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ON AID EFFECTIVENESS
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# EFFECTIVE AID Better Health



THE WORLD BANK

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# EFFECTIVE AID
# BETTER HEALTH

Report prepared for the Accra High Level Forum on Aid Effectiveness

2-4 September 2008

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# Executive Summary

## Aid for health matters

It captures the public imagination: combating illness and disease is often the first thing people think about in any discussion of foreign aid. In recent years, aid for health has more than doubled, standing at around US$ 16.7 billion in 2006 from official and private sources. Health aid has produced tangible results, saving the lives of millions of individuals and the livelihoods of their families. The challenge now is to scale up aid to levels that will make it possible to achieve the Millennium Development Goals[1]. For this to happen we need to show that aid for health is being used effectively, and that the challenges identified in the Paris Declaration are being addressed in ways that translate into real improvements in people's lives.

## Major progress towards the MDGs has been made; much more needs to be done

In health, there has been major progress in reducing child mortality, in all regions except sub-Saharan Africa and even here, there have been striking declines in some countries. The slowest progress in reducing child mortality is in countries with high prevalence of HIV or those affected by conflicts. However, there has been dramatic progress in access to antiretroviral treatment in low- and middle-income countries in recent years from about 240 000 recipients in 2001 to almost 3 million in 2007. But great health inequities still exist, within and between countries. Moreover, slow progress in reducing maternal mortality is a major concern. While middle-income countries have achieved decreases in maternal mortality since 1990, declines in sub-Saharan Africa have been negligible.

## Health is a litmus test for broader aid effectiveness efforts

Aid has made a significant contribution to health gains achieved so far. This report argues that greater adherence to the Paris Declaration would accelerate progress still further. As such, health is a litmus test for broader aid effectiveness efforts. Improvements in the effectiveness of health aid are already happening: increased predictability of aid, more harmonization of the efforts of various donors, better alignment of health aid with countries priorities, and greater accountability - from both donors and recipients - for the results aid achieves. However these achievements need to be extended to more countries and broadened to include a wider group of aid actors.

## Aid for health is fragmented and characterized by marked disparities between and within countries

Analysis of trends over the last ten years shows aid for health is fragmented into large numbers of small projects; more than two-thirds of all commitments were for less than US$500,000. Relatively little is provided directly into countries' budgets, and an important proportion of funds are channeled into multi-country and regional projects. This makes it harder for developing countries to influence what aid is provided for or how it is provided. This report finds that aid for health still needs to be much more aligned to countries' priorities and, wherever possible, channeled through their national health plans. In countries where solid national plans are emerging, such as Mali, aid for health is becoming more coordinated and coherent. But at the global level, there needs to be a better match between the needs of individual countries and the support they receive from donors to address them. There are marked disparities between countries - Zambia receives US$20 per person for health, Chad just $1.59. Equally within countries, donor funding is often concentrated in a particular area such as HIV, to the detriment of other priorities, as is the case in Cambodia.

1 The Millennium Development Goals that refer directly to health are Goal 4 - Reduce Child Mortality, Goal 5 - Improve Maternal Health, Goal 6 - Combat HIV/AIDS, malaria and other diseases.

### *There is more money for health, but more could be done to align with country priorities*

Health is at the forefront of a growing number of new funding bodies such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). This diversity and innovation is welcome, and has helped to leverage much higher levels of resources. But the large number of aid channels may also pose challenges for co-ordination and alignment with country priorities. Some developing countries are becoming dependent on individual donors, and increasingly vulnerable to any changes in their behaviour. High profile initiatives and programmes need to put more of their funding directly into countries' own health strategies and plans, and focus on making these funds as long-term and predictable as possible.

### *Investment in building effective country systems is also crucial*

The question of how aid can help build effective country systems is a particularly critical one in the health sector. Well-managed hospitals and clinics, skilled health workers, and efficient drug procurement channels are vital if countries are to make real strides in improving the health of their populations. But building this infrastructure has proved a challenging proposition in which development aid has so far played a mixed role. The example of one region of Tanzania shows how child deaths were halved in ten years (1997 – 2006) following intensive investment in local systems. These investments included new tools for planning and management and strengthening the health information system.

### *Efforts to harmonize different donors have been pioneered in the health arena*

Sector Wide Approaches (SWAps), which pool donor support, have now been adopted in many countries. A case study from the Kyrgyz Republic shows how this greater coordination has helped donors provide aid more predictably. The International Health Partnership (IHP+) is now taking the Sector Wide Approach a step further with the development of 'Country Compact' agreements to streamline the management of aid for health. The need for an effective 'division of labour' between donors in each country, based on the comparative advantage they bring, is also a key aspect of harmonization that has so far yielded mixed results.

### *Predictability of aid flows is essential for the health sector*

Predictability of aid flows is a crucial issue in health where so many costs are recurrent such as staff salaries and long-term drug therapies for chronic illnesses. A study by the World Health Organization of seven major health donors finds increasing evidence of commitments for health over at least five years, but says there is scope for further improvement within donors' existing rules and regulations. The right incentives must be set for donor agency staff to commit to longer-term aid, as well as to improve their co-ordination with other agencies. The International Finance Facility for Immunisation is welcomed as an innovative development for long-term health financing.

### *New kinds of aid partnerships are strengthening accountability*

Accountability for the results achieved by aid is being strengthened in the health sector by new kinds of aid partnerships. The International Health Partnership (IHP+) and the new Country Compacts lay out specific commitments for governments and their

development partners. A case study from Ethiopia illustrates how these accountability mechanisms could work. Civil society is also strongly involved in lobbying and monitoring governments' performance in health, making them more accountable to their citizens for results. The Uganda Debt Network for example, uses a community based monitoring and evaluation system to make sure debt relief money reaches health facilities to serve the people who need them most.

### *Progress is possible even in the most difficult circumstances*

Countries emerging from conflict have been identified as particularly testing for aid effectiveness efforts. The challenge with fragile states, in health as in other sectors, is to strike a balance between achieving immediate results that will save lives, while contributing at the same time to building the capacity of the state. Recent work in the Democratic Republic of the Congo provides a vivid example of how progress is possible in the most difficult circumstances. Strong leadership from within the Ministry of Health has started to breathe new life into the country's shattered health system, from the district level upwards.

### *A strong focus on human rights and gender is central to aid effectiveness*

As in all sectors, they must be integral to all health strategies and plans. Gender and women's empowerment have a particularly important role to play in improving health outcomes – activities that enhance women's development play into a virtuous circle. If women are excluded, the reverse is true. This is highlighted in a case study from Nepal, which describes an initiative aimed at enhancing the voice of lower caste women on issues of maternal health and service provision.

### *The health sector embodies all the key challenges of making aid more effective*

It demonstrates that it is possible to address these challenges, and provides evidence that when this is done, results follow. The health sector's strong focus on results provides a constant reminder of the fundamental purpose of aid effectiveness efforts. Its benchmarks against which to measure success could not be more powerful: to protect people from ill health, to provide appropriate and quality health care, ultimately, to save lives.

### *This report highlights positive examples and ongoing challenges*

In writing this report the Task Team on Health as a Tracer Sector has tried to strike a careful balance, highlighting both positive examples and ongoing challenges. The report draws a range of new analyses and case studies carried out in preparation for the Accra High-Level Forum. It is organized into four parts. Part 1 examines trends in aid for health from a global perspective, focusing both on how increases in aid finance have been used, and on financing modalities and patterns that impact on the implementation of the Paris declaration. Part 2 then draws on a series of country cases studies - including Rwanda, Uganda, Cambodia, Vietnam, Ethiopia, the Kyrgyz Republic, Mali and Tanzania - looking at practical experience from the perspective of the main pillars of the Paris Declaration. Part 3 examines current issues and future directions, highlighting new work on predictable financing, showcasing developments in mutual accountability through country compacts, and innovations in cross-cutting issues such as gender and human rights. Part 4 summarizes the key messages and recommendations following the structure and format of the Accra Agenda for Action.



**Source:** WHO photo library

# INTRODUCTION
## WHY AID FOR HEALTH MATTERS

**Aid for health matters.** It captures the public imagination: combating disease and hunger is often the first thing people think about in any discussion of foreign aid. Aid for health has doubled in recent years; it has produced tangible results, and saved the lives of individuals and the livelihoods of families. The challenge now is to keep aid flowing at levels which will make it possible to achieve the Millennium Development Goals (MDGs). For this to happen there is a need to show that aid for health is being used effectively and that the challenges identified in the Paris Declaration are being addressed in ways that feed through into better development outcomes. The present report addresses these issues.

In health, there has been significant progress in reducing child mortality, in all regions except sub-Saharan Africa and even here, there has been a striking decline in some countries. The slowest progress in reducing child mortality is in countries with a high prevalence of HIV, or those affected by conflicts. However, there has been dramatic progress in access to antiretroviral treatment in low- and middle-income countries in recent years: from about 240 000 recipients in 2001 to almost 3 million in 2007. But great health inequities still exist, within and between countries. Moreover, slow progress in reducing maternal mortality is a major concern. While middle-income countries have achieved decreases in maternal mortality since 1990, declines in sub-Saharan Africa have been negligible.

An examination of progress against the MDGs illustrates why the aid effectiveness agenda is so important. To what extent, for example, is there a match between the levels of health need in individual countries and aid allocations to the health sector? When interventions, such as immunization, can be delivered by outreach services, progress has been impressive. Safe delivery, however, requires a functioning health service, and here progress has been much less impressive. To what extent, then, does the way in which aid for health is provided help build better health service delivery systems? In a sector where long-term recurrent costs dominate, greater predictability translates directly into adequately staffed clinics and life-long access to drug treatment. Alignment of aid with country priorities translates into the new global funds and programmes providing more direct support to national health sector strategies and plans. Initiatives such as the International Health Partnership (IHP+) are giving practical expression to the idea of mutual accountability. Equally, the strong civil society presence in health strengthens accountability, and increases the likelihood that both donors and governments will be held to their commitments.

Recognition that progress in health is central to human development and poverty reduction has catalysed a massive global response to unmet health needs. The health sector is leading innovative efforts to generate long-term, predictable funding, through mechanisms like the International Finance Facility for Immunisation (IFFIm) and the levy on airline tickets that finances UNITAID (an international drug purchasing facility). In addition to increasing predictable funding at country level, aid for health can also influence the provision of global public goods such as new drugs, vaccines and diagnostics – through both the purchasing power of existing funds and advanced market commitments that provide an incentive to invest in research and development.

In sum, the health sector embodies the challenges of providing more effective aid. Further, it demonstrates that it is possible to address these challenges, and provides evidence that when this is done – and more effective approaches to aid management are adopted – results follow. The health sector's strong focus on results provides constant reminder of the fundamental purpose of aid effectiveness efforts, and benchmarks against which to measure success: to protect people from ill-health, to provide appropriate and quality health care, and ultimately, to save lives.



**Source:** WHO photo library

# PART 1 TRENDS IN AID FOR HEALTH

*This section summarizes trends in health official development assistance (ODA) over the last 10 years as analysed by WHO. The analysis is based on the OECD/DAC's aggregated Aid Statistics and the Creditor Reporting System (CRS), which are the most reliable sources of data on health aid, covering all traditional (OECD/DAC) bilateral and multilateral donors and major partnerships such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). Much of the data upon which this analysis is based pre-dates the 2005 Paris Declaration on Aid Effectiveness, so it is likely that reforms prompted by that agreement are not yet reflected in the statistics.*

## Health is capturing an increasing share of all ODA

Total bilateral commitments to health in 1980–1984 averaged US$ 2.8 billion (constant 2006 dollars) – or 5.3% of all ODA. This figure remained virtually unchanged until the end of the 1990s, increasing thereafter to an average of US$ 6.4 billion in the five years to 2006, equivalent to 7.8% of all ODA.

Total global aid for health also includes large flows from multinational agencies and private entities/foundations such as the Melinda and Bill Gates Foundation. The World Bank reported in 2008 that total development assistance to health (DAH), including private non-profit organizations, reached US$ 16.7 billion in 2006, up from US$ 6.8 billion in 2000. The analysis in this report focuses on ODA, official bilateral and multilateral development assistance, for which longer-term trend data are available.

## Funding for HIV accounts for a large share of the increase in health ODA[2]

In 2002-2006 aid for HIV accounted for almost one third (32%) of health ODA. The growth in HIV funding is in part due to new initiatives such as PEPFAR (the President's Emergency Plan for AIDS Relief – USA), and the Global Fund. While increases have been significant for HIV, the 2007 UNAIDS report on the subject stresses that HIV still faces a funding gap to reach targets for anti-retroviral drug availability. Funding needs may also grow further as the availability of these drugs improves survival rates.

## Commitments versus disbursements

Ministries of Health in partner countries often complain about commitments not being disbursed or delays in disbursement of funds. Reliable data on disbursements are available from 2002 (but not before), offering the possibility to assess at an aggregate level the relevance and magnitude of this issue.

There are difficulties in evaluating disbursements rates for each health commitment reported to the CRS, as the time frame of disbursements for each single commitment varies – from few months to several years. We have therefore compared disbursements for each of last three years (2004–2006) with average commitments three or five years earlier (which represent the average length of commitments). As Table 1 shows, the results of this comparison, though only indicative, are encouraging: **disbursements of health ODA being equivalent to more than 80% of the average annual commitment over the previous 3–5 years.** These data suggest that, when assessed over a multi-year period, the difference between commitments and disbursements is not great. However, the figures are likely to hide within-year delays in disbursement and implementation that may cause serious problems in specific contexts.

2 The figures quoted for HIV/AIDS here are proxies – very reliable ones – but still proxies, as aggregated figures from the CRS do not distinguish between commitments for HIV/AIDS and those for other STDs (sexually-transmitted diseases).

**Table 1: Relationship between commitments and disbursements for health ODA**

| Disbursements | 2004 | 2005 | 2006 |
|---|---|---|---|
| Proportion disbursed of the average commitments for a **5** yr period | 86% | 102%[3] | 98% |
| Proportion disbursed of the average commitments for a **3** yr period | 76% | 88% | 87% |

**Unpacking health ODA: what is it spent on, and how is it provided?**

The analysis revealed that an important percentage of aid is spent through multi-country initiatives, with a strong focus on technical cooperation (TC) and a large number of small projects and activities (see Annex 1 for CRS definitions of related terms). These patterns require further analysis and potential reform in light of the Paris Declaration on Aid Effectiveness.

Over the last five years **25% of health ODA has been provided through global and regional multi-country initiatives**[4]. The category of "global and regional multi-country initiatives" includes funds channeled mostly through multi-laterals, including UN agencies, international NGOs and the private sector, for projects that cover more th an one country, such as immunization, HIV/AIDS control or basic health care. They contrast with funds sent directly and unequivocally to countries through agreements between donors and recipient governments. Funds from global health partnerships such as the Global Fund or GAVI Alliance (successor to the Global Alliance on Vaccines and Immunization) are provided directly to countries and do not appear in this category. Although all sectors record multi-country regional activities, the volume in health is unusually high: only 6.3% of education ODA goes through multi-country activities.

The cross-border nature of many health threats and the corresponding requirement for "international" responses may in part explain the high-level of global and regional initiatives for health. Such initiatives are an important mechanism for targeting funding towards agreed global health challenges – such as polio eradication, TB, HIV and malaria – and for sharing experiences across countries with similar needs. Indeed, the proportion of HIV funding channeled through multi-country initiatives is particularly high: in 2002–2006, 40.7% of support for health global and regional multi-country initiatives was for HIV. However, when operational and programming priorities are mostly set regionally and globally, it will be a challenge to fully align with country priorities. Further, as funds associated with regional and global level often have their own budget cycles, reporting and monitoring procedures, they may impose an additional administrative burden on already over-stretched recipient governments.

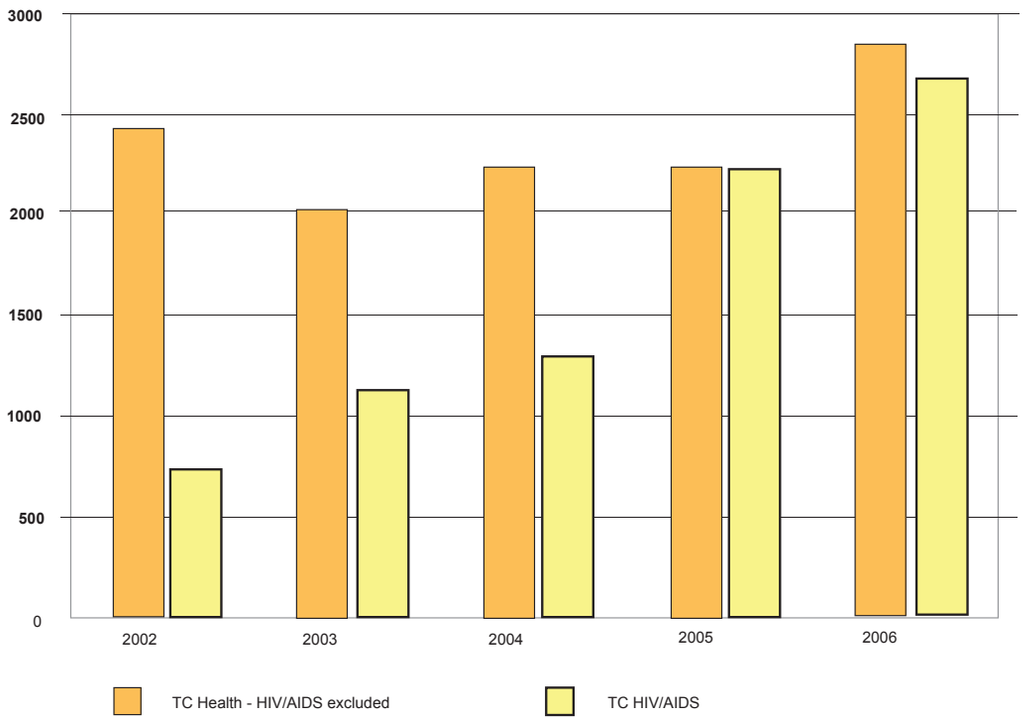
3 A disbursement rate of more than 100% can be explained as follows:
In a period of rapidly increasing levels of commitments, disbursements may exceed the average level of commitments of earlier years, especially when the volume of commitments increases substantially; commitments are sometimes originally notified under a general purpose code while disbursements are notified under more specific code.

4 These are activities which benefit several recipient countries. Regional projects and programmes are reportable under the most specific available "regional/multi-country" category (DCD/DAC(2007)39/FINAL - 04-Sep-2007 - Reporting Directives page 17).

**A substantial part of health ODA is spent on technical cooperation**[5]

- In the period 2002–2006, 41.7% of all health ODA and 43.5% of all health activities (i.e. projects) focused on TC aimed at building the "human capital" in recipient countries. This includes, for example, salaries for staff recruited locally and long-term international experts, consultants fees, training, etc.
- TC accounts for the lion's share of resources (58.6%) channeled through global or regional multi-country initiatives. TC delivered directly to individual countries was in the same period a more modest 36.2%.
- **TC also consumes much of the new HIV funding**, accounting for 53% of HIV commitments in the period 2002–2006. Technical cooperation for HIV control represented almost half of all TC in health in 2005–2006 (Chart 1).

**Chart 1: Technical cooperation - HIV/AIDS and health (constant 2005 US$ - million)**




Source: OECD DAC Statistics

The point here is not to suggest that TC is aid misspent. However, spending such large proportions of aid on TC can seem difficult to justify if other priorities such as access to drugs or clinical services remain significantly underfunded.

**The number of separate activities adds to transaction costs at country level**

Finally, the analysis reveals a **high level of fragmentation in health aid**, with an excessively high volume of small projects. This is important because large (in dollar terms) "activities" at country level are more likely to attract political attention, to warrant significant technical input and – crucially – to be of a scale that impacts on health and the

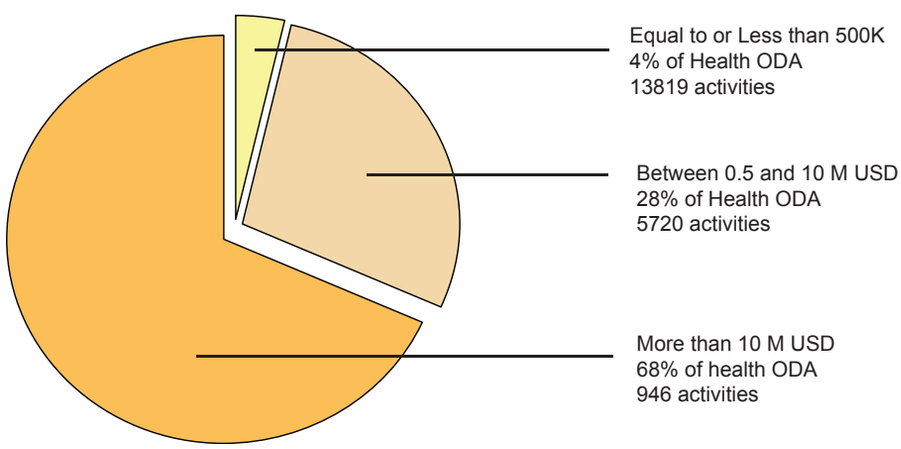
5 The definition of Technical Cooperation can be found in Annex 1

health delivery systems in recipient countries. This is not to say that smaller projects are of less value – they have an important role in piloting new approaches, testing innovation, delivering benefits to individual communities and covering emerging or unplanned health system needs. Analyzed in light of the Paris Declaration, however, **many small activities are likely to be associated with high transaction costs for government, divergence from national policies and lack of coherence between development partners.**

In 2002–2006, the CRS records 20 485 health and population activities. Of these, just 946 were for more than $10 million, accounting for just 4.6% of all aid activities reported to the DAC. They represent, however, 68.3% of total health ODA commitments in the period.

The CRS records 5 720 activities between US$ 0.5 million and US$ 10 million. These represent 28.1 % of the total value of health ODA and 27.9% of all health activities. However, there are some 13 819 commitments for activities each less than US$ 0.5 million. They represent 67.5% of all health activities in the period but provide only 3.6% of health ODA recorded by the CRS. Chart 2 summarizes information on the size of health activities.

**Chart 2: Size and number of health activities: Committments 2002-2006**




Source: OECD DAC Statistics

It is fair to assume that for some[6] of these small reported activities, the normal project cycle will have been followed: appraisal work will have taken place, possibly involving a mission; a project proposal would be discussed with government officials, written and submitted for approval to donors; a technical and financial report would be produced. This represents a substantial workload for recipients (and also donors). In the five-year period under examination, each Least Developed Country (LDC) received, on average, a commitment of around US$130000 every two-three weeks (1.7 projects each month)[7]. For example:



6 In general, a "reported activity" signifies allocation of funds to a specific project or programme in a given sector in a given recipient country. However, to improve the accuracy of CRS-based statistics, donors sometimes choose to compile CRS reports at a finer level, in which case a "reported activity" represents a component of an activity. But there are also cases where it is preferable to report at a more aggregated level (e.g. NGO activities). A "reported activity" can thus be the sum of several activities.

7 Note that these figures relate only to activities directly targeting recipient countries and do not take account of activities channelled through global and regional multi-country activities.

- In the five years under review, Ethiopia had commitments for US$ 1.1 billion. This includes 26 activities for a value of US$ 743 million (67% of total health ODA commitments) and 296 activities valued less than US$ 0.5 million.

**Therefore, the fragmented nature of health aid is a problem that predates, and is independent of, the recent emergence of new global health funds.**

### How much remains for scaling up?

The dramatic but welcome and overdue increase in HIV control activities and the prominence of technical cooperation in health ODA raises the question: how much aid remains for other health activities?

Data from the CRS are troubling. In the LDCs, in 2002–2006, out of all health ODA directly provided to countries (excluding, therefore, global and regional multi-country activities) more than 50% (53.2%) is absorbed by commitments related to MDG 6 (TB, malaria, control of HIV and other STDs and control of communicable disease). In the five years examined, this translates to **US$ 2.25 per capita/per year for MDGs 4 and 5, service delivery and strengthening of health system.** This buys very little: a forthcoming WHO review prepared for the Taskforce on MDG 8 (target 17) found that in 24 developing countries an average public expenditure on medicines per capita of US$ 2.67 was associated with availability of medicines in just one-third (34.9%) of public health facilities.

It is important to remember that additional resources to those mentioned above are made available to countries through multi-country activities. Further, the CRS's broad classification system may hide a more complex reality. In addition, perhaps as a consequence of funding imbalances presented above, both the GAVI Alliance and the Global Fund now provide support to health systems development in their efforts to enable recipient countries to address immunization and the three diseases. There remains an active debate however on the extent to which countries should rely for health systems development on institutions that were established primarily to address specific diseases.

### A relatively small proportion of aid for health comes in the form of budget support

Despite the interest in direct budget support (DBS) generated by the aid-effectiveness agenda, the level of ODA commitments to DBS has only in the last few years returned to the same levels as existed in the second half of the 1980s, having dropped in the intervening years. Overall, DBS commitments account for a small part of all ODA: for example, in 2002–2006 DBS commitments were equivalent to 6.4% of total ODA (excluding debt relief). Given that domestic allocations to health tend to be low, particularly in poor countries, the level of resources reaching the health sector via DBS is likely to be relatively small.

The CRS also reveals that the proportion of health aid spent on sector programmes is limited: 7.7% of all health ODA in 2002–2006 is so flagged. Even this may be an over-estimate. A preliminary review of data reported to the DAC in this category suggests that – despite substantial data quality improvements – it still includes funding for activities which do not appear to meet DAC's own definition of "sector support"[8].

8 The DAC definition of sector programme aid can be found with other definitions in Annex 1.

**Table 2** **Health ODA in selected Least developed Countries (more data for these countries is included in Annex 2)**

| Recipient LDCs | Average Population 2002-2006 | Health ODA per capita 2002-2006 | MDG 6 % of Health & Population Aid | MDG 5 % of Health & Population Aid | Technical Cooperation % of Health & Population Aid |
|---|---|---|---|---|---|
| | population (000s) | US$ | % | % | % |
| Zambia | 11,277 | 20.0 | 58.5% | 0.6% | 36.2% |
| Timor-Leste | 1,009 | 14.9 | 18.9% | 0.8% | 20.4% |
| Malawi | 12,905 | 13.4 | 49.9% | 1.5% | 22.4% |
| Lesotho | 1,965 | 12.7 | 72.1% | 0.7% | 19.3% |
| Rwanda | 9,085 | 10.8 | 73.9% | 2.1% | 53.8% |
| Haiti | 9,151 | 10.1 | 63.1% | 15.2% | 57.3% |
| Mozambique | 20,065 | 9.9 | 47.0% | 4.5% | 34.9% |
| Cambodia | 13,724 | 7.7 | 54.9% | 5.4% | 44.0% |
| Uganda | 28,059 | 7.6 | 69.0% | 1.3% | 47.1% |
| Senegal | 11,477 | 7.4 | 28.9% | 1.5% | 45.7% |
| United Republic of Tanzania | 37,522 | 7.2 | 57.1% | 5.5% | 32.2% |
| Benin | 8,228 | 6.6 | 46.4% | 2.9% | 27.1% |
| Afghanistan | 24,112 | 6.4 | 7.3% | 1.9% | 46.1% |
| Sierra Leone | 5,361 | 5.6 | 40.9% | 1.3% | 8.1% |
| Mali | 11,276 | 5.5 | 39.8% | 6.4% | 33.9% |
| Guinea-Bissau | 1,550 | 5.1 | 34.4% | 5.2% | 24.6% |
| Gambia | 1,570 | 5.0 | 79.2% | 1.9% | 3.1% |
| Eritrea | 4,349 | 4.9 | 45.1% | 26.3% | 18.6% |
| Lao People's Democratic Republic | 5,577 | 4.8 | 29.0% | 3.2% | 25.7% |
| Burkina Faso | 13,509 | 4.7 | 46.3% | 7.0% | 19.5% |
| Mauritania | 2,882 | 4.5 | 60.0% | 8.1% | 9.2% |
| Burundi | 7,588 | 4.4 | 67.6% | 9.0% | 18.9% |
| Liberia | 3,382 | 4.1 | 55.8% | 3.8% | 33.5% |
| Central African Republic | 4,127 | 3.9 | 65.4% | 2.0% | 9.6% |
| Angola | 15,641 | 3.8 | 54.1% | 2.5% | 29.6% |
| Guinea | 8,840 | 3.5 | 52.0% | 9.5% | 35.1% |
| Niger | 12,823 | 3.4 | 44.1% | 3.4% | 23.1% |
| Democratic Republic of the Congo | 57,003 | 3.2 | 39.1% | 0.5% | 31.1% |
| Nepal | 26,560 | 3.0 | 25.0% | 19.8% | 41.3% |
| Ethiopia | 77,036 | 2.9 | 68.3% | 5.8% | 35.8% |
| Madagascar | 18,143 | 2.8 | 41.9% | 3.6% | 30.2% |
| Togo | 6,074 | 2.4 | 65.0% | 2.2% | 10.8% |
| Somalia | 7,962 | 2.1 | 64.4% | 2.5% | 20.8% |
| Yemen | 20,496 | 1.9 | 17.8% | 35.2% | 22.8% |
| Sudan | 36,188 | 1.7 | 60.1% | 1.2% | 43.2% |
| Bangladesh | 150,497 | 1.7 | 9.9% | 18.4% | 34.2% |
| Chad | 9,802 | 1.6 | 39.7% | 4.6% | 36.9% |
| Myanmar | 47,570 | 0.6 | 53.6% | 3.6% | 24.6% |

**There are large variations in health ODA per capita among Least Developed Countries**

LDCs are the focus of substantial development efforts and the direct recipient of one-third of all health ODA, according to a 2005 DFID report. They include many states affected by or recovering from conflict, and are also the countries with the worst health outcomes and where the health MDGs are least likely to be met. It is therefore important to understand how aid is distributed in support of health development efforts and service delivery in these countries.

Table 2 summarizes the main features and focus of health ODA in those LDCs with a population above 1 million (on average, between 2002 and 2006). Countries are ranked in ascending order according to per capita health ODA. The table shows that there are huge variations in health ODA per capita within the LDC group: from almost US$ 20 per capita/year for Zambia to US$ 1.59 for Chad. The first 10 countries in Table 2 capture almost half (49.1%) of health ODA for LDCs, though they account for one fifth of the population of this group (21%).

The other major predictor of aid per capita in LDCs is HIV prevalence. In countries such as Rwanda there is evidence that these resources have a positive effect on the health systems as a whole. Countries with low HIV prevalence (but high levels of morbidity and mortality from other causes) receive much less aid and thus remain at a disadvantage.

## Summary and conclusions

Health ODA is rising, and health is capturing a bigger share of all ODA. While this overall increase is encouraging, financing to meet the health MDGs 4, 5 and 6 remain underfunded and there are some important imbalances within the allocation of health aid which run counter to commitments in the Paris Declaration. Countries with comparable levels of poverty and health need receive remarkably different levels of aid. Furthermore, funding for MDG 6 (HIV, TB and malaria) accounts for much of the recent increase in health ODA. Many other health priorities – including health systems strengthening, on which disease control programmes depend, and which is required if countries are to make an impact on maternal mortality – remains insufficiently funded. In a situation where the HIV response, despite its proportionately high levels of support, still suffers from a lack of investment, this raises a significant question regarding how the resource needs to address MDGs 4 and 5 can be raised.

Compared to other sectors, a substantial proportion of health aid is channeled through multi-country projects or spent on technical cooperation. This suggests that, even as the political momentum towards aid effectiveness increases at global level, the discretion to make spending decisions at country level is still limited, as global and regional priorities dominate aid allocation and resources to be invested flexibly in national health systems are limited. Indeed, the amount of aid channeled through sector and budget support programmes remains low, even though it is widely thought to be one of the more efficient forms of aid. In health, we are unlikely to meet the Paris Declaration target that 66% of aid flows be channeled through programme-based approaches. Greater reliance on programme-based approaches and alignment with country strategies should help target aid on areas of greatest needs and increase the efficiency of its use.

The imbalances that emerge from the analyses presented here predate the Paris Declaration. However, there is little doubt the challenges and problems identified will have an influence on results. Much of the debate in global health has focused on institutional fragmentation and reforming the architecture. This analysis demonstrates that monitoring financial flows can provide additional insight into the challenges facing donors and governments and inform the debate on how aid can be made more effective.




**Source:** WHO photo library

# PART 2 LESSONS FROM COUNTRIES

*This section summarizes lessons on aid effectiveness and health emerging from country experience. Findings are presented in relation to the main pillars of the aid effectiveness agenda: alignment, harmonization and managing for results. Within this framework an effort has been made to focus on those issues of particular concern to partner countries: conditionality, predictability, division of labour, incentives and capacity development.*



## Alignment

Alignment is a particular challenge in the health sector, given the large number of partners, the lack of costed and operationalized national strategies in some countries, the high proportion of earmarked aid and – in many contexts – the high level of donor support. These challenges have the potential to undermine progress in health outcomes.

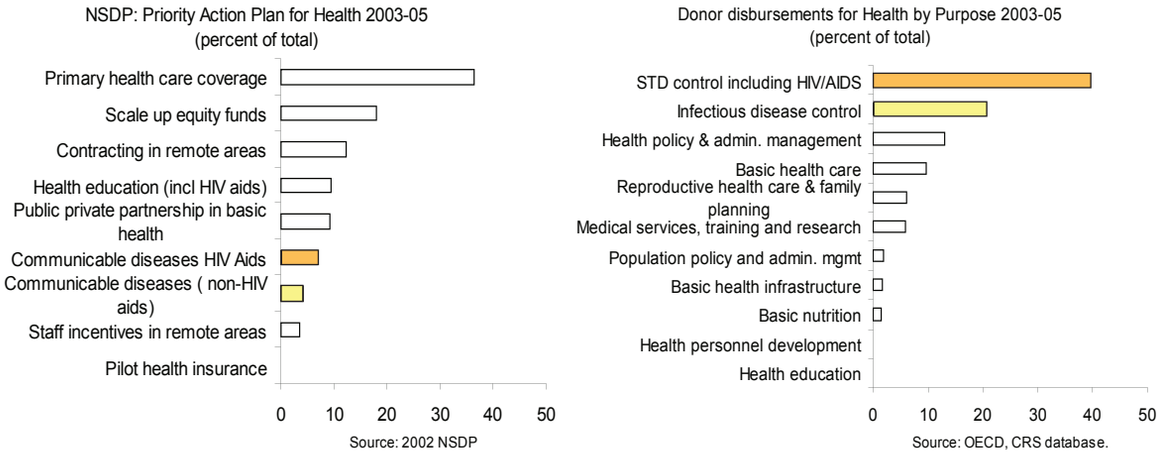
**In Rwanda, a massive scaling up of health aid has been associated with dramatic health improvements:** between 2000 and 2005, the under-five mortality rate dropped from 196 to 152 per 1000 live births; in the same period, maternal mortality rate fell from 1071 to 750 per 100 000 live births. Aid commitments for health in Rwanda rose to $251 million in 2008 or $27 per head (excluding spending financed by general budget support). Donor aid accounts for more than 50% of total health financing (2006), and aid dependence has reached 83% in the 2008 work plan (i.e. aid as a share of total aid and government spending). It is expected to remain above 67% until 2020.

**Further improvements in health in Rwanda are therefore potentially vulnerable to changes or disruptions in donor support.** A single source, USA bilateral aid focused on HIV, malaria and reproductive health, accounts for more than 50% of external assistance and the largest 3 donors (US, Global Fund, and Belgium) account for 75% of total donor aid. However, legislative restrictions mean that the USA cannot make firm commitments of future support beyond one-year (in contrast to government commitments from other donors that stretch to 2010, the end of the current MTEF [medium-term expenditure framework]). This poses risks for sustainability and makes it difficult for government to plan strategically over the longer term. In highly aid-dependent contexts such as this, the timing of aid disbursements during the fiscal year is equally important, because delays can cause significant problems to implementation of programmes.

**Even in contexts where overall donor dependence is low, there may be high dependence in particular programmatic areas.** In Viet Nam for example the Global Fund supports 60% of the National Malaria Programme. In these situations, the "on-off" nature of round-based funding, combined with the short planning horizons of donor projects and within-year delays in disbursement may create risks for sustainability. This is turn may lead ministries of health to favour certain aid management strategies, such as directing donor financing into capital rather than recurrent costs, and isolating donor funds from national resources through project management units. Global programmes and others are working to minimize these risks – for example by creating mechanisms for grant extensions, developing a national strategy application channel and encouraging governments to contribute. However, this can create a further challenge: that programmes that are already well supported by external resources end up consuming a large portion of domestic funding, because of counterpart funding requirements.

The large volume of funds flowing through disease control programmes can create distortions in health funding, when the sector is viewed as a whole. In Cambodia, for example, a disproportionate share of donor support for the health sector goes to HIV, while other sector priorities remain unsupported in comparison (see Figure 1). This does not mean that HIV is 'overfunded' - indeed, it continues to face a financing shortfall, as does the sector as a whole - but it does highlight distortions in the allocation of external resources.

**Figure 2 Health plan priorities versus donor disbursements (2003-2005) Cambodia**




Source: National Strategic Development Plan, Cambodia, and OECD/CRS

Similarly, in Uganda aid flows to HIV have on average been higher than those going to all other health areas. This is justified by the high prevalence of HIV in Uganda; however, other diseases such as malaria, which are responsible for a significant share of the country's burden of disease, have not received as much attention from donors. This is not only an issue in relation to disease control: in Rwanda, human resources for health (e.g. community health workers), rural health services, family planning and reproductive health all face relatively large funding gaps compared to other health sector activities.

In many instances funding – whether from global programmes or other sources – that is linked to particular diseases can strengthen delivery systems and thus impact on health outcomes more generally. The Rwanda case study points to examples of this. In the case of the GAVI Alliance, where the main goal is to increase immunization coverage, the Health Systems Strengthening window explicitly allows for broad-based health system strengthening. Similarly, the Global Fund also provides the possibility for countries to request funds for health system strengthening interventions. A range of work is currently in hand to further explore the extent to which funding that is disease-specific can be effectively used to improve service delivery.

Improving **alignment requires changes in donor behaviour, but also stronger national systems for partners to align behind.** In health, this synergizes well with building capacity for robust health sector plans, budgets and monitoring frameworks, and quality sectoral dialogue. All these elements need to be in place to allow government to identify needs, gaps, and priorities for donor support, and for donors to align their support accordingly. Equally, if public financial management systems do not function well, if there are delays in budget execution and poor tracking of expenditure, then improving the predictability of external resources alone will not be sufficient to improve aid effectiveness. This in turn requires **capacity**

**development** – both in terms of strengthening systems and in terms of building the skills of individuals. However, in many countries the focus of capacity development activities has thus far been at central level and not yet extended to line ministries.

**Harmonization**

Because health is central to development, it has traditionally been a priority sector for donor support. While this support has been welcome, it has been associated with high levels of fragmentation – as demonstrated in Part 1 – as well as duplication, and high transaction costs due to government having to deal with multiple partners. **These challenges have catalysed innovative responses.** The Sector Wide Approach (SWAp) predates the Paris Declaration but is nevertheless based on the underlying principles of harmonization, alignment and managing for results. More recently, the International Health Partnership attempts to take the SWAp concept a step further through the development of "country compacts" to strengthen **mutual accountability**. And, the HIV community has developed its own tools and principles to facilitate harmonization between HIV partners (see Part 3 for discussion of the International Health Partnership and the Country Harmonization and Alignment Tool [CHAT] for monitoring the "Three Ones" approach).

SWAp encouraged donors to support a government defined and led sector plan and to adjust donor financing modalities and instruments behind government systems and processes. At present, there are more than 80 SWAps (in all sectors) in low- and middle-income countries in Africa, Asia and Latin America. **Experience over the last twenty-years has shown that SWAps are adaptable to different contexts, although progress can be uneven as it may take years to develop all the components**. In hindsight, this has brought a growing realization that SWAps were much more than "a new way of working", and that obstacles to progress are as much political as they are technical. The boxes below on applying SWAps in the Kyrgyz Republic and Mali illustrate the challenges associated with sector-wide approaches in different national circumstances.



## SWAps in Action

Central Asia :: Kyrgyz Republic

The Kyrgyz Republic has been implementing a SWAp in the health sector since 2003–2004. It was one the first countries in Central Asia to take such steps. There are a number of development partners supporting the health sector and they have agreed to coordinate their assistance under a SWAp, utilizing a mixture of financing modalities, including sector budget support. There has been a coordinated approach among partners to strengthen national capacity and to increasingly move towards using Government systems.

Results show that ODA has become more predictable and disbursed on schedule compared to in the past, and this is particularly the case with sector budget support. Although there are a number of project implementation units (PIUs) in place, the number is stabilizing and development partners are increasingly utilizing the biannual health summits and joint reviews, moving away from separate missions to review sector performance and address future priorities.

Source: WHO Country Cooperation Strategy Brief. Kyrgyzstan, April 2006.

*How Manas Taalimi (national health strategy) and the SWAp are helping the Kyrgyz Republic make progress on the Paris Declaration.* A presentation prepared by the in-donor community involved in the Kyrgyz Health SWAp. May 2008.

Coordination between partners implies not only shared goals and approaches, but also a division of labour based on comparative advantage. Given the popularity of health as a sector for donors to invest in, this second aspect of harmonization is often more difficult to operationalize. **Country reports on the implementation of EU code of conduct on division of labour in health** are mixed. In some countries donors have pulled out of the sector, citing division of labour as part of the rationale, against the wishes of government, while in others, there is little progress in coordinating across a diverse range of actors. As health is one of the most crowded sectors, this is a concern.

Lessons to emerge from the many studies of SWAps include: the importance of strong government leadership and commitment at both sector and macro level; strong coordination among donors and with government; engagement of civil society; strong multisectoral linkages; and a commitment to utilize government's own systems and processes (e.g. planning, management, monitoring and evaluation).

## SWAps in Action

Africa :: Mali

In Mali, the development of a 10-year health plan and its operational 5-year programme, the Programme de Développement Sanitaire et Social (PRODESS), was led by the Malian Ministry of Health with technical assistance from several donors and with strong participation from civil society. The PRODESS was therefore conceived as the single health plan to be supported by all partners through different financing modalities. Some of the outcomes of PRODESS include the improved ability to monitor and evaluate the implementation effectiveness of numerous national initiatives as well as to continue development of a better Health Resource Information Management System.

Health-sector planning capacities of many of the health network actors in Mali have been strengthened by the introduction and improvement of existing measurement tools, thus resulting in a more harmonized and aligned planning cycle that can be synchronized with the goals of the State budget. This stabilization has had broad effects on external sources of funding as well. Due to the Ministry of Health's harmonization of goals with the Ministry of Finance, external funding has become slightly more predictable.

A set of specific PRODESS procedures were also developed for the management of a "pool fund" alimented by donors. The first and foremost "quick wins" observed were the respect by most donors of the sector programme priorities, the improvement of the programmatic framework and the development of a climate of trust and dialogue between partners. The quality of the dialogue has been such that most reforms are now developed in a consensual way, through the coordination and monitoring mechanism of PRODESS.

As a member of the International Partnership for Health (IHP+), Mali expects to sign its Compact with development partners by the end of 2008. The preparation of the Compact encompasses the prolongation of the PRODESS so as to be aligned with the national development plan. The prolonged PRODESS will be based on a coherent Health System Strengthening Plan (HSS) streamlining sub-sectoral policies, as well as a medium-term expenditure framework encompassing the new human resources for health and HSS strategies.

Source: Salif Samaké, Director, Planning and Statistics Unit, Ministry of Health, Mali (unpublished communication).

Several risks also emerge. These include the risk that SWAps are all about process, and that the results focus of aid gets lost (but see below). In addition, the focus on harmonization among donors can take precedence over building consensus between the wide range of national institutions that are critical to the delivery results. In practice there are few places where all of the positive elements are in place, where all sector funding is included, and all the risks are averted, As a result **most countries continue to receive their aid via a variety of funding modalities.**

While the existence of multiple funding arrangements is not a problem in its own right, it can create contradictory **incentives**. On the one hand, certain donors provide strong incentives towards programmatic or budget support. They may push too fast for the local context. Especially when systems are weak, this may create tensions with government and within the local donor group. On the other hand, the incentives associated with a project-based approach – salary supplements, the power and influence of operating a large PMU, opportunities for overseas training, etc – may lead some recipients to resist more harmonized and aligned approaches.



## SWAps in Action

Africa :: Tanzania

The health sector in Tanzania has for the last nine years implemented a SWAp that has supported a government-led health sector development programme aimed at improving access, delivery and quality of health-care services available in the country.

The establishment of the SWAp preceded a challenging period for the health sector in Tanzania where service provision was poor; under resourced (financial, human, infrastructure); highly fragmented; and with limited cooperation and coordination among the various stakeholders involved in supporting the sector.

During 2007 an external joint evaluation was undertaken in an attempt to assess how well the sector has done since the establishment of the SWAp. This evaluation has been described as the first that fully responds to the 2005 Paris Declaration on Aid Effectiveness and was led by Tanzania's Ministry of Finance & Economic Affairs with the support of all stakeholders in the sector (Ministry of Health & Social Welfare, civil society organizations, private sector, and development partners).

The findings from this evaluation indicate that the health SWAp has largely been a success with enhanced national ownership and access to higher levels of financing – domestic and external. As a consequence, this has delivered real improvements, including reductions in infant and child mortality, greater drug availability and improved service provision. The SWAp has been underpinned by far-reaching reforms, in particular decentralizing power to the district level coupled with an innovative pooling mechanism for external resources that have contributed towards such improvements.

However, the evaluation highlights a number of critical challenges for the sector, not least maternal mortality, which remains very high; the need to improve tertiary care and to strengthen public-private partnerships.

Although the evaluation recognizes the benefits from the Global Health Initiatives and large bilateral programmes in channeling critically needed resources into diseases which are national priorities, it finds that they generally operate outside existing health planning processes, distorting local priorities and threatening sustainability. It concludes that although significant improvements have been made under the SWAp, a further scaling-up of efforts, including resources (financial, human) will be required if Tanzania is to reach all the health-related MDGs.

**Source:** Joint External Evaluation, *The Health Sector in Tanzania, 1999-2006*, Ministry of Foreign Affairs of Denmark, October 2007. http://hdptz.esealtd.com/.

**This exposes the challenge of establishing country ownership**: if donors create extensive structures and incentives around the funds they provide, those who benefit are likely to feel "ownership", while those who don't, won't. Equally, moves towards "effective" aid modalities such as programmatic and budget support need to be made in partnership with government, and at a pace that national authorities are comfortable with.

**Managing for results**

Ultimately, **the impact of aid for health is measured through improvements in health outcomes.** Increasingly, partners are recognizing that attribution of health gains to support provided by particular donors is not only unfeasible (given the interconnected nature of the determinants of health status) but also counterproductive. Setting joint targets and reaching agreement on how progress will be monitored – through common monitoring frameworks – is therefore a critical element of improving the effectiveness of health aid.

There is evidence from a formal evaluation of the sector programme in Tanzania (see box above) that changes in ways of working have been associated with improvements in results. There is also evidence emerging from Mali that improvements in harmonization and alignment among health partners are correlated with health sector gains.

In addition to agreeing how progress in health will be measured, **partners and government also need to reach consensus on the policy actions that will be required to achieve those results**. At macro-level there is some experience of building "conditions" related to improvements in health into assessment frameworks used to trigger disbursements of general budget support. This is one important way of getting health onto the broader development agenda. However, because these instruments cover the whole development spectrum, the focus on health can only be limited, and there may be a tendency to choose unambitious triggers in order to ensure disbursements go ahead.

Policy-based support may be more promising at sector level, i.e., aid delivered as sector budget support tied to policy achievements in the health sector, for example, a new legislation on the establishment of regulatory bodies. This allows a dedicated focus on health support to be combined with an effective aid modality – budget or programmatic support.




**Source:** WHO photo library

# PART 3 CURRENT CONCERNS AND FUTURE DIRECTIONS

*This part of the report profiles areas in which the international health community, in response to identified challenges, is making progress in the health sector.*

**Long-term predictable financing**

The increase in aid for health provides an unprecedented opportunity to sustainably support a scaling-up of service delivery and through this, achievement of the health MDGs. **In addition to the overall level of aid, the predictability of finance is critical** to the longer-term stability and sustainability of health plans.

**Many health interventions require a long-term perspective**, notably: health systems strengthening, particularly training and deployment of skilled doctors and nurses; the development and introduction of new drugs for treating diseases in low-income countries; the treatment of chronic illnesses with drugs that are at present too costly for low-income countries, particularly for HIV/AIDS; and the eradication of diseases such as polio and malaria. Accordingly, the Millennium Development Goals envisage a 15-year period to make a substantial impact on child and maternal mortality, and the control of communicable diseases.

To better understand this issue, WHO commissioned a study which reviews the practices of the governments of the United States, United Kingdom, Sweden and Norway, the Global Fund, the GAVI Alliance and the World Bank in committing long-term development assistance funds for health. These agencies account for approximately two thirds of development assistance in the health sector. "Long term" is defined as beyond five years and "health" is defined as aid activities directly aimed at health and population, as used by the OECD in its classification of development assistance. A brief overview of the varying donor policies and constraints regarding appropriations and allocations is given in the box below.

On the positive side, there is increasing evidence of long-term commitments of aid for health in each of the seven agencies reviewed (USA, UK, Norway, Sweden, Global Fund, GAVI Alliance and the World Bank, International Development Association [IDA]). Many of these innovations have had high level political support and are in relatively new aid agency institutions. All of the agencies reviewed have examples of aid commitments to the health sector of five years or more, mostly in support of service delivery. The global health partnerships and their funders have pioneered many aspects of longer-term funding.

However, there is scope to improve the duration of aid within existing rules and regulations, or by extending special terms that are applied to segments of health aid by agency. The main constraint is therefore the lack of political commitment (rather than technical constraints) to increase the duration of aid for health more broadly.

The study recommends that more effort be made to **improve accountability of donors through measuring the duration of aid**, and the extent of forward commitments complementing the shorter-term focus on within-year aid predictability. In addition, the incentives for agency staff to commit longer term aid – and to understand and use existing provisions – need to be strengthened.

## Aid targets and appropriation of funds

Bilateral agencies that are able to make international commitments for future total development assistance are also better placed to make longer-term indicative commitments against the expected total financing envelope. Of the four bilateral agencies only the United States does not set a formal aid target and this also limits the ability to make indicative and firm forward commitments. The UK, Sweden and Norway have long-term aid targets and indicative medium-term budgets.

Annual budget approvals of all bilateral development budgets (UK, Sweden, Norway and USA) mean that longer-term binding commitments require separate parliamentary approval. By contrast, the global health partnerships (GAVI Alliance and the Global Fund) and the World Bank have been able to obtain multi-year financing through three-year replenishments (IDA and the Global Fund), long-term pledges and innovative financing arrangements (GAVI Alliance and the Global Fund), and the ability to accumulate funds on deposit.

**Allocation of funds - country strategies**

Bilateral and multilateral donors reviewed articulate country-level health sector support strategies over a period of 3–5 years albeit with varying amounts of information on the level of financial support. Typically country strategies align with recipient health sector strategies and or poverty reduction strategies. In most cases, there is a close correlation between country strategies and the duration of funding support.

GAVI Alliance and the Global Fund do not articulate country strategies. Funding is available for proposals submitted by countries, largely based on country strategies and reviewed by technical panels prior to submission for board approval. This approach introduces a different form of uncertainty (will the proposal be approved). In the case of GAVI Alliance funding is available for the duration of a country immunization strategy and/or national health plan, up to 2015.

Source: WHO, *Donor constraints on long-term aid commitments for health*, 2008

The study also recognized that national (recipient) procedures and processes for managing health sector reform and improving health outcomes are critical for bringing together external financing sources on a long-term sustainable basis. Initiatives to better coordinate health aid, such as the IHP+, can thus play a key role in providing coordinated longer-term support of well-defined national strategies. Significantly, the study pointed out that the terms of support for UN system health agencies create significant budgetary uncertainty – more so in some cases than aid provided to countries. This appears as a particularly neglected area.

One of the most innovative developments for long-term health financing is the International Finance Facility for Immunisation (IFFIm), which was created in 2006 to accelerate the availability of funds for health and immunization programmes in the world's poorest countries. IFFIm's anticipated investment of up to US$ 4 billion from 2006 to 2015 is expected to provide immunization for an additional half a billion people. (The box below provides a brief summary of IFFIm.)

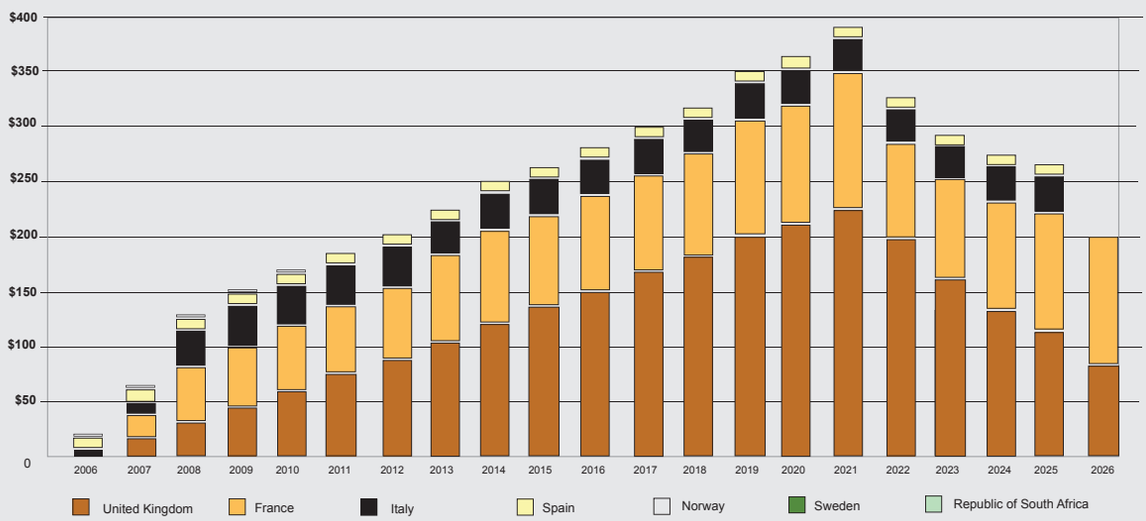
## International Finance Facility for Immunisation (IFFIm)

Now in its second year, IFFIm continues to maintain solid financial results and the bonds continue to be highly sought after by investors. After the initial US$ 1 billion bond issued in November 2006, a second issuance was completed in Japan in early 2008 which sought to raise over US$ 220 million. It, too, was oversubscribed. Donors have made up to 20-year commitments to IFFIm, proving that long-term predictable financing is achievable in development (see figure 2). IFFIm's founding donors are France, Italy, Norway, Spain, Sweden and the United Kingdom. South Africa joined IFFIm as a donor in March 2007 and other donors, including Brazil, are looking to join.

IFFIm funds flow through the GAVI Alliance to finance an accelerated scale-up of health and immunization efforts in more than 70 countries. The funding supports both "core" GAVI Alliance programmes for immunization and health development, plus a range of special one-time investments in disease eradication or control through operations run by GAVI Alliance's partners.

By greatly boosting available funds, on a sound base of long-term predictable donor contributions, IFFIm has helped GAVI Alliance to shape the market on both the demand and supply sides. With the confidence of being backed by significant funds, countries have shown a greater preparedness to expand their immunization programmes and vaccine manufacturers are able to plan expanded production, in turn stabilizing vaccine supply and driving down prices through increased competition.

Figure 2: Payment obligations by sovereign sponsors (US$ million)*




* Sums are approximate as changes may occur due to exchange rate fluctuations.

Source: GAVI Alliance

### Improving harmonization and alignment at country level

Building on lessons from SWAps, a number of new health initiatives, collectively referred to as the **International Health Partnership Plus (IHP+)** aim to both strengthen national health systems and bring greater coherence to the donor response at country level.

These include the IHP itself, the Catalytic Initiative, the Providing for Health Initiative, and others. The appearance of these initiatives reflects the strong political support for health, and recognition that aid effectiveness will be central to progress in health. Concretely, IHP+ focuses on the development of country "compacts" based on five principles: one single country health and HIV/AIDS plan; one single policy matrix and results framework; one single budget; one monitoring framework and process; and one single country-based validation process. These have results-oriented sound national plans and strategies at their centre, recognizing that all plans need to strike a careful balance between ambition and realism. They need to be sufficiently robust to facilitate partners (donors, governments and others) individually or collectively, to make funding decisions based on their assessment and the results that they aim to achieve.

## Country Compacts

Africa :: Ethiopia

The Health Compact on scaling-up for reaching the health MDGs that is currently under negotiation between the Government of Ethiopia and development partners puts in place mutually agreed understandings for the period 2008–2015. This Compact is embedded in the overall aid harmonization policy of the country and further builds on existing coordination processes established in the Health Sector, including the Health Sector Code of Conduct. The Compact establishes guiding principles and management arrangements to strengthen the effectiveness of ODA in support of the health related MDGs. It outlines specific commitments and obligations on both the side of the Government and development partners. At the same time, it sets out collective targets for the minimum level of total aid for health and addresses future practice for the management of such external assistance, including increasingly using government systems to procure, disburse, implement, report, monitor and account, and audit. It establishes a number of benchmarks for monitoring the Compact and puts in place a results framework for monitoring the performance of the sector generally.

**Source:** Federal Ministry of Health. *Compact between the Government of Ethiopia and development partners on scaling up for reaching the health MDGs*. June 2008.

### Validating national strategies and plans

At the heart of the idea of country compacts is a single national health strategy and plan. In many countries such a strategy forms the basis of a sector-wide or programme-based approach. The challenge in these cases is for a wider circle of development partners – including the global funds and programmes – to take part in a joint assessment of a national strategy as the basis for making funding decisions and as a means of aligning financial support to national priorities.

Building on ideas from other sectors (particularly the Fast Track Initiative in Education), work is in hand to define the key minimum attributes of national strategies and plans considered necessary to make a funding decision and to propose options for how they can be "validated". The latter process poses a particular challenge, given the need to strike a careful balance between a degree of independence, to reassure external financiers, while retaining a full sense of national ownership. Unlike the off-shore review process that is currently used by GAVI Alliance and the Global Fund to review proposals, the validation process will be country-based. This approach will be piloted in the IHP+ first-wave countries preparing to negotiate compacts in the second half of 2008. Additionally, robust country health strategies or disease-specific national

strategies will be the basis on which decisions on National Strategy Applications will be made by the Board of the Global Fund beginning in late 2009.

### Monitoring and evaluation (M&E)

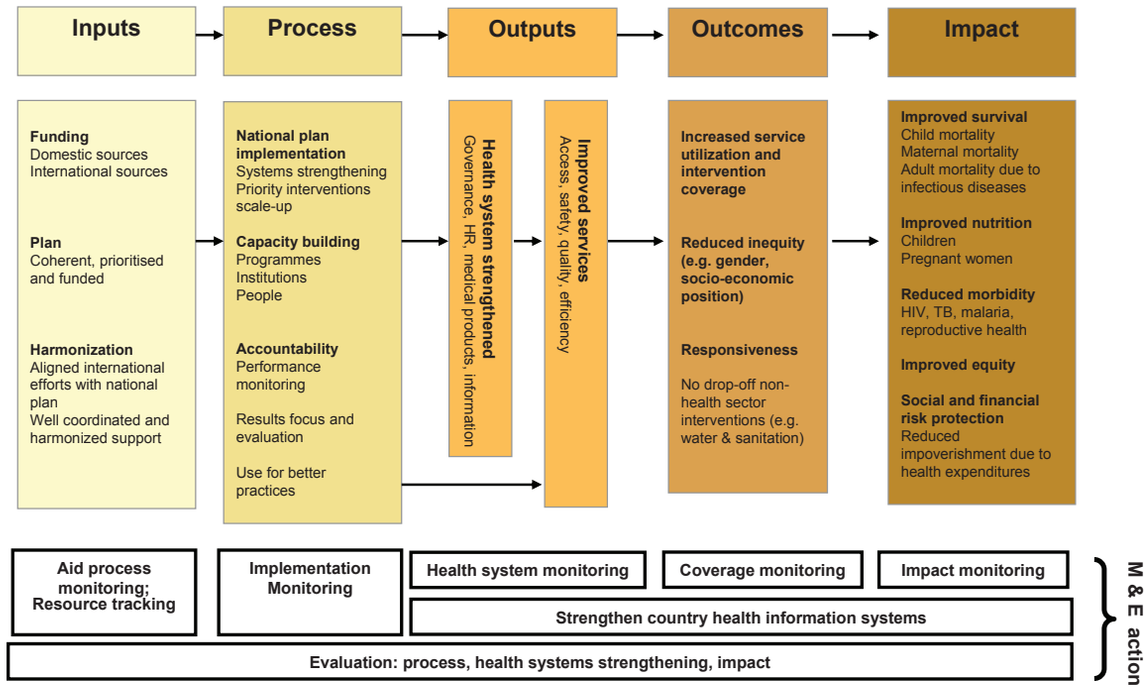
Key to harmonization and alignment at country level is a common approach to M&E. A common strategic framework for monitoring and evaluating scale-up initiatives in health has been designed by a working group of the IHP+ with country participation, and agreed upon with several other initiatives. The common framework specifies broad, generic categories of actions and results that are logically connected. Initiatives are expected to produce more detailed results frameworks adapted to specific countries and interventions when applying the strategic framework.

#### Principles of the common M&E framework

- **Collective action:** focus is on the contribution of scale-up initiatives and country efforts to improve overall sectoral results;
- **Alignment with country processes:** build on national processes that countries have established for monitoring the implementation of national plans;
- **Balance between country participation and independence:** driven by country needs but conducted in a manner which maintains the independence of evaluations;
- **Harmonized approaches:** common protocols and standardized inputs, process, output, outcome indicators with appropriate country adaptations;
- **Capacity building and health information strengthening:** systematic involvement of country institutions;
- **Adequate funding:** between 5% and 10% of overall scale-up funds set aside for monitoring performance, evaluation, operational research and strengthening information systems.

The common framework includes a "dashboard" of health systems indicators which can be used to demonstrate progress in areas such as financing, service delivery, pharmaceuticals, health statistics and governance.

**Figure 3: The IHP+ common monitoring and evaluation framework**




Source: IHP+

**Monitoring aid effectiveness in health:** Many countries have expressed an interest in monitoring the effectiveness of aid for health, recognizing that the aggregate national picture that emerges from the OECD/DAC survey can disguise important differences – both positive and negative – at a sectoral level. Work is in hand to adapt the Paris indicators for this purpose. However, it has been agreed that it would not be appropriate to mount a parallel survey, rather to provide guidance to countries that want to use such an instrument for their own purposes, while retaining the potential for cross-country comparison.

**Monitoring the three ones:** In the field of AIDS the idea of "three ones" (one national authority, one strategic plan and one M&E framework) underpins efforts to improve harmonization and alignment. The Country Harmonization and Alignment Tool (CHAT) has been used in the context of annual reviews to assess progress over time. In Kenya, where the instrument has been used recently, it revealed that harmonization of donors is more visible among the multilateral development partners than among the bilateral agencies. It also highlighted the limited progress that has been made in the use of national systems in that country.

### Aid effectiveness in fragile states

The Paris Declaration made particular mention of the challenges of ownership, alignment and harmonization in states emerging from long-term conflict. The challenge in health, as in other sectors, is to strike a balance between achieving immediate results that will save lives, while contributing at the same time to building the capacity of the state. Recent work in the Democratic Republic of the Congo provides a vivid example of how progress in the most difficult circumstances is possible (see box below).

## Rebuilding national leadership in health

Africa :: Democratic Republic of the Congo

The reconstruction of the health system in the Democratic Republic of the Congo (DRC) in the aftermath of war and economic collapse, illustrates how renewed leadership can emerge in countries with extremely challenging situations, and demonstrates the results of skillful political management.

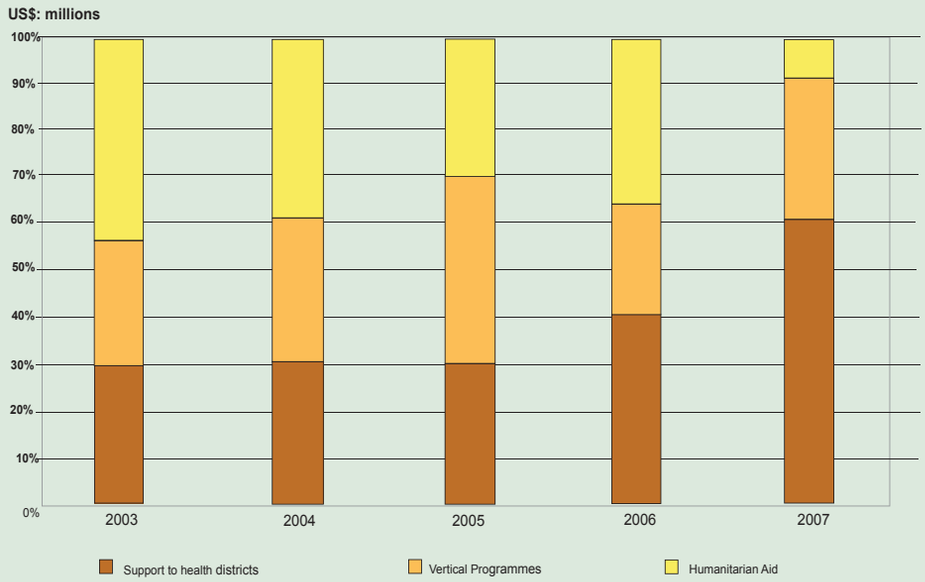
The country was a pioneer of health district model during the 1970s and early 1980s, with a health system constituted of a rather dense network of hospitals and health centers with a critical mass of cadres. The economic and political turmoil from the mid-1980s resulted in the breakdown of the central government authority, leading to the development of multiple coping strategies, such as commercialization of health care. As the war developed, donors and development partners started to fund multiple projects and disease programmes, with little regard to their long-term impact on health systems. Between 1999 and 2002, the Department of Planning had to manage more than 280 development partners, including bilateral and multilateral agencies, and NGOs – both international and national – as well as 53 disease control programmes, with 13 government donor coordination committees.

To address these challenges, the MOH decided to formulate a strategy for reform in 2005. They formed a steering group with representation from different partners which drafted a national health systems strengthening strategy (NHSSS). This strategy focused on strengthening the district model and preventing further distortions to the health system; managing donor fragmentation; setting up structures and networks for collaboration and negotiation with partners within the health sector, and with other government actors; and intensifying core public funding.

## Rebuilding national leadership (continued)

The national plan was endorsed formally by donors and civil society. The NHSSS became the health component of the national Poverty Reduction Strategy. Several development partners have aligned their projects or new initiatives to the NHSSS. The proportion of funds committed to system strengthening – relative to being earmarked for specific programmes – within provincial and district plans increased in the period 2004–2006. The position of the MOH for negotiating and re-financing the health sector has gained momentum.

**Donor contributions to health in DRC: a shift towards health systems support after MOH reformulated its health sector strategy in 2004.**




Source: WHO. *The world health report 2008, primary health care: now more than ever (in press)*. Geneva, 2008.

### Global funds and programmes

At 2003 meetings in Rome, global programmes were barely on the agenda of aid effectiveness. In 2005 in Paris, their importance was recognized in the declaration which addressed "insufficient integration of global programmes and initiatives into partner countries' broader development agendas…". In 2008 global programmes are an established part of the aid architecture in health, complementing and adding to existing sources of development aid, particularly in HIV.

Many of the advantages of global programmes have featured in other parts of this report – notably in relation to leveraging additional financing. In some senses, it could be argued that the global programmes are adapting more rapidly to the Paris agenda than some of the traditional bilaterals that provide the bulk of their funding. Their contribution has also been particularly notable in institutionalizing the involvement of civil society and the private sector in both the development and implementation of proposals. At the same time their mode of operation poses some significant challenges – both for recipient governments and for partners in-country.

Many of the challenges that have been touched upon in Part 2 of this report involve the potential distortion of national priorities that can result from a requirement for counterpart funding. As the global funds and programmes become more engaged in financing national strategies and plans, so their lack of country

presence and consequent reliance on other partners will become an important issue. These and other challenges emerge from a learning process that has been coordinated by the Global Fund but conducted by the Global Programmes Learning Group. The Learning Group includes global programs from a variety of sectors, such as health, education and the environment (see box below).

Lastly, it is important to reiterate a significant area of progress. Global partnerships are working to better harmonize the support they provide at country level. For example, the Global Fund Board commitment to supporting health systems has broadened the scope of what can be funded in this regard. It will also consider new approaches to funding national strategies through SWAps and other pooling mechanisms. PEPFAR spent around US$ 350 million on human resource development and on building health systems capacity in 2006. The GAVI Alliance Health Systems Strengthening window is linked to national planning processes and allows countries to focus on key systems constraints. A recent review shows that proposals more closely aligned to national priorities are more successful in receiving funds. Innovative funding, through IFFIm, allows GAVI Alliance to potentially enter into long-term financing arrangements with countries, thereby increasing predictability.

## Global Programmes Learning Group

### self assessment, challenges and good practices

**Ownership –** There is strong ownership from countries involved in supporting and implementing global programmes. A common innovative feature is stronger support from and inclusion of civil society and the private sector. Global programmes tend to get strong support from concerned sectoral ministries. Increasing ownership from overall coordinating mechanisms and ministries of central governments, including finance ministries, remains a challenge.

**Alignment –** Global programmes have been set up to carry out specific, generally sub-sectoral, mandates: their role is different from that of DAC donors. Global programmes are making efforts to adapt their funding rounds to country budget cycles.

**Harmonization –** The specific mandates and processes of global programmes as well as their general lack of direct field presence make harmonization at the country level challenging. Given their global focus, global programmes have tended to international best practice. But they are giving increased attention to balancing this with their objectives of acting jointly with other donors, in order to reduce transaction costs, particularly for partner governments. The challenge to global programmes applies, for example, in how to participate in-country donor groups or in joint missions and analyses.

**Managing for results –** Global programmes have been innovators in the emphasis they give to building in results and performance to their funding processes, as well as the emphasis that they put on monitoring and evaluation. All the programmes have given emphasis to results frameworks – as a vital element of monitoring, evaluation, and auditing systems – with an increasing focus on outputs and development outcomes as well as on sound management of programme inputs. Indicative country allocations conducted by some programs can help link results to predictability and cross-country impact. Global programmes differ substantially in the extent to which they make use of government and joint donor systems of monitoring, results, and auditing. For those which have made less use in the past, the challenge is how to align and harmonize in a manner that contributes to the improvement of overall government and donor monitoring and evaluation systems as well as to improvement of results.

**Mutual accountability –** Global programmes show strong accountability to their international constituencies, and some have set standards of good practice among donors on transparency. However, mutual accountability is more difficult at the country level, partly because of the global mandates of global programmes and their lack of direct presence on the ground. The greater involvement of civil society and the private sector in country strategy and implementation structures adds another dimension to mutual accountability.

### Integrating human rights, gender and women's empowerment

The two objectives of promoting human rights and increasing the effectiveness of aid are mutually reinforcing. Human rights, including the right to the enjoyment of the highest attainable standard of health, are enshrined in international human rights treaties and national constitutions. They provide an explicit basis for national health strategies and give people tools for holding governments to account for their commitments. Integrating human rights norms and principles in the way that the national health sector plan is developed means ensuring that the process promotes the rights to participation, equality and non-discrimination, and accountability. Key stakeholders such as civil society and vulnerable populations must be present, in addition to paying attention to gender equality throughout the design, implementation, monitoring and evaluation of the plan.

While a human rights approach to aid effectiveness requires both that women play an equal role in development planning as well as having equal access to the benefits that result, gender and women's empowerment is particularly important role in improving health status and is thus addressed separately. Improving health outcomes depends heavily on women, and development activities that enhance their status and economic independence, play into a virtuous circle. If women are excluded from the process of development, the reverse is true (see the box on Nepal, below).



## Inclusive participation for safe motherhood

South-East Asia :: Nepal

In Nepal, the implementation of the National Safe Motherhood Plan (2002–2017) is supported as part of the health SWAp. The programme of support includes an Equity and Access Programme (EAP), managed by ActionAid, which operates in selected communities in eight districts.

The aim of the EAP is to increase service utilization among socially disadvantaged women from lower castes and excluded ethnic groups. A key component of the EAP is the "voice capturing" exercise which uses participatory methods to obtain and record the views of women from excluded castes, ethnic and regional groups on maternal health issues and service provision. These reports provide a basis for discussion about maternal health services between women's representatives and service providers at village and district levels. Findings from the voice capturing are also fed up through the Ministry of Health and Population to inform decisions around resource allocations and planning.

Disaggregated data produced by the EAP indicates that over the two year period 2006–2007 there has been an increase in hospital deliveries in EAP districts across all social groups at an average rate around 12 times the national average. However, women from disadvantaged groups are still more likely to deliver in peripheral institutions or at home. This data has helped to support the case for government decisions to increase the proportion of the infrastructure budget allocated to construction of peripheral facilities. Evidence from the project on financial barriers to maternal services has also contributed to the national policy debate and decision to abolish user fees at lower-level health services. Lessons from the EAP on responsiveness to service-users' concerns are helping to inform Nepal's International Health Partnership.

**Source:** Clare Ferguson. *Linking human rights and aid effectiveness for better development results: Practical experience from the health sector.* Report for the Human Rights Task Team of the OECD-DAC Network on Governance (GOVNET), 2008.

Provision of effective aid at sector level must be underpinned with strong links to the broader development agenda – both "economic" and "human". The former means strong links between health and poverty reduction plans and budgets (see box on Uganda, below). Attention to process in how national health sector strategies and plans are developed can increase the effectiveness of aid as transparency and inclusion are enhanced. Conversely, effective aid is that which contributes to the realization of human rights. Paying attention to the core obligations and guiding framework of the right to health (availability, accessibility, acceptability and quality) as well as related principles such as non-discrimination and gender equality are essential to ensure that the realization of human rights is further enhanced through efforts to harmonize aid.

## Community-based monitoring and evaluation

Africa :: Uganda

As part of the HIPC (Heavily Indebted Poor Country) agreement, the government of Uganda must channel resources no longer going for debt servicing into a Poverty Action Fund (PAF) to finance poverty-reduction programmes. The PAF represents a major source of financing for Uganda's national budget, and a large proportion of the country's resources for health and education.

The PAF has become the focus of the Uganda Debt Network (UDN), a civil society network that monitors the utilization of public resources and ensures that social spending reaches the people who need it most. In 2002, the UDN initiated a Community Based Monitoring and Evaluation System (CBMES) to engage people who are poor and marginalized in monitoring and evaluating programmes for poverty reduction in their own communities. The programme provides people with information about poverty strategies and teaches them to do local budget analysis. It supports the participation of women and people from excluded groups in its work. As part of the CBMES, volunteer monitors work directly with health service providers to evaluate service delivery and discuss the results. The findings are also presented to local government officials by the community monitors, who use their knowledge to request further information and negotiate solutions.

The programme has documented significant obstacles to health service delivery, including deficiencies in management, procurement and control systems of local health units, as well as raising issues of bribery and corruption. It has also mobilized community support for the establishment of local health facilities and monitored construction of agreed facilities. The programme was originally piloted in four districts and is now being established in a further seven. An evaluation of the original pilot phase showed an improvement in health and education services and a reduction in substandard work in districts where the CBMES was operating.

**Source:** Uganda Debt Network www.udn.or.ug; Keith-Brown K. *Investing for Life: Making the link between public spending and the reduction of maternal mortality.* Report for FUNDAR, 2005.

**A growing role for civil society**

Activist groups have played a dominant role in transforming aspects of international health policy – most notably in the field of AIDS treatment and as advocates for increases in health spending. Lobby groups continue to exert their influence in arguing for greater attention to the issue of human resources for health. They are now turning their attention to the need for greater investment in health systems but in ways that do not compromise past gains in relation to funding for specific diseases.

In a different part of the spectrum, a wide range of non-governmental actors are responsible for the provision of services in many low- and middle-income countries. This reflects the long-established role of faith-based groups that work in otherwise under-served areas through to groups – particularly those working on sexual health – that operate on the margins of society, reaching groups in the population that otherwise tend to be ignored by more formal service providers.

Aid financing for civil society organizations (CSOs) throws up its own raft of issues. On the positive side many of the global partnerships, recognizing the important provider and advocacy role CSOs can play, have made specific provision for this in their financing strategies. At the same time, the wealth of funding – particularly for HIV and AIDS – has led to the establishment of large numbers of so-called "briefcase NGOs", founded largely for the purpose of capturing resources. At the same time, recent evidence collected by WHO on working with the non-state sector shows that the preference of bilaterals for focusing on government services is causing a significant migration of staff out of the mission services (particularly in Eastern Africa) because they cannot keep up with the salary increases now made possible through aid to the public sector.



**Source:** WHO photo library

# PART 4 AGENDA FOR ACTION

*Although there remains a large unmet need, significant new resources have been made available for investments in the health sector. Concerned to make best use of these monies, the international health community and partner countries have invested considerable energy in understanding aid effectiveness challenges in the sector and building consensus around solutions. Progress has already been made in many areas – including increasing the predictability of aid, strengthening harmonization and alignment mechanisms at country level, and establishing mechanisms for mutual accountability. These achievements need to be extended to a larger group of countries and broadened to include a wider group of actors.*

*The recommendations set out below center around the key areas of ownership, alignment and managing for development results. The six priority areas that were identified by partner countries (predictability, conditionality, incentives, division of labour, capacity building, untying) are also reflected in these proposals.*

**Ownership**

Countries need to invest in the **development of results-oriented national health strategies, plans and budgets**. These will facilitate better harmonization and alignment of health aid on a more sustainable and predictable basis. In designing and implementing their health strategies, **governments need to ensure a broad dialogue and participation with all parties including the private sector and CSOs**, building on the opportunities that aid provides for greater engagement with non-state actors.

**Countries also need to take the lead in clearly identifying needs, gaps and priorities for donor support.** Once these are clearly articulated, all development partners need to ensure greater alignment of their interventions within country plans, budgets and systems.

Development partners can support efforts to **improve the dialogue and coordination between health ministers and central ministers (finance, economy and planning)**. This will help ensure that health plans and budgets are properly reflected in the long-term country strategy, and activities are appropriately funded, particularly those that require long-term commitments such as human resources and drugs.

Country ownership is facilitated by **greater clarity on the roles, division of labour and comparative advantages of different types of health support**, particularly in the area of health systems strengthening. Development partners need to encourage clear, consistent, harmonized messages on this issue through their own organizations and the boards of global partnerships on which they are represented.

**Alignment**

Strengthening the **capacity of country institutions and systems** is key to alignment. Development partners can support countries through building capacity for planning, budgeting, monitoring, and better sector dialogue; all these elements need to be in place and operating well for donors to align their support.

Development partners need to set the **right incentives** for their staff to commit long-term aid, develop coordination with other agencies and encourage the move towards programme-based approaches under the leadership of countries.

Development partners need to ensure that new funds raised through innovative financing mechanisms in health is **programmed coherently and in line with country priorities.**

All development partners must aim **to report in a timely manner the size and duration of commitments and timing of disbursements** in order to support stronger countries budget and planning processes. Also, they must aim **to report on alignment to programme-based approaches in health and on using country systems**.

All development partners need to work towards **joint missions and joint annual sector reviews** as a critical opportunity to review shared objectives, agree on process and policy conditions and encourage further alignment within country plans, under country leadership.

**Managing for Development Results**

Managing for results remains central to the aid effectiveness agenda in health, but it requires increased focus on **managing complexity** - recognizing that diversity can help bring results and that the health sector benefits from a range of partners with different ways of doing business.

Development partners need to increase efforts to **harmonize existing monitoring and evaluation frameworks**, and refer to "contribution" to overall country results rather than "attribution".

Countries and partners need to prioritize the **strengthening of national health information systems**. All aid programmes, including those run by CSOs, should aim to use these systems as a default.

Development partners and countries need to **continue to track progress and results in health from an aid effectiveness perspective**. The DAC will continue to monitor and encourage progress through its work on health as a tracer sector.

Development partners need to make full use of existing mechanisms and flexibilities to provide **a greater portion of their health aid over the longer-term**. They also need to **eliminate conditions on the use of technical cooperation in health**.

# ANNEX 01 DEFINITIONS

## General Definitions

**Sector programme aid** comprises contributions to carry out wide-ranging development plans in a defined sector such as agriculture, education, transportation, etc. Assistance is made available "in cash" or "in kind", with or without restriction on the specific use of the funds, but on the condition that the recipient executes a development plan in favour of the sector concerned.

**Technical Cooperation** includes both (a) grants to nationals of aid recipient countries receiving education or training at home or abroad, and (b) payments to consultants, advisers and similar personnel as well as teachers and administrators serving in recipient countries, (including the cost of associated equipment). Assistance of this kind provided specifically to facilitate the implementation of a capital project is included indistinguishably among bilateral project and programme expenditures, and not separately identified as technical co-operation in statistics of aggregate flows (http://www.oecd.org/glossary/0,3414,en_2649_33721_1965693_1_1_1_1,00.html#1965580).

## CRS definitions

**Free-standing technical co-operation** is defined as financing of activities whose primary purpose is to augment the level of knowledge, skills, technical know-how or productive aptitudes of the population of aid recipient countries, i.e. increasing their stock of human intellectual capital, or their capacity for more effective use of their existing factor endowment. It includes the cost of personnel, training and research, as well as associated equipment and administrative costs.

**Sector programme aid** comprises contributions to carry out wide-ranging development plans in a defined sector such as agriculture, education, transportation, etc. Assistance is made available "in cash" or "in kind", with or without restriction on the specific use of the funds, but on the condition that the recipient executes a development plan in favour of the sector concerned.

Investment projects comprise a) schemes to increase and/or improve the recipient's stock of physical capital and b) financing the supply of goods and services in support of such schemes.

Investment-related technical co-operation is defined as the financing of services by a donor country with the primary purpose of contributing to the design and/or implementation of a project or programme aiming to increase the physical capital stock of the recipient country. These services include consulting services, technical support, the provision of know-how linked to the execution of an investment project, and the contribution of the donor's own personnel to the actual implementation of the project (managers, technicians, skilled labour etc.).

A **commitment** is a firm written obligation by a government or official agency, backed by the appropriation or availability of the necessary funds, to provide resources of a specified

amount under specified financial terms and conditions and for specified purposes for the benefit of the recipient country.

A **disbursement** is the placement of resources at the disposal of a recipient country or agency, or in the case of internal development-related expenditures, the outlay of funds by the official sector.

**The CRS sector classification contains the following broad categories:**

**Social infrastructure and services** (covering the sectors of education, health, population, water, government and civil society);

**Economic infrastructure and services** *(*covering transport, communications, energy, banking and finance, business services);

**Production** (covering agriculture, forestry, fishing, industry, mining, construction, trade, tourism);

**Multisector/cross-cutting** (covering general environmental protection, women in development, other multisector including urban and rural development); and

**Non-sector allocable** (for contributions not susceptible to allocation by sector, such as balance of payments support, actions relating to debt, emergency assistance and internal transactions in the donor country).

# ANNEX 02 ODA TABLE OF LEAST DEVELOPED COUNTRIES

| Recipient LDCs | Average Population 2002-2006 | GNI per capita current US$ (WB-05) | Under five mortality 2004 | Life Expectancy at birth 2004 | Average Per Capita total expenditure on health 2001-2005 | Health ODA per capita 2002-2006 | MDG 6 % of Health & Population Aid | HIV Prevalence (15-49) Est 2005 | MDG 5 % of Health & Population Aid | Technical Cooperation % of Health & Population Aid |
|---|---|---|---|---|---|---|---|---|---|---|
| | population (000s) | US$ | per 1000 live births | years | US$ | US$ | % | % | % | % |
| Zambia | 11,277 | 400 | 182 | 40 | 27.4 | 20.0 | 58.5% | 17.0 | 0.6% | 36.2% |
| Timor-Leste | 1,009 | N/A | N/A | N/A | 36.2 | 14.9 | 18.9% | N/A | 0.8% | 20.4% |
| Malawi | 12,905 | 160 | 175 | 41 | 16.6 | 13.4 | 49.9% | 14.1 | 1.5% | 22.4% |
| Lesotho | 1,965 | 730 | 82 | 41 | 34 | 12.7 | 72.1% | 23.2 | 0.7% | 19.3% |
| Rwanda | 9,085 | 210 | 203 | 46 | 12.8 | 10.8 | 73.9% | 3.1 | 2.1% | 53.8% |
| Haiti | 9,151 | 450 | 117 | 55 | 23.6 | 10.1 | 63.1% | 3.8 | 15.2% | 57.3% |
| Mozambique | 20,065 | 270 | 152 | 45 | 11.8 | 9.9 | 47.0% | 16.1 | 4.5% | 34.9% |
| Cambodia | 13,724 | 350 | 141 | 54 | 22.6 | 7.7 | 54.9% | 1.6 | 5.4% | 44.0% |
| Uganda | 28,059 | 250 | 138 | 49 | 19 | 7.6 | 69.0% | 6.7 | 1.3% | 47.1% |
| Senegal | 11,477 | 630 | 137 | 55 | 30.4 | 7.4 | 28.9% | 0.9 | 1.5% | 45.7% |
| United Republic of Tanzania | 37,522 | 320 | 126 | 48 | 12.8 | 7.2 | 57.1% | 6.5 | 5.5% | 32.2% |
| Benin | 8,228 | 450 | 152 | 53 | 21.4 | 6.6 | 46.4% | 1.8 | 2.9% | 27.1% |
| Afghanistan | 24,112 | 234 | 257 | 42 | 12.6 | 6.4 | 7.3% | 0.1 | 1.9% | 46.1% |
| Sierra Leone | 5,361 | 210 | 283 | 39 | 7.2 | 5.6 | 40.9% | 1.6 | 1.3% | 8.1% |
| Mali | 11,276 | 330 | 219 | 46 | 23.6 | 5.5 | 39.8% | 1.7 | 6.4% | 33.9% |
| Guinea-Bissau | 1,550 | 160 | 203 | 47 | 10.8 | 5.1 | 34.4% | 3.8 | 5.2% | 24.6% |
| Gambia | 1,570 | 280 | 122 | 57 | 13 | 5.0 | 79.2% | 2.4 | 1.9% | 3.1% |
| Eritrea | 4,349 | 190 | 82 | 60 | 11 | 4.9 | 45.1% | 2.4 | 26.3% | 18.6% |
| Lao People's Democratic Republic | 5,577 | 390 | 83 | 59 | N/A | 4.8 | 29.0% | 0.1 | 3.2% | 25.7% |
| Burkina Faso | 13,509 | 350 | 192 | 48 | 18.4 | 4.7 | 46.3% | 2.0 | 7.0% | 19.5% |
| Mauritania | 2,882 | 530 | 125 | 58 | 13.2 | 4.5 | 60.0% | 0.7 | 8.1% | 9.2% |
| Burundi | 7,588 | 90 | 190 | 45 | 3 | 4.4 | 67.6% | 3.3 | 9.0% | 18.9% |
| Liberia | 3,382 | 120 | 235 | 42 | 6.4 | 4.1 | 55.8% | 3.5 | 3.8% | 33.5% |
| Central African Republic | 4,127 | 310 | 193 | 41 | 11.2 | 3.9 | 65.4% | 10.7 | 2.0% | 9.6% |
| Angola | 15,641 | 930 | 260 | 40 | 25.2 | 3.8 | 54.1% | 3.7 | 2.5% | 29.6% |
| Guinea | 8,840 | 410 | 155 | 53 | 23.2 | 3.5 | 52.0% | 1.5 | 9.5% | 35.1% |
| Niger | 12,823 | 210 | 259 | 41 | 8 | 3.4 | 44.1% | 1.1 | 3.4% | 23.1% |
| Democratic Republic of the Congo | 57,003 | 110 | 205 | 44 | 4.2 | 3.2 | 39.1% | 3.2 | 0.5% | 31.1% |
| Nepal | 26,560 | 250 | 76 | 61 | 13.6 | 3.0 | 25.0% | 0.5 | 19.8% | 41.3% |
| Ethiopia | 77,036 | 110 | 166 | 50 | 5.6 | 2.9 | 68.3% | 2.2 | 5.8% | 35.8% |
| Madagascar | 18,143 | 290 | 123 | 57 | 9.6 | 2.8 | 41.9% | 0.5 | 3.6% | 30.2% |
| Togo | 6,074 | 310 | 140 | 54 | 14.8 | 2.4 | 65.0% | 3.2 | 2.2% | 10.8% |
| Somalia | 7,962 | N/A | N/A | N/A | 8 | 2.1 | 64.4% | N/A | 2.5% | 20.8% |
| Yemen | 20,496 | 550 | 111 | 59 | 31.4 | 1.9 | 17.8% | 0.1 | 35.2% | 22.8% |
| Sudan | 36,188 | 530 | 91 | 58 | 20 | 1.7 | 60.1% | 1.6 | 1.2% | 43.2% |
| Bangladesh | 150,497 | 440 | 77 | 62 | 11.8 | 1.7 | 9.9% | 0.1 | 18.4% | 34.2% |
| Chad | 9,802 | 250 | 200 | 46 | 16 | 1.6 | 39.7% | 3.5 | 4.6% | 36.9% |
| Myanmar | 47,570 | N/A | N/A | N/A | 3.8 | 0.6 | 53.6% | N/A | 3.6% | 24.6% |

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