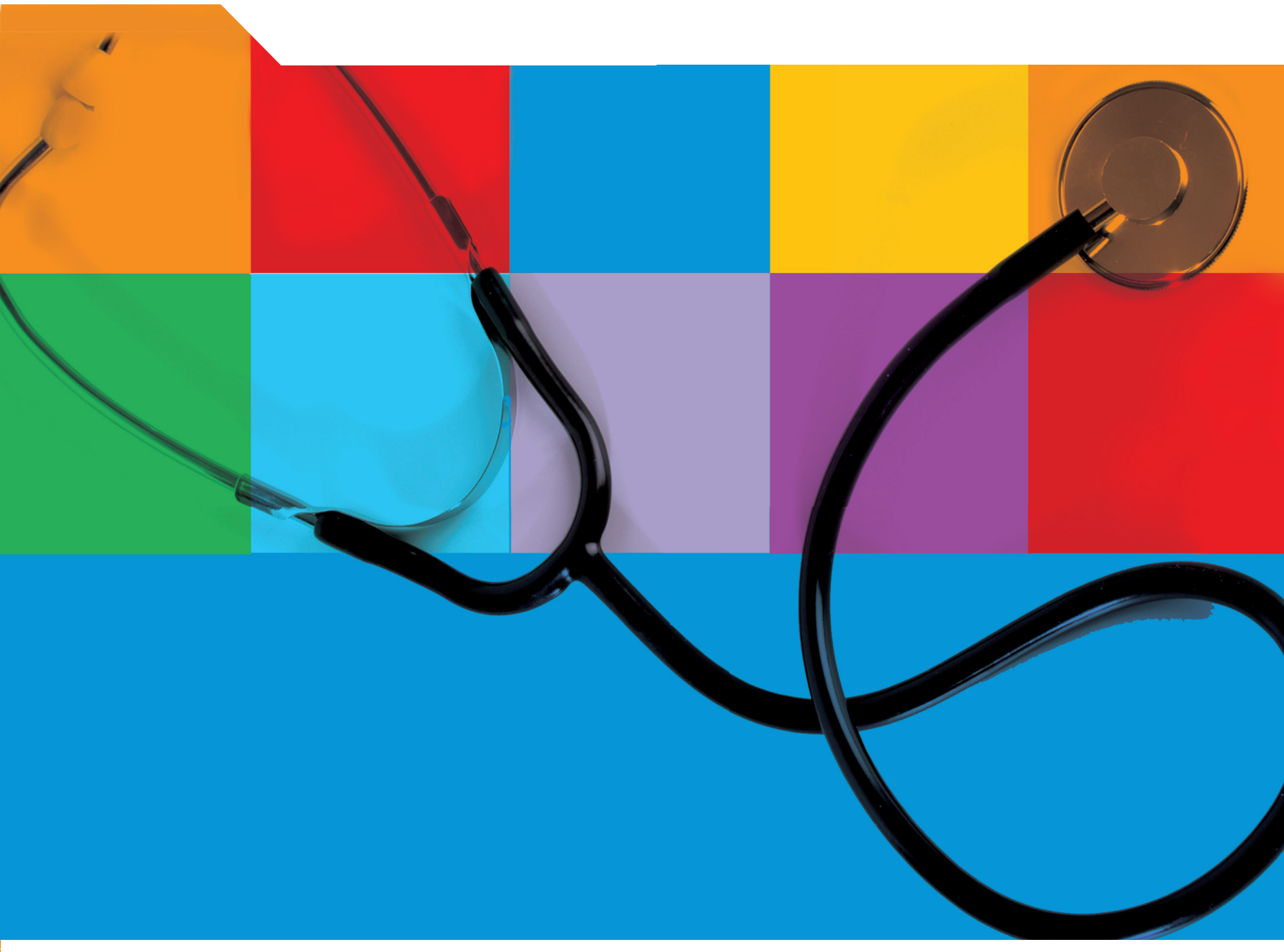
Better Aid

Aid Effectiveness in the Health Sector

PROGRESS AND LESSONS



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Foreword

The Fourth High-Level Forum on Aid Effectiveness (HLF4), held in Busan, Republic of Korea from 29 November to 1 December 2011, presented a critical opportunity for all development partners to work together on a new global compact to broaden and deepen the global development partnership. It was an opportunity to re-energise the development agenda, so that developing countries supported by their development partners can achieve better results and reach the Millennium Development Goals (MDGs). The work on aid effectiveness and health, which has been developed and regularly reported on for the past four years in the context of the Working Party on Aid Effectiveness, has been the most tangible effort to bridge the debate on the quality of development co-operation partnerships and the one on development results, including the MDGs.

This final report marks the end of a process which has seen senior-level officials from various important institutions, countries and organisations sharing their experience and agreeing to define common recommendations for further individual and collective improvements towards effective health aid.

Thanks to this candid and constructive process, we can report today on the progress made at both global and country levels. The Task Team on Health as a Tracer Sector (TT HATS) has used its leverage and outreach to collate information on progress from within its member institutions and ongoing important approaches, especially at the country level. It has constantly aimed at feeding the overall process on monitoring and promoting the implementation of the Paris Declaration with a view to being a source of lessons for other sectors and areas that face similar challenges in terms of co-ordination, alignment and proliferation of actors. It is encouraging to see that some find inspiration in this work for nurturing discussions on issues such as climate change or food security.

The objective of the TT HATS has been to be a resource for more effective action and decisions at all levels. The tools are in place. A lot of information is available. We know what needs to be done. It is now a question of responding to the urgent calls by developing countries to support them in their efforts to deliver on their development objectives to their people and build capacity in the health sector.

It is not enough to see how much aid to health has grown over the past years. This increase in donor and other sources of funding, especially in difficult budget and fiscal times, has come with increased responsibility and accountability to report on their use and impact at the country-level and to properly address the issues which could jeopardise the sustainability of achieved results.

It is not enough to recognise that health, more than other sectors, has developed tools to improve the effectiveness of aid, including sector-wide approaches (SWAps), the International Health Partnership (IHP+) and others. The success of these approaches still requires qualitative, consistent and collective engagement from all partners.

It is not enough to commend and popularise that child mortality has decreased, that the objectives set for malaria and tuberculosis by 2015 are reachable and that about six million people are under Anti Retroviral Treatments today. This very positive story needs to be embedded in a context of more effective health systems that are able to respond to the various needs of the population.

The global health landscape today with more than 100 global programmes, innovative ways of funding or delivering health inputs and increasing participation of non-traditional development actors has contributed to achieving significant results, and some market failures are being addressed through innovative partnerships. But, the current situation is also a source of concerns as these interventions have sometimes not paid the necessary attention to the need for countries to develop their own health system capacity, not least to benefit fully and sustain the results from this diversity of interventions. The global landscape requires further efforts to rationalise development assistance to health, address overlapping mandates and improve collective action at the country level.

These are but a few examples of the important work and story the TT HATS has put together in this final report. Its findings and recommendations should be useful and used by decision makers and thought leaders, be they from government, the private sector and NGOs, or academia, to further improve the effectiveness of development co-operation.

Finally, as Chair of the OECD DAC, I would like to congratulate and thank all colleagues and their partner institutions for their active contribution to the TT HATS as well as the Working Party on Aid Effectiveness for its constant trust and support in this journey.

J. Brian Atwood

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Abbreviations

AfGH	Action for Global Health
AMC	Advance Market Commitment
AMFm	Affordable Medicines Facility malaria
CCM	Country Co-ordinating Mechanism
CHeSS	Country Health Systems Surveillance
DAC	Development Assistance Committee
DFID	UK Department for International Development
EC	European Commission
EU	European Union
GAVI	Global Alliance for Vaccines and Immunisation
GBS	General Budget Support
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HACT	Harmonised Approach to Cash Transfers
HLF4	Fourth High Level Forum on Aid Effectiveness
HIA	Health in Africa Initiative
HSS	Health Systems Strengthening
IATI	International Aid Transparency Initiative
IFC	International Finance Corporation
IFFIm	International Financing Facility for Immunisation
IHP+	International Health Partnership and related initiatives
IHP+Results	Consortium providing independent annual assessment of IHP+ implementation
ISS	Immunisation Services Support
JANS	Joint Assessment of National Strategy
JFA	Joint Financing Agreement
MCC	Millennium Challenge Corporation
MoU	Memorandum of Understanding
MTEF	Medium-Term Expenditure Framework
NAC	National AIDS Council

NSA	National Strategy Application
ODA	Official Development Assistance
ODI	Overseas Development Institute
OECD	Organisation for Economic Co-operation and Development
PAF	Performance Assessment Framework
PBA	Programme-Based Approach
PEPFAR	President's Emergency Plan for AIDS Relief
PFM	Public Financial Management
PIU	Project Implementation Unit
PPP	Public Private Partnership
SBS	Sector Budget Support
SIDA	Swedish International Development Agency
SWAp	Sector-Wide Approach
TT HATS	Task Team on Health as a Tracer Sector
ULB	Université Libre de Bruxelles
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Aid plays an important role in reducing poverty and inequality, increasing growth, building capacity, achieving human development and accelerating achievement of the Millennium Development Goals (MDGs). Aid effectiveness is critical, both to maximise the impact of aid and to achieve the necessary changes for long-term, sustainable development.

Aid to the health sector is significant and complex and exemplifies many of the challenges for aid effectiveness. The health sector has pioneered action to improve aid effectiveness and offers valuable lessons for other sectors. This final report of the Task Team on Health as a Tracer Sector (TT HATS) provides an overview of progress in implementing the principles of the 2005 Paris Declaration and 2008 Accra Agenda for Action in the health sector with an emphasis on lessons learned from country experiences.

Key messages

There have been significant achievements in the health sector but more needs to be done. The health sector has made significant progress in aid effectiveness, spearheading innovative approaches such as the IHP+ to improve harmonisation, alignment and monitoring mechanisms. Further progress is needed, particularly to address the gap between commitments at the global level and practice in countries and to bring about sustained changes in the behaviour of both countries and donors. Experience from health informs other sectors and wider development. Monitoring progress in aid effectiveness commitments in health and continuing to capture lessons from the health sector remain highly relevant and should continue beyond Busan.

Effective aid creates conditions for success. There is evidence that aid effectiveness improves sector planning, budgeting and governance capacities, strengthens national systems, and contributes to health results through more efficient and sustainable implementation of national health policies, plans and strategies. In fragile and post-conflict situations, streamlined and co-ordinated policy and management processes are providing the basis for improving health and service delivery systems. An ongoing challenge in the health sector is striking the right balance and finding better complementarities between programmes that score well on delivering short-term measurable results though often at the expense of aid effectiveness and longer-term transformational change, and more sustainable whole-of-sector approaches that focus on greater alignment with country needs, institutions and priorities, but are more challenging to measure.

Health provides unique insights and lessons into the complexities of aid architecture. Aid to the health sector has increased substantially over the last 20 years

from USD 5 billion in 1990 to USD 21.8 billion in 2007 (IHME, 2010). Greater investment and programmatic scale-up has significantly improved some health outcomes. These developments have been accompanied by a growing number of actors and increasingly complex governance and aid management arrangements. Whilst diversity brings many benefits, it poses challenges for country ownership, alignment, and national systems and leads to duplicative and fragmented approaches at global and national levels. Using health as a "tracer" sector has deepened understanding of the risks and benefits of diversity and has leveraged action for a more co-ordinated and coherent approach to the global aid architecture. This was recognised by the G8 in the Deauville Declaration in May 2011. Important lessons from health can inform global efforts to tackle issues such as climate change and food security which show signs of following a similar path, including strong political commitment, significant needs, and the launch of new initiatives and funding channels, and similar aid architecture challenges.

Main findings

What has been achieved?

Good progress has been made in implementing the Paris Declaration principles in the health sector, particularly in strengthening country ownership, co-ordination, use of common arrangements, dialogue and information sharing between donors and countries. Examples include the increased focus on strengthening policy dialogue around national health policies, strategies and plans as supported by the International Health Partnership+ (IHP+) and the IHP+Results monitoring function which reports donor and country progress against adapted Paris indicators. Similarly, the creation of the Joint Funding Platform which aims to harmonise funding from the World Bank, Global Alliance for Vaccines and Immunisation (GAVI), and the Global Fund in health systems at country level is promising.

More effective aid can deliver improved health results. Available evidence suggests that aid delivered through programme-based and sector-wide approaches can increase overall resources for health and this is correlated with improved health service delivery, better coverage and health outcomes. These approaches are usually based on robust national health policies, strategies and plans that constitute the cornerstone of aid effectiveness in the health sector.

Country ownership is central to better aid effectiveness. In a number of countries, strong leadership, sound health policies and pragmatic use of resources to drive sector reforms and strengthen health systems have been key to improving health results. There are promising signs of stronger, more inclusive country ownership.

Civil society engagement in policy and planning processes has increased, but this is not consistent across countries and there is little evidence of systematic engagement including with legislatures or the private sector.

There are conflicting views about whether global programmes strengthen or undermine country ownership, although the slow pace of harmonisation and alignment of global programmes at country level and heavily earmarked funding potentially hinder country ownership.

Progress has been made in supporting greater alignment of aid. Country-led joint assessment of one national health plan, unified modalities to support the plan and

use of a common results framework to track plan implementation are key for alignment. Some countries have made considerable efforts, often as part of wider reforms, to strengthen procurement and public financial management systems and ensure these systems adhere to accepted standards. Country-led assessments, dialogue between health ministries and donors, and donor involvement in annual monitoring processes have contributed to sector reforms in this area.

Harmonisation, division of labour, and implementation of common arrangements are improving. Considerable efforts have been made by countries and donors to increase use of programme-based and sector-wide approaches, joint funding arrangements and common planning, financial management and procurement procedures.

Donors have made systematic efforts to improve aid predictability. Experience of innovative financing mechanisms, such as the International Financing Facility for Immunisation, shows that bilateral donors can enter into multi-year commitments and provide predictable funding. This highlights the need for better analysis of the role of different aid modalities in relation to predictability.

Established accountability frameworks offer the possibility of monitoring and improving mutual accountability for results in the health sector as demonstrated by IHP+Results and the Commission on Information and Accountability for Women's and Children's Health. The G8 Deauville Declaration notes that responsibility for aid effectiveness is shared between donors and partner countries and emphasises support for mutual accountability, with a strong focus on results.

What factors have hindered progress?

Many of the constraints to aid effectiveness identified by the TT HATS interim report (OECD, 2009) persist. This includes the complexity of the aid architecture, lack of donor alignment with country priorities and systems, poor donor harmonisation and difficulty in maintaining momentum once mechanisms are in place. Recent developments, in particular the emergence of new donors, also represent challenges for aid effectiveness.

There is significant 'disconnect' between commitments and practice. Some donors have made significant efforts to meet aid effectiveness commitments, but others, including some bilateral agencies and global programmes, remain unwilling or unable to engage. While project aid from traditional and emerging donors and global programmes is increasing, a significant proportion of this aid is still 'off budget', and the increase in aid for health is not matched by a commensurate increase in use of budget support. There is strong evidence that project aid undermines aid effectiveness, distorts priorities and resource allocation, increases budgeting, reporting and audit demands, and weakens mutual and domestic accountability.

Aid remains highly unpredictable, with most donors unable to give realistic commitments much more than 12 months ahead. Differences between donor commitments and actual disbursements are also significant. Furthermore, despite improvements in harmonisation, separate and uncoordinated donor reviews continue and harmonisation remains a significant challenge for global health programmes and some bilateral donors.

Global programmes score relatively well on aid effectiveness at the global level, but the extent to which they implement aid effectiveness principles at country levels is

less consistent. Pressure on donors to 'spend', to demonstrate short-term results and to reduce their transaction costs mean that aid is likely to be increasingly channelled through global funds in the future, with the expected challenges in aid management practices at country level.

Countries have not consistently met their commitments such as reaching the Abuja target for domestic expenditure on health[1], strengthening and reforming systems and broadening policy dialogue to include civil society and the private sector. Many of these changes go beyond the mandate of the health ministries. For example, progress in strengthening public financial management systems depends on wider government reform. Sector ministries may sometimes see the aid effectiveness agenda as a means of centralising control of resources by the finance ministry, thus reducing their autonomy and leverage with donors.

Political considerations influence implementation of commitments. Donor pressure to demonstrate results and retain accountability, concerns about losing influence, and inflexible rules and systems limit harmonisation and use of common arrangements. Donor constraints to longer-term aid predictability include unwillingness to commit funds beyond the current term of office, preference to retain political leverage and the flexibility to respond to changes in foreign policy priorities, and domestic rules and processes. Concerns about fiduciary risk and short-term planning horizons in recipient countries reduce incentives to provide multi-year commitments. Decisions about whether to remain engaged in the health sector also appear to be strongly influenced by donor headquarters.

Efforts have focused more on aid effectiveness processes than on the impact of better aid on health service delivery and outcomes. The transaction costs of aid effectiveness processes are high, in particular for donor country staff, and there is a risk that the costs are disproportionate to the benefits. In addition, demonstrating and attributing the impact of aid effectiveness is challenging and there is no common understanding of what results can realistically be expected or how these will be measured.

Aid effectiveness principles could benefit from better prioritisation at the country level. Experience in the health sector indicates that some principles are more important than others. Country ownership, alignment and predictability are fundamental to other aspects of aid effectiveness. For partner countries, harmonisation of donor aid, mutual accountability and management for results are important but secondary to a good plan, funding for that plan and knowing when funds will be available.

Significant gaps in knowledge remain. There is a paucity of evidence about the relevance, application or adaptation of aid effectiveness principles in different contexts, in particular in middle-income countries and fragile states, the effects of global programmes on aid effectiveness, and the political economy of aid effectiveness in health.

Recommendations

Reaffirm commitments to the principles of aid effectiveness and promote them among new actors. While all of the Paris principles are important and mutually reinforcing; country ownership, alignment and predictability of aid are the most powerful levers for achieving sustainable outcomes. Greater efforts are also required to improve wider understanding of aid effectiveness principles, including among non-traditional donors, parliamentarians and civil society, and to institutionalise aid effectiveness across donor agencies and governments.

Step up efforts to put commitments into practice. There is an urgent need to scale up implementation by a wider range of donors and countries and to identify incentives to make this happen. Greater efforts are required to strengthen and use country systems that meet accepted standards, to actively reduce project aid, parallel systems and separate missions, to increase the medium and longer-term predictability of aid and to institutionalise common results frameworks and mutual accountability measures. Global funds and programmes in particular need to identify ways in which they can better support harmonisation and alignment at country level.

Increase support for country leadership and capacity development. Donors and countries need to strengthen national leadership and the capacity of national systems, in particular those related to public financial management, procurement, and monitoring and evaluation. Countries also need support to strengthen their capacity to manage global initiatives, their impact and the increasing number of actors in health. Capacity development is a priority for African governments in particular. More intensified investment and technical assistance is required to strengthen national planning, budgeting and accountability processes, including the capacity of national legislatures, civil society organisations and the private sector to engage in these processes.

Agree on realistic results to be achieved through aid effectiveness and realistic timeframes for achieving change. Countries and donors need to achieve a consensus on what results might be expected from improved aid effectiveness and how these might be measured. It is important to be realistic about the time it takes to change behaviours and processes and about the constraints to progress.

Strengthen the evidence base. Specific gaps to be addressed include country experience that demonstrates the links between more effective aid and improvements in health service delivery and health outcomes as well as the analysis of the cultural and political factors that influence sector development processes as a way of understanding how politics drives or prevents change. Efforts to strengthen the evidence base should build on the work of the TT HATS and IHP+ in reporting on sector progress, addressing knowledge gaps, and providing lessons for other sectors.

Improve co-ordination of the global aid architecture There is an urgent need for more efficient co-ordination of the global aid architecture for health and for more effective collaboration on policy and decision making concerning global initiatives, to ensure greater coherence. This requires high-level leadership, greater alignment of accountabilities and incentives, and a stronger mandate for existing mechanisms such as the OECD DAC, rather than the creation of a separate global co-ordination initiative. Measures to ensure that countries are in the lead and their perspectives are taken into account, needs to be more consistent than at present. Greater efforts are also

needed to capitalise on the experience and comparative advantage of the diversity of actors in the health sector.

Revisit aid effectiveness frameworks, structures and processes. Reforms that have the potential to reduce the transaction costs of implementing aid effectiveness, to ensure that aid effectiveness principles can be applied in fragile states, and to engage a wider range of actors should be considered. The scope of global and country partnerships must be broadened to encompass emerging donor countries, global initiatives, private philanthropy, civil society and the private sector, and facilitate their contribution to increasing the coherence and effectiveness of aid for health. South-South collaboration is a priority for partner countries and also provides an important platform to increase the engagement of emerging donor countries.

Lessons from the health sector

- **In for the long haul:** Set realistic expectations about what can be achieved by when, recognising that transformational change in donor and country practices require long term commitment.
- **Politics matters**: Bringing about genuine and sustainable changes in donor and country behaviour is as much about politics as it is about technical fixes and changing aid modalities.
- **Focus on actions that make a difference:** The Paris principles are a means to an end**.** Concentrate efforts on those principles with greatest potential for development – aligning with national priorities and providing predictable, sustained and on-budget aid.
- **Don't reinvent the wheel:** Existing health sector compacts, codes of conduct, tools and accountability can be adapted and used for other sectors.
- **Think twice:** Avoid establishing new global funds and programmes that potentially duplicate or compete with existing organisational mandates and programmes, leading to fragmentation. Recognise that global approaches to country problems must be based on a clear analysis of the existing global and national institutional context.
- **Plan for measuring results at the start:** Invest early on in developing a common understanding and expectation of results and in regular, robust, independent monitoring and evaluation of aid effectiveness processes and impact.

Notes

1. Signed in 2001, the Abuja Declaration target commits countries to spending 15% of their annual budgets on improvements to the health sector.

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Introduction

The 2005 Paris Declaration on Aid Effectiveness outlines donor and partner country commitments to reforming the way in which aid is delivered and managed in order to maximise development results. Action required to improve the effectiveness of aid is reflected in the principles set out in the Paris Declaration:

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

These principles were further endorsed by donors and partner countries at the Third High-Level Forum on Aid Effectiveness in Accra in 2008. The Fourth High-Level Forum on Aid Effectiveness (HLF4), held in Busan in 2011, assessed progress towards the achievement of the Paris Declaration and Accra Agenda for Action commitments and set out the future direction of aid effectiveness. Overall progress is monitored by the OECD DAC Working Party on Aid Effectiveness.

The Task Team on Health as a Tracer Sector (TT HATS) was established in 2007 to monitor and report on progress in implementing the Paris Declaration in the health sector. Health was selected as a 'tracer' sector for several reasons. Aid to the health sector is significant, complex and subject to rapid change and has more global initiatives and donors than most other sectors. The health sector exemplifies many of the challenges for aid effectiveness and has also led the way in taking action to improve aid effectiveness and it therefore offers valuable lessons for other sectors.

The TT HATS has made a significant contribution to monitoring progress, analysis of policy, improving data and strengthening the evidence base, including sharing lessons at the Third High-Level Forum and publishing an interim report in 2009. It has also taken forward a work programme in areas where experience in the health sector can inform wider aid effectiveness and address issues including the role of non-traditional donors (see Annex B) the private sector, the contribution of the International Health Partnership, innovative financing mechanisms, and the impact of better aid on results. Experience from the health sector can also inform and promote broader public sector and country systems reform.

This final report from the TT HATS provides an overview of progress and challenges in implementing aid effectiveness in the health sector, with an emphasis on lessons learned from country experience. It highlights achievements and the main constraints to more effective aid, and sets out priority actions to accelerate progress. The report is based on the interim report, the outputs of the TT HATS work programme, the second phase evaluation of the Paris Declaration and IHP+Results progress monitoring, a literature review and interviews. The report is structured around the themes of the OECD DAC progress report for HLF4 *"Aid Effectiveness 2011: Progress in Implementing the Paris Declaration"* – ownership, alignment, harmonisation, predictability and transparency, accountability and results. Each section includes an overview of relevant Paris and Accra commitments, a review of the main findings and a summary of key points. The final section summarises available evidence on the contribution of better aid to better results in health.

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Chapter 1. Strengthening Country Ownership and National Plans

The Paris Declaration on Aid Effectiveness places partner countries' ownership of policies and programmes at the centre of the international agenda to make aid more effective. The Accra Agenda for Action deepens and broadens these commitments by calling for greater inclusion of development actors beyond the state. Strong country ownership in health has been shown to improve health service delivery. This chapter draws on a range of country case studies, tools and aid modalities that are aimed at improving country ownership over health policies. In particular, it reviews the evidence for increased involvement of non-state actors in the health sector, particularly civil society organisations, and assesses the impact of their involvement on health delivery and outcomes.

Context and commitments

Country ownership is central to development and to aid effectiveness. National strategies and plans provide the foundation for other areas of aid effectiveness. In the Paris Declaration partner countries committed to leadership in developing and implementing national development strategies through broad consultative processes, translating strategies into prioritised, results-oriented programmes expressed in medium-term expenditure frameworks and budgets, and co-ordinating aid in dialogue with donors, civil society and the private sector. Donors committed to strengthening country leadership and national development strategies. The Accra Agenda for Action reaffirmed commitments to broaden country-level policy dialogue and strengthen partner country capacity to lead and manage development.

Indicators to measure progress include:

- Partner countries with national development strategies with clear priorities linked to a medium-term expenditure framework and reflected in annual budgets

Strengthening country ownership and national plans

Country ownership is critical to improving health service delivery and outcomes as the examples in Box 1.1 illustrate (see also Chapter 6).

Box 1.1. Strong country ownership is fundamental to improving health outcomes

Ethiopia has demonstrated strong ownership of health policy and implementation. A clear strategic vision for health system strengthening has enabled Ethiopia to mobilise substantial external resources and co-ordinate donor support around national priorities. High-level political commitment has ensured that Global Fund disease-specific grants and Global Alliance for Vaccines and Immunisation (GAVI) health systems funds have been used for system-wide strengthening whilst improving specific disease outcomes. As a result, there has been considerable improvement in health services coverage and access for the rural poor (Bilal *et al*, 2010).

Recent improvements in health outcomes in Rwanda, particularly for women and children, have been linked to strong health sector leadership, step-by-step building of health policies and reforms – including health insurance, performance-based financing and fiscal decentralisation – and efficient and equitable use of resources. Government leadership in co-ordinating donor funding, technical assistance to the reform process and strategic use of donor funds to expand coverage of community health insurance schemes have been critical success factors (Sekabaraga *et al*, 2010).

Country ownership and leadership of national health policies, strategies and plans has been strengthened through programme-based approaches and aid instruments such as sector budget support. Evidence for this has been cited from Cambodia, Mali, Tanzania and Zambia (Walford *et al*, 2010) (see Box 1.2).

Box 1.2. Programme-Based Approaches and Sector Budget Support can strengthen country ownership

In **Tanzania**, the health sector-wide approach (SWAp) has strengthened country leadership of the development agenda, health reform processes and management of aid relationships, with the Ministry of Finance being more assertive in asking donors to commit to national development priorities (Zinnen, 2011).

Reports from **Mali** suggest that Sector Budget Support (SBS) and the signing of the IHP+ compact have strengthened collaboration within government, notably between the Ministry of Health, Ministry of Social Development and the Ministry of Finance (Samaké *et al*, 2011).

Country ownership and other aid effectiveness principles have also been strengthened with respect to HIV/AIDS through implementation of the Three Ones principles (see Box 1.3).

Box 1.3. The "Three Ones"

The "Three Ones" – which centre on the need for one national HIV/AIDS strategy or plan, one national HIV/AIDS co-ordinating authority and one national monitoring and evaluation framework for HIV/AIDS – have contributed to the implementation of the Paris Declaration principles of country ownership, harmonisation and alignment. While countries such as Benin, Cambodia and Malawi have demonstrated that strong country ownership can contribute to effective and sustained national HIV responses that involve a wide range of actors, there is still scope for improvement in implementation of the "Three Ones" principles.

While experience demonstrates that when shifting from humanitarian to development mode, more co-ordinated policy and management processes can assist in strengthening health systems and service delivery, there is a lack of evidence about the application of programme-based approaches n fragile states and post-conflict contexts. A study that explored the scope to move towards a SWAp in the health sector in three post-conflict states – Timor Leste, Sierra Leone and the Democratic Republic of the Congo – found that moves towards a sector approach are challenged by diverse aid modalities, fragile government leadership and capacity and unpredictable donor policy and behaviour. Despite the existence of sector and sub-sector strategies supported by committed donors and implementing agencies, improved leadership and ownership of policy and planning processes and the existence of basic sector co-ordination and budgeting processes, numerous challenges remain. These include poor sector stewardship, off-budget and unpredictable aid, significant amounts of vertical funding earmarked for specific disease programmes, limited use of country PFM systems, lack of accountability and transparency processes, and parallel monitoring and evaluation (Rothmann *et al*, 2011).

The process of establishing International Health Partnership (IHP+) country compacts can strengthen country ownership. Country compacts encapsulate donor and country commitment to a single national health strategy and to strengthening health systems to achieve health targets. Dialogue with other ministries, donors and civil society and the process of developing the compact is expected to enable health ministries to exercise leadership and build support for the national plan. However, some major donors are not IHP+ signatories, IHP+ compacts have been established in

relatively few countries, their impact on country ownership has not been rigorously evaluated and it is as yet unclear whether compacts will lead to improvements in aid effectiveness. There is also a need to co-ordinate IHP+ compacts with pre-existing arrangements such as SWAp Memoranda of Understanding (MoU).

Box 1.4. The International Health Partnership

The International Health Partnership and Related Initiatives (IHP+) established in 2007 and co-ordinated by WHO and the World Bank, aims to accelerate achievement of the health Millennium Development Goals. It seeks to achieve better health results by putting aid effectiveness principles into practice in the health sector. IHP+ encourages support for a single country-led national health strategy through support to national planning processes, joint assessment of national health strategies and plans (JANS), country compacts, reporting on a common results monitoring framework, and monitoring progress against compact commitments. The 52 IHP+ partners include developing and donor country governments, international agencies and civil society organisations. IHP+Results reports on progress against IHP+ commitments.

Use of the Joint Assessment of National Strategies (JANS) tool to assess national health plans appears to strengthen country ownership through the principles underlying the process – demand-driven, country-led and building on existing national processes and timetables – and the process itself. In countries that have used the JANS tool[1], such as Ethiopia, Nepal, Rwanda, Uganda and Vietnam, this is reported to have increased ownership by promoting wider consultation across government and national constituencies and to have been used in a way that fitted with country processes and timeframes for national health plan development. In May 2011, Mali used the JANS process for a joint review of national health and social development strategies and plans, in order to ensure consultation with a wide range of stakeholders. These included different levels and sectors of government, donors, global programmes, civil society and the private sector, and strong country ownership in the development of the follow-on plan to the PRODESS (the national plan for health and social development) for 2012-21.

The JANS process also has the potential to increase alignment of donor funding with national health plans, by improving the quality of, and confidence in, such plans. In Nepal, the JANS helped to ensure a systematic assessment of the draft plan and to enhance donor inputs (IHP+, 2010d) and a Joint Funding Agreement (JFA) has been signed by six key donors, who have agreed to support the health plan and to use one reporting mechanism and one shared audit (E2Pi, 2011). In addition, the World Bank and EU are committed to using the JANS as basis for funding decisions (IHP+, 2010c).

Global programmes are perceived to both strengthen and undermine country ownership and country plans. The Global Fund is credited with supporting broader country ownership through expanded stakeholder engagement, notably civil society participation in Country Co-ordinating Mechanisms (CCMs). However, CCMs have also been criticised for duplicating existing co-ordination structures, increasing the complexity of health governance and challenging other aspects of country ownership, such as national oversight of Global Fund financing (Spicer *et al*, 2010).

Case studies for the GAVI Alliance indicate that decisions to apply for GAVI Health System Strengthening funding are country-driven and based on country-identified priorities (HLSP, 2009). The Global Fund has introduced the National

Strategy Application (NSA) process, which uses the JANS tool and has been designed to facilitate alignment of Global Fund financing with country priorities within the framework of a country's national disease strategy, for example for HIV/AIDS, TB and malaria. Seven countries were invited to submit an NSA during the "first learning wave". There are divergent views about the NSA process. A review of the experience of three first learning wave countries suggests that the process enhanced consultation and ownership and strengthened strategies (Godwin, 2009). Other anecdotal evidence suggests that the experience was not so positive. One concern is the time and resources required to develop an NSA. In Kenya, over 100 meetings took place and more than 2 000 people were convened. In the three countries reviewed, NSAs were written by consultants, which limited national ownership (Godwin, 2009). Taking into account the lessons from the first learning wave, the Global Fund launched a second NSA learning wave in January 2011.

There is scope to increase collaboration between health and finance ministries. Country ownership goes beyond ministry of health leadership and ownership. Global Fund experience suggests that finance ministries are not always aware of health ministry funding or activities, and that concerns about IMF sector budget ceilings can be an impediment to open dialogue on sector aid.

Involvement of non-state actors

There is evidence of increased civil society participation in country health policy and planning processes. In seven of ten IHP+ countries surveyed in 2010, civil society is represented in the national health co-ordination mechanism. In two of these countries, Ethiopia and Mali, civil society constituted 25% and 30% of membership respectively (IHP+Results, 2011). The JANS process has stimulated civil society participation, for example, in the JANS planning team in Uganda and the JANS assessment team in Ghana (IHP+, 2010c). Expanded and positive participation of civil society in the Global Fund NSA process, compared to previous rounds-based proposals, is reported in Kenya and Rwanda (Godwin, 2009). Opportunities for civil society involvement in budgetary processes have increased, for example in Zambia, although there is little indication that civil society has had a significant impact on shaping resource allocations in health (Wild and Domingo, 2010b). Country studies from El Salvador, Mozambique, Nepal, Tanzania and Uganda report improved participation of civil society in national and sub-national health planning processes (AfGH, 2010)

Meaningful civil society participation in broader health policy processes remains limited. Even though civil society has participated in national planning processes in countries such as El Salvador and Nepal, the degree to which their views are reflected in policies is still limited (AfGH, 2010). Lack of meaningful participation is attributed to political factors, strong donor influence, weak networking capacity of umbrella organisations and limited incentives for small NGOs to engage (AfGH, 2011a). In some countries, there is little political space for civil society and governments limit participation to a few chosen organisations. In Ethiopia, civil society's role is restricted to service delivery with little involvement in advocacy (Pereira, 2009). In the NSA processes in Kenya, Rwanda and Malawi, civil society organisations were mainly involved in their capacity as Principal Recipients and service providers, not in playing a 'voice, accountability and watchdog' role (Godwin, 2009).

Other issues that limit meaningful civil society participation in health sector policy processes include lack of clarity about the role of civil society, concerns about selection of representatives, and donor and government perceptions of civil society (Pereira, 2009a, 2009b; Schmidt, 2009; AfGH, 2011a; Zinnen, 2011). A related challenge is assessing the aid effectiveness of civil society, an issue that is not well addressed in the current Paris Declaration framework. Some of these challenges are being addressed by civil society becoming better organised and by the inclusion of community based organisations at local and regional level, for example, through the National Health Forum in El Salvador.

Global initiatives and donor agencies have taken steps to support formal civil society participation. Civil society is represented on the Global Fund and UNITAID boards and the IHP+ Civil Society Consultative Group. UNAIDS has also promoted the involvement of civil society organisations in national HIV responses and through their participation in UNAIDS' Programme Coordinating Board. All of the 15 donors surveyed by IHP+Results in 2010 report support for civil society's participation in health policy processes. There are many examples of donor support to build civil society capacity, for example, the Civil Society Support Mechanism in Mozambique and the Independent Development Fund in Uganda, although these are not specific to the health sector (AfGH, 2011a). However, there is scope for better use of aid to leverage support for civil society to play a more meaningful role in decisions about policy and in accountability processes.

The private sector[2]plays an increasingly important role in funding for health and delivery of health services but has little involvement in policy dialogue at the country level. An International Finance Corporation (IFC) study supported by the Bill and Melinda Gates Foundation found that the private sector delivers 50% of health care goods and services in Africa, with 60% of financing coming from private sources (IFC, 2008). The private sector can increase quality standards, efficiency and access to health services, but government engagement with the private sector is limited in many countries. This is due in part to lack of recognition of the sector's potential contribution to improving health outcomes and in part to lack of formal organisation and representation in the private sector.

The IFC has developed the *Health in Africa Initiative (HIA),* to help governments harness private sector[3] potential to increase access to quality services. The HIA assists countries by supporting private sector assessments, workshops to agree an action plan for reforms, and implementation of the plan. The process aims to foster country ownership and is being implemented in Burkina Faso, the Republic of the Congo, Ghana, Kenya, Mali and Uganda. Initial findings from Kenya suggest that it is fostering greater private sector participation in health policy processes and strengthening government ownership and accountability (see Box 2.5).

Box 1.5. Promoting Public-Private Partnerships (PPP) for health in Kenya

The private sector assessment in Kenya (IFC, 2011) promoted dialogue between the public and private sectors and greater recognition of the role of the private sector in delivering better health outcomes and of the government as a steward for the health sector including non-state actors. Priority actions in the resulting action plan include:

- Policy dialogue to engage the private sector including institutionalising the PPP Health Council into a formal entity that represents key groups in the health sector in all policy health forums.
- Policy reforms to create an enabling environment for PPP including accelerating the review of the National Health Policy framework to integrate a PPP perspective.
- Partnerships to improve the availability and accessibility of health care including integration of the private sector into National Health Insurance Fund pilots.

At the global level, development funding from the private sector is becoming more significant and the private sector is also a source of innovation, experimentation and adaptation of approaches to deliver aid (FORO Nacional Internacional, 2010). However, private sector engagement in the aid effectiveness agenda has been limited and there is considerable scope to share experiences and identify ways in which public-private partnerships can improve aid effectiveness and health outcomes.

Key messages

- Country ownership is critical to other aspects of aid effectiveness. A strong national health strategy with clear priorities, a realistic budget and well-defined roles and responsibilities is the pre-requisite for alignment, harmonisation, accountability and achievement of results.
- Programme-based approaches have made important contributions to strengthening country ownership. Processes such as IHP+ country compacts and joint assessments of national strategies have the potential to strengthen country ownership, but it is too soon to judge their impact. There are conflicting views about whether global programmes strengthen or undermine country ownership and more evidence is needed.
- While there is evidence of some progress in strengthening country ownership of national health policies, strategies and plans, countries need to provide stronger and more effective leadership and donors need to do more to support this.
- There has been some improvement in engaging non-state actors, especially civil society organisations, in national health policy and planning processes – attributed in part to global health programmes that give high priority to civil society participation – but involvement is not always consistent or meaningful. There is little evidence of consistent engagement with the private sector in national health policy or planning processes.

Notes

1. The JANS tool and guidelines are public goods that have been used in non-IHP+ countries, for example, Bangladesh and Ghana, and by donors that are not IHP+ signatories, for example, USAID.
2. The private sector is not defined in the Paris Declaration or the Accra Agenda for Action. Unless otherwise stated, this report defines the private sector as foundations, philanthropy groups and for-profit private sector companies.
3. IFC defines the private sector as non state actors, for- and not-for-profit. Not included in this definition are global funds and traditional and informal providers.

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Chapter 2. Using and Strengthening Country Systems in the Health Sector

Aligning aid to partner countries' development priorities, and supporting and using partner countries' own systems and institutions builds countries' capacity to manage their own development processes. This chapter outlines the progress made in using and strengthening these systems in the health sector. The chapter further outlines the advances and remaining challenges in increasing the amount of aid that is channelled through the country's own systems, and the impact on the health sector of these reforms, or lack thereof.

Context and commitments

Alignment with country strategies and plans and use of country systems ensures that aid supports the achievement of national development objectives and builds country capacity to lead and manage development. In the Paris Declaration, donors committed to aligning aid with country priorities, strategies and budgets, and to using country institutions and systems to the maximum extent possible. Donors and partner countries committed to strengthening national capacity, including use of mutually agreed frameworks to assess country systems and procedures, and support for and reform of public financial management and procurement systems. The Accra Agenda for Action reaffirmed commitments to use country systems.

Indicators to measure progress include:

- Partner countries with reliable public financial management and procurement systems that adhere to accepted standards of good practice
- Aid flows reported on partner government budgets
- Co-ordinated and aligned technical support
- Use of country public financial management and procurement systems
- Reduced use of parallel project implementation units
- Scheduled aid recorded in national accounting systems

Strengthening and using country systems

There is mixed progress in countries improving their public financial management (PFM) systems and insufficient evidence to conclude that country procurement systems are improving. Countries such as Burkina Faso, Burundi and Mozambique improved their PFM systems between 2005 and 2009, but Nepal registered a decline and the five other IHP+ countries showed no change from their baselines (IHP+ Results, 2011).

Country-led assessments that involve a wide range of stakeholders have contributed to progress in reforming procurement systems in Ghana and Madagascar. Other critical success factors include institutional stability of health sector and procurement reforms, dialogue between health ministries and donors, donor involvement in annual monitoring processes and involvement of all key actors in procurement decisions (OECD, 2009).

Donor commitment to using country systems has increased but is not matched by practice. The EC has emphasised the need for the EU to increase its support for implementation of national health strategies through country systems and to channel 80% of its health ODA using country procurement and public financial management systems (EC, 2010). Similarly, USAID has set a target for providing funds directly to partner governments, has issued guidance to encourage expanded use of country systems, and plans to increase capacity-building support for PFM systems, based on a PFM risk assessment framework.

Of the total amount of donor funding reported to the IHP+Results 2010 survey in five countries whose country financial management systems were considered to adhere to broadly accepted good practices[1], 63% used PFM systems in 2009, an increase of 18% over the baseline years. Four of the 15 donors surveyed achieved the target for using PFM systems. A high proportion of donors channelled aid through the country systems of Ethiopia and Mali, whereas Burundi, Democratic Republic of the Congo, Djibouti and Nigeria have seen little improvement in the use of country systems (IHP+Results, 2011). Even in the context of well-established SWAps, such as in Cambodia, Malawi, Mali and Zambia, or in countries with PFM systems that achieve over and above the score at which donors are expected to use them, there continues to be modest and sometimes inconsistent use of country systems (*e.g.* Mali). Use of separate procurement channels continues in Ethiopia, Uganda and Zambia (Pereira, 2009a, 2009b; Schmidt, 2009).

Of the donors reporting only 53% of funding for procurement used national procurement systems in 2009, a decrease from the baseline of 60% (IHP+Results, 2011). The Global Fund reports that 80% of funding to government recipients was aligned with national procurement systems and procedures in 2010[2] (Global Fund, 2011). In Rwanda Global Fund-supported procurement takes place under the country-led pooled procurement mechanism (Global Fund, undated). Factors that affect a donor's decision to use public procurement systems, for example in Ghana and Madagascar, include efficiency, transparency and accountability. UN agencies are still more likely to use their own procurement systems.

Weak capacity hinders the use of national systems, but politics also plays a role. Concerns about government capacity to administer funds efficiently and misallocation of resources limit donor use of national systems. Use of country systems is a particular challenge in fragile states where systems do not function or donors are unable to channel funds through government systems for political reasons. Evidence from Cambodia suggests that while donors are increasingly aligning their assistance to national priorities through the Sector Wide Management Approach (SWiM), the shift to the use of national systems has been slow, due to the weakness of PFM systems and donor reluctance to assume increased fiduciary risk (OECD, 2010). In some cases donor decisions to limit the use of PFM systems are driven less by technical or fiduciary reasons and more by political factors.

Alignment of funding, management and technical assistance

Progress in reporting funds on budget is uneven. IHP+Results reports, among donors surveyed, an increase in the proportion of donor support reported on national budgets from 52% in 2005 to 79% in 2007 (IHP+Results, 2011). Mali's experience suggests a more mixed picture (see Box 2.1).

Box 2.1 Significant funding for health is "off budget"

In Mali a recent evaluation of budget support indicated that more aid for health (including the indirect contribution of budget support) is reported on budget. However, while some donors use national financial management procedures, others have developed parallel financing systems with specific procedures. Despite annual audits of the PRODESS, with terms of reference developed and agreed by donors, there were five separate donor audits in 2010, increasing the workload of the Ministry of Health finance department (Samaké *et al*, 2011).

Global programme funds report greater efforts to ensure that their funds are 'on budget', with grants aligned to the fiscal cycle, and use of national budget execution, financial reporting and audit procedures. The Global Fund reports that 79% of grants were aligned with country fiscal cycles in 2009. However, only 44% of aid disbursed to government recipients was using public financial management systems in 2011 (Global Fund, 2011). Global Fund initiatives, such as the consolidation of same-disease grants into Single Streams of Funding, are expected to facilitate better alignment with national systems. In Ethiopia alignment of Global Fund grants with national plans, health system priorities and decentralisation policies is reported to have improved (Banteyerga *et al*, 2010). Also in Ethiopia GAVI Immunisation Service Support and Health System Strengthening funds have been reflected in the Medium-Term Expenditure Framework. The extent to which these efforts are changing practice has not been systematically reviewed, but other evidence suggests that global funds are not so well aligned. Global Fund and GAVI round-based financing is reported to have contributed to the fragmentation of health sector financing in Vietnam, as the timing of the annual funding rounds is not synchronised with the national budget process (OECD, 2011).

Separate Project Implementation Units (PIUs) persist in many contexts. For instance, in Vietnam, PIUs have proliferated, with 28 in the Ministry of Health alone, even though external assistance accounts for only 5-10% of government health expenditure. This is due both to Vietnamese regulations requiring PIUs for projects over USD 50 000 and to donor practices. Compulsory salary supplements of 30% and other financial benefits for PIU staff also create distortions and undermines co-operation with non-PIU government staff (OECD, 2011).

The impact at country level of measures to improve co-ordination of technical assistance is unclear. There is limited evidence for the health sector on the extent to which donors have met the Paris Declaration commitment to implement 50% of technical assistance flows through co-ordinated programmes. Globally, some agencies have established MoUs to improve co-ordination of technical assistance, for example, between UNAIDS and the Global Fund. UNAIDS has also taken steps to better co-ordinate provision of technical assistance by UN agencies, through a division of labour and the development of Joint Programmes of Support in 72 countries, which are aligned with national HIV/AIDS strategies. IHP+Results (2011) reports that all development partners that provided data had met the target of 50% of capacity building support co-ordinated and aligned with national priorities. Country perspectives have not been systematically reviewed, but the recent evaluation of UNAIDS suggests that technical assistance remains supply driven and there is scope for further improvement in co-ordination of technical assistance.

Some countries are using pooled funding or SWAp mechanisms to improve co-ordination of technical assistance. In Tanzania and Zambia health ministries have identified technical support needs and used SWAp processes to formalise terms of reference and identify consultants. In Ethiopia, donors are providing harmonised technical assistance through the MDG Performance Fund (Walford, 2010). However, challenges remain including lack of national technical assistance plans, weak national ownership and capacity to manage technical assistance and continued provision of short-term bilateral technical assistance. For example, in Mali, despite the IHP+ Compact recommending the creation of a pooled fund for technical assistance, donors

continue to provide assistance on a bilateral basis, often imposing their priorities on the Ministry of Health (Samaké *et al*, 2011).

Key messages

- There is mixed progress in country strengthening of procurement and PFM systems and in donor use of country systems.
- Donors differ in their willingness to use country systems. Some have increased the use of country systems, while others have not, even in countries with systems that meet accepted standards. Donors are sensitive to fiduciary and reputational risk and also have concerns about speed and efficiency, transparency and accountability, and capacity of country systems. In some cases, donor decisions to limit use of country systems are motivated more by political factors.
- The extent to which donors use national procedures and accounts to manage funds varies. Some significant donors continue to provide aid 'off budget', with separate budgeting, financial reporting and audit procedures. PIUs have been reduced in some countries, but continue to proliferate in others. There is limited evidence for the health sector, but country reports suggest that donors continue to provide technical assistance on a bilateral basis.
- Lack of alignment undermines country systems, contributes to fragmentation of health sector financing, and increases the transaction costs of aid for recipient governments.

Notes

1. PFM systems in Burkina Faso, Ethiopia, Mali, Mozambique and Niger were scored with 3.5 or above on the CPIA/PFM rating – 3.5 is the point at which development partners are expected to start using country systems.
2. However, the result of the 2011 Paris Declaration Monitoring Survey is likely to be lower due to additional guidance given by the OECD.

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Chapter 3. Further Harmonising Aid to the Health Sector

The impact of aid is reduced when donors decide separately which programmes to fund based on their own criteria and impose their own planning and reporting arrangements on recipient countries, making aid distribution uncoordinated. The results are duplication of development efforts, high transaction costs and excessive burdens placed on partner countries. The challenges of harmonisation are particularly pertinent to the health sector where there is a large and increasing number of donors. This chapter draws on evidence from initiatives to reduce donor proliferation to outlines some of the key blockages to achieving more progress towards harmonisation of donor approaches.

Context and commitments

Excessive fragmentation of aid at global, country and sector levels impairs aid effectiveness. Parallel planning, financing, monitoring and evaluation, and reporting processes result in inefficiency, duplication of effort and high transaction costs for partner countries. In the Paris Declaration, donors committed to implement common arrangements and procedures and to implement a more effective division of labour. The Accra Agenda for Action highlighted the importance of building more effective and inclusive partnerships and reducing fragmentation of aid by improving the complementarity of donor efforts and the division of labour among donors at international and country levels.

Indicators to measure progress include:

- Use of common arrangements or procedures based on percentage of aid provided as Programme-Based Approaches
- Joint donor missions and analytical work

Common arrangements and co-ordination

At country level there has been progress with implementation of common arrangements. IHP+Results reports that 11 of the 15 development partners surveyed in 2010 had met the target of 66% of health aid delivered through PBAs. This has reduced aid fragmentation and transaction costs for health ministries. Other evidence of progress is provided in Box 3.1. However, a recent analysis of budget support as a mechanism for financing the health sector noted that budget support has increased less rapidly than overall aid for the sector (Paul, 2011).

Box 3.1. Country progress in donor harmonisation in the health sector

Paris Declaration phase 2 evaluations show progress in several countries. In Nepal, development partners have joined a joint financing arrangement that includes both pooled and discrete funding and established a common matrix for technical support. In South Africa there is good harmonisation in the health sector, due in part to the efforts of the EU+ Working Group. In Mozambique 13 donors participate in the Health Common Fund, donor co-ordination has improved and harmonisation of donor procedures has reduced the workload for government.

In Bangladesh there has been an increase in joint funding arrangements, use of common procedures in planning, financial management and procurement, and agreement to prepare a concept note on division of labour (Asian Development Bank *et al*, 2009). The health, nutrition, and population (HNP) sector programme has increased the number of partners providing sector-based support to cover 42% of the budget. Harmonisation has been enhanced through the HNP Forum and Coordination Committee and all donors participate in joint review and monitoring. However, after more than ten years of sector support, donor funds are still not channelled through the treasury.

In Mali nearly all significant donors, excluding global funds, are represented in SWAp mechanisms, improving co-ordination and reducing duplication (Samaké *et al*, 2011). A World Bank review of SWAps in Bangladesh, Ghana, Kyrgyz Republic, Malawi, Nepal and Tanzania concluded that SWAps are helping to co-ordinate stakeholders and strengthen sector plans. Benefits include less fragmented and more consolidated policy discussions between government and donors and more regular and structured co-ordination among donors (Vaillancourt, 2009). These findings are supported by reviews in Mozambique (Williamson *et al*, 2008) and Tanzania (COWI *et al*, 2007).

Box 3.1. (continued) Country progress in donor harmonisation in the health sector

In Rwanda, the Ministry of Health has co-ordinated the harmonisation of donor compensation packages to ensure donors use national pay scales and avoid creating distortions in the distribution of health workers (Sekabaraga *et al*, 2010).

Co-ordination of UN system action on HIV/AIDS has been strengthened through the joint programme – UNAIDS – and mechanisms including the Unified Budget and Workplan (now the Unified Budget Results and Accountability Framework) and Joint UN Teams on AIDS at country level, which are functioning in over 80 countries.

While donor co-ordination can reduce transaction costs for recipient governments, the transaction costs of co-ordination can be high for donor staff at country level. The Paris Declaration phase 2 evaluation notes that "heavy co-ordination machinery around the donor co-ordination group […] has led the majority of donors to complain that the cost in terms of time and resources of working on common approaches is higher than that occurred when working bilaterally".

Evidence cited in a report on aid effectiveness (Carlsson *et al*, 2009) highlights the transaction costs of SWAps for donors. In Mozambique the number of meetings proved untenable and contributed to a loss of policy focus due to the number of donors in the group. In Tanzania time and resources were absorbed by the large number of meetings. Another review cited notes that SWAps are complex, dialogue-heavy and negotiation takes longer; and donor monitoring missions, while less frequent, are larger and more intensive. However, there has been no systematic analysis of the transaction costs of harmonisation or of specific aid modalities (Vaillancourt, 2009).

Unaligned project aid undermines harmonisation and increases transaction costs for recipient governments. Even in countries with functioning mechanisms for donor co-ordination and common funding approaches, project aid represents a significant proportion of external funding for the health sector. Evidence suggests that project aid can undermine harmonisation (see Box 2.1 and Box 3.2). In Zambia, use of parallel reporting systems by some donors is reported to create high transaction costs for the Ministry of Health. In Ethiopia, the Ministry of Health reported to the JANS scoping mission that, as a result of fragmented aid, the finance department has to maintain over 20 ledgers.

Box 3.2. High levels of project aid are a challenge to harmonisation

In Bangladesh a considerable number of projects in the sector are funded outside the SWAp. Some donors also continue to implement technical assistance and studies on a bilateral basis (Asian Development Bank *et al*, 2009). Despite the adoption of the Harmonisation, Alignment and Results Action Plan 2006-2010, the 2008 Cambodia Aid Effectiveness report highlights continued fragmentation of aid in the health sector, with 115 active projects.

In Malawi more than 20 donors are funding more than 100 projects in the health sector outside the SWAp. In Mali, only 14 of the 50 donors to the health sector have signed the IHP+ compact. Donors that provide sector budget support also fund individual projects. In Mozambique only half the main donors for health, representing 22% of aid to the sector in 2008, participate in the Health Common Fund. Donors that do not participate cite the need to earmark funds to specific projects. The Global Fund moved out in 2009 due to difficulties in working through the Common Fund mechanism.

Donors cite a range of disincentives to harmonisation. Key factors are political pressure to retain direct accountability, deliver results and demonstrate attribution; concern about losing influence and leverage; and inflexible regulations and systems. The Zambia Paris Declaration phase 2 evaluation notes that donors are "caught between working collectively at country level and responding to differing priorities and the concerns of their headquarters. Inevitably, pressure remains on some development partners to retain direct accountability of their aid" (Chikwekwe *et al,* 2011). The need to demonstrate attribution is highlighted in the Nepal evaluation, while parliamentary emphasis on the visibility of aid is cited as a disincentive in the case of Japan.

Harmonisation is a challenge for global programmes due to their business model, lack of country presence and use of separate performance and reporting systems to enable performance-based funding. The Global Fund, for example, reports weaker progress in meeting indicators for joint analytic reports with other donors. Only a portion of Global Fund analytic work, such as diagnostic reviews, is conducted jointly, leading to a duplication of efforts. Harmonisation is also a challenge for UN agencies, despite efforts to take forward 'One UN', due to different planning, financial and reporting timeframes and systems. The Harmonised Approach to Cash Transfer (HACT) system, intended to address these challenges, has been introduced in countries such as Mali by UN agencies that are active in the health sector, but the HACT does not apply across all UN agencies or in all countries.

Efforts to improve harmonisation are challenged by the global aid architecture and growing diversity of actors in the health sector. The health sector has generated a large number of targeted global initiatives since 2000 – there are currently estimated to be at least 100 global partnerships and programmes – and despite commitment to 'think twice' before creating new initiatives, new global programmes and initiatives continue to be launched.

When new initiatives or global approaches are still perceived as required by developing countries, all efforts should be made to ensure that the design recognises and builds on existing country institutions and divisions of labour, and in all cases, avoids burdening countries and/or complicating the existing aid architecture further. The current multiplicity of initiatives, some with overlapping mandates, and lack of co-ordination between initiatives, increases transaction costs for countries, bi- and multi-lateral donors, and more generally for all development actors. With a few notable exceptions, such as the Global Fund and GAVI, countries are poorly represented in the governance of global programmes and partnerships.

The aid architecture for health has also become more diverse, with the increasing role of new donor countries (see Annex B), civil society organisations and private philanthropy in addition to global initiatives. While this diversity is a potential strength, existing co-ordination mechanisms were largely designed around traditional donors and may not be appropriate or sufficiently flexible to take account of new actors.

At the global level development partners have taken steps to implement common arrangements, although the benefits have yet to be demonstrated. Initiatives such as the Health Systems Funding Platform are intended to strengthen common arrangements (see Box 3.3). The US Global Health Initiative, launched in 2010, places greater emphasis on co-ordination and collaboration with partner country governments and other donors and building on existing plans and programmes.

Box 3.3. The Health Systems Funding Platform

The Health Systems Funding Platform, which involves the GAVI Alliance, Global Fund and World Bank and is facilitated by WHO, was established in 2009 to help countries use new and existing funds more effectively for health systems development in line with the IHP+ approach of: *(i)* one national health strategy supported by all development partners; *(ii)* one joint assessment of the national health strategy; *(iii)* one fiduciary framework which includes financial management and procurement; and *(iv)* one monitoring and evaluation framework based on country systems. The platform has developed a two-track approach: harmonisation of existing health systems funding of the three platform partners and in-country partners and alignment to country processes; and access to new health systems funding via a common GAVI-Global Fund application or through jointly assessed national health strategies. There is some concern that platform processes may undermine harmonisation and increase transaction costs for countries. Although it aims to simplify the flow of funding and partners have begun to harmonise their procedures, each agency still maintains its own processes for applications and separate funding channels (E2Pi, 2011). As yet, the platform has not developed into the mechanism for financing health systems that was recommended by the High level Task Force on Innovative Financing

Donor division of labour

Country level progress with implementing division of labour is slow and uneven and it is too early to assess the impact in terms of reduced fragmentation. Nine of the Paris Declaration phase 2 country evaluations found significant progress in reducing duplication and increasing rationalisation at the sector level, albeit with areas of continued high fragmentation and few formal arrangements for division of labour. The EU Code of Conduct and Nordic Plus Initiative have contributed to limiting EU donors' sector support in partner countries. Individual bilateral donors have also taken the initiative to rationalise sector engagement. For example, the Netherlands has made progress in sector concentration in its 36 partner countries, where Dutch support is now limited to two or three sectors. Examples of countries that have made progress in division of labour are included in Box 3.4.

Box 3.4. Country progress on division of labour

Malawi has embarked on a division of labour process across and within sectors (Government of Malawi, 2010). The health sector has the highest number of development partners. Of these, 17 are planning to delegate dialogue and nine to delegate finance. Budget support donors are more supportive of delegation.

In **Mali,** in response to the EU Code of Conduct, some donors, for example France and Belgium, are progressively withdrawing from the health sector; while others, for example Sweden and Spain, are adopting silent partnerships.

In **Mozambique** Norway and Finland have withdrawn from the health sector and Ireland represents the Clinton Foundation through a silent partnership. Within the framework of the EU Code of Conduct a Joint Action Plan has been agreed and a donor task force has established the comparative advantage of donors and proposed that some donors exit some sectors. However there has been little progress in sector rationalisation. Some donors characterise certain sectors as "non-focal" and hence not an area of engagement, despite still being present. The substitution of bilateral programmes on the ground with programmes managed from headquarters has done nothing to rationalise aid.

However, overall progress has been slow and the number of donors engaged in the health sector at country level, including donors that provide a relatively small amount of funding and therefore contribute to fragmentation of sector aid, remains high. For example, as Table 4.1 shows, there are on average five EU donors present in the health sector in recipient countries (Carlsson *et al*, 2009).

Table 4.1. Sector fragmentation: Disbursements by EU donors in 2007 (DAC 15 plus EC)

Sector	Number of recipient countries	Number of donor programmes	Total Disbursement 2007 USD million	Average disbursement per donor programme USD million	Average number of EU donors in the sector (recipient countries only)
Health	114	610	1 049	1.72	5

UN agencies have taken steps to implement division of labour. The UNDAF is cited as an important influence on division of labour among UN agencies. In the area of HIV/AIDS specifically UNAIDS co-sponsors have taken forward a technical support division of labour in response to the recommendations of the Global Task Team, and the division of labour has been further revised to respond to the recommendations of the recent Second Independent Evaluation of UNAIDS.

There has been limited progress in addressing donor division of labour between countries. Significant disparities between countries – 'aid darlings' and 'aid orphans' – remain, in development assistance overall and in health specifically. Aid distribution across countries is poorly co-ordinated – donors determine country assistance separately and aid allocation is driven by factors other than need – resulting in geographical overlaps and gaps (Rogerson and Steensen, 2009). In addition, there are concerns that allocation of aid for the health sector has focused on a few specific diseases, resulting in under-funding of other important health priorities.

Headquarters' priorities drive donor sector engagement. Donor sector involvement is influenced by history, expertise and the need for visibility. Evidence suggests that the agendas of donor headquarters are the most critical factor, and take precedence over country priorities. The Paris Declaration Netherlands evaluation notes that *"thematic targets currently set in Dutch development cooperation policy may negatively impact on the sectoral division of labour among the donors"* (Wood *et al*, 2011). In Zambia the government was proactive in identifying lead donors in the health sector, but the ultimate decision was often taken at donor headquarters. Similarly, in Mozambique donor decisions about whether or not to remain engaged in a sector are strongly influenced by headquarters.

Consultation is critical to successful implementation of division of labour at country level. Health ministries see benefits in spreading risk among donors and are concerned that uncoordinated withdrawal will reduce funding. Concerns that division of labour will be used to reduce health spending appear to be borne out by the decrease

in the proportion of EC aid allocated to health from 4.7% to 1.3% between 2005 and 2008 (Alliance 2015, 2010). In Zambia and Tanzania the division of labour led to the withdrawal of a major donor from the health sector, resulting in a decrease in funding. There has been little analysis of the process and outcomes of implementing division of labour. In a joint evaluation by Denmark, Netherlands, Norway and Sweden of completed and on-going exits in Botswana, Eritrea, India, Malawi, and South Africa (Slob and Jerve, 2008), the Dutch exit from the health sector in Malawi showed that carefully planned exit processes with due attention to capacity issues allows satisfactory handing over to government and other donors. But effective exit planning that focuses on sustainability of development results is the exception and the evaluation recommends that "provisions for exits are made more explicit in aid agreements".

Key messages

- At the country level there has been progress with the implementation of common arrangements and procedures in the health sector through increased use of PBAs, SWAps, joint funding arrangements and common planning, financial management and procurement procedures. At the global level the Health Systems Funding Platform is taking steps to implement common arrangements, although the benefits have yet to be demonstrated.
- The increasing diversity of the global aid architecture, with the advent of new donor countries, global programmes and private philanthropy, is a challenge to harmonisation. There is an urgent need for more efficient global co-ordination and to rationalise the aid architecture for health.
- Harmonisation is undermined by unaligned and parallel project aid and there is scope to improve the integration of global funds and programmes at country level. Disincentives for donor harmonisation include pressure to demonstrate results and attribution and to retain accountability, concern about losing influence and leverage,and inflexible rules and systems.
- There has been limited progress at the global level in addressing donor division of labour between countries. Greater progress had been made at the country level – the EU Code of Conduct and Nordic Plus Initiative have contributed to this – but progress has been slow and the number of donors engaged in the health sector remains high. Factors that influence donor sector involvement include history, expertise, the need for visibility and, most importantly, donor headquarters' priorities. Consultation is critical to successful implementation of division of labour at country level, in particular to avoid adverse impact on sector funding.

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Chapter 4. Improving Predictability and Transparency of Aid to the Health Sector

The Paris Declaration recognises that predictability is vital to the effective use of aid by partner countries. The Accra Agenda for Action committed donors to improve the availability of information on aid flows. This chapter examines the success of initiatives to improve the predictability of aid to the health sector, particularly looking at the reasons for the mixed progress in improving predictability. This chapter looks at the contribution of innovative financing as a means of reducing the financing gap in the health sector and the impact it has had on predictability and increasing the effectiveness of aid to the sector. This chapter reviews evidence for improvements in transparency in the health sector.

Context and commitments

Predictable and transparent aid enables countries to develop medium- and longer-term plans. Where aid information is poor, government planning and budgeting is based on partial or inaccurate information. Transparency about the use of aid is critical to donor and public confidence. In the Paris Declaration, donors committed to provide timely, transparent and comprehensive information on aid flows and more predictable, multi-year aid commitments to countries. In the Accra Agenda for Action, donors and countries agreed on actions to increase the medium-term predictability of aid, including strengthening national budget planning processes, donor provision of information about annual aid commitments and disbursements and three-to-five-year forward expenditure plans with indicative resource allocations. Indicators to measure progress include:

More predictable aid based on the percentage of disbursements released according to agreed schedules in annual or multi-year frameworks

Improving the predictability of aid

Some donors have made systematic efforts to improve the predictability of aid through multi-year commitments but others remain unable or less committed to improving predictability. Box 4.1 highlights key issues.

Box 4.1. Current status of donor efforts to improve the predictability of aid

- Review of seven funding agencies finds an increase in long-term commitments for health, with global funds and their donors taking the lead (Dodd and Lane, 2010). Of the bilateral agencies reviewed Norway, Sweden and the UK have set long-term targets for aid spending.
- The US is a major funder of global health programmes and the largest contributor to the Global Fund, but legislation prevents it from making multi-year and forward commitments. However, the US does announce the level of expected funding over the duration of programmes such as PEPFAR and the GHI.
- GAVI reports an increase in the share of multi-year donor government donations but long-term commitments to global funds are not yet the norm.
- Based on self-reporting by the 15 participating development partners, the IHP+Results annual progress report (2011) finds mixed progress in predictable financing for the health sector. The proportion of funding through multi-year commitments fell from 75% to 70% between 2005-07 and 2009, but in 2009 9 of the 15 were providing 90% of their health aid through multi-year commitments .
- The ability of UN agencies to make longer-term commitments is limited by the need to mobilise resources, but UNICEF and UNFPA have moved to five-year commitments where possible (IHP+,Results,2010).
- Available evidence suggests non-traditional donors are less likely to make multi-year commitments.
- Donor ability to make longer-term commitments is likely to be challenged by the current global economic environment. Development budgets and health aid are likely to stagnate (Germany) or be cut back (France, Italy, Spain) in 2010 and 2011 (AfGH, 2011).

Box 4.1. (cont) Current status of donor efforts to improve the predictability of aid

More specifically:

- The 2010 EC Communication on the EU role in global health suggests predictability for at least three years and encourages its member states to join EC MDG Contracts that allow commitments up to six years (70% of which is fixed funding, ensuring a high degree of predictability, and 30% is related to performance against selected outcome indicators).
- The UK is moving to five-year commitments where possible and in some countries is implementing ten-year Development Partnership Arrangements.
- The Netherlands' planning cycle provides scope for four-year indicative funding.
- The US government-funded Millennium Challenge Corporation (MCC) makes five-year agreements with countries that meet eligibility criteria. PEPFAR has five-year partnership frameworks. USAID must use appropriated funds within two years, while the MCC and PEPFAR have unlimited time to do so.
- The Global Fund has an eight-year indicative commitment from the UK and GAVI Alliance has 20-year commitments from Norway, Sweden and UK through the IFFIm (Dodd and Lane, 2010).

Impact on aid predictability and health sector budgets at country level is mixed. There is little consistency in the application of multi-year commitments across countries and no specific evidence that longer-term donor commitments have yet improved health sector budgets, for instance, through adjustment of a country's Medium-Term Expenditure Framework (IHP+Results, 2010). This is confirmed by findings from Paris Declaration phase 2 evaluations, which show progress in some countries, but not in others. Seven of 14 country evaluations report improvements, due to an increase in the number of donors operating within multi-year frameworks, including in the health sector (see Box 5.2). Studies on aid predictability for the health sector in Ghana, Tanzania and Uganda concluded that aid is highly unpredictable, with most donors unable to give realistic commitments more than 12 months ahead. Volatility in aid receipts is compounded by an increase in off-budget aid (ODI and CAPE, 2010; Handley *et al*, 2010; Smith and Leyaro, 2010).

Box 4.2. Uneven progress in improving predictability of aid

In South Africa, the EU Joint Country Strategy 2007-2013 provides the basis for more predictable and multi-year commitments. The new Primary Health Care programme involves a ten-year commitment to sector budget support and PEPFAR has agreed a three-year partnership with the Department of Health. In Mali nine donors now announce funding for two to three years ahead and IHP+ signatory donors have made their financing announcements up to the end of the current health sector programme (Samaké *et al*, 2010). In Malawi, much of the improvement in the predictability of aid is attributed to the Paris Declaration. Specific factors include donor peer pressure to meet commitments and harmonisation of reporting procedures, reducing delays in government submission of reports and funding requests.

In contrast, in Vietnam there has been slow progress towards greater predictability and in Zambia there has been a decline in the predictability of aid. In Mozambique, predictability beyond one to two years remains weak and estimates in the MTEF are often above what is actually disbursed.

Predictability is influenced by donor political considerations and the relationship with and capacity of recipient governments. Donor constraints include unwillingness to commit funds beyond the current term of office, preference to retain political leverage and flexibility to respond to changes in foreign policy priorities, and domestic rules and processes. Changes in donor country governments, resulting in a shift in development priorities, and in the economic and financial situation, also influence predictability of aid.

The relationship with the recipient government, in particular around issues of trust and accountability, also affects donor decisions to provide multi-year commitments. Concerns about corruption and mismanagement of aid, absorptive capacity, short-term planning horizons and reduced incentives for recipient governments to deliver results or to raise domestic resources are also constraints to greater predictability. Studies in Ghana, Tanzania and Uganda found that predictability is influenced by PFM and fiduciary risk, including inability to spend according to agreed plans, which affect donor confidence. These studies highlight the need for stronger government leadership and management of aid, and to improve planning and budgeting capacity (ODI and CAPE, 2010). Donors are especially reluctant to commit to long-term arrangements in fragile states.

Box 4.3. GAVI and country co-financing of vaccines and analysis of fiscal space

Implementation of the GAVI co-financing policy began in 2008 and a revision of this policy commenced in 2010. The first stage of revision included a review of experience to date and an assessment of the fiscal space available in GAVI-eligible countries to sustain GAVI's existing and future vaccine portfolio. In 2008 32 countries were co-financing GAVI-supported vaccines; the number of countries required to co-finance increased to a total of 51 in 2009. Challenges have included getting co-financing amounts included in national budgets, working with fiscal years that differ from GAVI's. The number of countries in default, i.e. not meeting their co-financing commitments, fell from nine in 2008 to five by the end of 2009. Country defaults do not appear to be linked to income level, but relate to issues of political commitment, disbursement bottlenecks and immunisation programme management. Countries are responsible for procuring co-financed vaccines to encourage the use of country systems, but it is too early to evaluate the effect of this approach on country ownership and capacity. However, country consultations suggest that co-financing has increased ownership and visibility of immunisation within health ministries and helped to raise domestic revenue for vaccines.

Fiscal space relates to the ability of a government to make budgetary resources available for an area of activity without harming the sustainability of the government's financial situation. The GAVI fiscal space analysis aims to assess how much public spending would be required if governments assumed the full cost of vaccines. It assumed that vaccines represent around 5% of public spending on health – the largest share – in the poorest countries in 2010; this would increase to around 10% in 2015 with the addition of new vaccines. The projected share of public expenditure is lower in less poor countries. The analysis suggests that countries that are likely to lose GAVI eligibility soon are better positioned to assume new vaccine financing than the poorest countries. For just over half of the poorest countries, projected vaccine costs in 2015 would represent more than the entire projected increase in the health budget and these countries would continue to need external support over the medium-to-long term.

Source: GAVI

There is still a gap between commitments and disbursements. IHP+ signatories report that they perform well against their disbursement schedules, although this has not been independently verified. In 2008 GAVI reported disbursing 60% of funds within 90 days, UNICEF reported 100% on-time disbursement in Zambia and Mozambique and the Global Fund reported that actual disbursements were 95% of the expected amounts (IHP+Results, 2010). In 2009, 12 of 15 development partners surveyed reported that more than 90% of their health spending in 2009 was actually planned in 2009. However, Paris Declaration phase 2 country evaluations show there is often still a considerable difference between donor commitments and actual disbursements (see Box 4.4).

Box 4.4. The gap between commitments and actual disbursements

In Bangladesh, while the predictability of aid to the health sector has improved, this has not been matched by an improvement in disbursement rates. In Malawi, in 2007-08, donor disbursement was 10% above pledge due to increases by the World Bank and the Global Fund. In 2009-10 disbursement by pooled donors was below pledge by 39%, and disbursements for discrete donors were 72% below pledge. In Mali many donors do not uphold their commitments to provide information about future aid flows or to make disbursements on time, even when conditionalities are fulfilled. Little progress is observable in terms of in-year predictability as total aid disbursements are very different from what has been programmed. The Ministry of Health has estimated that the predictability ratio of IHP+ Compact donors was only 70% over the period 2009-10.

In-year unpredictability of aid is attributed on the donor side to making in-year cuts or providing additional support or disbursing funds late in the year. In-year predictability is a particular issue with respect to the Global Fund, as disbursements are linked to performance. On the recipient side, factors include failure to meet donor requirements, for example, completion of audit documents, or to meet performance targets, because of limited implementation capacity or over-optimism.

The contribution of innovative financing

Innovative financing mechanisms[1] have been established to address the financing gap for health. Development assistance for health rose from USD 4.4 billion in 1990 to an estimated USD 26.8 billion in 2010 (IHME, 2010). Much of this is accounted for by global health programmes. Aid through non-traditional donor countries (see Annex B), private foundations and NGOs has also increased over the past decade and may soon overtake official ODA (NORAD AHHA, 2009). WHO has estimated that an additional USD 251 billion is required for health in 2009-15. This is unlikely to be provided by traditional donors, even if commitments are met[2], or increased domestic expenditure. Innovative financing mechanisms have been established to mobilise additional resources (see Box 4.5).

Box 4.5. Examples of innovative financing mechanisms	
UNITAID	UNITAID membership includes 29 countries and the Gates Foundation. Proceeds from a solidarity levy on airline tickets collected by member countries represented 70% of contributions in 2009. UNITAID received USD 274 million in 2009, bringing the total since 2006 to almost USD 1 billion. As of November 2010, funding committed for 2011 totalled USD 180 million. France, UNITAID's main donor country, pledged annual funding of USD 150 million for 2011-13, to encourage others to make long-term commitments. UNITAID resources are being expanded by the MASSIVEGOOD initiative, which had raised USD 0.2 million by June 2010 (UNITAID, 2009).
International Finance Facility for Immunisation (IFFIm)	The IFFIm was established by GAVI with UK government support, to scale up immunisation coverage. As of the October 2010, France, Italy, Netherlands, Norway, Spain, South Africa, Sweden and the UK had entered into legally binding agreements to make payments totalling USD 5.9 billion over 20 years. Based on this guarantee, IFFIm issues bonds in the international capital markets, the resources from which go to fund GAVI programmes. Bond financing provides frontloaded access to funds. IFFIm expects to issue bonds totalling USD 4 billion through to 2015. As of October 2010, bond issuances amounted to USD 2.6 billion (IFFIm website; OECD, 2011).
Affordable Medicines Facility – malaria (AMFm)	The AMFm was launched in 2009 to provide affordable, effective, quality-assured ACTs[3] for patients in the public and private sectors. AMFm has negotiated lower drug prices with manufacturers and is subsidising a proportion of this lower price on behalf of eligible buyers though co-payments to manufacturers; buyers are expected to pass on the price benefit to patients. In 2010, the AMFm launched Phase 1 pilots in Cambodia, Ghana, Kenya, Madagascar, Niger, Nigeria, Uganda and Tanzania, to assess the effectiveness of the mechanism at country level. Total funds committed to date are USD 216 million. Key donors are the UK, Gates Foundation and UNITAID. Phase 2 funding will depend on the evaluation of Phase 1 (AMFm website and interview).
Advance Market Commitment (AMC)	The AMC is underpinned by long-term commitments from Canada, Italy, Norway, Russia, the UK and the Gates Foundation. It aims to attract private sector investment in new vaccine products by guaranteeing purchase volumes at agreed prices over a period of time, largely financed by binding aid commitments. GAVI aims to assist up to 60 countries to access low-cost vaccines through the AMC. Approximately USD 1.5 billion has been raised for the AMC for pneumococcal vaccines. GAVI has committed an additional USD 1.3 billion through 2015 (AMC website; OECD, 2011).

At the UN General Assembly in 2009, the High Level Task Force on Innovative Financing announced a series of new financing measures[4] to mobilise an additional USD 5.3 billion, to increase access to free health care for women and children. These included:

- USD 1 billion expansion of the International Finance Facility for Immunisation (IFFIm), funded by Australia, Norway and the UK.
- USD 515 million for results-based funding for health programmes, funded by Norway and the UK and managed through the World Bank Health Results Innovation Trust Fund.

- Up to USD 3.2 billion to be raised by 2015 by a new mechanism for voluntary contributions when buying airline tickets (see UNITAID above).
- Up to USD 220 million a year to be raised by a VAT tax credit pilot scheme in Italy.
- Commitment to explore a second AMC for vaccines.
- USD 360 million of debt conversions to generate additional funding for the Global Fund[5].
- New donor financing to fund commitments to expand access to health services in Burundi, Ghana, Liberia, Malawi, Nepal and Sierra Leone.

Innovative financing mechanisms have generated additional funding for health and, to a lesser extent, increased predictability of aid. There is a consensus that finance raised through some of these mechanisms, in particular the Advanced Market Commitment (AMC), IFFIm and UNITAID, represents new funding for health. Although not a revenue-raising instrument, Multi-Donor Trust Funds have the potential to mobilise additional resources by attracting more risk-averse donors. Mechanisms such as UNITAID have also succeeded in mobilising resources from additional countries such as Brazil and the Republic of Korea. However, some key donors, such as the United States, have had limited involvement in innovative financing for global health (Hecht *et al*, 2010). The IFFIm and AMC have contributed to increased longer-term predictability of funding through 20-year legally binding commitments (OECD, 2009). The contribution of other innovative financing mechanisms to longer-term predictability is less clear.

There has been no systematic assessment of the extent to which innovative financing mechanisms have generated new resources or increased predictability. While some may have generated additional resources, others may exercise a substitution effect diverting funding originally intended for other well-established funding modalities. Further analysis is required to ascertain whether funds mobilised represent genuine additionality or substitution (OECD, 2009).

Box 4.6. Lessons learned about innovative financing and aid effectiveness

OECD DAC work suggests that innovative financing will secure maximum development impact if it:

- Avoids discouraging countries from raising domestic revenues and developing equitable and fairly administered fiscal policies as a fundamental pillar of development.
- Complies with the Paris Declaration and the Accra Agenda for Action and donors avoid proliferation of delivery channels, institutions and reporting mechanisms.
- Takes account of the advantages and disadvantages of specific financial instruments.
- Is simple and transparent, especially when calling on private solidarity participation.
- Follows good PFM practice, in particular, that front-loading is not used or seen as a means of bypassing agreed government spending limits.

OECD DAC statistics provide only a partial picture of innovative financing for health and work is ongoing to establish a more complete picture (NORAD AHHA, 2009; OECD, 2008a). OECD is also taking action to monitor the relationship between

innovative financing, ODA and aid effectiveness. As a first step, it has conducted a mapping exercise, together with the World Bank, of innovative financing mechanisms (OECD, 2011).

Innovative financing mechanisms may undermine aid effectiveness. As one review noted, "Multiple channels for revenue raising are acceptable provided there are co-ordinated channels for disbursing funds to countries in ways that make use of government systems, reduce transactions costs and maximise results. However, little work has been done to assess the relative costs and benefits of various options for raising revenues and channelling resources to countries" (Pearson, 2008). Others have raised concerns about supply-driven funding and earmarking of resources channelled through innovative financing mechanisms. The World Bank has highlighted the need to review the implications of the increased use of trust funds and to analyse the extent to which these contribute to fragmentation and run counter to principles of donor harmonisation and country ownership (World Bank, 2010)[6].

Transparency and provision of information about aid flows

Aid effectiveness commitments have led to global initiatives to improve aid transparency but lessons from the health sector are limited. The commitment to increase aid transparency in the Accra Agenda for Action has prompted a range of global initiatives, such as the International Aid Transparency Initiative (IATI) and Publish What You Fund (PWYF). As yet, there is limited evidence of their impact, and available evidence relates to effectiveness of implementation rather than outcomes (McGee and Gaventa, 2010). The G8 has pledged to improve aid transparency and reaffirmed commitment to improving accountability and tracking of commitments. Global programmes, such as the Global Fund, have set standards of good practice on transparency of information (GPLG, 2008). The World Bank, with its open access to information policy, has also set standards for transparency. There are some examples of promising initiatives to strengthen donor transparency in the health sector, such as the Development Partners Group for Health in Tanzania website, which provides access to key policy documents and processes. However, efforts to increase transparency have yet to translate into consistent improvements in the provision of information about aid flows to recipient governments. This remains a major barrier to improving planning, budgeting and accountability (see Box 4.7).

Box 4.7. Donors are still failing to provide adequate information about aid

In Uganda donors do not provide enough information on aid commitments and disbursements, for on and off budget modalities. This undermines budgetary processes as they fail to capture the significant proportion of resources for health though off budget project aid. Donors should provide more complete, timely and accurate information on aid. Only DANIDA is viewed as providing comprehensive information (Wild and Domingo, 2010).

In Zambia there has been good progress in improving the quality and accessibility of information, facilitated by the Joint Annual Review and Performance Assessment Framework. In the Joint Annual Review there is information regarding specific delays in donor funding that have consequences for performance. However, donors are still not sufficiently transparent with regard to funding flows within the SWAp and on-budget aid, and challenges in accessing information are particularly evident in relation to vertical funds in health (Wild and Domingo, 2010).

Recipient government representatives have also highlighted the need for commitments to increase information on aid flows to be more explicit about the type of information donors should provide. Effective planning and oversight require information that is disaggregated by sector, actor and purpose. This means providing information, for example, on whether funds are allocated to the country office, the government, NGOs or other implementers, and whether funds are earmarked for technical experts or training (ODI, 2009).

Key messages

- Donors have made systematic efforts to improve the predictability of aid through multi-year commitments, and there is evidence of an increase in long-term aid commitments for health. Innovative financing mechanisms for health have also increased predictability of aid. However, some bilateral donors, UN agencies and emerging donor countries remain unable, or less committed, to improving aid predictability.
- Impact of these efforts on aid predictability, and on health sector budgets, at country level is mixed. There is little consistency in application of multi-year commitments across countries and no specific evidence that longer-term donor commitments have yet improved health sector budgets. Country case studies indicate that aid remains highly unpredictable, with most donors unable to give realistic commitments more than 12 months ahead. There is also still a considerable gap between donor commitments and actual disbursements.
- The main donor constraints to longer-term commitment are political, including unwillingness to commit funds beyond the current term of office, preference to retain political leverage and flexibility to respond to changes in foreign policy priorities, and domestic rules and processes. Donor willingness to provide multi-year commitments also depends on the relationship with the recipient government, in particular issues of trust and accountability, concerns about corruption and mismanagement of aid and about reducing the incentive for recipient governments to deliver results or to raise domestic resources, and short-term planning horizons in recipient countries.
- Global programmes have set standards of good practice on transparency at global level. However, donor commitments to increase transparency have not translated into consistent improvements in provision of information about aid flows to recipient governments, constraining efforts to improve planning, budgeting and accountability.

Notes

1. There is no agreed definition of innovative financing. The World Bank distinguishes between innovative finance mechanisms that generate additional funds, make funds more efficient, and link funds to results. OECD considers innovative financing to comprise mechanisms of raising funds or stimulating actions in support of international development that go beyond traditional spending approaches by either the official or private sectors.
2. The report prepared by the G8 in June 2010 notes that donors are USD 10 billion short of the USD 50 billion Gleneagles target.
3. Artemisinin-based combination therapies.
4. Other measures under discussion include an International Financial Transactions Tax, although this is not health specific (see Declaration of Santiago adopted at 7th Plenary Meeting of the Leading Group on Innovative Financing for Development January 2010) and a Currency Transaction Levy for Health which could raise US$33 billion a year (AfGH and ICSS, 2010).
5. In 2009 it was estimated that debt swaps would generate an additional US$ 450 million by 2010 for the Global Fund (UN General Assembly, 2009). The Global Fund has since launched the Debt2Health initiative, which involves agreements under which creditors forgo repayment of a portion of debts provided that beneficiary countries invest an agreed amount in health through the Global Fund.
6. In 2009, the World Bank was managing 1 045 trust funds. Health, the largest sector, accounted for 43% of disbursements.

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Chapter 5. Strengthening Mutual and Domestic Accountability for more Sustainable Development Results

The Paris Declaration calls for managing for development results to enhance country decision making, alongside efforts to improve donor-partner country accountability. This chapter highlights lessons learned from the health sector that contribute to the understanding of the impact of aid on domestic accountability. This chapter also looks at the extent to which donors are defining and using results as a basis for decision making and evidence of the impact of results-oriented decision making in countries.

Context and commitments

In the Paris Declaration, donors and partner countries committed to a focus on results in managing and implementing aid and to use information to improve decision making, with an emphasis on establishing and using results-oriented reporting and assessment frameworks and harmonising monitoring and reporting requirements. Partner countries also committed to strengthening the links between national development strategies and budget processes, the role of parliaments in national development strategies and budgets, and the involvement of a broad range of partners in assessing progress. The Accra Agenda for Action reinforced the focus on delivering results, including through improving national information systems, aligning monitoring to country information systems, enhancing developing country parliamentary oversight, strengthening mutual accountability and donor and partner country action to address corruption.

Indicators to measure progress include:

- Partner countries with results-oriented performance assessment frameworks
- Partner countries undertaking mutual assessments of progress

Strengthening mutual and domestic accountability

Recognition of the role of aid in promoting domestic accountability is growing. The EC, in its 2010 communication on the EU role in global health, highlighted the need for the EU to enhance support for participation of all stakeholders in monitoring national health policies and promoting parliamentary scrutiny in partner countries of public financing decisions that influence the delivery of health services. Case studies conducted to improve understanding of how aid influences domestic accountability highlight the link between poor accountability and poor service delivery outcomes despite significant investment in health. This is due in part to a failure to address accountability at service delivery level, particularly in the context of decentralisation. Addressing this "missing middle" requires stronger links between district actors and national decision makers, but there are few examples of effective links between the different actors involved in decentralisation processes (OECD, 2011c).

Some aspects of aid effectiveness appear to have strengthened domestic accountability including joint missions which bring together domestic stakeholders and donors and the use of common indicators to assess the performance of government and donors. There are, however, limits to what aid can achieve, as domestic accountability is an internally driven, complex and dynamic process.

Box 5.1. Parliamentary dialogue on aid effectiveness and results in Nigeria

Nigeria's Senate Committee on Appropriation has launched a parliamentary initiative on budgeting, appropriations, aid effectiveness and results with a view to strengthening parliamentary oversight of aid management and results. Questions about health aid and the development of indicators against which results can be measured in the health sector, in the National Strategic Health Development Plan 2010-15 and the IHP+ compact, have been the main catalyst for this initiative. Following a review of aid flows and institutional arrangements for aid management and effectiveness, a dialogue with parliamentarians was held in May 2011 to review the findings and identify next steps in mutual accountability and aid effectiveness. The dialogue highlighted the critical role of parliamentarians in mutual accountability and recommended that parliament should be more proactive in its oversight of aid flows, management and effectiveness.

Some countries are taking steps to strengthen domestic accountability (see Box 6.1). In Uganda, stronger systems for results-oriented budgeting, monitoring and reporting are improving government accountability for use of resources. Additionally, annual health sector reviews and performance reporting linked to National Health Assemblies and participation of parliamentarians and civil society in health sector working groups are enhancing domestic scrutiny and accountability (AfGH, 2011a). Rwanda's health reforms are accompanied by mechanisms to strengthen accountability between citizens and local government officials, health service providers and local government, communities and health providers (Sekabaraga *et al*, 2010).

IHP+ compacts have the potential to strengthen mutual accountability in the health sector, but collectively ensuring accountability through these is challenging. IHP+ places a strong emphasis on mutual accountability. Country accountability mechanisms are in place through country compacts or equivalent agreements and joint annual health sector review mechanisms. Seven of ten countries surveyed in 2010 reported mutual assessment of progress (IHP+Results, 2011). Burundi and Kenya are improving monitoring of progress on IHP+ and Paris Declaration commitments through integrating indicators into health sector monitoring and annual reviews, and similar action is planned in Ethiopia and Nepal.

The IHP+ independent monitoring function has developed internationally agreed indicators for the health sector, adapted from the Paris Declaration, to monitor and report on progress with commitments, using an annual survey and scorecard approach (see Annex C). Donors and country partners participating in the process use the scorecards to report annually on their IHP+ commitments, although only 10 of 27 countries and 15 of 25 development partners have participated. This reflects the variable quality and lack of specific accountability commitments of IHP+ country compacts and slow progress in incorporating IHP+ commitments into internal performance targets or joint annual health reviews.

Efforts to improve accountability are undermined by donor practices. Some donors continue to operate outside of co-ordinated aid management and mutual accountability processes. While aid approaches that support country systems do not appear to contribute substantively to greater domestic accountability, aid delivered outside of these systems appears to weaken domestic accountability. Evidence from Uganda and Zambia suggests that off-budget aid and poor information on aid create challenges for domestic and mutual accountability (Wild and Domingo, 2010b). Governance and accountability constraints beyond the health sector, including weak capacity of domestic accountability institutions and civil society, also mean that health budget processes in many countries are unchallenged.

Box 5.2. Stronger accountability and transparency for women and children's health

Resources for improving the health of women and children, mobilised by the UN Global Strategy for Women and Children's Health, will be tracked by the Commission on Information and Accountability for Women's and Children's Health. The Commission, co-chaired by the President of Tanzania and the Prime Minister of Canada, will ensure resource pledges are delivered, funds are spent wisely and transparently and results are achieved. The Commission has agreed a series of actions including developing plans to strengthen country capacity to collect essential data, monitor and report on the results of resource allocations; aligning with country priorities, strategies and reporting cycles and streamline reporting; developing a limited set of common indicators for maternal and child health and promoting these as part of a single global mechanism for reporting on outcomes; and strengthening mechanisms to track and report domestic and external financial resources.

Source: Commission on Information and Accountability for Women's and Children's Health (2011)

Managing for development results

There is no common understanding of managing for results and it is seen by some as the same as results-based financing. Different agencies also use different terms to describe similar concepts of results-based financing, for example, results-based aid, payment by results, cash on delivery, performance-based aid and output-based aid. Donors have different priorities, with some prioritising short-term results and others longer-term capacity development. A focus on immediate results can be detrimental to longer-term development if donors finance only what is easy to measure. A focus on quantitative outputs may also undermine the quality of implementation, and short-term results may be achieved at the expense of longer-term capacity development and more sustainable results (OECD, 2011b). Linking aid to results may also penalise the countries that face the greatest challenges.

Donors are using results-based financing to enhance results but there is limited evidence of impact. For example, Global Fund and GAVI funding disbursements are dependent on results. While there is some evidence, including from the Global Fund and GAVI, that a focus on results can have a positive impact on performance and outcomes, the evidence base is limited (see Box 5.3).

"Only one example can be found of a well-designed study aimed at assessing the impact of a results-based approach. Given the limited experience, lack of robust evaluations and risks of the distorting effects and incentives of results-based funding mechanisms, there is a need for a positive but cautious approach. Results-based approaches are new and as yet largely unproven; they are promising but need to be closely monitored in relation to their effects on health systems as a whole". (Pearson, 2010a).

Box 5.3. Issues to consider in results-based financing approaches in the health sector

Focus on the right interventions and results. Aid for health continues to be poorly targeted towards the most cost effective and equitable interventions. Simply using results-based approaches to support more of the same may simply help us deliver the wrong results more efficiently.

Results-based funding is not a simple way to address attribution. Donors are under pressure to show value for money. Results-based funding might seem to be a solution, but progress is typically achieved through a package of approaches and it is difficult to determine which factors are responsible.

Box 5.3. (continued) Issues to consider in results-based financing approaches in the health sector

Ensure approaches involve payment for results rather than payment by results. There is a crucial difference between rewarding commitment to achieving results and rewarding results achieved. Most approaches focus on the latter. In addition to structural problems poor countries are vulnerable to external factors, including unpredictable aid flows, which can impair capacity to deliver results. The question is whether results-based funding is attempting to reward those *trying* to deliver the right results or those *able* to do so. Strong incentives may be insufficient when capacity is lacking.

Ensure a higher degree of consistency with aid effectiveness principles. Adherence to Paris principles is variable among agencies that use results-based approaches. Funds are often channelled outside government systems, raising questions about whether these approaches are truly 'country owned'.

Do not assume benefits are sustainable. Early adopters of any reforms are usually the most energetic and motivated. Results-based approaches may also act as a 'sticking plaster', enabling a system to operate at low levels but preventing crises that might precipitate more fundamental reforms. In Cambodia, for example, it may be better to replace the numerous government and donor-sponsored results-based funding initiatives with a more comprehensive approach to public sector reforms.

Source: Pearson (2010a).

As a review of global funds noted:

"Results-based financing holds real promise as an allocation mechanism. However, it is not a panacea. It needs to be implemented in a manner that balances its incentive effect with the need for programmatic support and for predictability. And it needs to address long-run results and sustainability rather than just short-term easily-measurable ones. Global funds should take a portfolio approach in allocations between programmatic and results-based financing. Both are aimed at achieving development results: the differences between them are primarily of means and of timeframe. Programmatic and results-based financing can also readily be combined in the same grant, as in EC MDG Contracts". (Isenman *et al*, 2010)

Progress is mixed with respect to results-oriented reporting and performance assessment frameworks. "A single performance assessment framework (PAF) is central to a government's efforts to measure health outcomes, monitor progress and identify areas of under-performance" (IHP+ Results, 2011). Seven of ten countries surveyed in 2010 reported that they had a single PAF in place. There is evidence in Mali, Nepal and Uganda of an increased results focus in health sector plans and budgets and greater emphasis on measuring impact and strengthening related performance reviews and monitoring and evaluation systems. In Mozambique results-based reporting on the health sector uses indicators embedded in the PAF that are updated annually and rely on a national health information system of data collection that provides the foundation for joint reviews of health sector progress.

However, most countries do not yet demonstrate how available resources are used to achieve health results. More systematic assessment of the extent to which countries have developed results-based sector plans and PAFs is required (IHP+Results, 2011). In Tanzania, "spending plans, programmes and activities are still not sufficiently directed to achieving goals such as improving maternal mortality and public expenditure is not sufficiently results focused" (Smith and Leyaro, 2010). A World Bank review concluded that health SWAps "have not substantially strengthened the

health sector's results focus or accountabilities, but in some countries these are reported to be slowly evolving". Incentives to encourage monitoring performance, sharing performance data and using this data to enforce accountabilities are critical to a results focus (Vaillancourt, 2009).

There is some evidence of increasing donor use of PAFs but not all use PAFs for their results reporting. More than 60% of development partners surveyed in 2010 report using the national PAF as the main basis to assess the performance of their health aid (IHP+Results, 2011). The Funding Platform for Health Systems is looking to adopt country PAFs for monitoring and evaluation. GAVI has announced that it will use annual reviews if these provide the information they need. There are, however, some concerns about plans to create EU Donor Performance Assessment Frameworks, rather than strengthening existing country-owned frameworks.

Some donors still require parallel reporting or reporting on additional indicators outside the national PAF, for example, in Ethiopia, Mali and Niger. In Uganda, the Annual Health Sector Performance Report is viewed as useful for scrutinising sector performance, but some donors continue to commission external monitoring reports due to a lack of confidence in government reporting. Many countries still report on a large number of indicators and are required to submit multiple reports. At the 2010 Global Health Information Forum, WHO reported that more than 1 000 health indicators are currently in use. "Managing multiple performance monitoring and reporting requirements to meet the demands of different donors incur high transaction costs" (IHP+Results, 2011), absorb significant resources and divert attention away from effective management of the health sector.

The capacity of national health monitoring and evaluation systems is variable. The quality, comprehensiveness and timeliness of health information remains a challenge, and greater efforts are required to strengthen systems for generation and use of data. The Mozambique Paris Declaration phase 2 evaluation found that there is a need to increase investment in government capacity and systems strengthening for monitoring and evaluation (KPMG, 2011). In Malawi, efforts have been made by the Ministry of Development Planning and Cooperation to build monitoring and evaluation capacity at sector level, but "most M&E systems remain weak" and this is "coupled with lack of quality data and access to such data by stakeholders". In five of the six countries included in the World Bank review of SWAps "the neglect of M&E capacity building and use relative to the strong emphasis on procurement, disbursement and financial management has resulted in an insufficient results focus", whereas, "the establishment of good M&E capacity and of a strong results focus prior to the SWAp in the Kyrgyz Republic led to a good balance in emphasis between implementation and results" (Vaillancourt, 2009).

The Third IHP+ Country Health Sector Teams meeting in December 2010 highlighted the need for a manageable number of indicators, for monitoring and evaluation to be linked to national plans, and for more investment in institutional capacity and monitoring and evaluation systems. To address this, and demand for better data, global partners and countries, led by WHO, are developing a common platform for monitoring and review of national health strategies. In July 2010, WHO convened a meeting with global and country partners to agree on practical guidelines for strengthening the monitoring and evaluation component of national health strategies and monitoring and evaluation capacity. As of March 2011 joint assessments of monitoring and evaluation systems had been completed in Benin, Kenya, Mozambique, Nepal, Sierra Leone and Uganda, covering analysis of country review

processes, data availability and quality, institutional capacity for generating and analysing data, and the use of data in health sector reviews; and multi-country analytical workshops had been held in Cape Town and Nairobi. Partners actively engaged in these processes at global and country levels include WHO, GAVI, Global Fund, UNICEF, USAID, CDC and the World Bank.

Donors continue to conduct separate review missions. The increase in the number of countries that have established joint annual health sector review mechanisms does not appear to have significantly reduced the number of separate and uncoordinated donor missions. Despite progress in conducting joint reviews of national AIDS responses in a number of countries, a UNAIDS review in West and Central Africa (2010) found that reviews and analyses are not always conducted jointly, and several countries reported multiple simultaneous or parallel missions, sometimes with similar objectives.

Findings from the Paris Declaration phase 2 evaluations note that in Nepal there is a perception that the number of donor missions has increased; in Mozambique while joint reviews assess progress against the PAF, global funds and USAID use additional evaluation processes; and in Mali, although there is a single results framework and joint sector review process, nearly all donors active in the sector continue to organise bilateral missions. In most cases, uncoordinated missions are initiated by donor headquarters and relate to implementation of non-delegated budgets or additional monitoring and evaluation and audit requirements. Global programmes also appear to be less likely to participate in joint missions. For example, in 2008 only 14% of Global Fund missions were conducted with other partners[1].

Key messages

- Progress is being made at country and global levels to improve mutual accountability for results through developments such as the agreement and reporting against indicators for IHP+Results, derived from the Paris Declaration, and the Commission on Information for Accountability for Women's and Children's Health. However, moving beyond commitments and the establishment of accountability mechanisms to implementing mutual accountability remains a challenge.
- There is an increasing focus on aid delivering results but, with no common understanding of the concept of managing for results, this has often been interpreted as results-based financing. Donors are using results-based financing but as yet there is limited evidence of impact.
- There is some progress with countries developing PAFs and evidence that PAFs are increasingly used by donors, but most countries do not yet demonstrate how resources available are used to achieve results and some donors still require reporting on additional indicators outside the PAF.
- Reporting on health results requires strong national health monitoring and evaluation systems, but quality is variable and more effort is required to strengthen systems for generation and use of data.
- The increase in use of joint annual health sector review mechanisms does not appear to have reduced the number of separate and uncoordinated donor review and monitoring and evaluation missions.

Notes

1. In 2009 82% of Global Fund grants were reported as being aligned to national monitoring and evaluation systems. The 2010 Global Fund target is 90%.

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Chapter 6. Aid Effectiveness and the Impact on Health Results

This chapter examines the relationship between the effectiveness of aid and progress in health results. This chapter brings together a wide range of evidence from various sources and examines correlations and causalities between impacts in health and the improved delivery of aid.

Demonstrating and attributing health results to better aid management practices is challenging as improved health outcomes are determined by many factors both within and beyond the health sector. OECD and others have highlighted the difficulties of drawing a direct causal link between inputs and outcomes, suggesting that it would be more realistic to assess the contribution of aid effectiveness to health through creating the conditions for sustainable impact, *i.e*. through its effect on health system strengthening, on transformation of institutions and accountability and on other conditions required for longer-term development (GRAP-PA Santé, 2011).

There needs to be consensus on what results might be expected from aid effectiveness in the short, medium and longer term and how these might be measured. The evidence base on the link between aid effectiveness and health results is limited. This is partly because there is no agreed framework for monitoring the impact of aid effectiveness on health outcomes (GRAP-PA Santé, 2011), partly because there has been little systematic analysis or evaluation, particularly from the perspective of partner countries, and partly because changes in aid management practices and the effects of these changes take time. While "there seems to have been an overall improvement in the effectiveness of how aid is being delivered and used in the health sector [...] it is too early to state whether these improvements are contributing to stronger health systems or better health outcomes" (IHP+Results, 2011).

Various studies have highlighted the need for better and more complete evidence on the relationship between aid effectiveness and development results at sector level (ODI, 2008; OECD, 2009; Walford, 2010). Nevertheless, review of the available evidence suggests the following:

Aid effectiveness can result in increased resources for health. The global decline in under-fives deaths, from 11.9 million in 1990 to 7.7 million in 2010, is attributed in part to increased resources for health and improved global health co-operation (You *et al*, 2010). There is some evidence that PBAs have increased donor and domestic financing for health, for example, in Malawi, Nepal and Tanzania (see Box 6.1). Sector Budget Support has facilitated and contributed to a rapid increase in public expenditure in a number of countries (Williamson and Dom, 2010), and supported the expansion of basic health care in Tanzania and the introduction of free basic healthcare in Zambia (Walford, 2010).

Box 6.1. Aid effectiveness and resources for health

In **Malawi** the SWAp seems to have leveraged increased funding, both from donors and from government. Commitments for health and population accounted for around 15% of total ODA pre-SWAp, but 25% post-SWAp. Much, but not all, of the increase is due to AIDS support, but the share to non-HIV interventions in the sector still rose from 10% to 15% of aid commitments (Pearson, 2010).

In **Nepal**, although it is difficult to state with certainty that improved aid effectiveness has contributed to progress with health indicators, aid represents 50% of health spending and indicators have improved since the SWAp was established in 2004 (Schmidt, 2009).

In **Tanzania** there has been progress in the allocation of funds to the health sector since the start of the SWAp, with an increase in external contributions, although the health share of the government budget has remained at around 11% (Zinnen, 2011).

Aid effectiveness appears to be correlated with increased coverage and utilisation of essential services, improved health service delivery and health outcomes (see Box 4.3). The Paris Declaration phase 2 evaluations found some evidence of "catalysing, strengthening and legitimising a platform and framework for action and coordination in sector development efforts, and facilitating greater investment, efficiency and results". Ten country evaluations found some plausible contribution to improved health services or outcomes.

There is some evidence to suggest that PBAs are having a positive impact on health outcomes (see Box 6.2). A review of six African countries with SWAps found that all appear to have made progress on some indicators. For example, Zambia made progress on several key indicators such as drug availability, immunisation coverage and supervised deliveries. Ghana showed some increase in skilled birth attendance and tuberculosis cure rates, with limited improvement in use of outpatient services, and saw modest improvements in health status in the first sector programme and substantial improvements in the second, alongside a modest reduction in fertility (Walford, 2007).

Box 6.2. Aid effectiveness, health services and health outcomes

Ethiopia has registered significant progress in the health sector. The under-five mortality rate decreased from 204/1 000 to 101/1 000 and the maternal mortality ratio from 1 068/100 000 to 580/100 000 between 1990 and 2008. Antenatal care coverage rose from 46% in 2004-05 to 68% in 2008-09, according to the Ministry of Health. Malaria mortality has also fallen by 55% (Bilal *et al*, 2010).

Successive phases of Ethiopia's Health Sector Development Programme (HSDP) have focused on strengthening the health system and have introduced important reforms, such as the Health Extension Programme (HEP) which aims to ensure universal primary health care coverage.

While it is difficult to attribute better health outcomes to better aid effectiveness, the Ministry of Health 2010 MDG Report suggests there is a strong correlation. Since 2006 the government, with support from development partners, has prioritised harmonisation, alignment and co-ordination. The Ministry has been a strong advocate of aid effectiveness and has introduced major policy initiatives that have helped to improve harmonisation of aid at national level, including drafting national policies for governance and aid effectiveness and signing an IHP+ compact. Key factors that have helped to improve health outcomes include strong political leadership for health systems strengthening and pragmatic use of global programme funds for system-wide interventions, including expanded access to basic health services through the HEP, task shifting and expansion of health facilities from 3 544 in 2004 to 17 300 in 2010. The influx of external resources has "played a large role in strengthening the government's ability to improve coordination across policies and priorities" (USAID/Abt Assoc, 2010; Bilal *et al*, 2010; Federal Ministry of Health, 2010).

In Malawi the SWAp has contributed to improved health outputs by: ensuring that the programme of work reflects priorities for the health sector and key challenges are addressed; enabling the delivery of a prioritised essential health package (EHP) and an emergency human resources plan (EHRP) in ways which would not have been possible under earlier vertical approaches; and supporting reform of procurement systems, human resource management and service level agreements with public-private partnerships which are expanding access to key services (Pearson, 2010).

There have been demonstrable improvements in services. The proportion of facilities able to deliver the EHP increased from 9% in 2003 to 74% in 2009, and the availability of maternal health services increased significantly. The EHRP has enabled more staff to be trained, recruited and retained, so providing better clinical cover in the facilities.

Box 6.2. (continued) Aid effectiveness, health services and health outcomes

An independent evaluation for DFID in 2010 found that the EHRP had increased the number of heath workers by 53%, and "ample evidence that worker numbers and quality are positively associated with immunisation coverage, outreach of primary health care services and maternal and child health". The most significant increases were seen in outpatient attendances (49%), assisted deliveries (15%), immunisation (10%) and antenatal care (7%). District Health Officers reports improvements in infrastructure and their ability to use funding for supplies and maintenance to improve the quality of services. In addition, links between predictable recurrent funding provided through the SWAp to services delivered can be observed, for example, in maternal health services where problems with lack of recurrent funding to run transport for outreach clinics was resolved and has continued to improve (Vaillant *et al*, 2010).

The impact on health outcomes was measured by approximating number of lives saved as a result of increased service utilisation. Increased antenatal coverage was estimated to have saved an additional 265 lives, increased assisted delivery to have saved 6 433 additional lives, and increased immunisation coverage to have saved an additional 2 842 lives between 2004 and 2009. Overall, the SWAp has contributed to modest improvements in health outcomes but more could have been achieved. Unresolved issues include the appropriateness and cost-effectiveness of the EHP, allocation of resources based on need, and unpredictability of donor funding.

In Mali, there is anecdotal evidence that delivery of more efficient aid is contributing to positive health outcomes (Walford, 2010; Samaké *et al*, 2011). The Paris Declaration phase 2 evaluation concludes that "even if no causal relationship can be established between aid mechanisms and sector performance, the health sector has performed well over the past decade and most indicators of outputs and outcomes have progressed". During 2002-09, the number of functional community health centres increased from 605 to 993 and during 2004-09 the number of health care staff increased from 3 147 to 9 704. During 2002-09, the percentage of births attended by a skilled attendant increased from 40% to 66% and immunisation coverage increased from 74% to 100% (national information system).

The Mozambique Paris Declaration phase 2 evaluation highlighted improvements between 2003 and 2009, in access to rural health services and in the number of facilities providing maternal care. While there are few certain links between the Paris Declaration and results because there is "too large a gap between high-level agreement and the reality of implementing development on the ground", comparison of the health and agriculture sectors suggests there may be a link between good government-donor dialogue and development results. Outcomes are better in health, which has a well functioning SWAp and strong government leadership. Another review (HLSP Institute, 2010) notes that "Since Mozambique adopted a SWAp approach in 2001, the coverage of health services has increased substantially and key health indicators have improved. Progress could be attributed to socio-economic advances after the end of the civil war as much as to the improved performance of the health system. Nevertheless measurable improvements in the quality and outputs of health services in countries that have a good SWAp are a strong indicator of the benefits of the approach".

Health outcomes have improved in Rwanda. Under-fives mortality fell from 196/1 000 in 2000 to 103/1 000 in 2007, with a particularly dramatic decline among the poorest quintile, and maternal mortality has decreased by 12% a year since 2000. This is attributed to increased utilisation of essential health interventions, particularly immunisation, assisted deliveries, family planning and insecticide treated nets. Use of contraceptives increased from 3% in 2000 to 27.4% in 2007 and the proportion of assisted deliveries from 39% to 52% between 2005 and 2007 (Sekabaraga *et al*, 2010). Success in improving health outcomes can be linked to increased resources and implementation of sector reforms. Funding has been used to strengthen the health system and reforms include community-based health insurance, performance-based financing and fiscal decentralisation. Government leadership and co-ordination of aid in the form of a SWAp has been critical to ensuring that aid has been used effectively and aligned with national priorities (Sekabaraga *et al*, 2010). **(cont…)**

Box 6.2. (continued) Aid effectiveness, health services and health outcomes

In South Africa, strategic interaction among development partners, foundations and global funds in line with the principles of ownership, alignment and harmonisation is credited with supporting the introduction of new national policies and programmes including a National Service Delivery Agreement, as well as the development of a health aid effectiveness plan. The Paris Declaration phase 2 evaluation notes that "these are important achievements across a complex sector".

Tanzania has seen a fall in infant mortality from 99/1 000 to 58/1 000 and in under-five mortality from 147/1000 to 91/1 000 between 1997 and 2008 although there has been little improvement in maternal mortality. The World Bank evaluation of SWAps (Vaillancourt, 2009) rated improvements in service delivery in Tanzania as substantial. A recent study in four districts (Zinnen, 2010), which assessed the contribution of effective aid to results, reported that while overall use of health services remained unchanged, use of public sector health facilities accounted for a higher share of consultations. The adoption of a health SWAp and sector basket funding played a key role in increasing resources and contributed to the implementation of key health sector reforms, including decentralisation, which have strengthened health systems and brought about modest improvements in service delivery and health outcomes. There have been improvements in infrastructure, production and recruitment of health workers, and availability of drugs, supplies and equipment for disease-specific programmes, resulting in improved measles vaccination coverage, tuberculosis treatment completion rates and use of insecticide-treated bed nets by children. However, despite strong government and donor commitment and reasonably well implemented policies, results are modest.

But aid effectiveness can only do so much, and impact depends on effective implementation by partner countries. For example, in Uganda, early successes achieved through the SWAp including substantial increases in resources to the health sector and progress in achieving the targets of the Health Sector Strategic Plan (2000-05), appear to have been lost (Ortendahl, 2007). The Paris Declaration phase 2 evaluation concluded that health indicators had stagnated or declined, and this is attributed to lack of leadership in critical positions which has resulted in reduced funding for the sector, and to a failure to improve staff capacity at district level to support effective decentralisation of health service delivery.

Key messages

- Attributing health results to better aid management practices is problematic due to multiple causal pathways affecting health outcomes. To date, aid effectiveness in the health sector has focused mainly on the process and co-ordination of aid rather than the downstream impacts of those processes on health service delivery and outcomes. There is a notable dearth of rigorous analysis and country studies that look at the impact on health results or that use the Paris principles as the starting point for analysis of results.
- Based on the limited evidence available aid effectiveness can result in increased resources for health, and it appears to be correlated with increased coverage and utilisation of essential services, improved service delivery and health outcomes in some countries. However, aid effectiveness is not the only factor driving these changes.
- Government prioritisation of harmonisation, alignment and co-ordination of donors, strong vision and sector leadership, sound policies and plans, and pragmatic use of resources to drive system-wide reforms are critical factors in improving health results. That said, there are also a number of cases where, despite strong government and donor commitments and evidence of reasonably well implemented policies, results continue to be modest.

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Annex A: Definitions

Aid (i) Support provided by countries, international agencies, institutions, NGOs or foundations, to developing countries in the form of monetary grants, loans at low interest rates, in kind, or a combination of these; (ii) shorthand for resource flows that qualify as Official Development Assistance or Official Aid according to criteria used by the OECD.

Budget support An aid instrument whereby aid is channelled directly to a country's budget, to be disbursed according to its own allocation, procurement and accounting systems. Budget support is untied aid given in support of a national development strategy. For some countries and donors, budget support is considered an ideal form of assistance, automatically aligned with country plans and systems. **Sector Budget Support** An aid instrument whereby aid is transferred to the national treasury in support of a narrow range of development or reform policies as set out in a sectoral strategy. The focus is on specific sectoral development and reform objectives.

Medium-term plan and expenditure framework (MTEF) (i) A tool for linking policy, planning and budgeting over a medium term (three years) across the whole of government and at a sectoral level. It consists of a top-down resource envelope, a bottom-up estimation of the current and medium-term costs of existing policy and, ultimately, the matching of these costs with available resources in the context of the annual budget process; (ii) a rolling plan, typically for three years, which focuses on translating the national strategic plan into organisation of work, allocation of resources and division of tasks for implementation, and links the national strategic plan with the operational plans. MTEF often have two dimensions: identification of national investment priorities, updating the M&E framework, defining the overall resource envelope; and allocation of resources to objectives and projection of future resource needs and availability.

On-/Off-budget funding The capture (or lack of it) of funds (internal, such as user charges or fines, or external) by the budget process of the recipient government.

Programme-Based Approaches (PBA) Development co-operation based on the principles of co-ordinated support for a locally owned programme of development. These include a national development strategy, a sector programme, a thematic programme or a programme of a specific organisation. Programme-based approaches share the following features: i) leadership by the host country or organisation; ii) a single comprehensive programme and budget framework; iii) a formalised process for donor co-ordination and harmonisation of donor procedures for reporting, budgeting, financial management and procurement; and iv) efforts to increase the use of local systems for programme design and implementation, financial management, monitoring and evaluation.

Project aid Aid earmarked to a specific purpose or a discrete set of activities.

Sector-Wide Approaches (SWAp) A SWAp is a programme-based approach at the sector level whereby donor funding supports a single, comprehensive sector policy and independent programme, consistent with a sound macro-economic framework, under government leadership. Many SWAps include pooled funding from several donors to support the implementation of a sectoral strategy. Supplementary technical assistance projects to strengthen country systems and capacities and project aid may also count as part of a SWAp if closely associated with a country-led, multi-donor effort to organise aid in accordance with the principles of programme-based approaches.

Annex B: Emerging Donors and Aid Effectiveness in the Health Sector

Non-traditional donors play an increasingly important role in development aid. According to the 2010 MDG Gap Task Force report on MDG 8, aid from non-DAC countries is growing, with significant contributions made by countries that do and do not report to OECD DAC. These include OPEC members (Kuwait, Saudi Arabia, Venezuela and the United Arab Emirates), middle-income, emerging donor countries (Brazil, China, India, South Africa, Thailand, Turkey and the Russian Federation) and others such as Iran, Korea and Chinese Taipei. However, there are wide variations in estimates of the contribution of these donors. The Supplementary Study on Development Resources Beyond the Current Reach of the Paris Declaration (Prada, F. *et al*) notes that one data set puts flows from non-DAC donors that might be considered ODA-like in the range of USD 12.3-14.4 billion for 2008, based on various sources (including the Reality of Aid 2010, Kragelund 2008, Shuchan and Marcoux 2010). While this is similar to the range of USD 9.5-12.1 billion suggested in a UN commissioned study in 2006 (ECOSOC, 2008) it is about 300% larger than the OECD estimate of just under USD 5 billion for 2005 (OECD, 2007). The latter study also concluded that:

- There are significant gaps in available data with regard to modalities, allocation patterns and use of specific instruments and conditions, and in transparency in reporting.
- There are questions about whether a substantial proportion of transfers from non-DAC donors to developing countries would qualify as ODA, but these financing sources are increasing the diversity of channels and financial instruments for development.
- There are concerns about the extent to which financial flows from non-DAC donors meet Paris Declaration principles.
- There is a need for more inclusive systems to promote co-ordination, harmonisation and transparency in the context of the overall aid architecture.

A brief review of the literature for this report, focusing on Brazil, China and India, highlights the following issues:

Comprehensive and accurate data is not available on the contribution of Brazil, China and India, either overall or to specific sectors such as health. It is difficult to obtain information on aid commitments and aid flows (Kragelund, 2010). In the case of Brazil, for example, AidData[1] indicates a total figure for 2008 of USD 15.2 million, whereas The Reality of Aid figure for 2010 is almost 23 times higher at USD 340 million (FORO Nacional Internacional, 2010). The Paris Declaration phase 2 evaluation found that, in all countries where non-traditional donors are present, resources are noted for being less transparent. There is also limited evidence about the quality, impact and value-

added of aid from emerging donors and further analysis is required, based on criteria defined by recipient countries (ODI, 2010).

Lack of information reflects fragmentation of aid across a range of institutions. An IDRC review noted that "administrative structures for development assistance programmes tend to be relatively diffuse and uncoordinated. Most countries have subordinated their development assistance co-ordinating agencies to other ministries" (Rowlands, 2008). In Brazil, for example, development cooperation is provided through a range of different ministries, research institutions and private organisations. In China, similarly, a range of government ministries is involved, although China's institutional arrangements are reported to be more co-ordinated than those of Brazil or India, through the Department of Foreign Aid within the Ministry of Commerce. India is reported to be considering the establishment of a centralised aid agency to improve the coherence of its development programmes.

Political and economic objectives are central. Development assistance emphasises mutual benefits, strategic and trade interests (Rowlands, 2008). China and India have tended to target support to the productive rather than the social sectors. China's contribution to Uganda, for example, has been growing over time and has been mainly directed to infrastructure development, technical co-operation and business-related activities. India has also increased engagement in Uganda, again mainly in terms of trade and investment (Kragelund, 2010). The Paris Declaration phase 2 evaluation for Malawi noted that China's focus appears to be on infrastructure and that China and other emerging donors stress strategic economic interests as the primary rationale for their development investments.

There are examples of multilateral engagement. China contributes an estimated USD 50 million to each of the African and Asian Development Funds. China is also a donor to the Global Fund and has been a board member representing the Western Pacific region since its foundation (Barr *et al*, 2010). China's African Policy (2006) in its discussion of multilateral co-operation states that: "China is ready to enhance consultation and co-ordination with Africa within multilateral trade systems and financial institutions […] It will step up co-operation with other countries and international organisations to support the development of Africa and help realise the Millennium Development Goals in Africa". The Global Fund has also mobilised support from a wide range of donor governments including China, Korea, Kuwait, Nigeria, Russia, Saudi Arabia, South Africa, Thailand and Tunisia.

There is limited engagement in donor co-ordination mechanisms at country level. In Nepal, for example, where China and India are reported to be important donors to the health sector, there is no interaction with traditional donors or involvement in co-ordination processes. Lack of engagement is attributed to institutional and technical capacity constraints – unlike traditional bilateral donors, Brazil, China and India do not have in-country development missions or staff (ODI, 2010) – and to a preference to work through alternative institutional arrangements. For example, India collaborates through structures such as the Development Cooperation Forum. Insufficient incentives for emerging donors to engage with current aid co-ordination mechanisms are also cited as a challenge (Chanana, 2010). However, there is evidence that this is changing. For example, China has worked with other donors through regional programming in the Mekong sub-region and in partnership with the Asian Development Bank, and India played a positive role in joint efforts following the Indian Ocean tsunami in 2004. Another example is the IBSA arrangement between India, Brazil, and South Africa.

Brazil has been more actively engaged with other donors, mainly through trilateral partnerships with a traditional donor and a recipient country. There are several examples of Brazil partnering with Germany, Japan and the UK. Both USAID and DFID have engaged bilaterally with China in its role as a donor country and there are opportunities to build on this.

Project aid is the norm, focusing on infrastructure, equipment and technical assistance. For example, in health, under the framework for co-operation of the Forum for China and Africa Cooperation, China has made a commitment for 2010-12 to provide medical equipment and anti-malaria materials worth RMB 500 million and to train 3 000 doctors and nurses in Africa (Christensen, 2010). Previous commitments related to training, hospital construction and provision of anti-malarial drugs (Kragelund, 2010).

Under the auspices of the TT HATS, WHO is leading an assessment of the contribution of the BRIC[2] countries to the health sector and the extent to which their approach is in line with Paris Declaration principles.

Notes

1. The database AidData was launched in March 2010 to improve tracking of aid and transparency.
2. Brazil, Russian Federation, India and China.

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Annex C: IHP+Results Scorecard Summary of Development Partner and Country Government Performance

Indicator	Standard performance measure	AusAID	Belgium	EC	GAVI	GFATM	Netherlands	Norway	Spain	Sweden	UK	UNAIDS	UNFPA	UNICEF	WHO	World Bank
1DP	Partner has signed commitment to (or documented support for) the IHP+ country compact, or equivalent agreement, where they exist.	✓	✓	✓	→	→	✓	✓	→	→	✓	→	✓	✓	✓	✓
2DPa	Percent of aid flows to the health sector that is reported on national health sector budgets.	!	!	→	?	✓	!	!	✓	✓	→	→	!	✓	→	✓
2DPb	Percent of current capacity-development support provided through co-ordinated programmes consistent with national plans/strategies for the health sector.	?	✓	✓	–	–	✓	✓	✓	–	✓	✓	✓	✓	✓	✓
2DPc	Percent of health sector aid provided as programme based approaches.	✓	✓	✓	✓	✓	✓	!	→	✓	→	✓	!	✓	✓	✓
3DP	Percent of health sector aid provided through multi-year commitments.	→	✓	✓	✓	!	✓	✓	!	✓	✓	–	✓	!	!	✓
4DP	Percent of health sector aid disbursements released according to agreed schedules in annual or multi-year frameworks.	→	?	✓	✓	✓	✓	✓	!	✓	✓	✓	✓	✓	✓	✓
5DPa	Percent of health sector aid that uses country procurement systems.	✓	✓	!	–	✓	✓	!	✓	✓	→	?	→	→	!	!
5DPb	Percent of health sector aid that uses public financial management systems.	✓	✓	✓	?	✓	✓	!	✓	✓	✓	?	→	→	!	✓
5DPc	Number of parallel project implementation units (pius) per country.	✓	!	→	–	✓	✓	!	✓	✓	→	–	✓	✓	✓	!
6DP	Partner uses the single national performance assessment framework, where they exist, as the primary basis to assess progress (of support to health sector)	✓	→	→	!	✓	✓	✓	→	→	✓	✓	→	→	✓	✓
7DP	Partner has participated in mutual assessment of progress implementing commitments in the health sector, including on aid effectiveness, if a mutual assessment process exists.	✓	→	✓	!	–	✓	–	→	✓	✓	✓	→	✓	→	✓
8DP	Evidence of support for civil society to be actively represented in health sector policy processes – including health sector planning, co-ordination and review mechanisms.	✓	→	→	→	→	✓	✓	→	→	→	✓	→	→	→	→

Indicator	Standard performance measure	Burkina Faso	Burundi	DRC	Djibouti	Ethiopia	Mali	Mozambique	Nepal	Niger	Nigeria
1G	IHP+ Compact or equivalent mutual agreement in place.	→	✓	!	→	✓	✓	✓	✓	✓	→
2Ga1	National Health Sector Plans/Strategy in place with current targets and budgets.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2Ga	National Health Sector Plans/Strategy in place with current targets and budgets that have been jointly assessed.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3G	Proportion of public funding allocated to health.	→	→	?	→	!	!	!	→	→	!
4G	Proportion of public funding disbursed against the approved annual budget.	→	!	?	✓	?	!	→	✓	!	✓
5Ga	Public Financial Management systems for the health sector either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	✓	✓	!	!	✓	✓	✓	!	✓	!
5Gb	Country Procurement systems for the health sector either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	?	?	?	?	?	?	?	?	?	?
6G	An agreed transparent and monitorable performance assessment framework is being used to assess progress in the health sector.	✓	✓	!	!	✓	✓	✓	✓	✓	!
7G	Mutual Assessments, such as Joint Annual Health Sector Reviews, have been made of progress implementing commitments in the health sector, including on aid effectiveness.	→	✓	✓	!	✓	✓	✓	✓	✓	→
8G	Evidence that Civil Society is actively represented in health sector policy processes – including Health Sector planning, co-ordination and review mechanisms.	✓	✓	✓	?	✓	✓	?	✓	✓	?

Source: IHP+Results Annual Progress Report 2011

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