how services are organized and overseen.

## Challenges associated with Swedish aid to health system strengthening

There are challenges that limit the extent to which Sweden's support has translated into broader health system-wide strengthening. Interviewees across the two countries noted that donor-supported projects, including some supported by Sweden, have created parallel reporting or management systems, contributing to fragmentation rather than to integration. In Bangladesh, respondents emphasized that while pilots and targeted interventions have shown strong potential, a system-wide adoption has been constrained by low public health spending, weak regulatory capacity, and political–economic factors. This highlights how structural constraints on behalf of the recipient government can limit the sustainability of HSS efforts. Regardless of donor intent, unless the government commits to implementing health system reforms, they are unlikely to be successful and sustainable.

# Main lessons and recommendations from the evaluation

In this section we reflect on the results from the evaluation, highlight what we consider to be some of the key lessons learned and make suggestions for how Sweden can work more effectively with development cooperation in health going forward.

## Swedish support has focused on health system *support* rather than health system *strengthening*

Findings from our review of programmes in Uganda and Bangladesh indicate that Sweden's bilateral DAH *supported* rather than *strengthened* the health system. For a programme to be considered health system strengthening, the functioning of the system must be changed, the change must be permanent and the performance of the system as such need to improve. We found a few examples of programmes that met these requirements, two of which we presented as case studies. Other programmes supported by Sweden in Uganda and Bangladesh have in different ways supported the health system and reportedly saved lives and improved health outcomes, which are important achievements and in line with the goals they set out to achieve. However, our point is that these gains are not sustainable or automatically translates to improved health systems performance.

An important point to emphasize is that stronger health systems is not an end goal. A stronger health system is a means to achieve universal health coverage, improved financial protection, and ultimately improve health outcomes.

## Health system strengthening is not an explicit goal in Swedish development cooperation strategies

Findings from our review of strategies and policies in Swedish development cooperation show that while Sweden state that HSS is a

policy priority, HSS is rarely mentioned in the country cooperation strategies. This was an unexpected finding as the cooperation strategies are the Government's central instruction for how Sida should prioritize and focus resources in development cooperation.

Given that HSS is rarely mentioned in country cooperation strategies, it was less surprising that the bilateral health programmes reviewed in this evaluation rarely have explicit objectives or goals that target HSS. In the absence of clear expectations from the Government, HSS has seemingly been interpreted as "improving access to care" or "improving basic health". The interviews with Sida staff reinforced this notion.

Findings from the interviews suggest that Sweden's contribution to HSS has been shaped as much by individual staff capacities and longstanding partnerships as by deliberate strategic decisions. While Sida staff demonstrated a deep understanding of system dynamics, respondents consistently noted the absence of clear organizational guidance, shared definitions, and systematic monitoring of HSS. This absence of guidance has contributed to uneven practices across programmes and challenges in identifying, designing, and tracking contributions with explicit HSS ambitions. As a result, even when Sweden has engaged in system-strengthening work, this has often not been clearly articulated in programme documents or monitored through system-level indicators.

One explanation for the limited number of programmes targeting HSS is that HSS is not an operational goal of the Swedish government. While health system strengthening is mentioned in the government's development assistance policy and features centrally in the broader conversation on aid effectiveness, our review shows that HSS is not an explicit objective in the Government's development cooperation strategies across the entire evaluation period. This absence is noteworthy, as the success of Swedish bilateral DAH is assessed against the specific goals set out in these strategies.

Instead of referring directly to HSS, goals in the Government's bilateral development cooperation strategies typically use formulations such as "increased access to SRHR" or "improved basic health." While these are worthy aims, improvements in access to SRHR or basic health do not necessarily signal a stronger health system. Such goals can be achieved by expanding service provision through additional inputs, even if the underlying system remains weak or inefficient. Our analysis further shows that health systems strengthening is rarely appearing as overall or specific objective in partner programmes. This lack of explicit HSS objectives is perhaps unsurprising as programmes are designed to deliver results in relation to the Swedish government's strategic goals, which again lack such specific HSS goals.

The lack of strategic direction for HSS was further underscored by the limited, or at times absent, coherence in Sida's support. We found no evidence that achieving coherence in country-level support, with the aim of contributing to HSS, has been treated as a strategic priority. Swedish bilateral DAH to Uganda and Bangladesh appears instead as a collection of disparate projects, largely shaped by other organizations (only partly by the governments), and selected by Sweden primarily to fulfil country cooperation objectives.

We argue that if Sweden is serious about contributing to HSS, a more coherent approach, based on a firm understanding of HSS and supported by institutionalized competence in HSS, is needed within bilateral programs—one in which HSS is clearly articulated as the overarching goal of cooperation.

## Health system strengthening requires coherency and long-term engagement

Reforming and transforming the core functions (performance drivers) of a health system is inherently complex, difficult, and takes time. This evaluation identified a few examples of Swedish-supported projects in Uganda and Bangladesh that have contributed to such re-

forms. A common feature of these reforms is their long duration: they have unfolded over many years, spanning multiple funding and strategy cycles, and in some cases began even before the evaluation period. For instance, the midwifery reform in Bangladesh formally started in 2010, with preparatory work initiated even earlier. This underscores the long-term perspective required of any development actor aiming to contribute to HSS.

One conclusion we draw is that, given the time horizons involved, it is challenging to evaluate results in terms of HSS without adopting an equally long-term perspective. It also highlights the difficulty of attributing specific contributions of Swedish support to HSS outcomes. Over such extended periods, numerous actors are typically involved, priorities in both Sweden and recipient countries may shift, and economic, political, and cultural contexts evolve.

## Moving away from working with recipient government hampers HSS efforts

We argue that there is a fundamental tension between the way Swedish development assistance for health is currently implemented and Sweden's stated ambition to contribute to health systems strengthening. Our analysis of aid data show that only a small share of Swedish bilateral DAH to the six countries in this evaluation is disbursed to recipient government or intermediaries such as the World Bank. This follow a general trend observed over the last two decades where Sweden, along with many other development partners, have shifted away from working directly with recipient governments. There has also been a move from broader, sector-wide programs toward more discrete, project-based approaches. This shift is driven by several factors, including concerns around corruption, a desire for clearer attribution of results, and frustration with perceived slow progress.

While this evolution is understandable from the perspective that Swedish politicians are accountable to Swedish taxpayers, we contend that distancing development cooperation from recipient gov-

ernments undermines Sweden's ability to support meaningful HSS. Effective health systems strengthening requires working alongside, and supporting, government-led reforms. Although health services may be delivered by private providers and medical training by private institutions, the government must ultimately ensure that core health system functions operate in a way that advances universal health coverage, financial protection, and responsiveness.

The importance of the stewardship role of the recipient government in the health system cannot be overstated. The government is ultimately responsible for policymaking and legislation, thereby deciding over how organisations and institutions in the health system should work. For example, improving financial protection in Bangladesh, where out-of-pocket spending on health is among the highest in the world, will not be possible without increased public financing and mechanisms for pooling funds across the entire population. Without such government-driven reforms, Swedish support for HSS cannot achieve its intended outcomes.

## HSS requires increased domestic funding

"Lack of funding" is a challenge to high performance in any health system and even if there are considerable potential efficiency gains in the Uganda and Bangladeshi health system, these countries will never achieve UHC unless domestic funding for health is increased. Generating fiscal space to increase resources in the system is difficult for both countries. Uganda is grappling with a high level of debt and debt servicing consumes about 57% of the national budget (2024-2025), placing severe constraints on public spending (ISER, 2024). In Bangladesh, the share of public spending on health is among the lowest in the world with less than 1% of GDP, largely explained by the low priority to health (about 5%) in the budget (Khatun, Yusuf, & Ferdous Richi, 2024). This contributes to that out-of-pocket spending on health is among the highest in the world, leading to poor financial protection, which is a key health systems performance metric.

HSS requires country commitment to system reforms and budget priority to the sector is one of the ways to move from stated ambition to actual change. A recent analysis from the World Bank argues that countries can do more and must do more in a context of shrinking development assistance for health, to increase domestic funding for health. The report argues that prioritizing health is a political choice for countries, however ultimately all low- and lower-middle income countries require broader macro fiscal reforms to spur growth and increase government revenue (Kumar et. al., 2025).

## Swedish government institutions have limited capacity to be an active partner in HSS

Sweden currently has limited capacity to act as an active and technically informed partner in health systems strengthening. Designing and delivering HSS support requires a critical mass of health systems expertise, yet we found no indication that Sida functions as a competent strategic partner in this area.

Our case studies suggest that Sweden and Sida tend to adopt approaches to system-level work developed by other organizations, rather than applying a clear, internally defined HSS framework or strategy. This is understandable: Given the importance of subject competence within a development partner, also in the field of HSS, we note the current general lack of such technical, analytical, and policy development competence on the part of Sida. It is noticeable, however, that this has not always been so as the Health Unit at Sida-HQ did have a dedicated health systems team in the late 1990s with the expressed purpose of Sida being a competent partner in the emerging field of health systems analysis. Regrettably, this competence does not seem to have been firmly institutionalized as the ability of Sida to act as a competent partner in HSS appear to have waned over the past decade or so.

While there are many skilled individuals within Sida, health systems expertise cannot be considered an institutional strength. Sida is con-

sequently less able to evaluate partner proposals or ensure that funded activities will effectively contribute to HSS objectives. As a result, programmes are sometimes labelled as "HSS" without a clear rationale linking them to actual system strengthening.

Within health, the focus has long been on sexual and reproductive health and rights, where Sweden has indeed had tangible impact, for example in Uganda. However, gaining influence in broader health system reform requires sufficient technical knowledge and capacity to engage meaningfully in the national and international dialogue. Interviews further revealed that Sida staff themselves perceive their health systems competence as insufficient. Overall, Sida functions primarily as a financier rather than a technical partner, which constrains Sweden's ability to drive or influence health systems strengthening in partner countries.

## Measurements of HSS in Sweden's development assistance for health needs to be developed

A central question when supporting HSS is: What should be measured? In many cases, particularly in results-based financing interventions, impact has been assessed mainly from a health outcomes perspective rather than through indicators of system change. While measuring improvements in health outcomes is important, it is not sufficient. If the underlying objective is to transform the health system and move closer to universal health coverage, it is essential to also track the mechanisms that produced the improvement, not only whether the results were positive.

We must also recognize that achieving measurable improvements in system performance takes time and HSS support is difficult and complex to evaluate. While there is currently a push from the Government for increased use of randomized controlled trials (RCTs) as a method for evaluating Swedish development assistance, none of the HSS interventions supported by Sida would lend themselves to a RCT or similar implementation research design. There is also no

indication that such a design would have meaningfully improved results.

Finally, attribution becomes increasingly difficult over the long-time horizons required for HSS. System reforms unfold over many years and involve numerous actors, making it challenging to identify the specific contribution of Swedish support.

## The new aid landscape

Recent developments in 2025 and 2026, not least the significant aid reductions announced by several countries, have put HSS in renewed focus. The OECD estimated that development assistance for health will fall with approximately 19-33% in 2025 compared to 2023 (OECD, 2025).

In the last 2-3 years, initiatives aimed at reforming global health aid have been launched, including the Lusaka Agenda and the Accra Reset. The Lusaka Agenda, launched in December 2023, sets out five strategic shifts to reform how global health initiatives operate including stronger support for primary health care, increased domestic financing of health systems, more equity, streamlined governance, and coordinated research and development (R&D)/manufacturing. The Accra Reset, announced in 2025, is a new global development framework that calls for ending "business-as-usual" aid patterns and reengineering global governance, financing, and partnerships.

Both the Lusaka Agenda and the Accra Reset aim to shift power toward country leadership by reducing donor-driven priorities and strengthening nationally led decision-making. The agendas emphasize increasing domestic financing and building resilient, system-wide primary health care rather than continuing vertical, siloed programs. Both also call for reforming global governance to improve alignment, accountability, and equity across international partners.

In summary, our findings show that Sweden has contributed to HSS in Bangladesh and Uganda, most notably in midwifery reforms, financing and accountability mechanisms, and governance improve-

ments. These contributions align with the definition of HSS used in this evaluation. However, direct HSS efforts have not been consistent across the portfolio and have been constrained by both internal and external factors. Sweden's strengths, including long-term engagement, equity focus, and strong partnerships, have enabled meaningful contributions when aligned with national reform processes. Yet, the absence of a coherent organizational approach to HSS and the structural constraints within partner countries have limited the scale and sustainability of these contributions. The recent Lusaka Agenda and Accra Reset initiatives provides an opportunity to rethink how Sweden, and others, approach development cooperation in health broadly and health system strengthening specifically.

# Recommendations

## Make health system strengthening an explicit strategic objective in country cooperation strategies

The evaluation shows that HSS is not mentioned as a goal or sub-goal in any reviewed country strategies, despite being a policy priority. If the Swedish government is serious about HSS, it should be made an explicit goal in country cooperation strategies. Without explicit goals, Sida is not expected to design or monitor programmes for HSS, which risk leading to fragmented portfolios and focus on short-term service delivery rather than systemic reform.

## Work more closely with country governments

The report repeatedly emphasizes that health system strengthening is impossible without government leadership and ownership. Sweden has increasingly moved away from working directly with governments. We recognize that in many countries where Sweden provides bilateral DAH, working in close collaboration is challenging. However, not working closely with governments undermines Sweden's ability to support structural reforms in financing, governance and policy, to contribute to health system strengthening.

## Improve HSS capacity, guidance and coherence within Sida

If Sweden wants to pursue HSS in development cooperation in health, Sida's capacity in this field should be strengthened. Interviews show that Sida's capacity to work on HSS is limited and often depend on individual staff skills rather than institutional knowledge. Further-

more, Sida lacks a shared definition, tools, and monitoring indicators for HSS. This can also strengthen Sida's ability to ensure adequate HSS efforts for Swedish priorities such as SRHR outcomes in joint programs with development partners.

## Prioritize program designs that strengthen health system performance drivers rather than short-term outputs

The evaluation shows most Swedish bilateral DAH has been health system support rather than health system strengthening. Only a few of the programs evaluated contributed to lasting systemic change. If Sweden wants to improve how bilateral DAH contribute to HSS, programs should to a larger extent demonstrate how they address systemic constraints, avoid creating parallel structures and contribute to HSS goals.

## Improve dialogue and coordination between Swedish strategies for development cooperation

The current governance model in Swedish development cooperation, with thematic, country and regional strategies makes it challenging to take a coordinated HSS approach at country level. While there are potential synergies between, for example, health research capacity building support and HSS, the vertical nature of strategies with specific strategy goals risk creating friction and undermining HSS impact.

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# Appendix 1. What is a health system?

In everyday conversation we can talk about "the health system" without paying much attention to what we really mean by this term. Most of us would probably think about health services provided by health workers in a health care facility as the health system. While "traditional" health services clearly is a central part of the health system many would also soon realize that a health system extends beyond the confines of online services, primary health centres and hospitals.

## A common ground for description and assessment

The first comprehensive approach to describing and assessing health systems and their performance was introduced by Murray and Frenck at the turn of this century in a series of publications (Murray & Frenk, 2000; World Health Organization, 2000). As all health systems vary in design, governance and outcomes, regardless of income level, the authors saw a need to enable a more systematic analysis of health systems to "quantify the variation in health system performance, identify factors that influence it and articulate policies that will achieve better results in a variety of settings" (p 717). While acknowledging earlier attempts, which were generally more medically focused, they suggested an approach derived from the fundamental question "what are health systems for?" (p 718). The framework presented consisted of two dimensions of health systems, applicable to all countries and contexts:

- Definitions of what a health system is and how they can be described. The starting point is the boundaries of a health system, based on the purpose of the action, "any set of activities whose primary intent is to improve or maintain health". This primary intent criterion implies that activities such as education, which undeniably contribute to health, are not included. This does not mean that the educational sector's contributions to health are not

important or should not be considered in a health sector assessment, but rather that it is important to be able to hold institutions in regulation, financing and provision of health accountable, and to assess their effectiveness. Further, within the defined boundaries, any health system always provides four functions: Service provision, Governance, Financing, and Resource creation. These were defined in generic terms to enable description and comparison of each function (see 'building block' below).

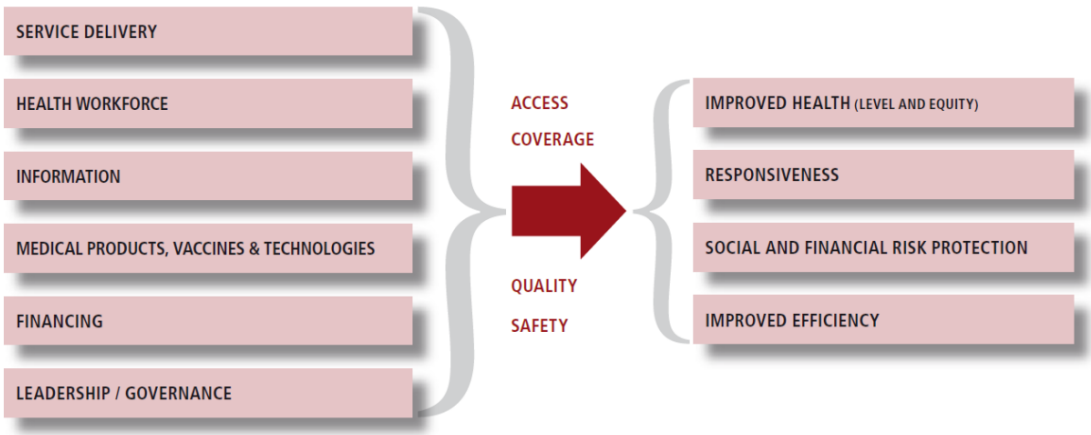
- Definitions of what objectives or goals a health system are aiming for. These enable systematic description and assessment of how well the system performs. While it is recognised that they can vary in importance between countries and over time, they are arguably generic and indeed presented as such. The authors distinguish between goals intrinsic to the health system (see final goals below) and instrumental goals (see intermediary goals below). The goals they defined as intrinsic were: (i) to improve the health of the population and the distribution thereof; (ii) to enhance the responsiveness of the health system vis-à-vis expectations of the population, and (iii) to achieve fairness in financial contribution.

Even if many organisations, researchers and organisations have come up with their own interpretations and specifications of what health systems are, the fundamental concept through the primary intent formulation, as well as the functions and the goals, seem to have stood the test of time. Important elements have complemented the framework, such as education and income as social determinants of health. Another example is the more recent "One Health Approach", which seeks to harmonize actions in health, agriculture and environment, which allows to for attention to for example increasing microbial resistance. Most of the continued discussion on how to analyse, measure progress and strengthen health systems, however, is based on the principles given in World Health Report 2000.

## Specifying the description: introducing the building blocks

WHO continued its elaboration on advancing health systems thinking in 2007 (World Health Organization, 2007) with the introduction of health system building blocks. The objectives, both intermediary and final, were also further specified, with emphasis on efficiency of health systems.

**Figure 1. Health systems building blocks**




Source: WHO (2007).

The 2007 World Health Report emphasized the importance of interaction between the different building blocks and to the overarching systems which health operations relied upon, such as overall poverty eradication concepts, education and overarching governance and financing structures.

Still, a major criticism to WHOs health system framework development has always been the absence of explanatory links between functions or building blocks and goals, or tools to explain how these building blocks are contributing to the attainment of the objectives. The separation of objectives in levels is an important feature, with two levels in the framework and often more in practical assessments

and analytical work. The notion that an instrumental goal like access is not a final objective of the health system is important but carries limited guidance about what explains higher attainment of the ultimate goals.

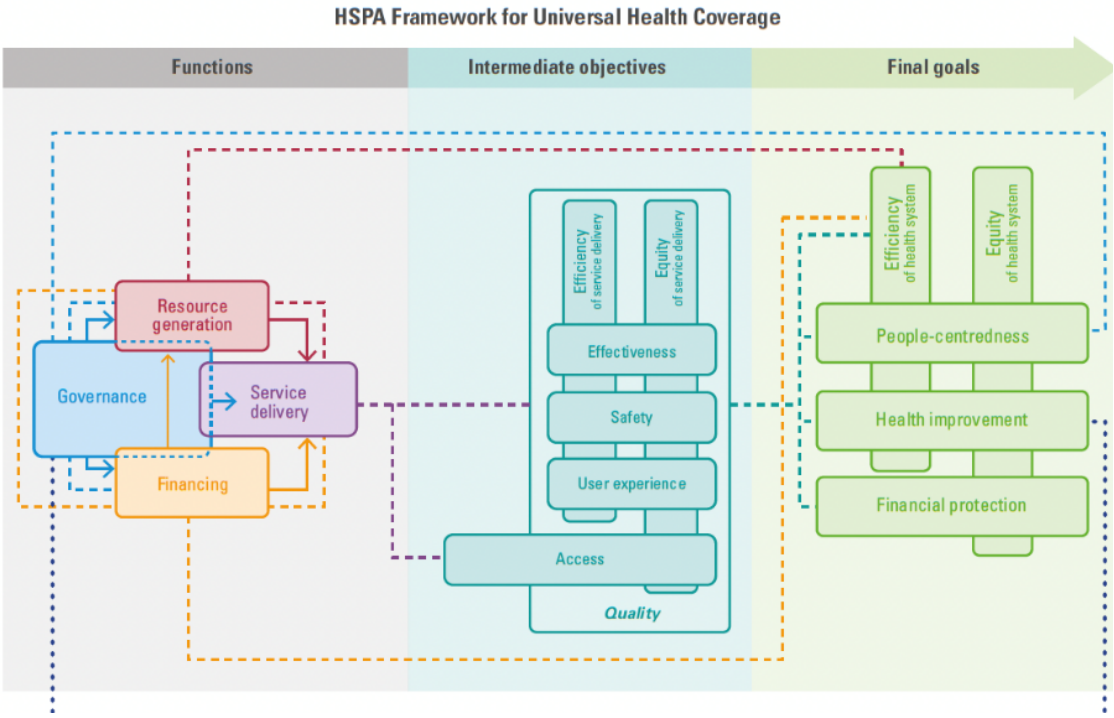
Even though WHO has been leading the overall development of HSS frameworks, many concurrent efforts to define frameworks and measure performance have been developed, all adding additional layers. There are plenty of suggestions for how to operationalise the WHO framework and 'unpack the black box' between functions/building blocks and objectives, for example the 'Donabedian' approach to assessment and monitoring which applies a typical results framework approach, outlining inputs, outputs outcomes and impact, where outputs and outcomes illustrate the link between health system functions and goals. An additionally useful perspective of how to frame health system approaches is the categorisation by Shakarishsvili et al (Shakarishvili et al., 2010), which classifies specifications of the generic framework by the purpose of the exercise and the subsequently chosen method:

- The descriptive approach, which describes the different components within the system, but not how the system works or why it would perform better than another.
- Analytical models with funding and care process flows, including organisational entities in the system, which can keep the functional components of the system and
- Deterministic and predictive models divided into the actuarial, the economical and the and the macro-policy models, which aim at describing why some systems seem to work better than others.

One of the most recent frameworks for assessing health systems performance was published in 2022 by the WHO and the European Observatory (World Health Organization & European Observatory on Health Systems and Policy, 2022). In this report, they present a Health Systems Performance Assessment Framework (HSPA), which is arguably the most detailed framework presented so far. The

HSPA framework outlines health systems functions that contribute to achievement of health systems intermediate objectives and final goals (World Health Organization & European Observatory on Health Systems and Policy, 2022).

**Figure 2. Health systems performance assessment framework for universal health coverage**




Source: World Health Organization & European Observatory on Health Systems and Policy, (2022).

Still, the dominant 'role-model' framework for analysis and for measuring progress is arguably the 2007 WHO publication (Cleary, 2020; Rwabukwisi et al., 2017). Recently, and applied in this evaluation, Kutzin et al. argue that the traditional frameworks (by WHO) need careful contextualisation in their application, with respect to that all countries face challenges that are specific and hence need tailored solutions (Kutzin, Sparkes, Earle, Gatome-Munyua, & Ravishankar,

2024). They suggest that health reforms should be what they call "objective oriented", i.e. that any policy efforts to improve the system are: "(i) problem-oriented (focusing on solving a performance problem); (ii) consistent (extent to which reforms are connected to the problems they are meant to address); and (iii) continuously evaluated". This approach goes back to starting with the performance problem, i.e. identifying underperformance and what causes it and then define objectives based on this analysis, which can guide the design of reform or development effort.

In summary, while the thinking on health systems and health systems performance has evolved over the last 25 years, the functions and goals formulated back in 2000 have largely stood the test of time.

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# Appendix 2. Review of previous evaluations of development assistance for health system strengthening

As part of the background of this study, we have reviewed evaluations of health systems strengthening (HSS) conducted by other development partners. Not least the more disease or intervention specific global health initiatives (GHIs) have conducted several evaluations of their HSS support. In the following sections we summarize the main findings from this review.

## How has HSS been defined in previous evaluations?

A core challenge in evaluating HSS initiatives is the absence of a universally accepted definition. This lack of conceptual clarity has hindered the development of comprehensive and consistent evaluation frameworks. Without a shared understanding of what constitutes HSS, or what HSS grants are intending to achieve, previous HSS evaluations vary widely in scope, methodology, and focus.

Many institutions that support HSS claim to adopt an HSS approach yet often do so without clearly defining what it entails or aims to achieve. Major GHIs - including the Global Financing Facility (GFF), Gavi and the Global Fund have been criticized for their lack of a clear, transparent definition of HSS (Cambridge Economic Policy Associates Ltd, 2016; Global Financing Facility, 2025; Swiss Tropical and Public Health Institute, 2019; The Global Fund, 2023, 2024). While many GHIs base their HSS approaches on the WHO Health Systems Building Blocks, they often tailor their support to align with their own organizational strategies or program goals (Cambridge Economic Policy Associates Ltd, 2016; Global Financing Facility, 2025; The Global Fund, 2023). Thematically structuring a strat-

egy or a development contribution by "building blocks" can mean utilizing the framework as a conceptual anchor. This does not necessarily mean that GHIs apply a health systems approach, neither to performance and problem analysis, nor to intervention design. The United Kingdom Foreign, Commonwealth & Development Office (FCDO) discuss their approach to HSS in detail (Foreign Commonwealth and Development Office, 2021), yet without explicitly defining a set of criteria or characteristics distinguishing HSS interventions from others. This lack of clarity of what constitutes HSS undermines the foundation for evaluation, making it difficult to measure progress, assess impact, or compare outcomes across different contexts.

Evaluations have tried to address this definitional gap in various ways, for example by distinguishing between health system support— improvements in health systems functioning primarily driven by increases in inputs —and health system strengthening, activities that drive long-term changes in how the health system operates (Cambridge Economic Policy Associates Ltd, 2016; The Global Fund, 2023; Waife, Witter, & Jones, 2019). However, likely due to the conceptual difficulty, most evaluations don't explicitly discuss a HSS definition utilized in evaluation.

One exception is the performance evaluation of the United Kingdom Department for International Development's (DFID) 'Making Country Health Systems Stronger (MCHSS)' programme (Waife et al., 2019), which drew on a global review and impact assessment of HSS interventions (Witter et al., 2021). They characterize HSS interventions as cross-cutting (spanning multiple WHO building blocks), non-disease-specific, system-wide (extending beyond individual facilities to subnational or national levels), and influencing the entire patient pathway. This definition emphasizes four key dimensions, including scope (cross-cutting interventions affecting multiple building blocks and diseases); scale (national reach and influence across all levels of the health system); sustainability (long-term, systemic im-

provements beyond short-term gains); and effects (tangible impact on outcomes, equity, and financial protection).

## Methods applied in evaluations of HSS in development cooperation

Evaluations of HSS have predominantly employed mixed methods approaches, combining both quantitative and qualitative techniques to assess the design, implementation, and outcomes of HSS interventions. Quantitative analyses often rely on existing policy, disbursement and health service data (Alebachew & Osman, 2015; CURATIO International Foundation, 2014; JaCro Consulting PLC, 2014). Qualitative methods have drawn from desk reviews of country-level documents and relevant literature (Alebachew & Osman, 2015; CURATIO International Foundation, 2014; Governance Institute-Afghanistan (GI-A), 2014; JaCro Consulting PLC, 2014; John Snow Inc., 2015; SCHOOL OF HUMANITIES AND SOCIAL SCIENCES, 2016; Tettey & Associates, 2015; Waife et al., 2019; Witter et al., 2021), key informant interviews with stakeholders (Alebachew & Osman, 2015; Biacaba, Queuille, Haddad, & Sia, 2014; CURATIO International Foundation, 2014; Governance Institute-Afghanistan (GI-A), 2014; JaCro Consulting PLC, 2014; John Snow Inc., 2015; SCHOOL OF HUMANITIES AND SOCIAL SCIENCES, 2016; Tettey & Associates, 2015), field visits to implementation sites (Alebachew & Osman, 2015; John Snow Inc., 2015; SCHOOL OF HUMANITIES AND SOCIAL SCIENCES, 2016), and SWOT analyses (Governance Institute-Afghanistan (GI-A), 2014).

Evaluations are largely theory-based, often grounded in Theories of Change (ToC) or logical frameworks as analysis frameworks to assess whether the intended intervention logic has held in the implementation, and whether the intended results have been achieved (Global Financing Facility, 2025; Shorten et al., 2021; The Global Fund, 2023, 2024; Waife et al., 2019; Witter et al., 2021). One per-

formance evaluation found it useful to distinguish between four levels of analysis when assessing the ToC (Waife et al., 2019):

1. A broad framework for understanding how different parts of the health system interact, which shapes the overall programme approach.
2. The programme-specific ToC as defined in the HSS design (e.g., business case).
3. A general model for analysing technical assistance interventions.
4. Updated ToCs that reflect practical learning during implementation.

Many evaluations focus on specific building blocks or components of the health system, such as management, health planning, financing, information systems, monitoring and evaluation, and human resources (Alebachew & Osman, 2015; Waife et al., 2019). Several evaluations structure their analysis around input-process-output-outcome-impact chains (CURATIO International Foundation, 2014; Tettey & Associates, 2015; The Global Fund, 2024; Waife et al., 2019), while others assess design quality, implementation fidelity, efficiency, equity, sustainability, and effectiveness (Alebachew & Osman, 2015; Cambridge Economic Policy Associates Ltd, 2016; SCHOOL OF HUMANITIES AND SOCIAL SCIENCES, 2016; Swiss Tropical and Public Health Institute, 2019; Tettey & Associates, 2015; Waife et al., 2019). A more comprehensive approach, the Health Systems Strengthening Framework, assesses inputs, mechanisms of change, system goals, and resulting outputs and impacts (Witter et al., 2021).

Evaluations have often relied on funders' results frameworks and key performance indicators (Global Financing Facility, 2025; John Snow Inc., 2015; Tettey & Associates, 2015; The Global Fund, 2024). However, many donors lack robust indicators tailored to health system performance (Global Financing Facility, 2025; Swiss Tropical and Public Health Institute, 2019), instead using general metrics like health outcomes, service coverage and outputs. Evaluations of Gavi

and the Global Fund point out the tendency of assessing HSS investments using inputs and short-term outputs rather than the long-term structural changes that define HSS (Cambridge Economic Policy Associates Ltd, 2016; Swiss Tropical and Public Health Institute, 2019; The Global Fund Technical Evaluation Reference Group, 2019). GHIs also tend to assess progress against their strategic priorities rather than broader health system improvements.

An evaluation of the Global Fund's Resilient and Sustainable Systems for Health investments found misalignment between their definition of HSS and stakeholder expectations—particularly due to assumptions that disease-specific investments yield cross-cutting benefits (The Global Fund, 2023). Without appropriate and shared indicators, evaluations struggle to assess long-term impact or ensure comparability (The Global Fund, 2024). Most continue to focus on short-term results rather than sustainable system transformation (House of Commons International Development Committee, 2024). An exception is FCDO's "making country health systems stronger" program, which defines its outcomes and impacts using a clear health systems orientation, with explicitly stated goals and measurable indicators aligned to system performance and resilience (Waife et al., 2019).

## Challenges in evaluating development assistance for HSS

Evaluating HSS is challenging, largely due to the lack of a shared definition. This hampers the design, measurement, and monitoring of HSS grants, making it difficult to assess their relevance, effectiveness, sustainability, and overall impact. While some agencies try to differentiate between system support and strengthening, these distinctions are often subjective and poorly informed (The Global Fund, 2023).

Evaluation methods frequently lack rigor, with weaknesses in sampling, data analysis, and reliance on grant proposals rather than im-

plementation data. Disbursement figures are often used instead of actual expenditures, and short project timelines, missing baselines, and complex multi-donor environments further limit impact assessment (Cambridge Economic Policy Associates Ltd, 2016; Swiss Tropical and Public Health Institute, 2019; The Global Fund, 2023; Waife et al., 2019; Witter et al., 2021).

Additional challenges include blurred lines between HSS and disease-specific interventions, as well as the difficulty of isolating effects due to overlapping programs. Measurement is further complicated by the absence of clear milestones, weak attribution, and misaligned logic models and key performance indicators (Global Financing Facility, 2025; Swiss Tropical and Public Health Institute, 2019; The Global Fund, 2023; Waife et al., 2019). Limited post-approval tracking of HSS grants also hinders detailed spending analysis, preventing clarity on whether support is contributory, cross-cutting, or truly strengthening (The Global Fund, 2023).

These conceptual and measurement issues complicate the validity and comparability of results, ultimately impacting the quality of HSS investments (The Global Fund, 2024). For example, an analysis of Gavi's HSS funding in 76 countries showed nearly 50% of spending went to activities like supply provision and health worker incentives—more aligned with system support than strengthening (Tsai, Lee, & Fan, 2016). Similarly, a prospective country evaluation found that a high proportion of funding in the "Resilient and Sustainable Systems for Health" program (ranging from 46-89% between countries) was directed towards activities supporting the system rather than strengthening it, often due to limited guidance and a focus on addressing input gap (Salisbury et al., 2024).

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# Appendix 3. Methods and material

## Part 1: Portfolio analyses

The first part of the evaluation consisted of an overview of Swedish aid for HSS to six countries: Uganda, Bangladesh, Zambia, Myanmar, DRC and Somalia. The selection of countries was outlined in the terms of reference and consists of countries where Sweden has had country strategies for development cooperation with specific health related goals.

### Data

A request for data was sent to Sida in January 2025. Each aid disbursement is coded according to the OECD-DAC creditor reporting system (CRS) and we requested data on all health aid disbursements for the period 2014-2023. Health aid was defined as disbursements under purpose codes 120 (health) and 130 (population policies/programs and reproductive health) (OECD, 2024). The request yielded at total of 2,479 disbursements. Furthermore, we downloaded all publicly available country strategies and strategy reports from openaid.se for the six countries over the period, in total 12 country strategies and about 50 strategy reports.

### Analysis

Aid disbursement data was analysed using Stata 18 to generate descriptive statistics on the amount of health aid disbursed over the period. Country strategies and strategy reports were analysed qualitatively. Strategy objectives, goals and indicators for follow-up were extracted and summarized in tables to provide an overview of how they address issues of health system strengthening.

# Part 2: Focus on Bangladesh and Uganda

The second part of the evaluation analyses the impact of Swedish support for HSS in Uganda and Bangladesh 2014-2023.

## Data

The evaluation is based multiple data sources including aid disbursement data, project documentation, and interview data. Table 1 provides an overview of data.

**Table 1. Data sources**

| Type of data | Description |
|---|---|
| Aid disbursement data (for all relevant aid to Uganda and Bangladesh) | - All aid disbursement under purpose code 120 and 130<br>- Additional aid data in dialogue with Sida staff |
| Project documentation (for selection of agreements relevant for HSS) | - Project proposals<br>- Assessment memos<br>- Decision on contribution<br>- Evaluations<br>- Annual reports<br>- Conclusions on performance |
| Interviews with current and former Sida staff | N=10. Staff that are currently working, or have previously worked in or with Uganda and Bangladesh |
| Interviews with partners | Key partners and government counterparts in Uganda and Bangladesh |

## Selection of agreements

For the second stage of the evaluation, we evaluated the effects of Swedish support to HSS in Uganda and Bangladesh. This required identification of agreements of relevance for HSS. Relevant agreements were identified using two sources: a) the list of agreements to Uganda and Bangladesh based on the mapping in stage 1 and b) a list of agreements of potential relevance for HSS in Uganda and

Bangladesh, provided by staff at Sida. The list from Sida included additional agreements, not identified in our first mapping because these agreements are financed by other Swedish development cooperation strategies (e.g. the Global Social Strategy and the regional SRHR strategy).

We reviewed both lists and made a qualitative assessment of the HSS relevance of each agreement based on the overall project description to generate the final sample for the evaluation. All agreements were reviewed by independently by at least two project members and assessed for HSS relevance. The following inclusion and exclusion criteria were used for the assessment:

## Inclusion criteria

- The agreement should be of a certain size (at least 5 million SEK annually) as it is reasonable to assume that very small projects would have not an effect on HSS outcomes of a country.
- The agreement should explicitly (in writing) or implicitly (by focus area) target HSS as part of the strategy objective or project description.

## Exclusion criteria

- No indication of HSS in description of project aims or by focus area.
- Projects clearly focused on improving outcomes primarily by increasing inputs (for example procuring medicines, distributing mosquito nets and or increasing health worker salaries).
- Less than 5 MSEK annual budget.

The inclusion criteria were applied generously to ensure that we include all potentially HSS relevant agreements. In cases of uncertainties or conflicts, these were resolved through a discussion in the project team. We have excluded COVID-19 specific projects, as they

were short term in character and our assessment is that they did not target more long-term HSS.

This approach generated a sample of 23 agreements to be included in the evaluation, 14 in Bangladesh and 9 in Uganda (Table 2 and Table 3).

**Table 2. Agreements under the Bangladesh country strategies included in the evaluation**

| Agreement | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|---|---|---|---|
| 51060001: Health sector programme in Bangladesh 2011-2016 | – | – | – | – | – | – | – | – | – | – |
| 52170010: Health sector programme in Bangladesh 2017-2022 | – | – | – | – | – | – | – | – | – | – |
| 51060044: RHSTEP 2014-2016 | – | – | – | – | – | – | – | – | – | – |
| 51060023: Urban Environment Water Aid | – | – | – | – | – | – | – | – | – | – |
| 51060002: Urban Health 2012-2017 | – | – | – | – | – | – | – | – | – | – |
| 52170025: Urban Health 2019-2023 | – | – | – | – | – | – | – | – | – | – |
| 52170014: UNFPA Midwifery 2016 | – | – | – | – | – | – | – | – | – | – |
| 52170012: UNFPA Midwifery 2017-2021 | – | – | – | – | – | – | – | – | – | – |
| 13393: Midwifery program UNFPA 2022-2025 | – | – | – | – | – | – | – | – | – | – |
| 52170040: Water safety for the wellbeing of mothers and children in Bangladesh | – | – | – | – | – | – | – | – | – | – |
| 11123: WASH4UrbanPoor | – | – | – | – | – | – | – | – | – | – |
| 14914: WASH for Urban Poor (Phase II) | – | – | – | – | – | – | – | – | – | – |
| 12966: Mental Health Cox's Bazaar | – | – | – | – | – | – | – | – | – | – |
| 14200: WHO-strengthening health systems | – | – | – | – | – | – | – | – | – | – |

**Table 3. Agreements under the Uganda country strategies included in the evaluation**

| Agreement | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|---|---|---|---|
| 51180046: UNFPA SRHR 2013-2014 | – | – | – | – | – | – | – | – | – | – |
| 51180056: UNFPA SRHR 2015-2017 | – | – | – | – | – | – | – | – | – | – |
| 51180075: Naguru Teenage Centre extension 2014-2015 | – | – | – | – | – | – | – | – | – | – |
| 51180095: Naguru Teenage Health & Info Centre 2015- 2020 | – | – | – | – | – | – | – | – | – | – |
| 51180090: Umbrella fund SRHR & HIV 2016-2021 | – | – | – | – | – | – | – | – | – | – |
| 10191: World Bank RMNCH 2017-2021 | – | – | – | – | – | – | – | – | – | – |
| 10717: UNICEF maternal and newborn health West Nile 2017-2021 | – | – | – | – | – | – | – | – | – | – |
| 14600: UNICEF Uganda – country programme support 2021-2025 | – | – | – | – | – | – | – | – | – | – |
| 11739: WFP-UNICEF joint programme on social protection 2019-2024 | – | – | – | – | – | – | – | – | – | – |

## Agreement documentation

A request for documentation for all 23 agreements was sent to the Swedish Embassies in Uganda and Bangladesh in April 2025. The following documents were requested:

1. Project proposals from partners (including Annexes and budgets).
2. Assessment memos.
3. Decisions on contribution.
4. Annual conclusion on performance.
5. Annual reports from partners.
6. Internal and external evaluations (including evaluations conducted by partners for contributions that were jointly funded with other partners.
7. Any other material deemed relevant by the Embassy staff.

Data was provided by the embassies in April-May 2025 and reviewed for completeness by the research team. In case documents appeared to be missing, these were requested and provided by the embassies. While we cannot be completely sure that no documents are missing, the material was comprehensive and included several hundred files.

## Interviews with current and previous Sida staff

Interviews were conducted with current and previous Sida staff in Uganda and Bangladesh. The interviews addressed the overall issue of the perception of Sida staff regarding the overall trends and developments of support to health systems strengthening in recipient countries. The purpose of the interviews is to collect qualitative information of the support to facilitate interpretations of the quantitative and other findings.

Respondents were identified in dialogue with Sida. A request for interview was sent to 12 people, of which 10 agreed to/were available to participate. Interviews were conducted over Zoom in May and June 2025. The interviews were semi-structured and guided by a questionnaire. Questions were open-ended and broad, but with carefully prepared probes to ensure all relevant areas were covered. The full interview guide can be found in Annex 5. One interview was also conducted with a representative of the Ministry for Foreign Affairs to obtain the Swedish Government's perspective on HSS in development cooperation.

Before starting the interview, the participants were informed about the background of the study and the voluntary nature of their participation. Verbal consent was obtained to record the interview and generate transcriptions.

## Field visits to Uganda and Bangladesh

Field visits were conducted in Uganda and Bangladesh during September 2025. During the visits, we met with Sida staff at the Embassies as well as representatives of partners that have received support

from Sweden during the evaluation period. We also met with selected key informants knowledgeable about HSS in Uganda and Bangladesh respectively. Informants were identified through recommendations from staff at the Swedish embassies.

The interviews were semi-structured and focused on stakeholder's perceptions of if Sweden's support has been effective in achieving set targets for HSS? If the support has contributed to long-term changes in how the health system performs? And if there has been alignment between set objectives of the support and changes in the how the health system performs. The interviews also focused on the character and quality of the evidence for any observed effects and on any specific or general lessons that can be learned.

Before starting the interview, the participants were informed about the background of the study and the voluntary nature of their participation. Verbal consent was obtained to record the interview and generate transcriptions. The interview guide for the field visits can be found in Annex 6.

## Analysis

The agreement documentation and interviews was analysed qualitatively and guided by the analytical framework. The following section describes our analytical approach in further detail.

## Analysis of agreement data

Agreement data was compiled and organized using Microsoft Excel. For each agreement we extracted overall and specific objectives, indicators for follow-up and results reported against these indicators.

For each agreement we conducted an assessment if the overall objective was formulated in a way that targets health system strengthening (i.e. contributing to more comprehensive changes to health system functions or allow for more effective use of resources). Furthermore, we made an assessment if the overall objective was followed up using relevant indicators (i.e. measuring performance re-

lated to final HSS goals of equity, financial protection and people centeredness). Agreements were assessed as:

A. **"YES"** – the overall objective target performance drivers AND imply change or reform to these drivers.
B. **"PARTLY"** – the overall objective target performance driver OR imply change or reform to performance drivers.
C. **"NO"** – the overall objective does not target performance driver NOR imply any change or reform to these drivers.

## Analysis of interviews with key informants

Interviews with Sida staff were transcribed using Zoom's integrated transcription function. The transcripts were reviewed by the two researchers who took part in all interviews for accuracy. Field trip interviews were recorded and transcribed verbatim.

Interviews were analysed qualitatively using a deductive approach based on the overall themes of the interview guide. Transcripts were anonymized and uploaded to ChatGPT (5.0) to generate a summary focusing the manifest content of the interviews. The summary was reviewed by the researchers for accuracy, compared with transcripts, discussed and revised.

## Health system strengthening: case studies

To illustrate how Sweden has supported health system strengthening in Uganda and Bangladesh we have developed 2 case studies of Swedish support for HSS, one from Uganda and one from Bangladesh. The cases were selected among the programmes that, according to our assessment, were the most relevant examples of successful HSS. As illustrated by our review of all contributions (Table 3 and Table 4) only a few programmes explicitly targeted HSS, limiting the number of possible cases studies. The case studies should therefore be seen as illustrative of successful Swedish HSS rather than representative of all Swedish bilateral DAH to Uganda and Bangladesh. The case studies are based on agreement and interview data as well as

other relevant material to provide a rich description of both objectives, goals and results in relation to HSS, but also provide nuances about factors that have influenced implementation. This include contextual factors in Sweden (different strategies, goals and priorities), international factors (priorities of other development partners and trends in how development assistance is being provided) and finally country specific factors (priorities at country level and ability to work with and through recipient governments).

## Effectiveness of Swedish support for HSS: what can we say about causality?

Generally, the term and concept of causality refer to the ability to attribute the effect on some outcome to a cause. For example, the effect of taking Ipren (reduced pain) can be attributed to ibuprofen, the active ingredient in Ipren. The rational for this attribution is a sound evidence base consisting of, among other things, multiple, well-conducted experiments with random allocation of participants and, importantly, an understanding of the biological and physiological processes involved (See Box 1).

Causality, in the current context, refers to the question of whether any change in some outcomes can be directly or indirectly attributed to the Swedish support, i.e., the extent to which it can be stated that the Swedish support has had a direct or indirect (causal) impact on relevant health systems performance indicators (as identified by the analytical framework). The current evidence base does not consist of any experiments, well-conducted or otherwise, and it does not rest on a sound understanding of all processes involved. This begs the question: on what basis would the evaluation be able to conclude that the Swedish aid has had a causal effect on strengthening the health systems in Uganda and Bangladesh?

**Box 1. The Randomized-controlled trial (RCT)**

A tried and tested way of evaluating the difference in effect of an intervention is to randomly assign the units of analysis (people, geographic regions, organizations) to either of two groups (or "arms"), the treatment group and the control group. These types of studies are referred to as randomized controlled trials (RCT) to describe a situation where subjects are randomly allocated across treatment status in a manner fully controlled (i.e. prior knowledge about other factors generating the data) by the investigator. If the randomization process has been conducted properly, the units in the two separate groups would be identical in all respects except that one group would receive the treatment and the other would not receive the same treatment during the study period. An evaluation of the effect of the intervention would then compare the mean outcome between the two groups. The random allocation of the subjects provides the opportunity to make causal inference and the conclusion from such a study would be that the intervention had a causal effect on the outcome in question of some magnitude and direction.

Source: (Olofsgård, 2014).

Given the fact that Sweden's support for HSS has not been implemented in a randomized controlled manner, our evaluation is not able to base any conclusions on such types of evidence. Furthermore, any non/quasi-experimental (statistical/econometric) approach to assess causality would require detailed and comprehensive time-series data on a broad range of factors. The evaluation cannot draw on any such evidence either. The reasons for this include the very nature of the support (aid on this level is rarely randomly allocated to recipients) and the nature of the subject (health systems are complex units, not amenable to randomized interventions). Consequently, one conclusion of the evaluation is that given the current

available evidence, it is not possible to make a judgement as to the causal effects of the Swedish support on the HS outcomes, in the experimental (or quasi-experimental) sense.

## Are there other ways to assess or ascertain a causal effect of the Swedish aid?

There are other ways than the experimental and quasi-experimental approaches to assess the effect of an intervention on some defined outcomes. For example, causal diagrams (or, Directed Acyclic Graphs, DAG) are a method to illustrate the causal relationship between an intervention and an outcome (Pearl & Mackenzie, 2018). This approach is technically complex and has been criticized by, for example, econometricians for lacking empirical justification in certain contexts (Imbens, 2020).

There are also qualitative approaches to investigate the causal impact of an intervention on some outcomes. These approaches usually rest on some definition of causality, that may not be fully incompatible with traditional definitions, and on alternative approaches to the scientific quest. For example, Maxwell presents a framework for how to assess (an understanding of) causality using qualitative methods that rest on a realist understanding of scientific ideas (partly aligned with the constructivist and the positivist/empirical views) (Maxwell, 2004). The presentation discusses the approaches of the variance-theory (closely associated with statistical analysis of variables and their relationship) and process-theory, involving the analysis of a limited number of events or cases on which to base causal conclusions. Our current evaluation rests on the latter approach; see also (Sandahl & Petersson, 2016) for a discussion on alternative approaches to investigating causal effects.

If it cannot be stated that the aid has had a causal effect, then what type of effect has it had on these outcomes? Evaluators tasked with assessing the effect of an intervention on some outcome may refrain from making a causal claim about the relationship between the ob-

served units. For example, in the absence of experimental results, they may conclude that it is not possible to say anything about the causal effect of the intervention. The problem then arises of what they are prepared to say about the relationship between the cause and the effect. This problem is valid both in research and in more operational work. It is, for example, common to read in medical and other research reports that "since the data are observational, we cannot say anything about the causal effect of X (the intervention) on Y (the outcome)". Instead, the researchers go on to explain that they have found an "association" between X and Y (usually reported as an odds-ratio). There are at least two problems with this statement. First, it is not the observational nature of the data that is a problem. Rather, the problem is that the units of analysis have not been randomly allocated to either X or not-X. If they had been, they would still have been "observed" but been so in a specific design.

Second, calling the estimated odds-ratios measures of "association", rather than causal effects, do not make them any less biased. The main issue is if the effects have been estimated in a model that meets the basic conditions for fitting a model producing unbiased and consistent estimates. In many cases, the readers of the reports are unable to say if this is the case. Importantly, the issue of causal or association becomes not one of research but one of semantics (Hernán, 2018).

In the absence of both randomized allocation of Swedish aid and of access to quasi-experimental investigations of the effects of the contributions, as well as limitations in the ability to conduct such studies or alternative investigations, what can we say about the effects of Swedish aid to health systems strengthening in Uganda and Bangladesh over the years 2014 to 2023 and what can we not say?

We can conclude that Sweden (through Sida) has disbursed funds to these countries over the period for purposes that can be defined as HSS (overall or specific objectives of the programmes are formulated in a way that addresses health system strengthening). We can thereby say that Sweden has (financially) contributed to the aims of the activities to which these funds were directed/allocated.

We cannot say that Swedish aid has had a causal effect on any changes in the health systems in the countries. Nor can we say that Swedish aid has had any other type of effect (e.g., association with observed changes) on the countries' health systems. The main reasons for this inability to say something about the effects of the Swedish aid are the nature of the support (non-random allocation toward multiple objectives and through multiple channels), the nature of the targets (complex health systems), an absence of impact evaluations (using quasi-experimental methods), a poor monitoring and evaluation system (limited information about the nature of the support and its potential effects), unrealistic objectives as what the aid can reasonably achieve (as seen from the sector strategies), and a poor understanding on the part of Sweden and its partners as to the nature of health systems strengthening objectives and measures.

Based on the findings of the evaluation, we discuss the extent to which it can be stated that the Swedish support has had a direct or indirect (causal) impact on UHC indicators and make a weighted and balanced judgement as to the causal effects of the Swedish support on HSS.

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# Appendix 4. The health sector in Uganda and Bangladesh

This section provides an overview of the respective health sector and the Swedish support to health in Uganda and Bangladesh. The profile is organized according to the three goals of a health system: (i) Health, (ii) responsiveness and (iii) fairness in financial contribution (Murray & Frenk, 2000).

## Country Profile: Uganda

### Improving health

The population of Uganda in 2023 was 48,656,601 with a projected increase of 76% to 85,431,202 by 2050 (WHO Data, 2024b). Even if significant achievements have been made in terms of for instance maternal and child mortality, Uganda's health burden remains dominated by communicable diseases (e.g., malaria, HIV/AIDS) alongside maternal and neonatal conditions, including reduced maternal and child mortality Even so, health improvements remain off-track for SDG targets. Persistent inequities—driven by geography, gender, and socioeconomic status—undermine progress. The COVID-19 pandemic further exposed systemic weaknesses in both settings Table 9 provides the top ten causes of burden of disease in Uganda but also the changes over the last decade

**Table 1. Top 10 causes of deaths per 100k in 2023 in Uganda, and rate change 2013–2023, all ages combined**

| Cause | 2023 rank | % change 2013-2023 | Cause type |
|---|---|---|---|
| Neonatal disorders | 1 | -14.2 | Communicable, maternal, neonatal, and nutritional diseases |
| Malaria | 2 | -10.8 | Communicable, maternal, neonatal, and nutritional diseases |
| HIV/AIDS | 3 | -35.1 | Communicable, maternal, neonatal, and nutritional diseases |

| Cause | 2023 rank | % change 2013-2023 | Cause type |
|---|---|---|---|
| Road injuries | 4 | 52.9 | Injuries |
| Lower respiratory infect | 5 | -19.2 | Communicable, maternal, neonatal, and nutritional diseases |
| Congenital defects | 6 | 9.55 | Non-communicable diseases |
| Diarrheal diseases | 7 | -45.3 | Communicable, maternal, neonatal, and nutritional diseases |
| Interpersonal violence | 8 | 17.8 | Injuries |
| Dietary iron deficiency | 9 | 9.78 | Communicable, maternal, neonatal, and nutritional diseases |
| Stroke | 10 | 19 | Non-communicable diseases |

Source: Institute for Health Metrics and Evaluation (2025).

Thus, the overall disease burden has been reduced. Maternal mortality ratio (per 100 000 live births) has improved from 5752 in 1990 to 170 in 2023, neonatal mortality has reduced from 36, 7 per 1000 in 1990 to 19 in 2023. A worrisome issue, however, is that even if adolescent pregnancies has reduced, it remains high at 1114 per 1000 in 2017. The highest disease burden derives from Neonatal disorders, Malaria and HIV/. The biggest increase by far is traffic injuries, with interpersonal violence being second. All the "traditional" infectious diseases have been reduced with diarrheal diseases showing the biggest reduction. Life expectancy at birth had increased from 48.9 years in 2000 to 66 years in 2021 (Institute for Health Metrics and Evaluation, 2025b).

Apart from injuries, the transition towards non communicable diseases being the biggest disease burden has not yet taken place. The change in demography suggests, however, that added to the population increase due to a high fertility rate, a change in the epidemiological pattern should be emerging within the next decade thus putting additional pressure on the Country's health system.

## Responsiveness

The responsiveness goal addresses how well systems meet the demand and expectations of the population. Defined by the World

Health Organization (WHO), responsiveness refers to non-clinical aspects of health care that reflect how well the system meets patients' expectations. Parameters are: dignity, autonomy, confidentiality, communication, prompt attention, quality of basic amenities and choice of provider.

Responsiveness of the health system has been analysed using data from a nationally representative household survey, where 60.6% of respondents had visited a healthcare facility in the past 6 months. In this study, higher responsiveness was reported by wealthier, urban, and more educated individuals especially those accessing private facilities and continuity of care (seeing the same provider). High responsiveness was strongly associated with greater patient satisfaction, better self-rated health and a higher trust in the health system (Fifield et al., 2022). Other observations are:

- A study at Mpigi Health Centre IV found that 58% of patients were satisfied overall, but that 53.9% felt staff were not responsive to their needs. Key factors influencing satisfaction were time and attention from staff, privacy during diagnosis/treatment and availability of medicines (Omona, 2021).
- District health system strengthening efforts in West Nile Region Between 2019–2021 led to client satisfaction with maternal and newborn health services increasing from 26.5% to 39.8%. Other improvements were noted in governance, access to medicines, and health workforce capacity as a consequence of a support intervention (Muhumuza et al., 2025).

In summary, there seems to be a disparity between perception of responsiveness between private and public facilities, that urban privileged persons perceive receiving better services than less privileged persons living in rural areas, but that staff engagement in patients is low in many facilities. Underlying causes appear to be staff shortages, other resource shortages, and limited training in relations building.

## Fairness in financial contribution

The fairness goal aims to prevent high costs due to poor health, this to promote equitable access to health services. In many low- and middle-income countries, however, the overall financing of especially the public sector is a primary concern. Resource gaps in the public sector usually leads to badly functioning facilities and public health programmes, particularly in rural areas. Generally, the share of GDP attributable to health is lower in low- and middle-income countries despite commitments in different international fora for the opposite. The overall health expenditure per capita in Uganda was US$ 44, in 2022, which is significantly lower than in Zambia (76 US$ in 2022) but significantly higher than in Somalia (15 US$). The overall National budget contribution to health was 5% in 2022, a decrease by 3% since 2000 and significantly below the 15% of the national budget recommendation by the Abuja call (African Union, 2006). While donor funding has historically played a central role, declining external support has created uncertainty and underscored the need for sustainable domestic financing.

From an equity perspective, out of pocket spending is a critical indicator as fees and other charges is the biggest barrier for the poorest to seek health care. 34% of the total resources envelope for health care was out of pocket spending in Uganda, which could be compared with 10% in Zambia and 73% in Bangladesh (World Health Organization Global Health Expenditure Database, 2025). Efforts to introduce a National Health Insurance Scheme remain stalled, underscoring weak financial risk protection.

The Limited fiscal space also restricts available human and other resources. Uganda has one of the lowest doctor-to-population ratios globally (1.9 per 10,000), but relatively more nurses and midwives compared to regional averages (WHO Data, 2024b). Workforce shortages are exacerbated by difficulties in retention, especially in rural areas. Challenges emerge in ensuring equitable access to essential medicines, due to frequent shortages in public facilities and reliance on private markets. A paradox is, however, that there are still unem-

ployed health workers (Hutchinson et al., 2024), which has led to some development partners financing employment of midwifes on contract. Interviews during the recent trip to Uganda indicate that the funds provided through the Results based financing project often were used to buy drugs when the supply through the Government was failing.

The Ugandan parliament passed the National Health Insurance Scheme Bill in 2021 to strengthen financial risk protection and advance UHC. However, its implementation remains stalled, pending amendments by the Ministry of Health. The Uganda National Minimum Health Care Package developed in 1999 has been recently reviewed by the MoH and redefined as the National Essential Health Care Package (UNEHCP) in 2024 to accelerate progress towards UHC and SDGs. The goal of the UNEHCP is to increase UHC coverage in Uganda to 85% by 2030 through delivery of an affordable and responsive health benefits package through public and private sector (The Republic of Uganda Ministry of Health, 2024).

## Stewardship/governance

The stewardship role means setting, implementing and monitoring the rules of the health system. While other parts of the system can be delegated to and executed by for instance the private sector, the role as systems steward lies with the government. It is also a subset of Governance which also includes issues such as accountability prevention of corruption and management.

After the catastrophic presidencies of Idi Amin and Milton Obote, Uganda was in a poor state and the incoming president, Yoweri Museveni, was initially seen as providing stability, thus enabling the rebuilding of the country. Based on the organisation of the National Resistance Movement, the Uganda embarked on a decentralisation policy, decentralizing extensive powers to districts in many areas including health. The decentralized structure, which is outlined in chapter 11 of the constitution and operationalized by the Local Governments Act was initiated in 1993 and meant that planning, revenue

collection (not taxes), financial management, making bye laws and ordinances and local administration of justice through Local Council courts fall under districts (Baryehukyi, 2024). The role of the Ministry of Health was limited to policy development, oversight and strategic planning.

Services are provided through national, district/ local government structures, alongside private and not-for-profit providers. Thus, Uganda's structure emphasizes decentralization, encouraging local decision-making and community participation, though challenges remain in implementation and resource allocation. In terms of health, all public institutions apart from the national and regional hospitals fall under the districts. Coordination between the public and private parts of the health system is weak.

In the beginning, the extensive authority on resources allocation led to the districts allocating about one third of what could be expected to Primary Health Care, which lead to the introduction of the still existing PHC Conditional Grant. the grant earmarked allocations to PHC and not to hospitals thus restricting the authority of the districts. Operational plans are developed for each health facility and approved by the District Health Board. Direction is provided through the strategic health plans developed by the Ministry of Health, which feeds into the national Development plans.

## Swedish support to health prior to 2014

Swedish Aid to Uganda dates to 1986, after the end of the civil war. The Swedish support was initially channelled through other organisations such as UNICEF and the World Bank. After 1991 Uganda became a Swedish programme country with bilateral cooperation programmes in direct cooperation with the Government. During this period of developing structures and systems for decentralised management for health, the health sector received Swedish sector budget support, which lasted until 2011 (Andersson, Andersson, Bigsten, & Ståhl, 2016). The introduction of the Sector Wide Approach (SWAp) to health, within which Sweden was participating,

provided the framework for coordinating different inputs at the national level but led also to an even more restricted autonomy for the districts as allocations in practice were determined at national level in negotiations between international organisations and the Ministry of Health (Jeppsson, 2004).

From 1993 and up to 2008 Sweden also provided technical assistance to both the decentralisation process and to the SWAp process through long term advisors, first within the framework of the World Bank District Health Services Project and later directly seconded to the Ministry. The focus of the technical support was on health services management and on financial management at district level.

At the same time, Sweden also supported research, mainly through the Makerere university. This support also included Secondment of Swedish researchers/technical officers within the Child Health and Development Centre and later to the School of Public Health. There is some documentation of the contributions made by the University to evaluation/assessment of different support programmes in different parts of the country (Muhumuza et al., 2025).

Lastly, Sweden has also supported different international organisations in Uganda by seconding Swedish officers to different positions, usually as Junior Professional Officers and this type of support is still ongoing.

Despite progress in several health indicators, Uganda's health system faces persistent challenges, including limited resources, under-functioning facilities, and difficulties in recruiting and retaining qualified health workers, particularly in rural areas. These gaps contribute to low-quality health services and information, especially in public facilities (World Health Organization, 2018). The COVID-19 pandemic and lockdown measures have further strained the system, reducing access to care (Tumwesigye, Okethwangy, Kaakyo, & Biribawa, 2021), stagnating neonatal mortality improvements, and exacerbating high adolescent pregnancy rates (UNFPA Uganda, 2022).

# Country Profile, Bangladesh

## Improving health

The population of Bangladesh in 2023 was 171,466,990, with a projected increase of 25% to 214,709,097 by 2050 (WHO Data, 2024a). Since gaining independence in 1971, Bangladesh has made remarkable progress in health outcomes. The country initially faced high mortality rates, low female literacy, and frequent natural disasters, relying heavily on donor-funded projects focused on population control and primary healthcare. Political resistance, however, delayed the adoption of a National Health Policy until 2011.

As donor priorities shifted from project-based aid to Sector Wide Approaches (SWAps), the government implemented three major sector programs between 1997 and 2016: the Health and Population Sector Strategy (HPSS, 1997), the Health, Nutrition and Population Sector Program (HNPSP, 2003–2011), and the Health, Population and Nutrition Sector Development Program (HPNSDP, 2011–2016). These programs aimed not only to expand access to essential health, population, and nutrition services—particularly for poor women and children—but also to strengthen governance, improve efficiency, and ensure cost-effectiveness (Udechukwu et al., 2023).

Largely as a result of these coordinated efforts, health outcomes in Bangladesh have improved substantially, with life expectancy at birth reaching 74.9 years in 2024 (World Population Review, 2025). At the same time, however, the country now faces a double burden of disease: while progress has reduced mortality from infectious and maternal-child conditions, non-communicable diseases (NCDs) are increasingly driving mortality patterns (Institute for Health Metrics and Evaluation, 2025a), as outlined in Table 10.

**Table 2. Top 10 causes of deaths per 100k in 2023 in Bangladesh, and rate change 2013–2023, all ages combined**

| Cause | 2023 rank | % change in deaths per 100k, 2013-2023 | Cause type |
|---|---|---|---|
| Neonatal disorders | 1 | -34.0 | Communicable, maternal, neonatal, and nutritional diseases |
| HIV/AIDS | 2 | -49.2 | Communicable, maternal, neonatal, and nutritional diseases |
| Malaria | 3 | -24.2 | Communicable, maternal, neonatal, and nutritional diseases |
| Road injuries | 4 | +8.1 | Injuries |
| Lower respiratory infect | 5 | -11.8 | Communicable, maternal, neonatal, and nutritional diseases |
| Stroke | 6 | -2.8 | Non-communicable diseases |
| Ischemic heart disease | 7 | +1.7 | Non-communicable diseases |
| Chronic kidney disease | 8 | +1.5 | Non-communicable diseases |
| Diarrheal diseases | 9 | -21.2 | Communicable, maternal, neonatal, and nutritional diseases |
| Congenital defects | 10 | -2.8 | Non-communicable diseases |

Source: https://www.healthdata.org/research-analysis/health-by-location/profiles/bangladesh

Progress in maternal and neonatal health has been particularly strong. The introduction of a standardized midwifery cadre in 2008 improved the quality and outcomes of SRMNAH care (Begum et al., 2023). Between 1990 and 2023, maternal mortality ratio declined from 870.4 to 115.1 per 100,000 live births (WHO Data, 2025), neonatal mortality rate from 65.5 to 18 per 1,000 live births (UNICEF Data, 2025a), and under-five mortality rate from 146 to 31 per 1,000 live births (UNICEF Data, 2025b). Despite this, the country continues to face critical challenges in maternal and child health care and outcomes, and progress remains insufficient to meet SDG targets.

A severe health workforce shortage remains a major barrier to improving health outcomes, with only 7.2 doctors and 6.2 nurses and midwives per 10,000 people, below regional averages of 7.7 and 20.6, respectively (Global Health Observatory, 2025b; WHO Data, 2024a). Unequal distribution, variable education quality, and gaps in

professional competence further limit access to and quality of care (Udechukwu et al., 2023).

With the population projected to grow by 25%, from 171 million in 2023 to 215 million by 2050 (WHO Data, 2024a) adding pressure for the health system, a simultaneous shift toward an aging population presents an additional challenge (Fahim et al., 2019). The recent COVID-19 pandemic and Rohingya refugee crisis have exacerbated the strain on the health system.

## Governance

The Ministry of Health and Family Welfare (MoHFW) leads national health policy, regulation, and service delivery from national to "Ward" level (Uddin et al., 2021). While the MoHFW leads institutional healthcare delivery nationally and in rural areas, responsibility for urban PHC lies with municipalities and city corporations under the Ministry of Local Government, Rural Development and Cooperatives. With the Ministry of Health and Family Welfare (MoHFW) serving as the central planning authority, and with only limited involvement from the Ministry of Local Government, Rural Development and Cooperatives—urban primary healthcare has remained largely excluded from national health planning processes (Udechukwu et al., 2023).

Bangladesh's pluralistic health system includes government agencies, NGOs, private providers, and donors. Weak regulatory oversight of the private sector has fostered corruption, uneven quality, and inequitable access (World Health Organization, 2015). Persistent governance challenges, including absenteeism, poor monitoring, and lack of transparency and accountability, further weaken service delivery (Karim & Alam, 2019). Inadequate decentralization and reluctance to delegate power limit local capacity to manage resources effectively, undermining improvements in governance and service quality (M. Islam, 2017).

The public sector's limited curative capacity drives patients toward private providers, concentrated mainly in urban centers such as Dhaka and other major cities (Shahen, Islam, & Ahmed, 2020). Rapid urbanization has further strained primary healthcare provision, forcing many residents to rely on expensive alternative services, often contributing to catastrophic health expenditures among poorer households (Hamid & Begum, 2019).

## Responsiveness

Responsiveness as a goal refers to the non-medical aspects of how well systems address the demand and expectations of the population, including aspects of dignity, autonomy, confidentiality, communication, prompt attention, quality of basic amenities and choice of provider (Murray & Frenk, 2000).

In urban areas of Bangladesh, one-third of patients rated the PHC system's responsiveness as poor. One study found that while over two-thirds of patients were satisfied with care at most facilities, satisfaction at MoHFW facilities was 55% (Hamid & Begum, 2019). Key weaknesses included prompt attention, dignity, communication, and confidentiality. When asked about healthcare fees, more than 80% of patients, except those in private facilities, considered fees reasonable, while nearly half of private facility patients found them excessive (ibid).

In rural areas, evidence is limited, but recent studies suggest responsiveness remains low across both public and private sectors. A recent study comparing public and private sector physicians found that, although responsiveness was higher in the private sector, neither met patients' expectations. Patients reported poor communication, lack of compassion, and a perception that physicians were more business-like than caring, which undermined trust. Public sector responsiveness was constrained by high patient loads, while private sector physicians were slightly more attentive, but systemic issues and heavy workloads were cited as key factors behind these gaps (Joarder, 2023).

In summary, responsiveness issues persist across the system, varying by sector and provider type, and are largely driven by systemic factors such as staffing shortages, resource constraints, and high service costs.

## Fairness in financial contribution

Fairness in financing, also a central aspect of UHC, remains a major challenge. Although donor funding and reforms increased total health spending, this has not led to higher public expenditure or improved financial protection (Udechukwu et al., 2023).

In 2022, current health expenditure per capita in Bangladesh was estimated at US$ 61, continuing an upward trend over the past two decades (World Bank, 2025a). Public health expenditure is funded by national taxes and accounted for only 3.1% of general government expenditure and 2.1% of GDP in 2021 (WHO Data, 2024a), approximately half of the regional average of 5.0% (Bitran, Jahan, Huque, & Islam, 2023) and well below the 15% Abuja target (African Union, 2006). With minimal insurance coverage, financing relies heavily on out-of-pocket (OOP) payments (Saha, Reza, Mazid, & Dewan, 2025).

OOP spending has steadily increased over the years, reaching 72.5% of current health expenditure in 2022 (World Bank, 2025b), among the highest globally. In 2016, 8.45% of households faced catastrophic health expenditure (Global Health Observatory, 2025a), disproportionately affecting the poor and those with chronic illnesses (M. R. Islam, Rahman, Islam, Sultana, & Rahman, 2017). Families affected by NCDs spend over twice as much on healthcare and are more likely to forgo treatment due to prohibitive costs (Rahman, Gasbarro, & Alam, 2022). High OOPs and catastrophic health expenditures pose a major barrier to achieving UHC and represent a significant equity concern, as the poorest and most vulnerable households are disproportionately affected by the financial burden of healthcare. In 2016, 8.45% of households faced catastrophic health expenditure, defined as spending more than 25% of total

household expenditure or income on healthcare (Global Health Observatory, 2025a), a very high level compared to many other countries.

## Swedish support to health prior to 2014

Sweden as one of Bangladesh's oldest development partners has been supporting development in the country since its independency in 1971. Reflecting Sweden's strong commitment to human rights and justice in overall development, support for health prior to 2014 has primarily focused on improving access to healthcare services, particularly in maternal and child health, sexual and reproductive health and rights, and for vulnerable populations. Support has primarily been channeled through multilateral organizations, most notably the World Bank Group and various UN agencies, funds, and commissions, while also extending to academic and research institutions, public sector bodies, NGOs, and civil society actors (OpenAid, 2025).

Since 2005, Sweden's sustained leadership in midwifery development has made it one of the first partners to help establish the profession in Bangladesh, working closely with UNFPA and Swedish universities such as Gothenburg and Dalarna (Knutsson, 2025). Sweden's work in establishing and strengthening midwifery with UNFPA, alongside health sector programs and capacity- and research-support for ICDDR,B[15], represent some of the most influential contributions to the development of Bangladesh's health system prior to 2014.

In summary, significant inequities persist in access to and utilization of health services, with wealth, geography, and gender as key determinants (World Health Organization, 2015). Insufficient public funding, poor governance over mix of actors and responsibilities, workforce shortages, inadequate service facilities, and high OOP spending have left large segments of the population without access

[15] International health research institute based in Dhaka, Bangladesh https://www.icddrb.org/

to quality healthcare and hindering progress towards UHC (World Health Organization, 2015). At the same time, the demographic shift toward an aging population presents an added challenge (Fahim et al., 2019). The recent COVID-19 pandemic and Rohingya refugee crisis have exacerbated the strain on the health system.

## Comparing Uganda and Bangladesh

Uganda and Bangladesh present notable contrasts in their health systems. In terms of service delivery and governance, Uganda operates a highly decentralized system led by local governments, whereas Bangladesh has a more centralized structure under the Ministry of Health and Family Welfare, with urban care managed by municipalities. Regarding the health workforce, Uganda has one of the lowest doctor-to-population ratios globally (1.9 per 10,000), though relatively more nurses and midwives, while Bangladesh has more doctors (7.2 per 10,000) but fewer nurses compared to regional averages. Financing also differs: Uganda's per capita health expenditure (US$44) is lower than Bangladesh's (US$61), yet Bangladesh is far more dependent on out-of-pocket payments (72.5% vs. Uganda's 34%), exposing households to catastrophic costs. Both countries face inequities and resource shortages, but Uganda's burden is still dominated by communicable diseases like malaria and HIV, while Bangladesh increasingly struggles with a double burden, where non-communicable diseases are overtaking infectious causes. These differences illustrate how structural organization, financing, and workforce distribution shape distinct challenges in progressing toward universal health coverage.

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# Appendix 5. Interview guide for interviews with Sida staff

## Interview Guide – HSS Uganda & Bangladesh

Interviews with current and previous Sida staff

## Introduction

- Introduction of interview/evaluation team
- Purpose of the interview and the evaluation

In this project, commissioned by Expertgruppen för Biståndsanalys (EBA), we aim to evaluate the effects of Swedish aid in health systems strengthening to Bangladesh and Uganda between 2014-2023.

The purpose of this interview is to gather qualitative insights of current and former Sida staff regarding trends and developments in support for health systems strengthening in the recipient countries, to help interpret the quantitative and other findings of the project.

- **Confidentiality and voluntary nature of participation**
  Your participation in the interview is entirely voluntary. You're free to choose whether to answer a question, and you can stop the interview at any time. Everything you share will be kept confidential, and your name and any identifying information will not be shared in any reports or publications that result from this interview. The information you provide will only be used for the purposes of this project and handled in accordance with data protection guidelines.

- **Obtain verbal consent to proceed and take notes/record**
  With your permission, we'd like to record this conversation and generate transcripts to ensure accuracy. The recording and transcript will be stored securely and not shared with anyone outside the research team. They will only be used for analytical purposes.

Do we have your consent to proceed with the interview and record our conversation?

## Background of the participant

- Can you briefly describe your background, current role and your involvement with Sida's HSS support now and historically?

1. **Probes:** What is your academic background? Have you had any continuous education in health systems or health systems strengthening?

## Defining HSS

- Which programs were, in your view, the ones where HSS was most important? Why?
- How did you define HSS in design of support targeting HSS in the country you worked in?

2. **Probes:** What informed your definition of HSS? What was it based on? Existing literature, an official Sida definition, or other sources? In your view, is there a difference between *health system support* and specific efforts to *strengthen the system*? If yes, how was that distinction made? Were activities or interventions classified as HSS or not HSS? How was this determined? Can you share some examples?

## Design of and decision-making on contributions

- How did you reason around HSS and how was HSS considered in analysis, design and decision making on contributions?

3. **Probes:** Was HSS a specific requirement for certain contributions? How was HSS assessed proposal from partners? Was HSS explicitly prioritized in funding decisions? Why was HSS a priority in Sida's support? How, if at all, was the HSS context analysed?

## Sida's contribution to HSS in the country

- In your view, how has Sida's support contributed to strengthening the health system in the country where you worked?

4. **Probes:** Can you give specific examples of changes or improvements that, from your assessment, are results of Sida's support? Were there particular programmes or projects that had a notable, long-term, impact? Which areas of the health system do you think have been most affected (e.g., governance, financing, service delivery, workforce, relationships between them)? Were any unexpected results observed—positive or negative?

## Measuring HSS

- How did you reason around measuring progress/results in terms of HSS?

5. **Probes:** Did any specific frameworks, methods or tools inform this? Were any goals or indicators set for measuring progress in HSS specifically? If so, what kind? Intervention-level, broader systemic? How was sustainability of HSS outcomes considered? What indicators were reported within Sida? How are/were achievements described? Was the programme evaluated?

- How did you reason around being able to attribute HSS results to Sida's support?

6. **Probes:** Did you rely on specific frameworks for HS performance? How did you measure progress? Did you develop a theory of change? Did you apply any RBM model?

## Perception of results

- From your perspective, what is your overall perception of how successful Sida's support for HSS has been?

7. **Probes:** What do you see as the main contributing factors for the success in Sida's role in HSS? What do you see as the main

obstacles to achieving success in Sida's role in HSS? What were, according to you, the main lessons to Sida from supporting HSS?

## Sida's capacity to work with HSS

- What is your perception of Sida's institutional capacity and competence for working with HSS?

8. **Probes:** What internal/external factors have supported or limited this capacity? How could capacity be improved for more effective HSS support?

## Other

- Is there anything else you would like to share that we haven't already discussed?

# Appendix 6. Interview guide for interviews with key informants

## Interview Guide – Evaluation of Sweden's development assistance for health system strengthening

Interviews with key informants in Uganda and Bangladesh

## Introduction

In this project, commissioned by the Swedish Expert Group for Aid Studies (EBA), we aim to evaluate the effects of Swedish aid in health systems strengthening to Bangladesh and Uganda between 2014–2023.

The purpose of this interview is to gather qualitative insights in your organisation regarding your impression of Swedish support for health systems strengthening in Uganda/ Bangla Desh, to help interpret the quantitative and other findings of the project.

### Confidentiality and voluntary nature of participation

Your participation in the interview is entirely voluntary. You're free to choose whether to answer a question, and you can stop the interview at any time. Everything you share will be kept confidential, and your name and any identifying information will not be shared in any reports or publications that result from this interview. The information you provide will only be used for the purposes of this project and handled in accordance with data protection guidelines. If we decide to quote you directly in the report, the quote will be anonymous, but we will contact you and get your consent should we decide to do so.

## Obtain verbal consent to proceed and take notes/record

With your permission, we would like to record this conversation and generate transcripts to ensure accuracy. The recording and transcript will be stored securely and not shared with anyone outside the research team. They will only be used for analytical purposes within the study team.

Do we have your consent to proceed with the interview and record our conversation?

## Background of the participant

- Could you please introduce yourself?

9. **Probes:** What is your role in the institution (MoH, WB, etc).

- Sweden has supported Bangladesh/Uganda through projects X,Y,Z. Can you briefly describe your involvement over time with Sweden's support to the health sector or projects funded by Sweden?

10. **Probes:** How were you involved in the projects with the Swedish support: proposal writing? Managing the project? Monitoring and reporting? Have you had any other involvement with projects related to HSS?

## Defining HSS

- How do you understand health systems and Health Systems Strengthening?

11. **Probes:** Does you organisation have a formalized definition of HSS? Is there a policy document/ similar which you could share? Is there any other document on HSS which you follow in project development? How well do the principles align with the objectives and approach in the project(s) supported by Sweden? In your view, what is required from a partner who wants to strengthen health systems?

## Design of and decision-making on contributions

- How did you and the Embassy/Sweden/Sida cooperate in the different stages (planning/proposal writing/appraisal, implementation/ reporting/, end appraisal/reporting?

12. **Probes;** Did you discuss with the Embassy prior to the project? Is Sweden in any way involved in the monitoring and implementation process? What were the focus areas discussed before and during project implementation? Was HSS a specific requirement?

# Measuring HSS

- How did you reason around measuring progress/results?

13. **Probes:** Did any specific frameworks, methods or tools inform this? Did you use any specific frameworks for HS performance? Were any goals or indicators set for measuring progress in HSS specifically? If so, which? Intervention-level, broader systemic? How was sustainability of HSS outcomes considered? How are/were achievements described? Was the programme evaluated?

- How did you reason around being able to attribute results to Sida's support specifically?

14. **Probes:** Were indicators discussed with Sida? Did you discuss how to measure progress? Did you develop a theory of change? Did you apply any specific RBM model?

## Perception of results

- In your view, has external support addressed the most urgent areas in health? What are those areas? Give examples?
- What is your perception of how Sweden's support has contributed to HSS overall and the country's progress towards universal health coverage? Explain, Give examples?

15. **Probes:** What do you see as the main contributing success factors or obstacles? In general? In relation to HSS? What were, according to you, the main lessons to Sida from supporting HSS?

- Are there any changes you would like to see in Sweden's support to country Bangladesh/Uganda?

16. **Probes:** Any suggestions on (i) the overall design and implementation; (ii) how results are measured/reported (iii) on HSS activities?

## Other

- Is there anything else you would like to share that we haven't already discussed?

Do you have additional material that you think would help us?

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Denna utvärdering granskar Sveriges stöd till att stärka länders hälso- och sjukvårdssystem (HSS). Den kartlägger bilateralt hälsobistånd till sex länder (Demokratiska republiken Kongo, Somalia, Zambia, Uganda, Bangladesh och Myanmar) och analyserar särskilt stödet till Bangladesh och Uganda (2013–2023). En huvudslutsats är att Sverige kan bidra till att stärka länders hälso- och sjukvårdssystem när stödet är långsiktigt, samordnat och i linje med regeringsledda reformer, men HSS behöver formuleras som ett tydligt strategiskt mål i regeringens bilaterala samarbetsstrategier.

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*The Expert Group for Aid Studies (EBA) is a government committee with a mandate to independently analyse and evaluate Swedish international development aid.*