HEALTHIER RETURNS

MAKING AID FOR HEALTHCARE MORE EFFECTIVE

Save the Children

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A REPORT BY SAVE THE CHILDREN INTERNATIONAL
FOR THE FOURTH HIGH LEVEL FORUM ON
AID EFFECTIVENESS IN BUSAN, SOUTH KOREA,
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Save the Children works in more than 120 countries. We save children's lives. We fight for their rights. We help them fulfil their potential.

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ABBREVIATIONS

CAFOD	Catholic Overseas Development Agency
CAFS	conflict-affected and fragile states
CCS	Mozambique's Health Sector Co-ordination Committee
CNCS	Mozambique's National AIDS Council
CSOs	civil society organisations
DAC	Development Assistance Committee
DFID	Department for International Development
EC	European Commission
EHRP	Emergency Human Resources Programme
ERG	Expert Review Group
EURODAD	European Network on Debt and Development
FMoH	Federal Ministry of Health
GAVI	Global Alliance for Vaccines and Immunisation
GBS	General Budget Support
GNI	gross national income
HLF4	Fourth High Level Forum on Aid Effectiveness
HMIS	health monitoring and information systems
HSFP	Health Systems Funding Platform
HSDP	Health Sector Development Plan
HSDP III	Ethiopia's Health Sector Development Programme
IATI	Independent Aid Transparency Initiative
IERG	Independent Expert Review Group
IHME	Institute for Health Metrics and Evaluation
IHP+	International Health Partnership and related initiatives
IMF	International Monetary Fund
IPs	Implementing Partners
JANS	Joint Assessment of National Strategies
JARs	Joint Annual Reviews
JFA	Joint Financing Agreement
KODI	Kenya Open Data Initiative
MDG	Millennium Development Goal
MNCH	maternal, newborn and child health
MoF	ministry of finance
MoH	ministry of health
MoU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NHSP II	Nepal Health Sector Programme II
ODA	Official Development Assistance
ODI	Overseas Development Institute
OF	Open Forum
PAF	Performance Assessment Framework
PAPs	Programme Aid Partners
PATHS2	Partnership for Transforming Health Systems Phase II
PBS	Protection of Basic Services
PEPFAR	President's Emergency Plan for AIDS Relief
PESS	Mozambique's health sector strategic plan
PFM	public financial management
RBPEF	Results Based Performance Evaluation Framework
SADC	Southern African Development Community
SBS	Sector Budget Support
SWAp	Sector-Wide Approach
TA	Technical Assistance
TTHATS	Task Team on Health as a Tracer Sector
UN	United Nations
UNFPA	United Nations Population Fund
US GHI	US Global Health Initiative
WHO	World Health Organization

FOREWORD

The number of children under five years old who die each year has been steadily declining for 20 years. In 1990, about 33,000 children around the world took their last breath every day. Today that number is about 21,000 – the child mortality rate has dropped 35 percent.

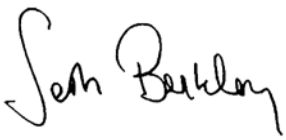
This is a significant achievement, particularly as the number of babies born has increased year on year. But too many kids are still dying – and outrageously, many are dying from diseases that we know how to treat, or even more reprehensibly, they are dying from diseases that we know how to prevent. Rapid advances in science and technology, such as in vaccine development, have provided the world with simple tools to prevent needless death and disability.

Most of the credit for declining global child mortality rests squarely with the governments and communities of the developing world. Nonetheless, aid has played a significant part. What we in the international community need to focus on is how to most effectively deploy our assistance.

Some of the most innovative and impactful endeavours in development assistance over the past decade have been in global health. As this report documents, the health sector has pioneered new approaches to performance management, accountability and transparency. We have fostered inclusive public-private partnerships and are testing new ways of harmonising aid and aligning our support behind developing country plans and systems. Yet getting simple life-saving tools to those who need them most remains a challenge.

The Busan High Level Forum on Aid Effectiveness provides an opportunity to share our experience and learn from others. This report by Save the Children contributes to our collective knowledge.

In sub-Saharan Africa, one in eight children is still dying before she reaches her fifth birthday. That fact ought to be unacceptable to anyone at anytime. More than a decade into the 21st century it is simply outrageous. We must do better. And we can. But only if our learning is based firmly on data and evidence.



Seth Berkley MD
CEO
Global Alliance for Vaccines and Immunisation

EXECUTIVE SUMMARY

The international community has made significant progress towards improving children's health over the last 20 years. Child mortality rates have fallen by 35%, and the average annual rate of reducing deaths among under 5s has doubled.[1] There are many reasons for these achievements, but they would not have been possible without aid.

International aid flows have increased substantially during the same period. In 1990, Development Assistance Committee (DAC) countries gave a total of $80.4 billion. By 2010, this had increased to $127.53 billion.[2] Recent estimates suggest that total health aid quadrupled from $5 billion in 1990 to $21.8 billion in 2007.[3]

Yet an estimated 7.6 million children died in 2010 – most of them from easily preventable and curable diseases.[4]

Around another $17.5 billion is needed every year in order to meet the Millennium Development Goal (MDG) target for maternal, newborn and child health (MNCH) in 49 low-income countries by 2015.[5] This funding gap is probably the world's biggest obstacle to achieving universal healthcare. But more effective use of existing health funding – including Overseas Development Assistance (ODA) – is also vital.

The health sector is complex and fragmented, with a multitude of actors whose different priorities and reporting requirements lead to high transaction costs for countries receiving aid (partner countries). As such, it was identified as a tracer sector to monitor the impact of the Paris Declaration on Aid Effectiveness.[6] This Declaration set out five central principles of effective aid, each reinforced by a set of global targets and indicators that can be monitored. The principles are country ownership, donor alignment, donor harmonisation, managing for development results, and mutual accountability.

OBJECTIVES

This report charts the extent to which the Paris Principles (as well as those pledged at Accra in 2008)[7] have been implemented in the health sector to date. It outlines attempts at reform, highlights successful initiatives – globally and nationally – and identifies persistent challenges.

These lessons should inform the Fourth High Level Forum on Aid Effectiveness (HLF4), taking place in Busan, South Korea, in November 2011. Participating decision makers should negotiate a better framework and identify concrete, measurable targets for accelerating progress.

FINDINGS

There has been much innovation in the health sector, for instance through the development of tools that facilitate participatory strengthening of national plans, efforts to improve public financial management (PFM) and promote transparency in some countries, and wider use of programme-based approaches. These lessons should be extended and replicated across other sectors.

However, this progress remains ad hoc and contingent on political will rather than binding obligations. Only with a firm and genuine commitment from *all* health donors, other development actors and partner countries can new mechanisms result in the improvements identified in Paris in 2005. Busan must match commitments with measurable targets.

The health sector's persistent challenges are not just technical and procedural. They are symptomatic of the need for greater clarity about how global health initiatives are governed. Good global health governance would involve a coherent framework with clearly defined roles for all actors in collective pursuit of common agendas. Priorities should also be determined by the needs of people living in poverty, rather than by the donor community's interests. These challenges are common across many aid sectors and must be addressed at Busan.

A step change in donor behaviour is required to realise a genuine partnership model, whereby aid is disbursed on the basis of a country's determination of its own national needs. As the Paris Monitoring Survey makes plain, this has not yet happened.[8]

RECOMMENDATIONS

Save the Children recommends reforms in six key areas in order to make health aid more effective (full recommendations are on page 30). Decisive action should be taken on these issues at the Busan HLF4, and subsequently at the World Health Assembly in May 2012 and the United Nations (UN) General Assembly in September 2012, as appropriate.

1) Strengthening harmonisation and alignment for country ownership

At Busan:

- The Outcome Document must state the importance of greater commitment to country ownership, specifically of national health and nutrition strategies.
- Donor assistance should be reflected in national budgets instead of being 'off-budget', and should be aligned with national priority health and nutrition needs. Greater use of programme-based approaches, as well as local procurement mechanisms, can help to increase ownership and reduce transaction costs.

Beyond Busan:

- Support for the International Health Partnership and related initiatives (IHP+) should be reaffirmed with a clear mandate defined for 2012–15. Partner countries and development agencies should be encouraged to sign the Global Compact and to actively engage in IHP+ processes at the national level.
- Partner governments must undertake sufficient reforms to widen confidence in national financial systems with capacity-building support from donors.

2) Supporting local capacity building

At Busan:

- All donors should commit to distributing aid in ways that strengthen local institutions and organisations, including civil society.

Beyond Busan:

- Guidance should be created for partner and donor governments directing engagement with local and international civil society organisations, both during policy development and at all stages of the project cycle.

3) Managing *for* results

At Busan:

- Donors must agree to value-shared results instead of a narrow focus on results associated with individual donor funding streams.
- Donors should align their transparency efforts by signing up to the Independent Aid Transparency Initiative (IATI) and its common data and reporting standard.

Beyond Busan:

- International NGOs should take steps to improve transparency, including dialogue with stakeholders about subscribing to the relevant provisions of IATI.
- Within the health sector, discrepancies in global monitoring efforts should be reviewed and debated at the World Health Assembly, so as to reduce the burden on partner countries. All efforts to monitor aid flows should adhere to the common standard set by IATI, with sector-specific standardisation of the indicators used by the Independent Expert Review Group (IERG) and IHP+Results, as well as others.

4) Institutionalising mutual accountability mechanisms

At Busan:

- The Outcome Document should strengthen peer accountability mechanisms.
- Donors and partner countries should make a measurable commitment to promoting and institutionalising national mutual accountability mechanisms.

Beyond Busan:

- Within the health sector, continued and increased support should be given to IHP+Results to produce and improve annual performance reviews. More IHP+ signatories should be encouraged to participate.
- Donors should strengthen the capacity of civil society to serve as effective watchdogs holding government and donors to account.

5) Addressing aid effectiveness in conflict-affected and fragile states (CAFS)

At Busan:

- Donors and partner states should support the g7+ proposal for a New Deal on International Engagement in Fragile States. The New Deal proposal should be accompanied by clear guidance on how donor and recipient countries – as well as citizens – will hold each other to account for abiding by this agreement.

Beyond Busan:

- Develop detailed country plans on how to apply the New Deal to different CAFS contexts.
- Agree on a better medium-term funding arrangement to bridge the humanitarian and development funding gap and finance recurrent expenditures (including health worker salaries) and health systems sustainably.

6) Filling the funding gap

Beyond Busan:

- All donors should commit to allocate 0.7% of Gross National Income (GNI) in ODA, where possible by 2015, and increase the share spent on health.
- Partner countries must meet the Abuja commitment to allocate 15% of government budgets to health and ensure that the WHO-recommended minimum expenditure of $60 per capita is met by 2015.
- Donors and partner countries should pursue the recommendations of the High Level Taskforce on Innovative International Financing for Health Systems to establish progressive innovative sources of funding to supplement government and donor allocations.

INTRODUCTION

The international community has made significant progress towards improving children's health over the last 20 years. Child mortality rates have fallen by 35%, and the average annual rate of reducing deaths among under 5s has doubled.[9] There are many reasons for these achievements, but they would not have been possible without aid.

International aid flows have increased substantially during the same period. In 1990, Development Assistance Committee (DAC) countries gave a total of $80.4 billion. By 2010, this had increased to $127.53 billion.[10] Recent estimates suggest that total health aid quadrupled from $5 billion in 1990 to $21.8 billion in 2007.[11]

Yet an estimated 7.6 million children died in 2010 – most of them from easily preventable and curable diseases.[12]

Around another $17.5 billion is needed every year in order to meet the Millennium Development Goal (MDG) target for maternal, newborn and child health (MNCH) in 49 low-income countries by 2015.[13] This funding gap (domestic and international) is probably the world's biggest obstacle to achieving universal healthcare.

Despite honourable pledges to increase spending on health, most governments and donors continue to fall short. African leaders committed to allocating 15% of their total government budget to health in 2001. 'EU15' member states reiterated their commitment to spending 0.7% of gross national income (GNI) on international development in 2005.[14] Allocating 0.1% of donor GNI to health has since been recommended.[15]

If these promises were realised, the funding gap for the health MDGs would be filled. But when it comes to translating promises into practice, progress has been slow.

More effective use of existing health funding – including Official Development Assistance (ODA) – is also vital.

The health sector has traditionally been exceptionally complex and fragmented, with a multitude of actors whose different priorities and reporting requirements lead to high transaction costs for countries receiving aid (partner countries).

There have been many attempts at reform, particularly since 2005, when ministers, donor agency leaders and senior officials signed the Paris Declaration,[16] a commitment to five central effective aid principles, each reinforced by a set of global targets and indicators that can be monitored. The principles include the following:

- **Ownership**: developing countries set their own strategies for reducing poverty, improving their institutions and tackling corruption.
- **Alignment**: donors align behind these national strategies and use local systems.
- **Harmonisation**: donors co-ordinate, simplify their procedures and share information to avoid duplicating efforts.
- **Results**: developing countries and donors shift their focus to development results and measure those results.
- **Mutual accountability**: donors and partner countries become fully accountable for their development results.

This report charts the extent to which these principles (as well as those pledged at Accra in 2008)[17] have been implemented in the health sector to date. It outlines attempts at reform and highlights successful initiatives, globally and nationally. It identifies persistent challenges, including limited donor co-ordination, lack of transparent resource allocation, insufficient understanding of effective aid delivery and too few national accountability mechanisms.

The health sector's persistent challenges are not just technical and procedural. They are symptomatic of the need for greater clarity about how global health initiatives are governed, and for more coherent common objectives that can achieve better health for all.

Good global health governance would involve a clearer framework with defined roles for all actors and collective pursuit of common agendas. The normative leadership of the World Health Organisation (WHO) should be asserted. The OECD should continue to lead in monitoring progress on aid effectiveness across all sectors, in partnership with sectoral bodies. Priorities should also be determined by the needs of people living in poverty, rather than by the donor community's interests.

These challenges, which are common to many aid sectors, should be considered and addressed at the Fourth High Level Forum on Aid Effectiveness (HLF4), taking place in Busan, South Korea, in November 2011. Participating world leaders can negotiate a better framework and identify concrete, measurable targets for accelerating progress.

Realising a genuine partnership model, whereby aid is based on a country's own assessment of its people's needs, requires a step change in donor behaviour. The 2011 Paris Monitoring Survey makes plain that such a change has yet to happen.[18]

Save the Children recommends reform in six key areas in order to make health aid more effective (these recommendations are outlined in full on page 30):

- Strengthening harmonisation and alignment for country ownership
- Supporting local capacity building
- Managing *for* results
- Institutionalising mutual accountability mechanisms
- Addressing aid effectiveness in conflict-affected and fragile states
- Filling the funding gap.

A cross-cutting call is to extend the International Health Partnership and related initiatives (IHP+) mandate beyond 2011, with broader political support and wider participation.

LUCIA ZORO/SAVE THE CHILDREN

2

CURRENT HEALTH AID ARCHITECTURE

The health aid architecture is complex, fragmented and in many ways at odds with the principles of effective aid. It has many types of donors, each with their own budget cycles, reporting requirements and priorities. In 2005, it was therefore agreed that health should be the Paris Declaration's 'tracer sector'. This meant urgently reforming the health aid sector and closely monitoring these efforts to guide improvements in other sectors.[19]

COUNTRY OWNERSHIP AND ACCOUNTABILITY

Country ownership involves partner countries, including both partner governments and civil society groups, establishing their development priorities and implementing them with support from donors that are aligned behind the same priorities. This practice has typically been poor in the health aid sector. Many donors provide funds off-budget and allocate resources without consulting the national government.

A fundamental cause for this failure is the lack of genuinely mutual accountability between donors and partner countries, and between service providers and citizens. These relationships have been imbalanced, with donors dictating priorities and terms and many partner countries being forced to comply in order to receive funds.

Systems that enable 'bottom-up' accountability have also been inadequate. This is in part due to multiple actors complicating lines of accountability, and the range of modalities through which aid is provided.

MULTIPLICITY OF ACTORS

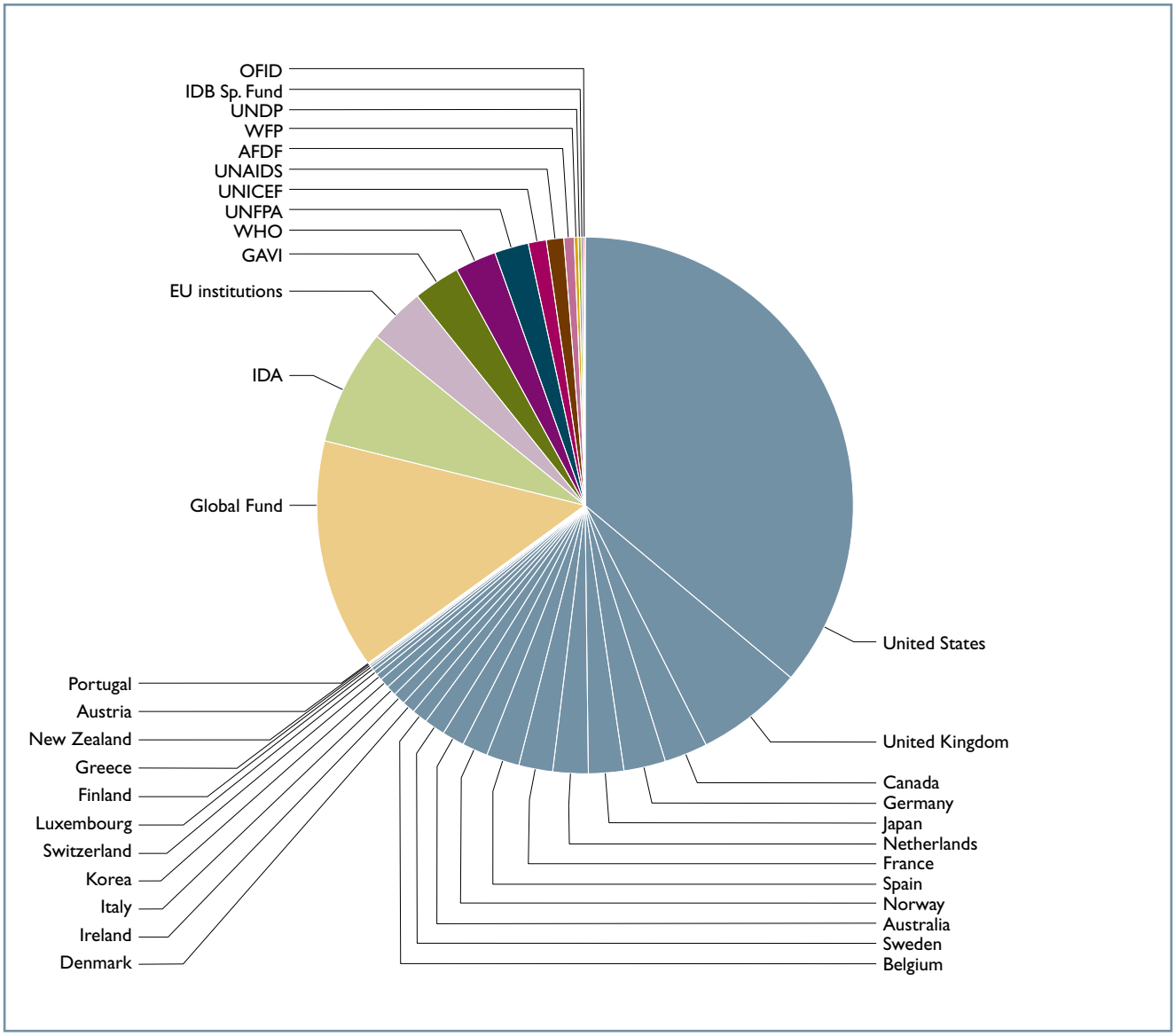
Tracking health sector aid flows remains a challenge. Nevertheless, the Institute for Health Metrics and Evaluation (IHME) has estimated that overall health aid, including from private sector sources, amounted to $21.8 billion in 2007.[20]

The largest source of reported health aid comes from bilateral donors – commonly classed as DAC donors and non-DAC, or 'emerging', donors (such as China, Brazil, South Africa and India). In 2009, DAC donors provided $10.9 billion in health aid.[21] It is much harder to quantify the flow of aid and resources from non-DAC donors since they have no agreed reporting standard. However, total aid from these donors was estimated to be between $12.3 billion and $14.4 billion in 2008.[22]

Multilateral donors, such as the World Bank and the UN, are the next largest source of reported aid, providing $5.9 billion for health in 2009. This includes contributions from a number of global health initiatives, though not all are classified as multilateral agencies. Global health initiatives (GHIs) are new structures created to raise and channel resources for specific communicable diseases. By some estimates more than 100 GHIS exist today.[23] Most notable are the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the Global Alliance for Vaccines and Immunisation (GAVI). Their success in securing new resources for their priority areas has been impressive. Their share of total aid for health is also substantial, reaching 16% in 2009.[24]

Global health initiatives should be differentiated from the United States Global Health Initiative,[25] which is a US government-wide strategy for global health focused on the health challenges and needs of those in low- and middle-income countries. The Initiative, launched by President Obama in May 2009, builds on the Bush Administration's efforts to address HIV, TB and malaria through the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative but also broadens and augments the focus on other global health challenges, particularly maternal and child health, family planning and reproductive health, and neglected tropical diseases. In addition, the initiative seeks to achieve significant, sustainable health improvements through an approach based on core reform principles, including country ownership and investment in country-led plans, building sustainability through health system strengthening, leveraging key multilateral organisations and global health partnerships, strategic co-ordination and integration, and improvement of metrics, monitoring and evaluation.

Chart 1 Aid to health by donor type, 2009[26]



Source: Author's own from OECD CRS (2011, accessed 12.10.2011)

The IHME also estimates private health flows. Approximately 27% of total health aid comes from private philanthropy foundations, individuals and corporate donations of drugs and medical supplies.[27] With no central database of health-related activities by non-governmental organisations (NGOs) worldwide, it is not possible to calculate their global proportion of health aid.[28]

POOR PREDICTABILITY

Donors often fail to disburse funds regularly and predictably. Across the aid sector, the lack of predictability has been estimated to cost 15–20% of the value of aid.[29] Changing political contexts can also prompt abrupt changes in aid allocations, resulting in health programmes being prematurely scaled down, or scaled up too suddenly.

Poor predictability is a major obstacle to using aid resources effectively and sustaining progress. It makes it difficult for partner countries to plan, budget for and implement their activities.[30] It is a particularly difficult problem for the health sector because a large proportion of the budget is for recurrent costs, such as staff salaries and drugs.

AID MODALITIES

Health aid can be disbursed through a range of different modalities. These include project aid, budget support or pooled funding arrangements such as Sector Wide Approaches (SWAps). See Box 1 overleaf for more information.

PROJECT AID

Project aid is the traditional aid modality, and the dominant form of aid to MNCH initiatives.[31] The number of projects is growing and the size of projects shrinking.[32] This exacerbates fragmentation and undermines the Paris Principles.

Each project has its own monitoring, reporting and budgeting arrangements, which are costly and time-consuming to administer. This imposes high transaction costs on the partner country, with health officials often spending a disproportionate amount of their time working to meet donor requirements instead of organising and improving services. In Tanzania, donor visits can take up 10–20% of a district medical officer's time, with report-writing consuming even more.[33] Without effective global or national co-ordination mechanisms, donor-driven projects can also be inappropriate and cause duplication.

Off-budget project aid creates further problems. Governments have no control over how it is spent and only a partial picture of the health portfolio. This makes it difficult to identify and prioritise gaps.

With no central database, gauging the levels of off-budget project aid is problematic. However, several country-level analyses suggest that it represents a considerable share of total health aid. In Zambia, off-budget allocations by PEPFAR reached US$269 million in 2008.[34] This is the equivalent of 51% of government health expenditure that year.[35] A report on Uganda in 2007 found that most health aid was off-budget.[36]

EARMARKED FUNDING

Donors earmark a large share of aid for particular diseases or population groups. This means funding opportunities for developing countries often don't reflect their national disease burden.

The increased focus on specific diseases in the past decade has skewed the available resources. Of the total increase in health aid between 2002 and 2006, 75% was allocated to HIV and AIDS.[37] These resources have helped to reduce morbidity and mortality in many countries through vertical, disease-specific programmes. But such progress can come at the expense of a sustainable health system.[38] The major causes of child deaths – pneumonia, diarrhoea, malaria and conditions related to birth and newborn care – all require a functioning and integrated health system.

BOX 1 DEFINITIONS OF AID MODALITIES

Project aid

Aid earmarked to finance specific, targeted activities with defined objectives, inputs, timeframe and outputs. It can be delivered with the national government (recorded in the budget) or without ('off budget' aid).

Programme-based approaches

These are an effort to overcome some project aid shortcomings, and have the following features:

1. Leadership by the host country or organisation.
2. A single, comprehensive programme and budget framework.
3. A formalised process for donor co-ordination, and harmonisation of donor reporting, budgeting, financial management and procurement procedures.
4. Efforts to increase use of local systems for programme design and implementation, financial management, monitoring and evaluation.

Budget support

Donor funding is channelled directly to the partner government's budget, using the government's own allocation and accounting systems. Unlike with project aid, resource use is less specific, giving the partner country more flexibility to determine how to use the funds. Any conditionalities will focus on policy measures related to poverty reduction, growth, fiscal adjustment and strengthening institutions, rather than a specific disease programme. There are various forms of budget support:

- General Budget Support (GBS) – a general contribution to the overall budget.
- Sector Budget Support (SBS) – earmarked for a specific sector (with any conditionality relating to this sector).

Budget support is one way of supporting programme-based approaches that meet the above criteria.

Off-budget aid

This type of aid is provided to a country outside the partner government's public financial management systems, or is not reflected in the national budget (commonly a medium-term expenditure framework). There is no global reporting mechanism for this kind of aid, and it can therefore be difficult to track. This can create over- or under-funding problems in some regions or for certain sectors/specific issues.

Pooling funds

Multiple donor funds are pooled in the government's accounts. The government manages and accounts for funds, preferably using the same standard budget procedures as for government revenues. Funds are earmarked for activities in a specific sector. The SWAp is an example of a pooled health fund. It can encompass a wide range of instruments, from a set of co-ordinated projects to SBS provision and sector pooling fund arrangements. SWAps usually include three components:

1. An approved sectoral policy document and overall strategic framework which define government priorities.
2. A medium-term expenditure framework for the sector.
3. A co-ordinated process among donors in the sector, led by the national government.

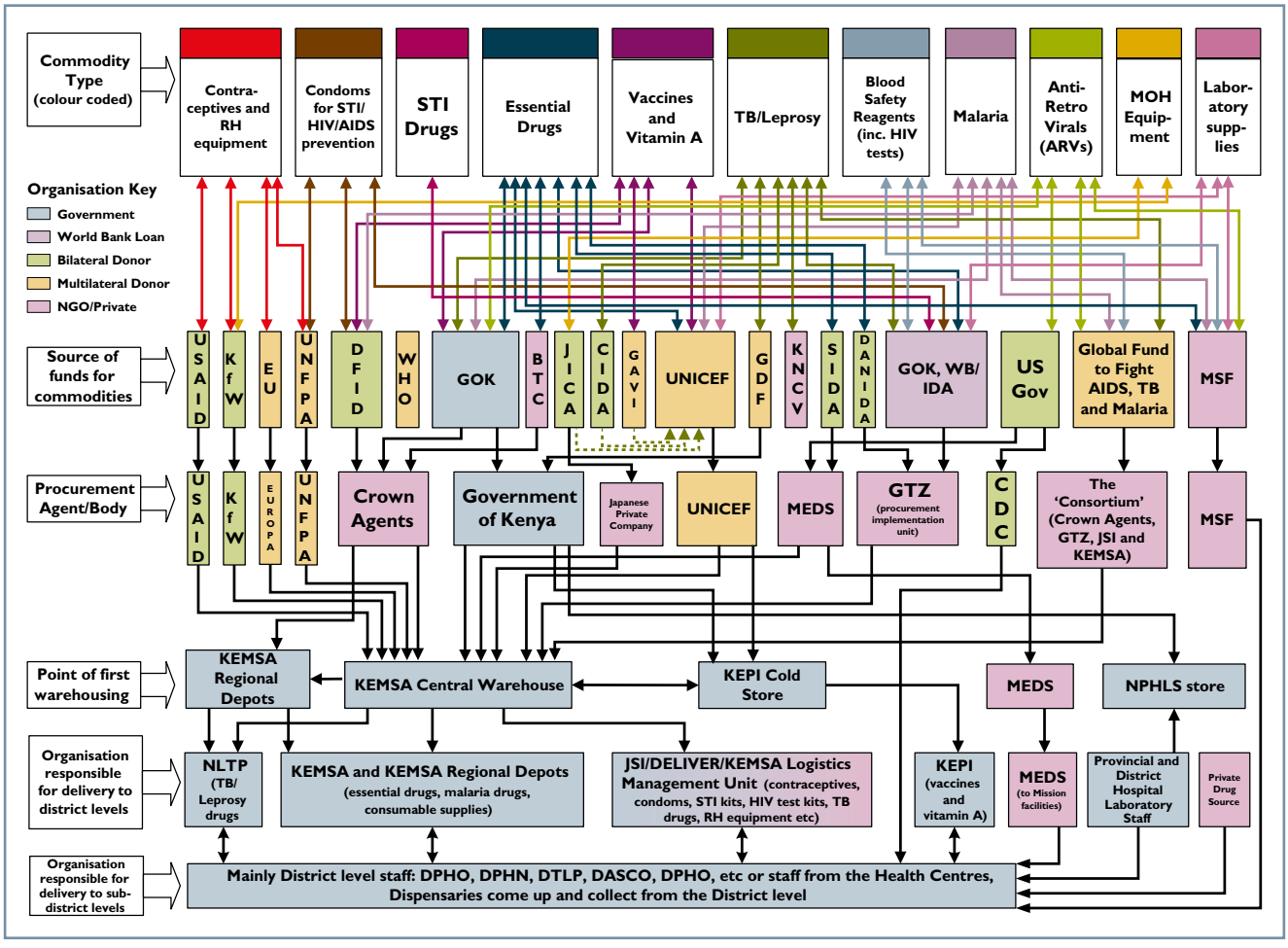
Sources
Author's own; OECD, *Aid Effectiveness 2005–10: Progress in implementing the Paris Declaration*, OECD, 2011; I Ohno and Y Niiya, *Good Donorship and the Choice of Aid Modalities: Matching aid with country needs and ownership*, GRIPS Development Forum, 2004.

PROCUREMENT AND TIED AID

Procurement accounts for a significant share of development aid. It is estimated at $69 billion a year – more than half of total ODA.[39] However, many donors tend to use external providers or set up parallel systems, often because of a lack of confidence in the partner country's capacities. This creates a complicated web of supply chains (see Figure 1).

'Tied' aid involves donors specifying that private sector involvement must come from the donor's home country. This means that substantial aid resources flow back to their source, rather than contributing to the recipient's economy.[40] In 2007, 44% of ODA was tied.[41]

Figure 1 Commodity supply chain in Kenya



Source: Kinzett (2004) in EC (2009) Seminar on EU Division of Labour, Madrid.

ATTEMPTS AT REFORMING HEALTH AID

There have been a number of attempts to reform existing health aid architecture. These are outlined below, and many will be further analysed in chapters 4 and 5.

AT THE GLOBAL LEVEL

The Paris Declaration in 2005 and the Accra Agenda for Action in 2008 both attempted to change how aid, in general, is delivered. Within the health sector, the expectation was that donors would make health aid more effective by harmonising and aligning with national priorities, plans and processes. They would also increasingly use country systems (such as local health procurement methods and public financial management), improving health monitoring and information systems (HMIS) and using national indicators – all aimed at establishing stronger national ownership.[42]

Efforts to implement and institutionalise these principles are currently underway at the global and national levels. The most evident in the health sector is probably **the IHP+**, initiated by the UK government in 2007. It is a voluntary alliance of 52 partners,[43] rather than a formally binding entity. The IHP+ works to develop global and national tools to encourage better alignment and harmonisation among donors.

In 2007, the IHP+ initiated a Global Compact agreement. It was signed by 43 developing and developed countries, as well as by 12 international agencies.[44] The Compact reiterates the aid

BOX 2 HOW DOES THE IHP+ DIFFER FROM A SECTOR WIDE APPROACH (SWAp)?

The IHP+ marks a departure from existing SWAps in the following ways:

- It involves more diverse actors, including wider stakeholders such as civil society organisations and GHIs.
- It explicitly links the national context to global aid effectiveness initiatives to bring about positive reforms in the way aid is channelled. In contrast, SWAps tend to look exclusively at the country situation.
- It uses the Paris definition of mutual accountability. This assesses both donor and recipient performance through mechanisms such as Country Compacts (described below).

effectiveness principles identified in Paris and Accra. It calls for sufficient and effective aid to strengthen health systems, enhancing country ownership and producing measurable results. It also calls for sustainable and fair health financing systems.[45]

Another global initiative is the **Health Systems Funding Platform (HSFP), which stems from the recommendations of the High Level Taskforce on Innovative International Financing for Health Systems in 2009**. It was envisaged to raise funds and pool or harmonise resources from various partners – initially GAVI, the Global Fund and the World Bank – to fill critical funding gaps in national health systems.[46]

AT THE NATIONAL LEVEL

The tools developed by the IHP+ include **Country Compacts and the Joint Assessment of National Strategies (JANS)**.[47] Both offer the opportunity to make aid more effective.[48] Although not legally binding, a Country Compact is a negotiated, national-level agreement between the government, donors and other stakeholders to apply the Paris Principles specifically to the country context.

A JANS is intended both to improve the quality of a country's national health plan and to increase donors, and other development partners' confidence in the plan to the extent that its resources are aligned with national priorities.

Two more recent initiatives seek to advance accountability as a core principle of aid effectiveness. In 2009, the IHP+ contracted **IHP+Results** – an independent consortium of NGOs and academic institutions – to produce annual reports. These reports use an agreed framework of indicators for the health sector, on which countries and donors self-report data on their performance, which is then used by the IHP+Results consortium to produce a scorecard for each participating signatory.

In 2010, the UN Secretary-General launched Every Woman Every Child, a global initiative to save the lives of 16 million women and children by 2015. The initiative was created to drive the implementation of the Global Strategy on Women and Children's Health (the Global Strategy), galvanising momentum and resources to accelerate progress towards MDGs 4 and 5. To date, more than 200 commitments have been made by governments, civil society, the private sector and other stakeholders as a contribution towards the shared objectives of the Global Strategy. These include commitments of additional resources to be invested into MNCH, as well as policy and service delivery commitments which will have significant resource implications.

Although not launched explicitly to reform the delivery of health aid, the strategy did contain some reform components.

A time-bound **Commission on Information and Accountability** was established to develop recommendations for an accountability framework tracking progress towards commitments made, recognising results and identifying bottlenecks. The Commission has mandated an independent Expert Review Group (ERG) to monitor and review progress towards commitments made as part of the Global Strategy. The ERG is also expected to propose ways of addressing aid bottlenecks. Reporting to the UN Secretary-General each year through the WHO Director General, the ERG has the potential to highlight where progress is being made and expose where shortfalls persist in the practice of countries, donors and other development partners. The ERG could thus serve as a powerful watchdog for mutual accountability.

These initiatives[49] have helped to bring about instances of positive change. However, progress has been painfully slow, largely because of insufficient political buy-in given their voluntary nature. Only with a firm commitment from all the donors providing health aid and their partner countries can these mechanisms result in the required improvements identified in Paris in 2005.

4

MAKING HEALTH AID MORE EFFECTIVE: PROGRESS SO FAR

Alongside partner countries' own initiatives, the mechanisms described in chapter 3 have improved many aspects of health aid delivery and management. This chapter outlines progress made on the Paris Principles, highlighting good practice examples that could be replicated across this and other sectors.

1. COUNTRY OWNERSHIP

Country ownership of its own health policies, strategies and plans is critical to improving service delivery and outcomes.[50] National health plans – that are developed in a participatory way with the involvement of civil society, and that are evidence-based – should be the basis for resource allocation.

For example, a clear strategic vision for strengthening Ethiopia's health system – the National Health Extension Programme – has enabled the country 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 GAVI health systems funds have also been used for wider health system strengthening.[51]

Country ownership can be strengthened by donors becoming better aligned with national health plans, and increased use of national systems for channelling aid (see Box 4).

The Paris Declaration commitment requiring donors to use national systems also implies partner country responsibility for strengthening state institutions, improving public financial management (PFM) and increasing transparency. Between 2005 and 2009, countries such as Burkina Faso, Burundi and Mozambique (see Box 6) improved their PFM systems for health funds. In other countries, progress on this has been mixed.[52]

Country Compacts

Country Compacts have provided an opportunity to bring donors and other relevant development partners together to discuss issues relating to health aid effectiveness. To date, eight have been signed and many more are in the pipeline. The process of establishing a Country Compact allows national ownership to be reasserted, prompts dialogue, and provides impetus for negotiating on better alignment and harmonisation. It can also strengthen the relationship between a country's ministry of health (MoH) and other government departments, particularly the ministry of finance (MoF).[53]

Another common government motivation is that a Compact produces a tangible product. Although it is not legally binding, it can still be an important acknowledgement of added value for partners, and particularly the government. Whether the IHP+ is required for Compacts to be established is unclear, but the process it has prompted can be an important one.

BOX 4 BUILDING THE CAPACITY OF LOCAL HEALTH SYSTEMS IN MALAWI

A key aspect of any local health system is the creation and support of a strong health workforce. Malawi has demonstrated how a country's health worker gap can best be filled by developing a national health workforce plan and budget that is then supported by donors. Malawi's Emergency Human Resources Programme (EHRP) increased the health workforce by 53% between 2004 and 2009, saving an estimated 13,000 lives.

The plan consisted of five interventions that addressed the country's long-term health worker needs, while also implementing temporary measures that met immediate needs:

1. Improving incentives through a 50% salary top-up for 11 different types of health worker, along with new recruitment and re-engagement strategies.
2. Expanding training capacity to double the number of nurses and treble the number of doctors who could be trained.
3. Using international volunteer doctors and nurse tutors in the short term while large-scale training was taking place.
4. Strengthening the ministry of health's ability to plan, manage and develop human resources.
5. Developing health-management information systems to monitor and evaluate human resource capacity.

The EHRP was implemented with the financial and technical support of development partners through a sector-wide approach, in which donors provided funding for the core health budget, enabling the government to set its own priorities and implement a single national plan.

The evaluation of the EHRP said that political will, the participation of multiple partners and stakeholders, long-term planning and the balance between different cadres of health worker had all been essential to the success of the programme. The government could not have paid for the entire plan, including the substantial salary top-ups, without donor support.

Source: Management Sciences for Health, 2010

The experience of IHP+ Country Compacts has been highly variable. Some are more detailed than others, and they have different levels of stakeholder engagement. However, the process of establishing a Country Compact has proved particularly useful where other, similar agreements don't already exist, for instance in Chad, Niger and Burkina Faso. A Compact is currently being developed in Sierra Leone, suggesting that Country Compacts may be a useful investment in post-conflict settings. Uganda's new Country Compact has brought in diverse stakeholders, with signatories that include NGOs.

2. HARMONISATION AND ALIGNMENT

On budget aid

Some progress has been made on harmonising and aligning donor aid to the health sector. In the countries surveyed by IHP+Results, the proportion of health aid reportedly given on-budget increased by 27% between 2005 and 2009.[54] The most significant progress was made in Ethiopia and Mozambique (see Box 6). More than 50% of

BOX 5 SUPPORTING COUNTRY OWNERSHIP IN GHANA BY USING PFM SYSTEMS

Ghana has shown strong leadership on reforming its PFM and procurement mechanisms, with very positive results for the health sector. The introduction of a Procurement Act in 2003 prompted a wave of reforms. Its national systems for planning, monitoring and evaluation, annual assessments of procurement and training have also improved.[55]

In 2008, 70% of Ghana's donors reported using the national public financial system, and 60% said that they used Ministry of Health procurement systems for disbursing health aid. A reported 50% of total health aid arrives through these systems.[56]

In Ghana, the decentralisation of financial management in the health sector has also resulted in favourable procurement practices and promoted management autonomy.[57] Decentralisation can lead to these kinds of important benefits when sufficient local capacity exists to ensure good, transparent and accountable programmes that address community priorities.

The UK's Department for International Development (DFID) has also noted the positive impact of decentralising heath sector financial management, commenting on top managers' commitment to new reforms and extensive financial training at the local level.[58]

surveyed donors active in these countries' health sectors met the target of halving the number of aid flows not reported on government budgets, with at least 85% of aid reported on budget.[59]

There has been an increase in aid provided through programme-based approaches: 11 of the 15 donors surveyed by the OECD reported having already met the target of delivering 66% of health aid using this approach. Some had exceeded this target.[60] According to the OECD, "in the health sector, programme-based approaches have made an important contribution to strengthening country ownership through country leadership of the development agenda, the health reform processes and management of aid relationships".[61]

One programme-based approach is budget support, either general or sector-specific.[62] A joint Oxfam and European Commission (EC) report showed that general budget support can have a very beneficial effect on the amount of social spending.[63] Similarly, an Overseas Development Institute (ODI) study of ten sectors across five African countries demonstrated that using sector budget support led to:

- more support for expanding service delivery
- improved planning, budgeting and financial management
- more predictable aid flows
- improved policy implementation with strengthened government accountability and policy ownership.[64]

Sector budget support has helped governments to introduce basic services that are free at the point of use, including for primary education in Rwanda, Uganda and Mali, and basic healthcare in Zambia. These policy decisions have resulted in increased demand for, and uptake of, these services. Questions about the quality of services and equal access, however, still remain.[65]

Effective budget support has to be sensitively implemented according to the particular local context. It is also often used alongside a range of

other aid modalities necessary to ensure service access for those who are hardest to reach. Donors also need to work with partner country governments to improve budget expenditure monitoring and evaluation. Collecting better data – disaggregated by gender, age and other criteria to reveal inequities, and including child-sensitive performance indicators – is critical to maximising the impact of budget support on children's wellbeing.

Use of country systems

Donors' use of partner countries' systems has also improved. IHP+Results found that, for five countries with sufficiently strong systems, 63% of total health funding from 15 donors used country PFM systems in 2009, which is an increase of 18% over the baseline year. This suggests that country action to strengthen systems can lead to reciprocal action from donors. By contrast, the Global Partnership for

BOX 6 MOZAMBIQUE – "A PIONEER"

Mozambique has been "a pioneer in the establishment of coordination mechanisms between government and donors", according to an independent 2008 evaluation on behalf of the European Network on Debt and Development (EURODAD), the Catholic Overseas Development Agency (CAFOD) and Trócaire. It had also "achieved impressive advances in the implementation of the Paris Declaration on Aid Effectiveness in a relatively short time, above all in aspects of harmonization, alignment and predictability of aid".[66]

Aid accounts for a significant share of Mozambique's national health budget, mounting to 44% in 2010.[67] Health sector aid comes from 26 different active donors.

To reduce the administrative burden of dealing with so many donor partners, the government and donors have established a number of different co-ordination and monitoring mechanisms. For example, a group of 19 donors in Mozambique, known as the G-19, have now committed to supporting the government's poverty reduction strategy. In 2003–2004, a Memorandum of Understanding (MoU) for Programme Aid was signed by 13 bilaterals, the EC and the World Bank, together known as Programme Aid Partners (PAPs).

Donor activities in the health sector are also monitored via the SWAp, launched in 2000. This co-ordinates activities according to the health sector strategic plan (PESS); a code of conduct; a sector financing framework (MTEF); joint annual reviews and biannual meetings of the Sector Co-ordination Committee (CCS).

Mozambique was one of the first countries to establish an IHP+ Country Compact in 2008. The Compact has been praised for recognising the synergy between the national health sector strategy, led by the MoH, and the national multi-sectoral response to HIV/AIDS, co-ordinated by the National AIDS Council (CNCS). It has also strengthened alignment between donors and government on the national health and HIV/AIDS response.

IHP+ also offers health aid donors the opportunity to co-ordinate with their SWAp partners within the broader, more flexible framework of the IHP+ Country Compact. For example, despite not being signatories to the Compact, by annexing a letter of support, USAID, the civil society network NAIMA, GAVI and the Global Fund were able to commit to a set of actions aimed at making health aid more effective. Finally, the IHP's validation of national documents has also attracted new resources, for example for the Human Resources strategy.[68]

Education, formerly the Education for All Fast Track Initiative, found that only 29% of aid in the education sector used PFM systems, and that 37% used country procurement systems in the countries surveyed.[69]

JANS

An assessment of the JANS depends on how its main objectives are defined. Like Country Compacts, the JANS has been used in various ways and with multiple objectives. Both governments and stakeholders see it as a very effective tool. Countries that have used the JANS have reported increased ownership as a result.[70] The tool has helped to facilitate a structured and participatory process for the development of national health plans. Having a single review process with multi-stakeholder participation reduces transaction costs.[71] It also allows stakeholders to examine whether or not the government's priorities reflect its people's true health needs.[72]

Another strength is that the JANS is both independent and joint – often facilitated by a consultant, but collectively undertaken. Wider stakeholder engagement has varied. There is often a perceived trade-off between how inclusive or streamlined the process is. However, some argue that the IHP+, and in some countries also the JANS itself,[73] have systematically made civil society party to official discussions that it could rarely access before. And despite the additional time, partnerships with civil society lead to a range of mutually reinforcing benefits that contribute to longer-term, sustainable programmes that are truly responsive to local needs.

In theory, the JANS could be an effective way to increase donor co-ordination and alignment: being part of developing the plan could make it harder for a donor to justify not supporting it. Yet, as a mechanism to promote donor resource allocation on the basis of funding gaps in the implementation of the national health plan, there is little evidence. One positive example comes from Nepal's recent Joint Financing Agreement (JFA) (see Box 7).

BOX 7 A WIDER FUNDING AGREEMENT IN NEPAL

In August 2010 the government and several donors signed a JFA to align their resources with the Nepal Health Sector Programme II (NHSP II).[74]

Plans for Nepal's pooled partners to pursue a joint appraisal already existed,[75] but the JFA's inclusion of non-pooled donors[76] marks a significant departure from traditional SWAps. The opportunity was seized to use the JANS to influence a wider JFA, and the World Bank brought in a financial management expert to facilitate the process. According to key informants, this process increased non-pooled partners' confidence in the NHSP II, encouraging a wider pool of donors to participate in the JFA. The US government decided to sign on to the JFA as a non-pooled partner, despite not being a signatory to the Nepalese IHP+ Country Compact or to the wider IHP+ Global Compact.

The JFA specifies how funding will be allocated to fill existing gaps in the NHSP II. It also provides a consultation framework for all signatories to collectively oversee, monitor and review the national health plan implementation.[77] The JFA in itself encourages donor harmonisation and alignment, and also mutual accountability. This has prospects for a more structured and genuine joint review, which could also lead to better performance monitoring. **Seizing the opportunity to apply a more systematic and participatory tool has thus led to tangible progress on aid effectiveness in the health sector in Nepal: quoting a key informant, these are "the beginnings of a virtuous cycle".**

Pooled technical assistance funds

Technical Assistance (TA) is an important ODA component for health, estimated at 42% of total health aid between 2002 and 2006.[78] It is essential that TA is of good quality, appropriate to the country's needs and aligned behind national priorities. In practice, TA quality varies and its focus is often determined by donors or tied to specific grants. To date, the IHP+ Country Compacts and the JANS have not addressed how to prioritise, co-ordinate or manage TA.

Some efforts have, however, been made to establish a joint agreement around technical co-operation, for example, in Nepal. In 2009, the Ethiopian Federal Ministry of Health (FMoH) developed TA guidelines for the health sector. It established a pooled TA fund that is housed within UNICEF and managed by an existing joint governance committee.[79] The FMoH identify this as a very useful way to strengthen technical staff capacity in the ministry. It has also supported national and district-level planning exercises and funding experience-sharing visits. In 2009–2010, this pool was supported by four bilateral donors and amounted to approximately $1.75 million.[80] One donor representative stated that the pooled TA fund is "very small but very effective, with clear added value".

3. MUTUAL ACCOUNTABILITY

Mutual accountability is essential to achieving effective aid delivery. The evidence demonstrates that ODA functions more effectively[81] and progress on implementation of the Paris Principles[82] is achieved where mutual accountability mechanisms exist.

The Paris Declaration includes a mutual accountability progress indicator, ie, "the number of partner countries that undertake mutual assessments of progress in implementing agreed commitments on aid effectiveness". The 2011 Paris Declaration Evaluation concluded that progress towards this objective has been slow. There is still a lack of clarity around what a mutual assessment entails, and further guidance on this should be developed.

Nevertheless, considerable strides have been made towards improving accountability mechanisms across some aspects of the health aid sector, for example through creating IHP+Results and the UN Commission on Information and Accountability for Maternal, Newborn and Child Health.

The independent Expert Review Group (ERG), mandated by the UN Commission on Information and Accountability is composed of seven well-respected individuals with strong technical experience in different areas of women's and children's health. The fact that the group is more technical than political, and now reports through the WHO rather than directly to the Secretary-General as was originally intended, has raised concerns about the extent to which the ERG's recommendations will be acted upon and whether it will have the political clout needed to hold stakeholders to account for their commitments.

The Global Strategy has reasserted the importance of monitoring progress. The emphasis on quality information systems seeks to strengthen monitoring and evaluation more holistically that the Strategy's focus on women and children, and to mobilise resources to support this. This would complement initiatives currently underway through the IHP+.

Many countries have implemented mechanisms to advance mutual accountability, such as aid flow databases and joint performance assessments. IHP+Results found that seven of the ten countries surveyed had a "mutual assessment of progress" in place, and two others reported plans to develop one.

The government of Rwanda, for example, has been noted for its strong leadership to encourage donor co-ordination and compliance with effective aid delivery practices in health.[83] A recent Mid-term Review of the Health Sector Strategic Plan was conducted in conjunction with a Joint Annual Review. It found that the Common Performance Assessment Framework has contributed to improved mutual accountability between the Ministry of Health and donors who provide pooled health funding.[84] Technical Working Groups are also used by the MoH, donors and other development

partners to collectively review performance.[85] Mozambique has also been successful in efforts to hold donors to account (see Box 8).

Mutual accountability also involves citizens having a stake in how aid is spent, how it is delivered and to whom. Unfortunately, the Paris Declaration only captures progress at the national level. It is therefore difficult to ascertain efforts to strengthen citizens' ability to hold their national and local governments and service providers to account. Similarly, little has been done to promote or monitor citizens' capacity to hold donors and NGOs to account. There are, however, a few promising approaches, for example DFID's support for the PATHS2 project since 2006 (see Box 9).

Nigeria also offers an example of how parliament can initiate accountability mechanisms to monitor aid effectiveness. A parliamentary stakeholder dialogue was held in Abuja in May 2011. Participants, including civil society representatives, reviewed ongoing aid effectiveness initiatives, such as efforts to monitor the implementation of the Paris Declaration by the National Planning Commission and the OECD, as well as the recent IHP+Results report on mutual accountability in Nigeria.[86]

The dialogue highlighted a variety of problems, such as too many institutions being responsible for aid negotiation and management, and the absence of an effective external partner co-ordination mechanism.[87]

BOX 8 MOZAMBIQUE: HOLDING DONORS TO ACCOUNT

Nineteen donors are committed to supporting Mozambique's poverty reduction strategy through an MoU, which includes a common **Performance Assessment Framework** (PAF). It outlines government priorities and sets targets – often in line with the Paris Principles – for both the government and donors. A joint review team assesses their performance yearly through a Partners' Performance Assessment. This provides the basis for donors' financial disbursements, which are determined within four weeks following the review.[88]

This assessment has been credited with improving donors' fulfilment of their commitments. With each donor's performance made public, peer pressure encourages donors to honour their pledges.[89]

The government of Mozambique has also set up an external assistance database, **ODAMOZ**. It was first developed to meet the government's need for more consistent, timely information on aid flows and to reduce data requests made to donors. Initially EC-led, by 2006 ODAMOZ includes all donors providing general budget support, USAID, Japan and the UN agencies. The database has delivered clear benefits in terms of donor co-ordination, transparency and information-sharing. It has been identified as a model of good practice and has reportedly also strengthened key domestic accountability documents.[90]

ODAMOZ suffers from several problems, namely inconsistent and incorrect data entry, and the fact that it is not yet linked to the government's new electronic state financial administration system, E-SISTAFE. These issues need to be addressed with the new version of ODAMOZ, set to be launched shortly.

BOX 9 PARTNERSHIP FOR TRANSFORMING HEALTH SYSTEMS PHASE II (PATHS2)

PATHS2 is a six-year national programme for strengthening health systems in Nigeria. It also aims to encourage greater government accountability by better involving citizens in planning, delivering and monitoring health services.

Facility and Ward Health Committees have been set up to involve the community in decision-making, increase access to health services and mobilise community action. Tools have been developed to enable committees to monitor drug supplies and drug revolving fund[91] accounts, consult effectively with communities, monitor health staff performance, support community mobilisation, and advocate on key health issues.

The work has reportedly already encouraged the committees to improve local services themselves, for instance by raising funds for better security to enable a nurse to stay overnight at a local health centre, and building latrines at the health centre. The committees have also reported inadequate staff performance to local government, resulting in staff being moved (though seldom dismissed or reprimanded).

In Jigawa State both Facility Health Committees have mobilised their communities to undertake tasks such as donating blood for patients; providing labour to help build pit latrines and dig channels for water pipes; staffing a new maternity ward service; donating money to help buy drugs if they run out; repairing doors and windows; cleaning the primary healthcare centres; and tackling flooding around these centres during the rainy season. In one town, the committee was able to persuade the existing health workers to work for longer and to provide more hours of service to the community.[92]

Charles Udeze from Ugwuto village, Nsude, Nigeria, said: *"Before we don't go to the health centre, but now so many things have changed. Three days ago, my wife went there and when she came back, she told me that the place is now equipped and women can go there for ante-natal and child delivery."*

Agnes Udeani, Assistant Officer in Charge at Nsude Health Centre, said: *"We admit and attend to patients even at nights because the security men are steadily available so we are no longer afraid."* [93]

4. TRANSPARENCY

Good financial management and transparency are essential to managing aid effectively. Transparent donor contributions help countries understand how the sector is being financed. This also reduces fragmentation and can lessen transaction costs, as more complete information improves national planning.[94]

Improved aid transparency has benefits across all sectors, and effectively communicated aid data can be an excellent accountability tool.

"WE MUST BE OPEN, TRANSPARENT AND ACCOUNTABLE IN HOW WE ARE SPENDING OUR TAXPAYERS' MONEY ... IN SO DOING, WE WILL HELP INDIVIDUALS UNDERSTAND THE RESULTS BEING ACHIEVED, PROVIDE DEVELOPING COUNTRIES A STRONGER VOICE, AND ENCOURAGE OTHER DONORS TO FOLLOW OUR LEAD."

President Barack Obama, 25 May 2011

Several initiatives have aimed to make international aid flows more transparent and to co-ordinate them at the national level. Globally, the UK, Sweden and the USA have led the way through the Independent Aid Transparency Initiative (IATI) and USAID's Foreign Assistance Dashboard.

IATI is a voluntary multi-stakeholder group, including donors, partner countries and civil society organisations (CSOs), that support the IATI Accra Statement.[95] IATI has developed and agreed a common, international standard that sets guidelines for publishing information about aid spending. The IATI standard builds on – and goes beyond – already agreed standards and definitions. It encourages donors to report on their aid volumes and their country and sectoral allocations, as well as the results of their development expenditure. The UK was the first donor to publish its aid figures according to the IATI standard, from 31 January 2011. A number of other donors have committed to following suit.[96]

The Foreign Assistance Dashboard[97] was created in response to the Paris Declaration principles and President Obama's Open Government Initiative. It aims to enable a wide variety of stakeholders – including US citizens and government agencies, CSOs, Congress, donors and partner country governments – to examine, research and track foreign assistance investments. The Dashboard currently reports on request and appropriations data for the Department of State and USAID since fiscal year 2006. Although the Dashboard is still in its early stages of development future versions will reportedly incorporate budget, financial, programme and performance data in a standard form from all US government agencies that are receiving or implementing foreign assistance, humanitarian and/or development funds. All funds are disaggregated by sector. Within the health data there are sub-categories for specific diseases, maternal and child health, family planning and reproductive health, water, sanitation and nutrition.

Partner countries have also started to implement transparency initiatives, for instance Mozambique's external assistance database, ODAMOZ (see Box 8 above). The Kenyan government has implemented the Kenya Open Data Initiative (KODI). The KODI website holds more than 160 datasets organised under six subheadings: education, energy, health, population, poverty, and water and sanitation. Users can explore data at the country level, and also by county or constituency. KODI is an important step forward. It will allow citizens to monitor Kenya's public resource allocation, which is particularly important in the light of Kenya's history of corruption.[98]

"TRANSPARENCY CAN BE PAINFUL, SINCE THE WORLD RARELY REWARDS BAD NEWS. BUT AS A DOCTOR I KNOW VERY WELL THAT WHAT HURTS BADLY AT FIRST WILL MAKE YOU STRONGER. IN OUR CASE, IT WILL SAVE LIVES."

Source: Michel D. Kazatchkine, Executive Director of the Global Fund to Fight Aids, Tuberculosis and Malaria (2011) 'Transparency Saves Lives', *The Huffington Post*, 6 June 2011.

5. MANAGING FOR DEVELOPMENT RESULTS

Managing for development results[99] is the most fundamental principle of effective aid. It focuses on aid achieving development outcomes, as opposed to just improving delivery processes.

The 2011 Paris Evaluation found some significant progress in development results since 2000–2005, notably in health. The Evaluation concluded that aid had contributed to the achievement of these results in many cases. In some cases this contribution was substantial.[100] In Bangladesh, Malawi and Vietnam, aid delivered according to aid effectiveness principles has reportedly improved the visibility of the poorest and most excluded people's needs. Also in Malawi, implementation of the Paris Principles has been credited with strengthening aid relations and increasing resources to certain sectors, and with those resources being associated with improved health outcomes: "Poverty data, infant mortality, education etc. all show improvement." [101]

Managing for development results is often assessed by looking at the result-focus of a sectoral development strategy; where results-based strategies have been employed there are often improvements in service delivery. For example in Malawi, the Global Fund reallocated $40 million of a programme budget to improve human resources for grant management following an assessment that revealed weak performance. That year, a 32% decline in HIV prevalence among pregnant women aged 15–19 was reported. Of course, this cannot be fully attributed to the Global Fund, but adjusting the allocation of resources is likely to have contributed to the impact achieved.[102]

BOX 10 DELIVERING DEVELOPMENT RESULTS IN SRI LANKA

Sri Lanka's MoH has developed a Results Based Performance Evaluation Framework (RBPEF), which monitors aid outputs and outcomes at the national, provincial and district levels. A situational analysis was carried out to ensure that all involved had capacity to generate timely and accurate information.

According to the Asia-Pacific Community of Practice on Managing for Development Results, the RBPEF has had a positive impact on health managers' performance. They began to link planning and budgeting better, and to achieve targeted results. Training workshops in results-based management helped District Planning Units to work in line with the Health Sector Master Plan. The MoH carries out web-based monitoring every quarter for projects of more than 50 million rupees. The monitoring and evaluation has brought new insights and solutions to problems encountered by the implementing teams. Sri Lanka's Health Master Plan identifies results-based monitoring as key to the successful implementation of the plan.[103]

BOX 11 THE UNITED STATES GLOBAL HEALTH INITIATIVE

As highlighted above (see Chapter 2) the US Global Health Initiative (US GHI) seeks to increase the effectiveness of US global health programmes. It acts as a framework for co-ordinating individual sector programmes, creating "a more integrated approach to fighting disease, improving health and strengthening health programs".[104] The initiative includes targets tied to the MDGs, including reducing under-five child mortality by 35% and maternal mortality by 30% across assisted countries, reducing under-five malnutrition by 30%, and preventing 12 million new HIV infections by 2013.

Many of the US GHI's core principles mirror the Paris Principles and the Accra Agenda for Action. They are also tied to the first ever US Presidential Policy Directive on Global Development and Quadrennial Diplomacy and Development Review.[105] A commitment to country ownership and strengthening health systems through support for health plans developed by national governments with civil society is a core element in the US GHI strategy.[106] Equally critical is the US GHI's push towards increased strategic co-ordination and integrated health service delivery across the board. It also has a strategic commitment to using "country-owned health delivery platforms [as] the basis for providing comprehensive services".[107]

Anecdotal results reported early in GHI implementation indicate that through more flexible, integrated and co-ordinated health programmes, US aid is now reaching more people with holistic health services, contributing to better health outcomes and more effective foreign assistance overall. According to USAID Administrator Dr. Rajiv Shah, the US government has successfully worked with PEPFAR to increase links between HIV/AIDS treatment and MNCH programmes in Kenya from just two to all eight of the country's districts, with no increased cost.[108] Recent research also revealed a dramatic uptake in health services when maternal health and HIV/AIDS programs were provided in one clinic.[109] US GHI has enabled the US government to begin to successfully integrate programmes that were previously implemented in silos.

Early results are reaching beyond PEPFAR clinics. Administrator Shah also cites an example from Mali, where the US government has integrated five separate annual health campaigns into one streamlined programme. This has increased vitamin A supplement-provision and treatment of neglected tropical diseases while cutting delivery costs by half.[110] Such investments by the US GHI are strengthening health systems and expanding cost-effective service delivery.

PERSISTENT CHALLENGES

Despite all global and national efforts to implement effective aid principles, many of the traditional issues that have characterised health aid prevail. Slow progress in one area can slow down reforms in another. For example, country ownership is more easily realised if donors first align their funding behind national priorities developed in partnership with civil society.

This section highlights six major and persistent barriers to delivering effective health aid. All of these need urgent consideration at the HLF4 and beyond.

1. SLOW PROGRESS ON HARMONISATION AND ALIGNMENT

The multiplicity of actors in the global health aid sector has made limited progress towards better co-ordination and harmonisation. Dialogue has increased, and tools and guidelines have been developed to facilitate more inclusive national planning processes. However, progress in strengthening and using national systems to manage donor resources has been mixed.[111] A substantial share of health funding remains project-based. Between 2003 and 2008 more than 90% of MNCH aid was project-based.[112]

Currently 30 developing countries and 13 donor countries are signatories to the IHP+. Several major health donors remain outside the global agreement, notably the USA and Japan.[113] As long as these key actors remain outside, any global agreement will have limited impact. Action for Global Health has already highlighted the effect of this lack of consensus, rating the IHP+ performance as weak because the limited number of signatories hampers the influence of Country Compacts.[114]

There are various reasons why donors have been slow to progress on harmonisation and alignment. One of these is the political pressure to demonstrate impact. Pooling resources makes it very difficult to attribute outcomes to specific donor inputs. A partial contribution can be a less powerful message than one of attribution. For political or other reasons, donors often have particular priorities or agendas that they are reluctant to set aside. With specific disease interests, funding opportunities may not be reflective of the national burden of disease and health system's needs.

Another barrier to progress is donors' lack of confidence in the capacity of government systems to absorb funds and use them efficiently and equitably. These fears may be very real and sometimes justified. While a JANS can increase donor confidence in a national health plan, no systematic mechanism exists to verify and strengthen domestic fiduciary systems. Capacity development was a core part of the Accra Agenda for Action, but it has witnessed slow or ad hoc progress since 2008. Evidence on how to build capacity and progress is fragmented and inaccessible. Many approaches have proved overly simplistic, and lessons learned have not been absorbed into national and sector-level policy.[115]

BOX 12 HEALTH AID MODALITIES IN ETHIOPIA

Despite impressive efforts to establish pooled funds in Ethiopia, project aid continues to dominate. ODA to health reflected on the government budget for 2009/10 was as shown in the figure below, with the Global Fund contributing the largest share at 26%.

In the Ethiopian health sector, three pooled funds exist. The MDG Pooled Fund and the TA Pooled Fund are received directly by the FMoH. The Protection of Basic Services (PBS) is a multi-sectoral pool administered by the World Bank and allocated through the Ministry of Finance and Economic Development.

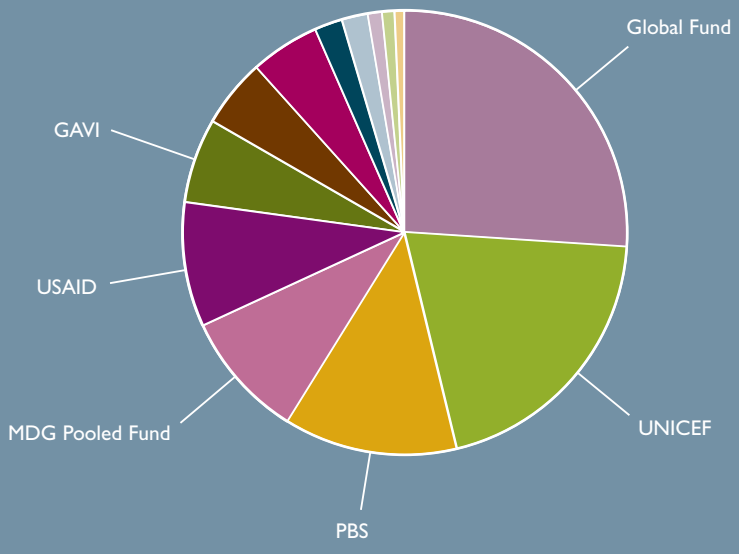
In 2009/10, the PBS received about 13% of health aid. The MDG Pooled Fund got 9% and the TA Pooled Fund 0.5%. Within the MDG Fund, the UK and Spain provide 50% and 40% respectively, with Irish Aid, United Nations Population Fund (UNFPA) and the WHO also contributing. This pooled funding amounted to just over a fifth of total health aid.[116]

The government currently has no systematic way of monitoring Implementing Partners' (IPs) commitments and planned activities at the federal, regional and district levels.

Having signed the IHP+ Country Compact, which specifies the government's preferred funding modalities, and having undertaken a consultative JANS to inform the development of Health Sector Development Plan (HSDP) IV, the FMoH is hoping to see increased donor resource allocation through the MDG Pooled Fund in 2012.

Efforts must be made to increase the share of donor resources that are jointly co-ordinated and reflected in the national budget. A mechanism should also be developed to systematically ensure that IP activities are aligned with the health system's plans and priorities and fill gaps in its implementation, and are negotiated with the relevant authorities within the government's health system.

Source: Interviews conducted in Ethiopia, August 2011



Source: Federal Ministry of Health, *Health Sector Development Programme III: Annual Performance Report 2009/10*, 2010.

BOX 13 A PRAGMATIC APPROACH TO POOLED FUNDING IN ETHIOPIA

In Ethiopia donors have used an innovative approach to increase confidence in pooled funding. In 2006 they set up a PBS fund. This multi-sectoral pooled fund was managed by the World Bank, which had oversight of the procurement processes.

Utilising these funds can be slow because of the World Bank's stringent approach to procurement. Resources are also channelled through the Ministry of Finance and Economic Development, rather than directly through the MoH. Nevertheless, the PBS is a positive compromise, which remains one of the MoH's three preferred funding modalities.

Source: Interviews conducted in Ethiopia, August 2011

GHIs have met additional challenges when trying to harmonise. Their performance-based business model and own reporting systems make it difficult to work collectively.[117] Those without in-country presence have limited participation in existing national joint accountability mechanisms or fora for strategic dialogue on policy and programme implementation. Unless joint proposal application and reporting systems are pursued, the burden on recipient partner governments will remain high.

Countries' use of Country Compacts and JANS has been varied, and these tools' recommendations have been criticised as weak expressions of interest rather than detailed contracts stating commitments to changing behaviour. There is also some concern that the JANS could become too formulaic.

Despite ambitious intentions, the HSFP has been slow to develop. A two-track approach is being pursued to promote World Bank, Global Fund and GAVI harmonisation in-country. This would increase their alignment with national plans, and increase access to funding for health systems. Progress has been limited. The different agencies still have their own processes for applications, reporting mechanisms and schedules for disbursing funds.[118] There is some concern that the Platform hasn't adequately prioritised community system strengthening.[119] It is also unclear how it will relate to a JFA or a JANS. Increased World Bank, Global Fund and GAVI coherence would certainly ease the burden on recipient countries. However, other donors, such as bilateral agencies and private foundations, would also have to engage. HSFP benefits for partner countries are yet to be felt.

2. 'BOOMERANG AID' AND LIMITED USE OF LOCAL PROCUREMENT SYSTEMS[120]

Using a partner country's own procurement systems is a vital way to strengthen national capacity and ownership.[121] While some donors have made full use of country procurement systems for their ODA, it has been sidelined by others, such as the USAID and the African Development Bank.[122]

IHP+ Results' survey found that only 53% of health aid spent on procurement in 2009 used own country systems. This decreased from a 2005–2007 baseline of 60%. Of the 14 donors surveyed, only six had met the recommended target for the proportion of funding that should be channelled through country procurement systems. Forty per cent failed to use country procurement systems between 2005 and 2007.[123]

Donors' reluctance to use national procurement mechanisms can be partly explained by the lack of a consistent methodology for measuring the quality of national procurement systems and therefore a

lack of confidence that money won't be wasted or fall prey to corruption. But it is also explained by some donors preferring to use contractors from their own country so that there is an economic return on their aid investment. Or donors prioritise narrow value for money considerations (such as the lowest price), rather than wider developmental considerations which factor in external benefits such as job creation and capacity development. According to a recent study of all aid flows, the majority of formally untied aid contracts from bilateral agencies go to donor country firms. Two-thirds are awarded to firms from OECD countries, and 60% 'in country', to firms from the donor country that funds a project.[124]

Building on the successes of the US Millennium Challenge Corporation, USAID has embarked on an ambitious reform effort called USAID FORWARD. It includes procurement reform to "strengthen partner country capacity to improve aid effectiveness and sustainability by increasing use of reliable partner country systems and institutions to provide support to partner countries". Previous research on the use of country systems in Ghana shows that US aid agencies are constrained by policies and regulations set at headquarter level. Many vertical funds or multilaterals continue to under-use country systems, in spite of improvements in quality.[125]

As the example from Namibia demonstrates (see Box 14), donors' failure to use national procurement systems may reflect their lack of confidence in PFM systems. Partner countries are responsible for implementing reforms that will build confidence in their national systems. In a recent white paper, PATH highlights the value of a comprehensive approach to procurement capacity development in developing

BOX 14 PROCUREMENT IN NAMIBIA

Namibia's own PFM system is sound, and has passed EC eligibility tests for budget support. Examples such as the procurement of pharmaceutical supplies by the MoH and Social Services have proved the benefits of a centralised national procurement process. Yet approximately 70% of ODA is not disbursed through Namibia's State Revenue Fund. Parallel implementation by foreign aid agencies is widespread, including parallel procurement. Budget support is only given to three sectors: education, roads and rural development.[126]

Part of the reason for poor local procurement levels is the small scale of local production. Namibia lacks pharmaceutical industry capacity. All anti-retroviral drugs, for example, have to be imported. Their purchase is an enormous drain on the country's foreign exchange stock. This puts supply sustainability at risk, particularly since large donors such as PEPFAR and the Global Fund might in future reduce or phase out their assistance, which is currently being contributed in foreign currency.

Pledges from countries such as Brazil to support Namibia in building their own pharmaceutical capacities have so far not materialised. According to one source, Namibian government negotiations for local production capacity building with different pharmaceutical corporations failed because the companies demanded a guaranteed purchase period of five years. The government refused to accept this, since the corporations could not guarantee quality. The Southern African Development Community (SADC) member states are currently working towards pooled production of anti-retroviral drugs in the region.[127]

countries. The paper found that use of national procurement systems involves consideration of the following issues:[128]

- **Technical capacity of procurement personnel**: Key stakeholders and research have identified numerous challenges facing procurement personnel related to technical capacity, including data collection, requirements forecasting, distribution, use of information systems, the ability to meet international bidding requirements, and compliance with World Bank procurement rules and procedures.
- **Human resources retention and management**: Almost all stakeholders highlighted the problem of staff retention. Contributing factors included unclear roles and inadequate support, motivation and remuneration.
- **Institutional infrastructure**: Lack of systems and procedures that provide guidance, clear lines of accountability, and compliance with national and international regulations, was another problem raised by key stakeholders.
- **Legal, policy and regulatory environments**: Legal, policy and regulatory environments are recognised as providing an important foundation for stimulating local procurement, but this is also an area with significant procurement-related capacity development challenges.

3. POOR PREDICTABILITY AND CONDITIONALITY

Unpredictable aid continues to blight the health sector and compromises the value of the aid received. For instance, the UK government was influential in Burundi's decision to remove healthcare user fees, and provided essential support for implementing the policy. However, following the Bilateral Aid Review earlier this year, the UK government decided to end this support in 2012.

High variance in aid flows creates distortions and substantial costs, estimated at up to 15% of the value of total aid flows.[129]

Joint annual reviews can help to improve predictability in some countries, but only a few countries have implemented them. Increased transparency and better reporting on resource flows across the sector, with sufficiently disaggregated indicators, would improve peer accountability, and potentially also predictability. The IATI, the Commission on Information and Accountability and IHP+Results mark strong movement in this direction. However, they also highlight the importance of regular, effective communication in order to avoid duplication and to ensure that transaction costs are minimised.

Conditions also continue to affect the regularity and equity of health aid flows. For example, conditions attached to IMF lending and programmes affect the funding available for recurrent health expenditures. In the past, these conditions have placed restrictions on public sector wage bills, limiting countries' ability to expand the number of public sector employees.

Such conditions can have a significant, if indirect, impact on the governments' ability to address health worker supply shortages and/or to address inadequate wages. In countries such as Zambia, this has undermined IMF and other donors' wider commitments to protecting priority social expenditures. More liberal macro-economic policies are needed to create space for the poorest countries to address chronic health worker needs.[130]

4. MANAGING 'BY' RESULTS

Managing *for* development results is the most fundamental aid effectiveness principle.[131] It ensures that aid is always focused on achieving development outcomes, as opposed to improving processes.

Nevertheless, it remains unclear what is meant by managing *for* results, which is often misinterpreted as managing *by* results. This has resulted in an emphasis on indicators which are easy to measure and generate more rapid returns. In such cases, easier-to-reach populations – low-hanging fruit – may be targeted, which misses the hardest to reach, and can even widen the equity gap.[132]

There also appears to be a lack of clarity about how to apply the principle in practice. Both the 2008 and 2011 Paris Declaration Evaluations found that management for results was often conflated with financing by results.[133] This raises two key problems that are at odds with the aid-effectiveness agenda.

First, results have to be achieved before funds can be released, thereby encouraging short-termism and instantaneous outcomes. This can limit support for important long-term initiatives, such as strengthening health systems and building strong institutions. A key informant concluded that one of the great challenges in the current global health system is the battle of short-term versus long-term results.

Second, results-based financing can also mean that failure to achieve an agreed outcome leads to immediate funding cuts.[134] However, many factors can contribute to a country or project not meeting an agreed target, including structural problems, external circumstances and unpredictable aid flows. A system that makes aid conditional on achieving certain results penalises those countries that face the greatest challenges and lack the capacity to cope.[135]

The emphasis on results has led to a proliferation of monitoring and evaluation indicators. Reporting on indicators takes up considerable time and resources. Although many countries have joint annual health sector reviews, which should include a single results framework, this has not reduced the number of separate, additional donor reviews.[136]

In Uganda, the current emphasis on quantitative health targets has led to burdensome parallel reporting systems. It may have influenced funding to focus on easier areas to monitor, such as patient treatment numbers, rather than prevention.[137] Ethiopia's Health Sector Development Programme (HSDP III) includes 93 indicators, 17 of which are considered core and approximately 35 of which were used for the 2007/08 Annual Review Meeting report. In addition, each *woreda* (an administrative area, of which there are more than 800), has targets for 27 indicators in the HSPD-III annuals core plan for 2008/09 – implying more than 20,000 targets in total. The Ethiopia Country Compact presents 46 indicators. In many cases, there is deliberate and considerable overlap between these indicators, but they still have separate reporting mechanisms. The New Health Management Information System has approximately 105 indicators, 18 of which are related to HIV.[138]

Extra reporting takes time that could otherwise be spent on delivering services. As a result of this demand for results and reporting, high transaction costs can be incurred for both donor country staff and government officials. The OECD has noted the risk that the transactions costs of addressing aid effectiveness principles can outweigh efforts to achieve better health outcomes.[139] In Rwanda, five district health professionals spent five hours every month validating data.[140]

Another challenge is the difficulty of attributing health results and outcomes to effective aid delivery practices. Many contributing factors, both inside and outside the health sector, can affect health outcomes.[141] The OECD and others have therefore suggested that it may be more realistic to look at how effective aid strengthens health systems, and develops health institution capacity and other more sustainable health sector impacts.[142] However, improving child survival and child health targets is another vital part of health aid effectiveness.

"THERE IS A DANGER THAT THE NEW FOCUS ON VALUE FOR MONEY AND MANAGING FOR RESULTS WILL DIVERT ATTENTION FROM THE BROADER COUNTRY CONTEXT OF PROVIDING HEALTH SERVICES FOR ALL – WHICH IS PARTICULARLY IMPORTANT FOR THE MOST MARGINALISED AND STIGMATISED GROUPS IN SOCIETY."

Source: Action for Global Health, *Aid Effectiveness and Health: Towards the 4th High Level Forum, Busan 2011, Making Health Aid Work Better*, 2011, p 24

5. ACCOUNTABILITY TO WHOM?

There has been a lack of clarity about what the principle of mutual accountability means or what is expected on each side.[143] Its complexity stems from the fact that it refers to three different groups – donors, partner countries and their citizens. Each one is expected to be accountable to the others, albeit through different ways and means.

An established accountability mechanism can enable all stakeholders, including citizens, to demand a voice in the aid system. However, according to a key informant the mutual accountability principle is the most politically charged, with little space or incentive available to tackle it. In 2009, ODI reported that no fully developed mutual accountability systems had had any significant transformational impact on the aid relationship at country level.[144]

The very essence of mutual accountability is that all stakeholders have a voice in the country's aid system. However, top-down accountability is apparently considered more valuable than bottom-up accountability.[145] Governments need to feel empowered enough to hold donors to account when they are not abiding by aid effectiveness principles. Donors also need to feel comfortable with a change in dynamics, whereby governments can assess donor performance. However, this remains a challenge for many countries. When the Rwandan government asked donors to assess their efficiency in line with the Paris Declaration, they were reluctant to peer review each other's performance.[146]

Many countries have little space for engaging civil society on aid spending. The Paris Evaluation Survey found that less than a third of the evaluated countries heeded civil society inputs.[147] Key informants reported this as a particular problem in Ethiopia, where CSOs had little or no voice in how health sector aid was managed. This was attributed to the government giving little space to civil society within policy development, and to Ethiopian CSOs not being very well organised. It can also be difficult for CSOs receiving donor funds to genuinely play the role of watchdog. This means domestic accountability remains very weak, both inside and outside the health sector, and often leaves the health budgeting process unchallenged.[148]

Many stakeholders in Ethiopia, interviewed for this report, donors included, raised concern about the lack of transparency and dialogue among implementing partners operating in parallel with the government health system. A MoH official emphasised the need for a mechanism to monitor NGO and implementing partners' activities and budget cycles, in order to strengthen mutual accountability and improve government awareness of health sector spending.

Given the large amount of development funding channelled through international and national NGOs, improving their accountability and transparency is vitally important, not least so that partner country governments are aware of the activities of all actors operating in their country. As NGOs are not signatories of Paris and Accra, they have had to develop their own agreement on how to apply aid effectiveness principle across the NGO sector. The Istanbul CSO Development Effectiveness Principles (2010)[149] and the Siem Reap CSO Consensus on the International Framework for CSO Development Effectiveness (2011)[150] recognise and attempt to kick-start efforts to tackle the challenges of NGO effectiveness.

IHP+ Country Compacts may provide an opportunity to develop an accountability mechanism that creates space for governments to hold donors (bilaterals and multilaterals) and NGOs to account about spending aid, and also an opportunity for citizens to hold the government to account. However, as voluntary agreements with no independent monitoring mechanism, they have been criticised for being very hard to enforce.

Health sector Joint Annual Reviews (JARs) can be an appropriate forum for assessing performance on mutual accountability indicators. Seven of the ten countries that responded to the IHP+Results survey indicated that they have performance assessment frameworks in place. Unfortunately, the IHP+Results

survey didn't capture qualitative information on the added value of such processes. Exactly what a JAR entails in each country may differ: what indicators are tracked, whether they consider aid effectiveness performance, and how this influences policy dialogue. Aid effectiveness indicators on donor performance are often absent from JARs, which removes an opportunity to strengthen mutual accountability. In addition, one key informant contends that the important aspect of JARs is how the information is used and further adds that the challenge remains in getting "the Ministry of Health to use it and to assert confidence in their leadership role". It is important that guidance is developed to bring better clarity to JARs, enabling partner countries to institutionalise a process whereby mutual accountability and results can be pursued.

IHP+Results has attempted to strengthen accountability, but has been criticised for using self-reported data. Key informants have stated that comparing findings between countries is less important than within a country over time, and that resources are needed to support vital interpretation of findings at the country level. The need to support country-level discussions and to institutionalise the process at country level has been highlighted as an important next step in the evolution of accountability within the IHP+, and it is anticipated that steps will be taken to strengthen this aspect in the next round of IHP+Results monitoring in 2012.

The ERG could play a critical role in monitoring donor and government commitments to aid effectiveness principles. However, it is likely to also use voluntary self-reporting. As with IHP+Results, there is concern about potential unwillingness to respond to evaluations, and inconsistency in the quality and methodologies of reports.

Unfortunately, until donors and governments make data more routinely available and transparent, it is unlikely that this limitation will be addressed. In the meantime, it is essential that mechanisms for triangulation are developed. This will be an evolutionary process, and although the methodologies are flawed, the data provides an important basis for real mutual dialogue about how results can be improved.

6. DELIVERING AID IN CONFLICT-AFFECTED AND FRAGILE STATES

There is currently no consensus on how to deliver aid effectively in conflict-affected and fragile states (CAFS). This is a major challenge for the aid effectiveness agenda and for the effective delivery of healthcare worldwide.

In 2008, CAFS represented eight out of ten of the most aid-dependent countries, and 50% of the OECD's bilateral aid programmes.[151] CAFS are home to 1.5 billion people, many of whom are living in insecure and impoverished environments. The recent World Development Report highlighted that not a single MDG is going to be met in fragile states.[152] Addressing the challenge of delivering effective aid in these contexts is therefore vital.

Most of what is empirically known about effective aid and the best ways to finance and deliver healthcare is based on stable, low-income countries. In CAFS, delivery and scaling-up of health services is more difficult than in other low-income settings. This is usually the result of a combination of governance issues, the challenges of operating in insecure environments, and severe human resource and financial constraints. For example, by the end of the war in Liberia, there were fewer than 15 physicians left, and 80% of the health services were provided by non-governmental and faith-based organisations.[153] Similarly, 80% of health services in South Sudan are being provided by non-governmental and faith-based organisations.[154] The world's newest country currently has 100 midwives, an increase on nine since the signing of the Comprehensive Peace Agreement in 2005. And it still has the worst maternal mortality rates in the world.

Aside from the operational challenges of working in CAFS, efforts to develop health systems and provide consistent services are also compromised by a reliance on international aid and extremely volatile funding. According to the 2011 World Development Report, "A country that experienced 20 years of violence experienced twice the volatility in aid of a country that did not experience violence.

Volatility of revenues has considerable costs for all governments, but particularly so in fragile situations where it may derail reform efforts and disrupt institution-building."[155]

The funding provided often also constitutes short-term grants. This can prevent aid workers from gaining local community acceptance and a detailed understanding of local context, thereby undermining the intervention's effectiveness. This short-termism reflects widespread donor risk aversion. Donors are often concerned about the transparency, direction and accountability of longer-term aid in situations of conflict and instability.[156] But short-term funding hinders the development of institutions, including health systems, and of other governance apparatus that would improve aid accountability, creating a 'Catch-22'. Short-term contracts can also have a human cost – health workers leave because they aren't getting paid regularly or enough. This compromises the consistency and quality of the health services provided, as well as civilian's willingness to utilise them, given that accessing healthcare in such contexts is often exceptionally difficult.

Another major hindrance to the effective financing of healthcare and health systems is that fragile states are the prime victims of the well-documented gap between emergency and development funding.[157] Donors have a poor track record of sequencing aid to transition from humanitarian relief to long-term development. A patchwork of humanitarian aid has to be used as the bridging mechanism, when more long-term predictable funding might actually enable systems and institutions to be built and enable the financing of recurrent expenditures such as health worker training and salaries. Poorly sequenced aid can result in gains reached during the immediate post-conflict/emergency period being lost until longer-term development funding comes on line.

The Principles for Good International Engagement in Fragile States were set out in 2007, and in 2008 donors convening at Accra for the Third High Level Forum on Aid Effectiveness discussed these challenges at length. But there was little consensus on how best to remedy these problems. There has been slow but steady progess since. Fragile state actors have been involved in an International Dialogue in Statebuilding and Peacebuilding. In the run-up to Busan (The Fourth High Level Forum on Aid Effectiveness) (HLF4), the g7+ (a grouping of fragile states) has put forward a New Deal on International Engagement in Fragile States. This represents a promising opportunity for identifying a concrete process to address some of the challenges of delivering aid in fragile states, as long as donors, states and the populations the aid is supposed to reach are involved in a three-way dialogue, and provided that agreements at international conferences turn into action on the ground. How donor and recipient countries – as well as civilians – hold each other accountable for abiding by this New Deal, and what the recourse would be if there were lapses in compliance, remains to be worked out.

In addition, both the New Deal and the draft outcome documents of Busan miss humanitarian voices. Humanitarian voices were notably absent from the recent Global Assembly of the Open Forum (OF) for CSO Development Effectiveness in Cambodia – an important milestone on the road to Busan in November 2011.[158] Given the predominance of humanitarian funding in fragile states, it is essential that both humanitarian actors and development aid providers are around the same table, to ensure equal support for a long-term solution to delivering aid more responsively in these contexts.

6

CONCLUSIONS AND KEY RECOMMENDATIONS

There is increasingly strong and widespread rhetorical commitment to aid effectiveness principles. In practice, some progress has also been made: for instance, tools now exist to facilitate participatory strengthening of national plans, there have been efforts to improve PFM and promote transparency in some countries, and programme-based approaches have now increased national ownership.

But this progress remains ad hoc and contingent on political will rather than binding obligations. Within the health sector, progress is evident and there are a number of innovative mechanisms which should be extended and replicated across other sectors. It is one of the largest and most complex sectors, however, and many of the traditional characteristics outlined in chapter 2 still apply. Health aid architecture remains complex and fragmented, globally and nationally. The multiplicity of actors, dominance of project aid, scarcity of effective donor harmonisation mechanisms, poor alignment and limited use of national systems, as well as insufficient national capacity, have all undermined national ownership.

The quantity of health aid is also under threat in the current economic climate of fiscal austerity. The prevailing focus on short-term results threatens to diminish the quality of existing health aid. Seeking easily measurable and attributable investments, many donors are pursuing short-term outputs at the expense of supporting long-term health system strengthening which would yield wider, more integrated and sustainable outcomes.

The speed and scale of aid effectiveness reforms have been hindered by inadequate political buy-in. Only with a firm and genuine commitment from all health donors, other development actors and partner countries can new mechanisms result in the improvements identified in Paris in 2005. Busan must match commitments with measurable targets.

Moreover, many of the successes to date relate to establishing processes rather than achieving tangible results. Process is important, but the key challenge for Busan will be institutionalising processes to deliver results. A step change in donor behaviour is required to realise a genuine partnership model, whereby aid is disbursed on the basis of a country's determination of its own national needs. As the Paris Monitoring Survey makes plain, this has not yet happened.[159]

Save the Children recommends reform in six key areas in order to make health aid more effective:

1) Strengthening harmonisation and alignment for country ownership

Country ownership is at the heart of aid effectiveness. Weak donor co-ordination continues to be problematic for partner countries trying to manage health sector development, not least because so much aid is still provided off-budget.

At Busan:

- The Outcome Document must state the importance of greater commitment to country ownership, specifically of national health and nutrition strategies.
- Gaps identified through a JANS should be filled by donors (both DAC donors and new donors), using the government's preferred modalities where feasible.

- Donor assistance should be reflected in national budgets instead of being 'off-budget', and should be aligned with national priority health and nutrition needs. This can help strengthen national health systems and financial leadership capacity. Greater use of programme-based approaches can help to increase ownership and reduce transaction costs.
- Donors, other development partners and partner countries must commit to more transparent resource flows and project management, with a measurable set target.
- All donors must reaffirm their commitment to strengthening and using local procurement mechanisms, matched with a measurable target.

Beyond Busan:

- Support for the IHP+ should be reaffirmed with a clear mandate defined for 2012–15. Partner countries and development agencies should be encouraged to sign the Global Compact, and to actively engage in IHP+ processes at the national level.
- Partner governments must undertake sufficient reforms to widen confidence in national financial systems with capacity-building support from donors, especially where budget support is denied or insignificant.
- The HSFP must accelerate progress on harmonising financial management across the three core agencies (the Global Fund, GAVI and the World Bank), with wider participation at the country level.

2) Supporting local capacity building

Local civil society organisations play an important role in ensuring development programmes yield sustainable results for people living in poverty. Involving local stakeholders will address local needs and priorities and target critical resources. When people are engaged in the decisions that most affect them they develop a stake in a programme's success or failure. This creates incentives for long-term community investment, as well as mutual accountability between donors and partners. To facilitate this path toward sustainability, donors and partner governments must commit to building the capacity of local civil society organisations and communities to develop, design and implement their own programmes.

At Busan:

- The Outcome Document must recognise the added value of civil society organisations as partners in poverty reduction efforts. It should include a commitment to building the capacity of local institutions.
- All donors should commit to distributing aid in ways that strengthen local organisations.

Beyond Busan:

- Guidance should be created for partner and donor governments directing engagement with local and international civil society organisations, both during policy development and at all stages of the project cycle.
- This guidance should identify clear metrics to track progress and improve long-term capacity-building efforts for greater sustainability.

3) Managing *for* results

Using results indicators to assess the impact of aid and aid effectiveness reforms on health outcomes is clearly important. However, it is also essential that aid is not provided according to narrowly defined results criteria, for example purely quantitative and/or output-based indicators. All development actors and partner countries should align with globally agreed indicators (such as those recommended by the Commission on Information and Accountability for Women's and Children's Health) and improve the quality of data collection to track progress and results.

At Busan:

- The distinction between managing for results and managing (or financing) by results should be articulated in the Outcome Document.
- All donors must agree to value shared results instead of a narrow focus on results associated with individual donor funding streams.
- Donors should align their transparency efforts by signing up to the IATI and its common data and reporting standard.

Beyond Busan:

- International NGOs should take steps to improve transparency, including dialogue with stakeholders about subscribing to the relevant provisions of IATI.
- Within the health sector, discrepancies in global monitoring efforts should be reviewed and debated at the World Health Assembly, so as to reduce the burden on partner countries. All efforts to monitor aid flows should adhere to the common standard set by IATI, with sector-specific standardisation of the indicators used by the IERG and IHP+Results, as well as others.

4) Institutionalising mutual accountability mechanisms

Transparency is key to ensuring mutual accountability, but there are other ways to strengthen accountability and to ensure that free data exchange actually results in progress. Most importantly, partner countries should create an environment conducive to this, for example, by guaranteeing freedom of association. Civil society should also be consulted on national and local health planning and budgeting, and supported by donors and international NGOs to become local accountability watchdogs. Support for local, independent media is also essential.

At Busan:

- The Outcome Document should strengthen peer accountability mechanisms, for instance using the Paris Monitoring Survey and IATI data to produce an annual 'name and shame' report on aid flows and aid effectiveness.
- Donors and partner countries should make a measurable commitment to promoting and institutionalising national mutual accountability mechanisms.

Beyond Busan:

- Within the health sector, continued and increased support should be given to IHP+Results to produce and improve annual performance reviews. More IHP+ signatories should be encouraged to participate.
- Both donors and partner governments should ensure that there is dialogue on the basis of the results at country level.
- Donors should strengthen the capacity of civil society to serve as effective watchdogs holding government and donors to account.

5) Addressing aid effectiveness in CAFS

The voices of people from CAFS and humanitarian agencies have been largely absent from aid effectiveness discussions. Operating in two parallel universes is not in partner countries' interest, nor is it likely to increase policy and operational coherence between humanitarian and development aid. To improve effectiveness in fragile states, particularly in delivering health aid, the HLF4 must set out a clear framework of activities to advance effective aid in CAFS. Commissioning a task team to harmonise Sphere and Red Cross standards with aid effectiveness principles and develop corresponding accountability indicators will be particularly important.

At Busan:

- Donors and partner countries should support the g7+ proposal for a New Deal on International Engagement in Fragile States. The New Deal proposal should be accompanied by clear guidance on how donor and recipient countries – as well as citizens – will hold each other to account for abiding by this agreement.

Beyond Busan:

- Develop detailed country plans on how to apply the New Deal to different CAFS contexts.
- Agree on a better medium-term funding arrangement to bridge the humanitarian and development funding gap and finance recurrent expenditures (including health worker salaries) and health systems sustainably.

6) Filling the funding gap

It is vital that the quantity of health aid and other sources of finance to the health sector continues to increase. There is an estimated average shortfall of $17.5 billion per year just in the funding required to achieve the health-related MDGs in 49 low-income countries.

The building blocks of the health system are interdependent. For instance, the potential impact of having a health worker in every health centre is undermined if only a few patients can reach it. Similarly, a health worker's ability to provide essential care is reduced if drugs and supplies are unavailable. The WHO has recommended allocating a minimum amount of more than $60 per person by 2015 to provide a basic package of health services.[160] Until this minimal funding can be invested to strengthen the whole system and achieve universal coverage, the effectiveness of both government and donor resources for health will be undermined.

Beyond Busan:

- All donors should commit to allocate 0.7% of GNI in ODA, where possible by 2015, and increase the share spent on health.
- Partner countries must meet the Abuja commitment to allocate 15% of government budgets to health and ensure that the WHO-recommended minimum expenditure of $60 per capita is met by 2015.
- Donors and partner countries should pursue the recommendations of the High Level Taskforce on Innovative International Financing for Health Systems to establish progressive innovative sources of funding to supplement government and donor allocations.

JAMES OATWAY/PANOS

ANNEX 1: KEY INFORMANTS

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[42] The five Paris Principles are: national ownership of recipient governments' own strategies and development processes; the alignment of donors with such strategies and local systems; the simplification of procedures and evasion of duplication through harmonisation of donor activities; a focus on results and systems by which these can be measured; and the mutual accountability of both donors and governments for the achievement of development results. The Accra Agenda asserted the predictability of aid, the need for donors to use national systems, and a move away from donor-set conditionalities inconsistent with national priorities as well as the untying of aid.

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HEALTHIER RETURNS

MAKING AID FOR HEALTHCARE MORE EFFECTIVE

The international community has helped to bring about significant improvements in children's health over the past 20 years. Yet 7.6 million children under five died in 2010 – most of them from easily preventable and curable diseases.

Despite pledges to increase health spending, most governments and donors fall short. Another $17.5 billion is needed every year if the world is to meet internationally agreed targets on maternal, newborn and child health by 2015.

More effective use of existing health funding is also vital. But to date donors have been slow to act on their aid-effectiveness promises. Meanwhile the current economic climate of fiscal austerity is creating a focus on short-term results that threatens to damage the quality of health aid.

Healthier Returns provides recommendations on how to address these challenges. It charts the extent to which the five principles of effective aid set out in the 2005 Paris Declaration have been successfully implemented. It outlines attempts at reform, highlights successful global and national initiatives, and identifies persistent problems.

On the eve of a critical forum on aid effectiveness in Busan, South Korea, the report calls on world leaders to seize this chance to deliver urgently needed reform in six key areas – and make aid for healthcare as effective as possible to save more children's lives.

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