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**ACTION FOR
GLOBAL HEALTH**



AID EFFECTIVENESS FOR HEALTH

**TOWARDS THE 4TH HIGH-LEVEL FORUM,
BUSAN 2011: MAKING HEALTH
AID WORK BETTER**

2011



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Thank you for your hard work every day to make aid effectiveness work.

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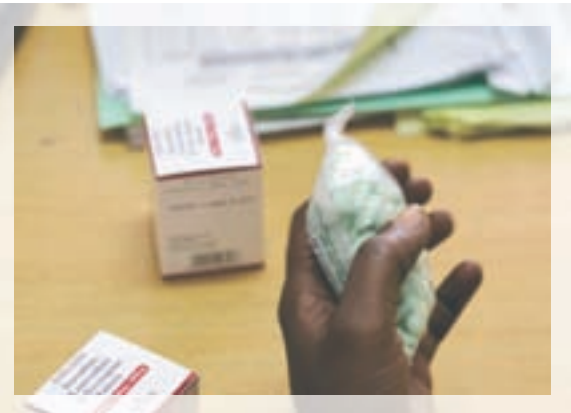
EXECUTIVE SUMMARY

Ensuring that development cooperation is effective has never been more important as the international community seeks to reach the Millennium Development Goals (MDGs) in less than five years' time. Realisation of the universal human right to health is inextricably linked to the effectiveness of aid. In recent years, the European Union (EU) has been committed to reforming its external aid instruments according to the principles established by the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008). However, in contradiction to these efforts towards aid effectiveness, European donors have at the same time allowed funding to health and other key social sectors to decrease significantly. Of the five largest economies in Europe, only the United Kingdom is currently on track to meet aid targets. As a result, total aid for health remains well below the levels that have been calculated as necessary to reach the health MDGs.

Currently, the aid effectiveness agenda is having unintended 'side-effects' for civil society, health outcomes and the MDGs that are decidedly unhealthy, both financially and practically. Three central problems require urgent attention:

Donor coordination and alignment –

These principles have not always been applied in the way that they were originally envisaged, and the impact has not been as strong as it could have been. Existing coordination mechanisms are complex, time-consuming and often process-oriented instead of impact-oriented. Moreover, 'division of labour' arguments have often been used by donors in order to cut Official Development Assistance (ODA) spending in



general and health aid in particular. Following the implementation of the Division of Labour, European Commission (EC) health aid decreased from 4.7% of total EC aid in 2005 to 1.3% in 2008¹.

Ownership - Civil society, including Parliament, is largely excluded from health policy decision-making. Where mechanisms to include non-state actors are in place, governments tend to hand-pick a select group to engage. The principle of ownership is not being defined or operationalised as it was originally intended, to the detriment of health outcomes. European donors are not using their weight adequately to insist on greater involvement of civil society in the formulation of national health policy.

¹ The EU's Contribution to the Millennium Development Goals: Keeping the Goals Alive, Alliance 2015, 2010.



Managing for Results - Aid could have much more impact. Even where policies are strong, implementation is weak. Being able to draw a straight line from aid flows to a tangible, visible improvement in the lives and rights of the poorest people is frustratingly challenging. Instead of addressing this from the perspective of recipients, managing for results is being misinterpreted as financing by results. Very little aid is actually filtering down to the poor and results are not tied to the MDGs. The EC's use of General Budget Support (GBS) has been ineffective in supporting health outcomes.

Due in large part to the global financial crisis, development budgets and health aid are likely to stagnate (in Germany) or be cut back (in France, Italy and Spain) in 2010 and 2011. European donors need to urgently review their health ODA spending in light of the strong commitments made on the global stage. In particular, they can ensure that their investment in health yields visible and tangible dividends by taking the following three concrete steps:

1. Improve health aid coordination through the use of an appropriate mix of funding mechanisms tailored to country needs, local contexts and aligned to national health plans.
2. Directly support Community Systems Strengthening (CSS) to enable civil society to participate meaningfully in the development and implementation of all national health plans and related policies.
3. Ensure that managing for results is aligned with country efforts towards long-term goals, including Health Systems Strengthening (HSS), universal access to primary healthcare and the attainment of the MDGs.

INTRODUCTION

“A cardinal objective of the aid effectiveness agenda is to improve the lives and well-being of people and, in particular, the most vulnerable in society.”

Dr Kwabena Duffour, Minister of Finance and Economic Planning, Republic of Ghana

At the global level, aid to health, both in absolute terms and as a share of total aid, has increased over the past two decades. Development assistance to health has risen from US\$4.4 billion in 1990 to US\$26.8 billion in 2010². However, compared with total aid disbursements, European donors contribute relatively less to health than other international donors. In 2008, the EU, its Member States and other European donors represented only 39% of health ODA, while accounting for 65% of global aid³. Of the five largest economies in Europe, only the UK is currently on track to meet the ODA target of 0.7% of GNI and 0.1% to health aid, as recommended by the World Health Organisation (WHO)⁴. Year on year, Europe represents a smaller share of the global health ODA. As a result, total aid for health remains well below the levels that have been calculated as necessary to reach the health MDGs.

According to the latest estimations, an additional US\$36-45 billion is required annually to meet the health MDGs⁵. These calculations, however, were limited to low-income countries and under-ambitious with respect to the goal of universal access to HIV prevention, treatment and care, and the removal of user fees. A truer estimate of the real financing needs - accounting for these additional costs - is US\$95 billion per year⁶.

More and better aid to the health sector equates to more lives saved, greater equity and better quality of life for people, and fewer people living in poverty. Two of the major causes of poverty and reason for the lack of progress on the health MDGs are discrimination and inequality. Without the immediate implementation of the Paris Declaration and the Accra Agenda for Action, it will be impossible to achieve the MDG targets on time.

² Institute for Health Metrics and Evaluation, Financing Global Health 2010. Available at: http://www.healthmetricsandevaluation.org/resources/policyreports/2010/financing_global_health_1110.html.

³ German Foundation for World Population and European Parliamentary Forum on Population and Development, Mapping European Development Aid and Population Assistance: Euro-mapping 2010.

⁴ For more information, please refer to the appendix in Chapter 3.

⁵ Taskforce on Innovative International Financing for Health Systems, More Money for Health and More Health for Money, 2009.

⁶ B. K. Baker, CTL-for-Health/FTT-with-Health: Resource-Needs Estimates and an Assessment of Funding Modalities, AfGH/International Civil Society Support, 2010. The author used subsidiary estimates on targeted global health needs to calculate a more global resource needs estimate for 2009-2016.

About this report

The aim of this report is to stimulate debate in the lead-up to the 4th High-Level Forum on Aid Effectiveness, to be held in Busan, South Korea in December 2011. The report draws extensively on original research developed by Action for Global Health (AfGH), including fact-finding missions on aid effectiveness in four developing countries - El Salvador, Mozambique, Tanzania and Uganda⁷ - and an online forum examining the impact of ODA on health. In the course of this research, AfGH has been able to identify three central problems that require urgent attention:

1. Donor coordination and alignment efforts to date are not improving health outcomes.
2. Civil society⁸, including Parliament, is largely excluded from health policy decision-making.
3. Managing for results is being misinterpreted as financing by results.

These three aspects of the aid effectiveness agenda are examined in depth in corresponding chapters of this report. In each case, AfGH examines the specific commitments, the underlying theory and actual progress made through the lens of the health sector. A review of the latest ODA health data is also included as an appendix to Chapter 3, to highlight the ominous forecast for health aid in four out of five of the largest European economies.



⁷ The DSW/AfGH policy briefings on health aid effectiveness in El Salvador, Mozambique, Tanzania and Uganda are currently available at: <http://www.euroresources.org/afgh.html>.

⁸ See box in Chapter 2 for a definition of civil society.

COORDINATION OF HEALTH AID: MISSION IMPOSSIBLE?

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“The effectiveness of aid is reduced when there are too many duplicating initiatives, especially at country and sector levels. We will reduce the fragmentation of aid by improving the complementarity of donors’ efforts and the division of labour among donors, including through improved allocation of resources within sectors, within countries, and across countries.” **Accra Agenda for Action, 2008**

Nowhere is the need for donor coordination more evident than in health. Over the past two decades, the number of donors, financing and delivery mechanisms in global health has grown exponentially. There are now more than 100 global partnerships in the health sector alone, with 80% of donors providing just 10% of total assistance⁹. Each of these donors has its own particular, and often conflicting, method of aid delivery, monitoring and evaluation framework and timeframe. The result is chaotic and expensive for the intended beneficiaries, with Ministries of Health overwhelmed by the weight of administration required to manage donor relationships and meet donor requirements¹⁰. According to Dr Giridhari Sharma Paudel, Deputy Director of the Family Planning Association of Nepal: *“There should be better coordination and collaboration among international donors... The focus should be on the poor, marginalised and under-served population.”*

To date, most of the debate around aid modalities has been about how to use them as a tool to increase ownership. On the one hand, there has been a progressive movement in the development field as a whole from donor control towards government control, and away from project-based aid to GBS. On the other hand, there has been a strong growth in the number of vertical initiatives and funds in response to health emergencies, particularly HIV/AIDS. Donors, however, appear to be unaware of these initiatives and funds and of how different aid modalities and approaches can interact with domestic power dynamics¹¹. A better understanding of the advantages and disadvantages of each health aid mechanism needs to be developed among all actors, including civil society and governments.

⁹ Development assistance to a particular country is said to be fragmented when there are more than 15 donors between them providing less than 10% of the country’s programmable aid.

¹⁰ See for example, AfGH, Health Spending in Mozambique: Impact of current aid structures and aid effectiveness, 2011.

¹¹ L. Wild and P. Domingo, Aid and accountability in health, what can donors do differently?, Project Briefing, No. 46, ODI/World Vision, September 2010.

Table 1

Mechanism	Past Performance	Priority Focus	Country Ownership/ Coordination/ Harmonization
Global Fund	Strong: results-based funding, long-term commitments, reduced volatility, equity	HIV, TB, malaria, Health System Strengthening (HSS)	Country-led but behind on harmonization
GAVI	Strong: long-term commitment, low volatility, equity	Immunization and HSS	Country-led but behind on harmonization
World Bank	Weak: poor performance-based funding, conditionalities and debt-based financing, not focused on the poor	Health Finance, multi-sectoralism, health systems	Engages with Ministries of Finance but behind on harmonization
UNITAID	Strong: Market impact, secure sources of revenue, value for money, medium-term commitments	Medicines and diagnostics for HIV, TB and malaria	N.A. in general but patent pool will make it easy to procure affordable medicines
EC MDG Contracts	Mixed: Has underemphasized health	HSS, general budget support (in theory)	Strong in theory, but mixed
IHP+	Weak: Only 4 compacts to date, has not been able to raise money	National health planning and financial accountability	Strong
Bilateral Aid	Mixed: Varies by donor in terms of volatility, duration, disbursement/commitment ratio, and conditionality	Varies by country, US historically focused on priority diseases; European donors focus more on child and maternal health, and HSS	Varies by country, generally very weak
Joint HSS Platform	Just being piloted now	HSS for priority diseases and positive synergies in regard to health systems more broadly	Expected to be strong
Proposed Global Fund for Health	NA, but plans to use Global Fund model	Comprehensive primary health care, human resources for health, and HSS	Undeveloped at present; potential for reduced transaction costs

Source: Brook K. Baker, CTL-for-Health/FTT-with-Health: Resource-Needs Estimates and an Assessment of Funding Modalities, AfGH/International Civil Society Support, 2010.

A major impetus behind the aid effectiveness agenda has been to address the lack of global oversight and organisation of overseas aid, and the detrimental impact it is having on progress towards the MDGs. One of the central aims is to ensure that donors harmonise and align their policies and aid modalities to suit government priorities. The United Nations (UN) and related agencies, including the World Health Organisation (WHO), are best placed to provide the necessary harmonisation, coordination and leadership at a global level to deliver on human rights commitments, but lack the required political and economic power to do so.

In Paris, signatories committed to work together on a range of concepts and tools, including joint actions and research, common procedures, comparative advantage, complementarity and delegation. Most of the focus, particularly within the EU, has been on the concept of 'division of labour' and reducing the number of donors reporting on key sectors at a national level. In Accra, effort was made to bring the concept of ownership back into the harmonisation agenda, to place the role of recipients more centrally to determine how they want donors to be active in their countries, and to warn against applying division of labour to the extent that the quality and quantity of aid diminishes.

The impact of European donor coordination on health aid so far

"Donors will respect developing countries' priorities, ensuring that new arrangements on the division of labour will not result in individual developing countries receiving less aid." Accra Agenda for Action, 2008

¹² EU Code of Conduct on Division of Labour in Development Policy, 2007.

¹³ Through delegated cooperation a donor has the power to act on behalf of other donors concerning the administration of funds and dialogue with the partner government. See: http://europa.eu/legislation_summaries/development/general_development_framework/r13003_en.htm#KEY.

In 2007, the European Union introduced a voluntary European Code of Conduct on the Division of Labour in Development Policy. The primary principle of the Code is that EU donors should focus their activities on two sectors based on their respective comparative advantages, and these should receive the bulk of available funding. In addition to the two focal sectors, donors "can provide general budget support where conditions permit and finance activities in other areas such as support to civil society, research, or university/school cooperation"¹².



The EU Division of Labour policy has not been good for health. In practice, it has led to the EC stepping out of the health sector in a number of countries that are struggling to meet the health MDGs, with serious consequences for progress. This has been the case in both Tanzania and Uganda, leaving the EU delegation without the necessary human resources and health expertise to oversee how aid is spent, as well as participate in health policy dialogue with the government and track performance, particularly with regard to new MDG contracts.

Meanwhile, in Mozambique, some European donors seem to have used the policy to justify significant cuts in their aid budgets, instead of applying the principle of 'delegated cooperation'¹³.

A European donor official described it as “the sector-exit strategy”¹⁴. Overall, following the implementation of Division of Labour, EC health aid was reduced from 4.7% of total EC aid in 2005 to 1.3% in 2008¹⁵. This is a clear example of how donor alignment can lead to lower financial commitment to health. As the Accra Agenda for Action makes clear, before embarking on the concept of division of labour, donors need to scrutinise the impact this may have on the overall amount of aid going to the sector.

“In line with aid effectiveness objectives, the EU should channel two thirds of health ODA through partner countries-owned development programmes and 80% using partner countries’ procurement and public financing management systems.”

The EU Role in Global Health, 2010

Since 2005, many European bilateral donors, including Denmark, Germany, Ireland, the Netherlands, Sweden and the UK have joined the EC in raising the proportion of aid allocated through GBS as a direct response to Paris and Accra Principles. The rationale behind GBS is that it gives developing countries greater control over how aid is used, as well as reduces the unpredictability of aid flows and transaction costs. Channelling funds directly through government systems builds planning and budgeting capacity and strengthens public accountability mechanisms. In terms of health, long-term and predictable support is ideal since 80% of health system expenditures are recurring costs. This is provided GBS is actually used to increase domestic funding to the health sector. GBS can also have a positive impact on health and universal access goals, in that funding can be used for infrastructure that benefits health in rural areas, such as roads and sanitation projects. Almost 50% of the 10th European Development Fund, equivalent to €11 billion, is to be disbursed in this way.



In 2010, the European Court of Auditors carried out a performance audit to assess whether the EC manages its GBS programmes effectively¹⁶. The report recommended that the Commission strengthen its management of performance-related conditions for GBS, which should include a clear and structured process for assessments and disbursements. This echoes the recommendations from the 2007 evaluation of EU health funding in Sub-Saharan Africa that urged donors to promote increases in national health budgets through the use of performance indicators, targeting such increases in GBS financing agreements¹⁷. Such indicators should be based on internationally agreed health targets, such as the 15% health sector share target of the Abuja Declaration. In addition, the Court recommended that much more is done to support the ability of civil society, including parliamentarians, academics and Civil Society Organisation (CSOs), to hold governments to account on the budget. To this end, the report called on the Commission to support specific, and targeted, capacity-building initiatives.

¹⁴ Health Spending in Mozambique: The Impact of Current Aid Structures and Aid Effectiveness, AfGH, 2011.

¹⁵ The EU's Contribution to the Millennium Development Goals: Keeping the Goals Alive, Alliance 2015, 2010.

¹⁶ The Commission's Management of General Budget Support in ACP, Latin American and Asian Countries, Special Report No.11, European Court of Auditors, 2010.

¹⁷ Development Assistance to health services in Sub-Saharan Africa, European Court of Auditors, 2008.

Providing funding directly to Ministries of Health in the form of Sector Budget Support (SBS) overcomes some, but not all, of the challenges associated with GBS. SBS combines use of government systems with donor preferences for how money should be allocated, and offers clear advantages over GBS in that Ministries of Health do not have to compete for their 'fair share'. This form of assistance can support the implementation of reforms or actions to overcome barriers to progress in the sector. In Uganda, for example, the Danish Government has supported the development of the national health plan over a number of years¹⁸. However, there is no guarantee that funds will be used appropriately. Health funding can still get stuck at the level of central or district authorities, as it has done in Nepal, holding back efforts towards universal access¹⁹. Research has demonstrated that government-controlled resources are slow to reach the local level and then only in small amounts - as little as 20% - where health programming is most needed²⁰.

In light of anxieties surrounding government handling of funds, Global Health Initiatives (GHIs) have preferred to create and use their own aid delivery systems. The rapid rise in the number of these initiatives has been one of the defining features of the global health arena in recent years. The Global Fund to fight AIDS, Tuberculosis and Malaria (hereafter the Global Fund), the President's Emergency Plan for AIDS Relief (PEPFAR), and the Global Alliance for Vaccines and Immunisation (GAVI) are often the largest contributors to health at the national level, dwarfing ministry budgets.

¹⁸ AfGH, Health Spending in Uganda. The impact of current aid structures and aid effectiveness, 2010.

¹⁹ AfGH, Health aid effectiveness in Nepal: Paris, Accra, civil society and the poor, 2009.

²⁰ B. Gauthier, PETS-QSDS in Sub-Saharan Africa: A Stocktaking Study. HEC Montreal, 2006. Available at: <http://siteresources.worldbank.org/INTPUBSERV/Resources/477250-1165937779670/Gauthier.PETS.QSDS.Africa.STOCKTAKING.7Sept06.pdf>.

²¹ D. Sridhar & T. Tamashiro. Vertical Funds in the Health Sector: Lessons for Education from the Global Fund and GAVI, 2009.

²² AfGH, Health Spending in El Salvador. The impact of current aid structures and aid effectiveness, 2011.



These vertical health funding mechanisms have been able to generate significant additional financial resources for health and achieve important results in terms of lives saved. However, there are widespread concerns that they are distorting partner country priorities by drawing resources away from basic health sector reforms, contributing to the brain drain of government health workers, and using burdensome reporting requirements and processes²¹. In El Salvador, there are as many as 22 vertical funds, with 60 disbursement systems²². Meanwhile in Nepal, CSOs are very critical of donor behaviour. In an interview with AfGH, Dr Bharat Pradhan, Executive Director of the Public Health Concern Trust, said:

“Everybody in Nepal knows that most of the health programmes are donor-driven. Most of the programmes are vertical, and one can easily see duplication of similar programmes in the same districts supported by different donor organisations.”

According to Janardan Thapa, a manager at the Child Welfare Scheme in Western Nepal:

“Donors are not adequately familiar with the local contexts, due to unavailability of valid and adequate information. Therefore, there is an over-generalisation of the problems by donors. Donor priorities do not fit with the on-the-ground reality and need more involvement of communities. International agendas have overshadowed local realities. In these cases, CSOs are forced to reconcile local need and donor preferences.”

Vertical health funding mechanisms are beginning to adopt a more integral approach in order to contribute to HSS and increase the implementation of the Paris Declaration principles. Recent efforts made by the Global Fund in that direction, through the HSS funding window, the Joint Health Systems Funding Platform, and support for the Joint Assessment of National Strategies (JANS), can be seen as positive developments in that respect. PEPFAR has recently been integrated into the US Global Health Initiative and is moving towards country ownership and supporting national strategies. However, the positive impact of these new approaches on HSS at country level still remains to be seen. The challenge is to make sure these developments do not lead to decreased investment in health.

Clearly, dependence on one aid modality to the exclusion of others is problematic for health outcomes. Only a mix of these financing mechanisms allows for a careful adaptation to the characteristics, politics, drivers and constraints in a specific country situation and sectors as well as targeted support to CSOs and Community-Based Organisations (CBOs), especially those working with marginalised and stigmatised populations, which often have limited or no access to government funding. Project-based aid, although limited in aid effectiveness terms, can be useful to provide policy and technical support and capacity-building, to finance pilot interventions and innovative programmes in health. In the case of HIV/AIDS - which is highly stigmatised and involves life-long drug treatment - there may always be a need for vertical funding. An approach in which vertical interventions are integrated into health systems in a way that does not dilute their importance is an efficient way to respond to public health challenges.



Effective and inclusive aid coordination should ensure that all aid modalities complement rather than conflict with one another. And importantly, as Jose Davuca, Coordinator of the National Association of Nurses in Mozambique, describes, decisions around the use of aid modalities need to be made by countries themselves, and not donors:

“Donors should gradually let the Government take the lead in developing the strategies and defining priorities for the (health) sector. This should, however, be based on an assessment of the country in this area. All the donors should be called to finance a strategy of the sector which needs to be developed with the involvement of all actors.”

Abuja, donors and the IMF: Incompatible goals?

In Abuja in 2001, African governments committed to allocating 15% of their national budgets to health. Only a handful of countries have met the target. In Mozambique, Tanzania and Uganda, the percentage allocation has in fact decreased in the past year from 11-12% to 10%²³. Moreover, in countries such as Tanzania, donor funding including SBS is being included in the target calculations, artificially inflating the measure of how much governments are investing in their health systems²⁴. This is contrary to the intention of the Abuja target to ensure greater government investment in HSS and ownership over health spending. In Tanzania, the Government tends to see the health sector in general as being 'taken care of' by PEPFAR and the Global Fund, freeing them to allocate GBS to other issues²⁵. As a result, gaps in funding programmes arise and public health problems persist.

Even where governments may wish to increase their health budgets, this may not be easily reconciled with their plans for economic growth. In many countries, health sector budgets are not set according to health needs, but macro-economic policies. Large public expenditures financed through donor aid inflows are thought to destabilise the economy for a number of reasons. Traditional advice from the International Monetary Fund (IMF) therefore specifically advises governments to divert aid to reserves rather than spend it²⁶. In countries such as Tanzania, where the Government has pledged to manage the economy conservatively, health as a non-productive sector has been de-prioritised in favour of trade and infrastructure. This trend in favour of cutting government expenditure is only likely to deepen given the current global financial crisis.

The EC requires the majority of countries in receipt of budget support to have IMF agreements in place. However, the impact of IMF macro-economic guidelines on health is significant. Health systems spending has been shown to increase twice as fast in non-IMF borrowing countries than in IMF-borrowing countries²⁷. In Uganda for example, ODA to the health sector cannot be used if it exceeds the annual ceilings committed to by the Government²⁸. Although the IMF claims that it has become more flexible, a recent report reveals that the institution continues to recommend sector expenditure ceilings, by stating that "establishing rules that put specific limits on spending and borrowing can strengthen fiscal credibility and discipline"²⁹. Moreover, there is no direct correlation between increasing economic growth and higher health spending. In Nepal, although the national budget has tripled, the budget for the Ministry of Health has only doubled³⁰.



²³ See respective AfGH reports on Health Spending in Mozambique, Tanzania and Uganda. Available at: http://www.actionforglobalhealth.eu/index.php?id=10&no_cache=1.

²⁴ AfGH, Health Spending in Tanzania: The Impact of Current Aid Structures and Aid Effectiveness, 2010.

²⁵ Ibid. AfGH, Health Spending in Tanzania: The Impact of Current Aid Structures and Aid Effectiveness, 2010.

²⁶ D. Stuckler, S. Basu and M. McKee, IMF and Aid Displacement, in *International Journal of Health Services*, Vol. 41, No. 1, pp 67-76, 2011. See also AfGH, The IMF, the Global Crisis and Human Resources for Health: Still constraining policy space, 2010.

²⁷ AfGH, The IMF, the Global Crisis and Human Resources for Health: Still constraining policy space, 2010.

²⁸ AfGH, Health Spending in Uganda: The impact of current aid structures and aid effectiveness, 2010.

²⁹ IMF, Budget Institutions and Fiscal Performance in Low-Income Countries, Working Paper, p. 13, March 2010.

³⁰ AfGH, Health aid effectiveness in Nepal, 2009.



³¹ Abebe Alebachew and Veronica Walford, Lessons from the Joint Assessment of National Strategy (JANS) Process in Ethiopia, 2010.

³² Interview with Mr. Shanta Lal Mulmi, Executive Director, Resource Centre for Primary Health Care, Nepal.

Best practices

A significant boost to donor coordination has also been provided by the launch of the International Health Partnership and Related Initiatives (IHP+), particularly in connection with the JANS process, which has been used in to develop national health strategies in Ethiopia, Mozambique, Nepal and Uganda. The aim of the IHP+ is to mobilise donor countries and aid agencies around a single country-led national health plan, guided by the principles of the Paris and Accra Declarations. Some of the positive health outcomes associated with IHP+ have been stronger country leadership to drive donors in the right direction to support their own national plans, better harmonisation between donors, and much stronger involvement of stakeholders, and specifically CSOs, in the planning and implementing of national plans. In Ethiopia, an evaluation of the process similarly concluded that JANS “is widely seen as improving the quality of the strategic plan, and has increased the buy-in and understanding of the resident and international partners as well as CSOs/NGOs”. JANS provided a mechanism for the systematic engagement of CSOs that had not been active in health policy previously³¹.

In Nepal, one of the pioneer IHP+ countries, CSOs have also witnessed improvements in HSS and access to health for the most vulnerable as a direct result of participation in the decision-making process at national level:

“The budget allocated for health sector by the Government of Nepal has increased. The Government has made special service provision for marginalised caste and ethnic groups. Free health services at the primary level is one of the good achievements.”³²

Table 2: Best practices in donor coordination

Aid effectiveness commitments	Best practices
<p>PARIS DECLARATION</p> <p>19. Partner countries and donors jointly commit to: Work together to establish mutually agreed frameworks that provide reliable assessments of performance, transparency and accountability of country systems (Indicator 2).</p>	<p>Joint Assessment of National Strategies (JANS), Ethiopia</p> <ul style="list-style-type: none"> ▪ Enhanced the quality and credibility of the national health strategy and system for implementation. ▪ Increased donor alignment with national strategy and priorities and lowered transaction costs. ▪ Provided more streamlined processes for getting funding approved (HSS platform). ▪ The inclusive approach increased the buy-in and understanding of resident and international partners as well as CSOs/NGOs.
<p>32. Donors commit to: Implement, where feasible, common arrangements at country level for planning, funding (e.g. joint financial arrangements), disbursement, monitoring, evaluating and reporting to government on donor activities and aid flows. Increased use of programme-based aid modalities can contribute to this effort (Indicator 9).</p>	<p>Development Partners Group for Health, Tanzania www.tzdpdg.or.tz/dpghealth</p> <ul style="list-style-type: none"> ▪ A collection of 10+ bilateral and multilateral agencies supporting the health sector in Tanzania. ▪ Funds are provided through general budget support, the health basket, projects, and technical assistance. ▪ Operates a sophisticated ‘troika’ system, ensuring that at least three donors are continuously taking a strong lead for health. ▪ Strong transparency via website giving a comprehensive overview of all key policy documents and processes in the sector. <p>Budget Support Group, El Salvador</p> <ul style="list-style-type: none"> ▪ Brings together all four major donors in the country - Spanish Development Agency AECID, the EC, the Inter-American Development Bank and the World Bank. ▪ Conducted a joint assessment of Public Expenditure and Financial Accountability (PEFA) in early 2009. <p>Joint Assessment Framework Initiative, Uganda</p> <ul style="list-style-type: none"> ▪ The first donor joint assessment framework with the Government to support the improvement of services in four critical sectors – education, health, water and roads via direct budget support over three years. ▪ The 11 Joint Budget Support Development Partners include: the African Development Bank, the EC, the World Bank, Belgium, Denmark, Germany, Ireland, the Netherlands, Norway, Sweden and the UK. Together, these donors contribute more than 80% of direct donor funding to Uganda. ▪ Provides a set of well-defined and shared targets and actions by which performance can be measured. ▪ Health sector performance indicators include a number of sexual and reproductive health-related indicators linked to MDG targets, and indicators on levels and distribution of qualified health workforce. These have been derived from the Government of Uganda’s own targets and reform commitments, as expressed in sectoral policy papers and the national budget framework.

Recommendations

“Developing countries will lead in determining the optimal roles of donors in supporting their development efforts at national, regional and sectoral levels. Donors will respect developing countries’ priorities, ensuring that new arrangements on the division of labour will not result in individual developing countries receiving less aid.”

Accra Agenda for Action, 2008

Primarily, donors need to increase their efforts on coordination. More unified and comprehensive donor report systems will allow governments to spend less time on reporting and more time on improving management of ministries. However, donors should be wary of harmonising around one single method of aid delivery but use an appropriate mix of financing mechanisms, ensuring that they are strongly aligned with nationally and democratically defined policy frameworks, plans and financial systems.

This can be achieved through:

- Enabling partner countries to choose between a range of aid modalities that are defined by the local context and not by donor and static standards.
- Reserving budget support for countries with a strong commitment to health, including solid and inclusive national health plans and implementation strategies. The IHP+ and JANS process is a good method for judging this level of commitment.
- Ensuring General Budget Support leads to HSS and CSS, fair access and achieving the right to health. This needs to be within the framework of coherent health strategic plans, using gender analysis and planning as well as health-specific and gender-sensitive qualitative indicators, based on internationally agreed targets, such as those in the Millennium, Abuja, Cairo and Beijing Declarations.
- Using budget support policy dialogue to advocate for domestic funding increases to reach the international targets mentioned above. To that end, the relevant line ministries, such as the Ministry of Health, need to be included in dialogue with the Ministry of Finance.
- Strongly support IHP+ implementation at the country level, encouraging bilateral agencies and GHIs to increase their participation in national process and ensure that civil society is meaningfully included. Europe should ensure that IHP+ has a strong working plan and sufficient resources post-2012 in order to allow a faster implementation of aid effectiveness principles.
- Fostering existing coordinating mechanisms, if proven to be efficient, instead of creating new ones. This is particularly relevant with IHP+ and the new Health Systems Funding Platform.
- Ensuring that money given through vertical funds is cost-effective and does not have negative externalities on efforts to strengthen health systems, using country systems where possible in order to limit fragmentation.
- Focusing on IHP+ implementation each time it is signed by a partner country in order to increase coordination and meaningful participation from all actors including CSOs. Donors also need to ensure that those countries that develop a country compact and go through the JANS process have fully-funded national plans.
- Using clear, shared and transparent criteria when applying Division of Labour to processes of decision-making regarding staying in or withdrawing from a partner country, to be agreed with CSO representatives, the Government and parliamentarians. Those criteria must guarantee that health sector funding remains at the same level and that there will not be a decrease in funds.
- Building the capacity of domestic accountability structures including national parliaments, national audit institutions, the judiciary and civil society.

NO OWNERSHIP WITHOUT CIVIL SOCIETY

02

“Country ownership is key. Developing country governments will take stronger leadership of their own development policies, and will engage with their parliaments and citizens in shaping those policies.”

Accra Agenda for Action, 2008

In 2011, a number of policy processes are underway to explore the meaningful participation of civil society. The Organisation of Economic Cooperation and Development (OECD) Task Team on Health as a Tracer Sector will report on CSO participation as part of the preparation for the 4th High-Level Forum on Aid Effectiveness in Busan. AfGH welcomes the fact that the EC is in the process of developing a Communication on the meaningful engagement of civil society in decision-making processes and drafting new guidelines on Policy Dialogue in the health sector, including a chapter on ‘inclusive leadership’³³. However, the process of elaborating these policy documents needs to become more transparent and participatory in and of itself to have any meaning.

³³ The aim of the Guidelines on Policy Dialogue on Global Health is to provide officials and representatives of the EU with the information and knowledge they need to establish regional, national or international dialogue and political negotiations, which respects and promotes the values agreed by the EU and Member States on Global Health.

³⁴ Accra Agenda for Action, 2008.

Why the voice of civil society is critical in health policy dialogue

“Civil society organisations (must be) fully engaged so that the needs of the most marginalised population are taken into account” - TTHATS 2009

The interface that civil society can play between governments, donors and communities, also enables CSOs to support greater political engagement and advocate for rights to be respected and reinforced. Civil society participation can contribute to enhancing government accountability and transparency whilst advocating for equitable and pro-poor health policies. Civil society can hold both donors and recipient countries accountable for effective utilisation of development aid. Without the full engagement of civil society, country health plans are unlikely to be effective.

A significant step towards recognising the value of civil society engagement in policy and decision-making processes was taken during the 3rd High-Level Forum in Accra. It was acknowledged that civil society actors have a legitimate role to play in the design and implementation of country health plans and in holding all partners accountable for delivering results and achieving improved health outcomes. Developing countries committed to engaging with their parliaments, citizens and CSOs in the preparation, implementation and monitoring of policies and plans via ‘broad consultative processes’. Donors pledged to directly support this process, by strengthening the capacity of both developing countries to exercise this leadership and CSOs to play an active role as ‘independent development actors in their own right’³⁴.

However, in practice, the Paris Declaration principle of 'ownership' is all too often interpreted narrowly as 'government' ownership, driven by the priorities of the Ministry of Finance. True democracies rely on the checks and balances provided by a variety of domestic accountability stakeholders, including parliaments, governmental audit institutions and civil society (the media, interest groups and academia), to function. The basis for democratic ownership is that the interests and voices of all citizens are included in national development strategies and that everyone benefits from development results³⁵. In the case of health, the democratic and fully inclusive formation of a country health plan should be a first step towards country ownership of the health agenda.

Current barriers to meaningful engagement

Research by AfGH has revealed that considerable efforts are still needed at the country level to ensure that the Accra commitments are turned into action³⁶. The lack of engagement is particularly evident with regard to government-led country health sector teams where CSOs are facing a number of challenges including being prevented from involvement in national health planning and monitoring. In many cases, CSOs are not even aware of the major policy processes and mechanisms that have been put in place to enable this.

This is due principally to the following reasons:

- Suspicion and mistrust towards CSOs within ministries: governments tend to prefer to work with a hand-picked group of well-known NGOs, smaller in-country and community-based organisations not usually on the guest list to participate in annual consultations, despite their strong role in health provision³⁷.

Civil society is variously defined as the actors that form an interface between citizens and their government, including registered charities, community groups, trade unions, and faith-based organisations. Civil society has a long history of engagement in the health sector, particularly in response to government inaction. The 1978 Alma Ata Declaration was a landmark for recognising people's participation in health systems as central to primary healthcare and for acknowledging the role that organised social action plays in securing health gains. In Sub-Saharan Africa today, a significant proportion of healthcare - 40% in Tanzania - is delivered by civil society, including Non-Governmental Organisations (NGOs) and Community Based Organisations (CBOs)³⁸. Among the important roles that civil society plays in health systems is monitoring the responsiveness and quality of health services and negotiating public health standards and approaches. Civil Society Organisations (CSOs) can build informed public opinion on health and shift social attitudes.

Moreover, their access to the most marginalised, vulnerable and difficult-to-reach populations and communities - including Lesbian, Gay, Bisexual and Transgender (LGBT) individuals, injecting drug users, and migrants - means that CSOs have the potential to make universal access a reality. There is considerable evidence that community participation in programme design and decision-making could play a significant role in meeting the MDGs³⁹.

³⁵ DAC Network on Gender Equality, *Making the Linkages*, 2008.

³⁶ For a full analysis refer to AFGH reports on Uganda, Tanzania, Nepal, Ethiopia and Zambia. Available at: http://www.actionforglobalhealth.eu/index.php?id=10&no_cache=1.

³⁷ See for example AfGH, *Health Spending in Uganda: The impact of current aid structures and aid effectiveness*, 2010.

³⁸ F. Omaswa, *Informal health workers: to be encouraged or condemned?*, Bulletin of the World Health Organisation, February 2006.

³⁹ S. Commins, *Community participation in Service Delivery and Accountability*, 2007. See also WHO, *Strategic Alliances: The role of civil society in health*, 2001.

“Many officials within the Ministry of Health are opposed to citizen participation in health as it represents a threat to their status. They do not have the slightest interest in following the guidelines on working with communities.”⁴⁰

- CSOs are not regarded as legitimate actors: CSO ‘partners’ are relied upon to deliver services but as ‘sub-contractors’, have little or no room for mutual influencing and accountability. This is particularly the case for organisations that are not engaged in service delivery and which focus on issues that are not considered to be a national priority, such as women’s rights, LGBT rights, or the rights and networks of people living with HIV.
- Severe restriction of CSO roles and activities: in Zambia for example, according to proposed legislation, all CSOs would have to operate under three-year licences, making strategic planning and fundraising extremely challenging. Donors are reluctant to question the introduction of such laws, perceiving them as a legitimate action by a democratic government, even as progress on alignment and harmonisation are held back by poor human rights records in these countries⁴¹. In Mozambique, NGOs and networks feel that there is much room for improvement:

“CSO engagement can be strengthened by increasing their involvement at all stages of policies and strategic planning. This also requires strengthening the monitoring of real usage of the spaces created for civil society participation since in most cases the degree of CSOs’ engagement depends on the openness of the person responsible on the government side.”⁴²

- Lack of transparency and of consultation of civil society and Parliament: the role of Parliament is often limited to basic oversight of the budget. In Uganda, Members of Parliament (MPs) only have one month to scrutinize the budget and in Mozambique and Zambia, health reports are not made available to Parliament. As a result there is a low level of awareness and acceptance of the MDG targets and aid effectiveness processes among MPs.
- Lack of funding for local CSOs’ capacity-building: CBOs and local NGOs on the frontline of service delivery simply do not have time or resources to invest in building their financial and resource mobilisation capacity. This does not mean that they are incapable of using funds well. The EC in particular does not have a strong track record in making its funds for advocacy easy for civil society to access.



⁴⁰ Interview with Dr Margarita Posada, Citizens Alliance Against Health Privatisation, El Salvador.

⁴¹ See AfGH, Zambia: Aid effectiveness in the health sector, 2009 and AfGH Ethiopia: Aid Effectiveness in the health

⁴² Interview with Helder White, Programme Director, Mozambique Network of AIDS Service Organisations.

Best practices

One of the key priorities of the new El Salvadorean Ministry of Health during its first 100 days in office was the establishment of a National Health Forum. The Forum, launched in May 2010, is designed to unify and strengthen the civil society movement by acting as an open platform for all non-state actors working on health. According to Dr. Adolfo Antonio Vidal Cruz, National Co-Coordinator of the Alliance for Sexual and Reproductive Health:

“The current National Health Policy was formulated on the basis of a broad consultative process with various civil society organisations at the National Health Forum and some of the ideas were used to begin designing a proposal for comprehensive health reform that is currently underway in El Salvador.”

Even though it was facilitated initially by the administration, the Forum aims to be an independent space to communicate CSO health concerns to the Ministry. René Alfredo Catalán, Vice-Chairman of Community Health for the Community Advisory Board in La Libertad, El Salvador is positive about its impact:

“Overall, there have been some changes as we are now working closely with health units participating in the planning and provision of health services and this is part of the new health policy and its implementation. We have seen increased interest of health authorities to learn of the reality we live in communities, and we feel included and heard through the National Health Forum.”

At the international level, progress has also been made to increase the role and recognition of civil society as key actors in policy and decision-making processes, notably in relation to the structure of the Global Fund and more recently with GAVI. The national coordinating mechanism of the Global Fund is considered by many CSOs - notwithstanding its limitations - to be a best practice model for civil society and parliamentary engagement⁴³. The Community Systems Strengthening Framework developed by the Global Fund in collaboration with WHO, the Joint United Nations Programme on

HIV/AIDS (UNAIDS) and CSOs provides an important guidance on how to support civil society capacity-building activities and strengthen community systems. The progress made towards meaningful participation of civil society in the national coordinating mechanisms should now be built upon to support similar engagement in the fields of child, maternal, reproductive and broader health.

Another example of strong CSO participation in the health sector is the IHP+, where both northern and southern civil society is now represented on the global management structure. According to Executive Director of the Resource Centre for Primary Health Care Shanta Lal Mulmi, the IHP+ process in Nepal *“has definitely made it easier for CSOs to engage in national health policy. It has acknowledged the role of CSOs in national and regional policy processes.”*

In Mozambique, organisations such as HelpAge International are also finding it easier to engage: *“The IHP+ creates opportunities for CSOs to access more information on the health sector and to interact more (often and deeply) with donors. These initiatives also have clearer mechanisms for channelling the debate between donors and civil society to the government structures through the Ministry of Health (via the Consultative Council).”⁴⁴*

It has been shown that in countries where an IHP+ Compact is signed, civil society participation in decision-making process increases⁴⁵.

In 2011, there are many opportunities for civil society to be engaged with national processes. IHP+ Compacts are already under development in Burkina Faso, Burundi, the Democratic Republic of Congo, Djibouti, Niger and Togo, and will be signed by Sierra Leone and Uganda. Malawi, Mali and Rwanda are looking at implementing JANS. However, in order to be meaningfully engaged in national health planning and budgeting, civil society needs practical and financial support.

⁴³ AfGH, Health Spending in Tanzania: The impact of current aid structures and aid effectiveness, 2010.

⁴⁴ Interview with Rosalia Mutisse, Project Officer, HelpAge International, Mozambique.

⁴⁵ See notes from the Third IHP+ Country Health Sector Teams Meeting, December 9-10, 2010 Brussels. Available at: http://www.internationalhealthpartnership.net/en/news/display/3rd_ihp_country_teams_meeting.

Table 3: Best practices in increasing civil society ownership

Aid effectiveness commitments	Best practices
<p>PARIS DECLARATION</p> <p>14. Partner countries commit to: Exercise leadership in developing and implementing their national development strategies through broad consultative processes.</p>	<p>Development Observatory, Mozambique</p> <ul style="list-style-type: none"> ▪ A consultative forum for monitoring the objectives, targets and actions specifically assigned to the public and private sector within the context of the <i>Action Plan for the Reduction of Absolute Poverty - II (PARPA II) 2005-2009</i>. ▪ Composed of representatives of the Government, the donor community and Mozambican civil society. ▪ Civil society is represented through a group called the G20, which includes churches, labour unions, networks of NGOs, the private sector and academics. ▪ Recommendations from the Observatory are part of the annual aid review. <p>National Health Forum, El Salvador</p> <ul style="list-style-type: none"> ▪ Designed as an open platform to unify the existing diversity and strengthen capacity of non-state actors working on health. ▪ An “Organising Committee” is in charge of organising regional conferences, thematic roundtables and establishing joint planning and monitoring systems for health sector policies, by prioritising community leadership.
<p>14. Partner countries commit to: Take the lead in coordinating aid at all levels in conjunction with other development resources in dialogue with donors and encouraging the participation of civil society and the private sector.</p>	<p>Health Policy Advisory Committee, Uganda</p> <ul style="list-style-type: none"> ▪ Meets on a regular basis in order to provide policy guidance to the sector. ▪ Composed of representatives from the Ministry of Health and key donors. ▪ CSOs and MPs are invited to annual health sector reviews in order to contribute to discussions on past performance and future targets. <p>Country Coordinating Mechanism (CCM), Global Fund for AIDS, TB and Malaria, Nepal</p> <ul style="list-style-type: none"> ▪ Recognises the equal contribution of all stakeholders including civil society, private sector, the Government, donors, affected communities and academics in the development of proposals. ▪ In Nepal, eight civil society members participate where they are able to contribute to proposal development as well as monitoring and implementation of the grant. ▪ Representatives of affected populations share a table with high-level Government officials, something unheard of before.
<p>ACCRA AGENDA FOR ACTION</p> <p>13. Donors will support efforts to increase the capacity of all development actors—parliaments, central and local governments, CSOs, research institutes, media and the private sector—to take an active role in dialogue on development policy and on the role of aid in contributing to countries’ development objectives.</p>	<p>Civil Society Support Mechanism (CSSM), Mozambique http://www.australcowi.co.mz</p> <ul style="list-style-type: none"> ▪ A five-year pooled funding mechanism for CSO capacity-building. ▪ Supported by DFID and IrishAid. ▪ Designed to improve governance and accountability for ordinary Mozambican citizens through strengthening and diversifying the engagement of CSOs with monitoring and advocacy on governance. <p>Civil Society Support website, Tanzania www.civilsocietysupport.net</p> <ul style="list-style-type: none"> ▪ Established by the EC and Canada with the contribution of all the major donors in the country. ▪ Makes it possible to compare the different funding opportunities for civil society made available by each donor, by sector and region. <p>Independent Development Fund, Uganda www.idf.co.ug</p> <ul style="list-style-type: none"> ▪ A grants-management fund chaired by Danish International Development Assistance (DANIDA), DFID, Swedish International Development Agency (Sida), The Netherlands, the NGO Forum, the Development Network of Indigenous Voluntary Associations (DENIVA) and the Human Rights Network Uganda. ▪ Designed to strengthen capacity of civil society to contribute to human rights, good governance and poverty reduction efforts. ▪ Open almost exclusively for proposals from national CSOs and CBOs; international NGOs can only apply as part of a consortium.

Recommendations

“Donors will support efforts to increase the capacity of all development actors—parliaments, central and local governments, CSOs, research institutes, media and the private sector—to take an active role in dialogue on development policy and on the role of aid in contributing to countries’ development objectives.”

Accra Agenda for Action, 2008

In order to ensure the meaningful participation of civil society and Parliament in health policy and programming, donors need to ensure that the ‘ownership’ principle is more comprehensively defined and is not considered to be in place without the involvement of all segments of civil society and national parliaments in policy-making processes. Donors must step up efforts to ensure the meaningful and systematic participation of CSOs with wider diversity, especially women’s and community-based organisations that represent marginalised and vulnerable groups, in the development of national health plans.

In line with their commitments under the Accra Agenda for Action, donors can specifically contribute to greater democratic ownership by:

- Allocating sufficient aid to directly support community empowerment and CSS, in order to increase communities’ awareness of existing health services, their participation in health decision-making at local and district level, and support for their role as community healthcare providers.
- Allocating sufficient aid to strengthen civil society in developing countries by funding advocacy capacity-building, taking care that funding opportunities are well-disseminated, accessible and straightforward.

- Using political dialogue to ensure governments involve a greater diversity of CSOs at all stages of the decision-making and monitoring process.
- Establishing transparency and accountability mechanisms to enable CSOs to understand and follow up on consultation processes.
- Actively supporting partnership-building amongst all actors. More efforts need to be made in order to improve and strengthen the relationship between International NGOs (INGOs), local NGOs, CBOs, local authorities and MPs, in order to ensure that these alliances contribute to true country ownership of development policies.
- Agreeing to country-based measures to advance democratic ownership.

The EC has announced the adoption of the Communication on the meaningful engagement of civil society and the new Health Sector Policy Dialogue guidelines. In this context, the EU should send out a strong message to all development actors and take the lead by making public how civil society and Parliament have been meaningfully engaged in these policy developments.

MANAGING FOR RESULTS SHOULD NOT MEAN FINANCING BY RESULTS

03

“We will be judged by the impacts that our collective efforts have on the lives of poor people.”

Accra Agenda for Action, 2008

Managing for results is a key theme in both the Paris Declaration and the Accra Agenda for Action. The aim is to ensure that all aid is directed towards its fundamental goal: the attainment of the MDGs and other core commitments, such as universal access to primary healthcare and the right to health. Until now, this aspect of the aid effectiveness agenda has tended to be taken for granted by the international community. However, in the context of increasing pressure on donors to account for spending on ODA to their constituencies, securing ‘value for money’ is now at the top of the agenda of the 4th High-Level Forum in Busan.

It remains all too easy for even the most scrupulous of donors to spend aid that makes no tangible difference to the lives of the world’s poorest people. A lack of robust statistical systems and monitoring frameworks at the country level makes accountability extremely challenging. Donors and governments are increasingly measuring the impact of their programmes and taking steps to increase the results focus of health sector plans. However, the Paris Declaration Evaluation Report found that progress had been very slow at the national level. Hence in Accra, it was emphasised that statistical and information systems in developing countries needed to be strengthened. According to the OECD Task Team on Health as a Tracer Sector, “in many countries the results orientation of health sector strategies

and programmes needs to be stronger”⁴⁶. In particular, 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.

In 2008, Alliance 2015 reported that less than 25% of EC funds within budget support programmes were being tied to achieving the MDGs, and only 50% tied to results⁴⁷. A significant opportunity for the EU to assess how well it has achieved concrete results has been the recent Mid-Term Review of the MDGs by the EC. The publication of this report is eagerly awaited.

⁴⁶ OECD, *Aid for Better Health: What are we learning about what works and what do we still have to do? Interim Report from the Task Team on Health as a Tracer Sector, Working Party on Aid Effectiveness, 2009.*

⁴⁷ Alliance 2015, *The EU’s contribution to the Millennium Development Goals. Poverty Eradication: From Rhetoric to Results?*, 2008.

Why aid is critical to the attainment of the MDGs and universal access to primary healthcare

“If we can invest the necessary energy and resources, we will see major improvements. But we must act now to save lives, to achieve the MDGs, and to ensure our increasing investments are not lost.”

UN Secretary-General Ban Ki-moon

Notwithstanding the challenges around proving cause and effect, there is considerable evidence that much of the progress made towards the MDGs to date - particularly in the areas of health and education - can be attributed to aid⁴⁸. One of the reasons for the lack of strong progress on MDG 5 is related to the fact that sexual and reproductive health is still suffering from a large funding shortfall⁴⁹ and is still neglected or denied in many countries⁵⁰. While trade, technical assistance and migration policies have a role to play, the need to fill the yawning funding gap is urgent. If managed well, aid can strengthen countries with poor governance, since it can be used to strengthen domestic accountability systems and build the capacity of countries to meet their development goals⁵¹.

Progress in reaching the MDGs on health is being severely constrained by the absence of fully funded and functioning health systems⁵². For example, in Uganda, the current Health Sector Strategic Plan (HSSP III) has only one quarter of the financing it needs to meet the health needs of the population. El Salvador's new Health Reform Plan has a funding gap of US\$100 million and in Tanzania, the primary healthcare programme needs an additional €6 billion. In Nepal, good policies are not being implemented because of a lack of resources: *“We have not been able to implement the concept of Free Health Services properly. The human resources, infrastructure, medical supplies for such provisions are still inadequate”*⁵³. Moreover, the current economic climate means there are very limited options open to developing countries seeking to increase their income.

In 2011, there are two opportunities to substantially increase aid to health: the EC's €1 Billion MDG Initiative and the proposed Currency Transaction Levy/Financial Transaction Tax, currently on the table for discussion during the French Presidency of the G20. Governments and CSOs need to jointly work on the ongoing improvement of aid architecture to ensure new funding will be spent in the most effective way possible.

The limitations of results-based financing

Results-based financing for health, sometimes referred to as 'managing for development results', is commonly understood to mean that the payment of aid is conditional on the achievement of certain results⁵⁴. This can take the form of a 'cash payment or non-monetary transfer made to a national or sub-national government, manager, provider, payer or consumer of health services after pre-defined results have been attained and verified'⁵⁵. Performance-based aid is used by multilateral agencies such as the Global Fund, GAVI and the World Bank, as well as PEPFAR.

⁴⁸ OECD, *Aid for Better Health: What are we learning about what works and what do we still have to do?* Interim Report from the Task Team on Health as a Tracer Sector, Working Party on Aid Effectiveness, 2009.

⁴⁹ http://www.euroresources.org/fileadmin/user_upload/Euromapping/EM2010/Euromapping2010_LoRes.pdf.

⁵⁰ More than 350,000 women die annually from complications during pregnancy or childbirth, almost all of them — 99% — in developing countries. UN, MDG 5 Factsheet, 2010. Available at: http://www.un.org/millenniumgoals/pdf/MDG_FS_5_EN_new.pdf.

⁵¹ L. Wild and P. Domingo, *Aid and accountability in health: Key themes and recommendations*, Project Briefing, No. 44, ODI/World Vision, September 2010.

⁵² WHO, *Investing in our common future: Joint Action Plan for Women's and Children's Health*. Draft for consultation, 2010. Available at: http://www.who.int/pmnch/topics/maternal/201006_jap_pamphlet/en/index.html.

⁵³ Interview with Dr Bharat Pradhan, Executive Director of Public Health Concern Trust, Nepal.

⁵⁴ OECD, *Aid for Better Health: What are we learning about what works and what do we still have to do?* Interim Report from the Task Team on Health as a Tracer Sector, Working Party on Aid Effectiveness, 2009.

⁵⁵ See www.rbfhealth.org.

The Meso-American Health Initiative 2015, funded in part by the Gates Foundation and the Spanish Government, uses results-based financing as its basis. In this modality, governments have to provide a substantial matching contribution to this health programme, of which 50% will be reimbursed upon the achievement of jointly agreed targets for policy reform, quality and coverage of health services⁵⁶. Similarly, in Europe, MDG Contracting is being introduced by the EC as a way to reward performance against MDG indicators. The MDG contract is for six years, with at least 70% of funds provided as a fixed tranche, and up to 30% as a variable tranche that is only paid out when specific targets are reached. If there are concerns, up to 15% of the allocation can be withheld⁵⁷.

Who decides what a 'result' is?

While numerous country case studies have shown that a results-based approach has indeed created effective incentives for countries to reach their development targets, it has not always had an only positive effect on development. Mozambique, for example, is seen as being a "bad" performer, according to the Global Fund's Aid Effectiveness Scorecard. Consequently, the Global Fund has, on numerous occasions, halted or reduced disbursements to the country, which resulted in serious aid effectiveness problems, including greater unpredictability of aid flows. Moreover, other development partners in Mozambique state that, contrary to the Global Fund's evaluations, the health sector in particular had developed in an extraordinarily rapid and progressive manner during the last decade, considering that all of the country's health infrastructure and services had been devastated during the recent civil war. CSOs active in the health sector in Mozambique support the view that progress is being made, as Jose Davuca, Coordinator of the National Association of Nurses explains:

"Access to primary healthcare is improving throughout the country which contributes to the achievement of the MDGs. However, a lot more needs to be done in the area of infrastructure, personnel and the provision of medicines. This is particular important in the remote areas, where communities still have to walk long distances to reach a hospital or health centre. For instance, less than 40% of the Mozambican population has full access to primary healthcare."

The Mozambican case highlights that the Paris Principle of 'managing for results' should not be confused with 'financing by results', in other words, results-based management of aid should take into account the progress made by developing countries towards achieving their development goals. This is especially true for fragile states, which should receive particular attention and assistance for rebuilding their social sectors, before tying aid to sector performance.

Furthermore, an essential prerequisite for effective results-based financing is the existence of a robust health information and management system, which is still not the case in many developing countries, including middle-income countries such as El Salvador. In such circumstances, incentives might induce recipients to exaggerate results or falsify reports to receive payment. Sometimes, however, incentives can do more harm than good. In Tanzania, for example, health workers receiving a bonus for carrying out certain vaccination programmes consequently neglected other health services they had been responsible for⁵⁸.

⁵⁶ AfGH Health spending in El Salvador: the impact of current aid structures and aid effectiveness, 2011.

⁵⁷ DSW, June 2008. Budget support consequences for sexual and reproductive health.

⁵⁸ AfGH UK, Results-based Financing: Making sure the UK's aid for health delivers more health for the money, 2011.

Best practices

Increased international attention to managing for development results has moved monitoring and evaluation away from its previously narrow focus on inputs and outputs to the achievement of outcomes and impacts. A case that stands out in this regard is the recently adopted Malawi HIV/AIDS Monitoring and Evaluation (M&E) system, defined around a four-tiered results pyramid of indicators on input, output, outcome and impact. The design of the M&E system included a number of innovative aspects based on managing for results principles.

All phases – from strategic planning through implementation to completion and beyond – were accompanied by dialogue on results for partner countries, development agencies and other stakeholders, through regular consultations. The M&E system was strongly aligned with a results-oriented National HIV/AIDS Strategy, conceived within the framework of international conventions and agreements. The results reporting system was set up as a simple, cost-effective, and user-friendly tool.

A newly designed Activities Reporting System was produced, following extensive consultation and district-level input, and a specific curriculum was developed to train grassroots organisations involved in the system. Results information is used for management learning and decision-making, as well as for reporting and accountability. Data are promptly distributed to stakeholders, thus enabling M&E results to be utilised for decision-making, reporting and accountability⁵⁹.



⁵⁹ M. Goergens et al, Malawi: A National HIV/AIDS Monitoring and Evaluation System, in: *Managing for Development Results Principles in Action: Source book on emerging good practice*, 1st Edition, 2006. Available at: <http://www.mfdr.org/Sourcebook/1stEdition/6-3Malawi-A-National-HIV-AIDS.pdf>.

Table 4: Best practices in managing for results

Aid effectiveness commitments	Best practices
<p>PARIS DECLARATION</p> <p>44. Partner countries commit to: Endeavour to establish results-oriented reporting and assessment frameworks that monitor progress against key dimensions of the national and sector development strategies (Indicator 11).</p>	<p>National HIV/AIDS Monitoring & Evaluation System, Malawi</p> <ul style="list-style-type: none"> Focus on managing for, not by, results, by arranging resources to achieve outcomes. The M&E system is itself a tool to allow the National AIDS Commission to manage for development results in the future. All phases – from strategic planning through implementation to completion and beyond – were accompanied by dialogue on results for partner countries, development agencies, and other stakeholders via regular consultations. The results reporting system was set up as a simple, cost-effective, and user-friendly tool. Data are promptly distributed to stakeholders, thus enabling M&E results to be utilised for decision-making, reporting and accountability. <p>Inclusion of human rights and gender assessments in health sector review, Uganda</p> <ul style="list-style-type: none"> Mid-term review of the health strategy involved Ugandan CSOs and Ministry of Health. Supported by the UN Special Rapporteur on the Right to Health missions. Public accountability and ownership of the national health strategy strengthened by means of broad stakeholder engagement.
<p>49. Donors commit to: Provide timely, transparent and comprehensive information on aid flows so as to enable partner authorities to present comprehensive budget reports to their legislatures and citizens.</p>	<p>National HIV/AIDS Monitoring & Evaluation System, Malawi</p> <ul style="list-style-type: none"> A publicly accessible unified online development cooperation database. All donors and NGOs are asked to indicate and regularly update the programmes they are implementing in the country. Currently provides access to information on all bilateral, multilateral and South-South aid flows, in future will include decentralised cooperation and technical assistance.
<p>ACCRA AGENDA FOR ACTION</p> <p>23 a) Developing countries will strengthen the quality of policy design, implementation and assessment by improving information systems, including, as appropriate, disaggregating data by sex, region and socio-economic status.</p>	<p>Data disaggregation, Nepal</p> <ul style="list-style-type: none"> The Ministry of Health and Population is piloting a data collection system using data from hospitals and health facilities. Data is disaggregated according to sex, age, caste, ethnicity and regional identity. Results will show which groups benefit most from abolition of user fees and other policies.
<p>23 b) Developing countries and donors will work to develop cost-effective results management instruments to assess the impact of development policies and adjust them as necessary. We will better coordinate and link the various sources of information, including national statistical systems, budgeting, planning, monitoring and country-led evaluations of policy performance.</p>	<p>African Community of Practice on Managing for Development Results (AfCoP-MfDR)</p> <ul style="list-style-type: none"> The AfCoP provides an innovative method to strengthen capacities required to achieve and account for development results. Over 1,000 members from 37 African countries sharing experiences, networking and building strong learning relationships between practitioners in Africa and around the world. Members strive to make their organisations more results-oriented, effective and accountable to ensure that the lives of their fellow citizens are improved. Web-platform is a key forum for the community to ask questions, exchange experiences and to ensure sustained dialogue.

Recommendations

“Developing countries and donors will work to develop cost-effective results management instruments to assess the impact of development policies and adjust them as necessary. We will better coordinate and link the various sources of information, including national statistical systems, budgeting, planning, monitoring and country-led evaluations of policy performance.”

Accra Agenda for Action, 2008

Aid must have a real impact on country progress towards the health MDGs and universal access to primary healthcare and the right to health. Results-based financing programmes should be designed by taking into account the specific context and social realities of each beneficiary country, ensuring that reductions in aid due to poor performance do not exacerbate inequities in developing countries.

To this end, donors should consider taking the following actions:

- Ensure that managing for results is linked to progress and not just results performance. This is especially relevant to the long-term process of HSS, health promotion and behaviour change, research and access to healthcare for stigmatised and marginalised populations. Managing for results should not be confused with financing by results.
- Ensure that the indicators used to measure results are country-specific and directly related to national health plans. In order to be able to measure progress towards these indicators, countries need to be supported in their efforts to improve their data collection, disaggregated by sex, age and income information and public financial management systems.
- In conformity with the 2010 EU Plan of Action on Gender Equality and Women's Empowerment in Development, integrate gender perspectives into national health plans, annual and multi-annual planning and budget cycles, including gender indicators in health monitoring systems.
- Work on policy dialogue to ensure that interventions showing scientific evidence of their impact are included in national health plans.
- Promote the linkages between disease-specific programmes and other health initiatives, such as, for instance, reproductive health and family planning programmes and efforts to scale up the health workforce.
- Provide technical and financial support to developing countries by means of long-term, sustainable financing mechanisms that make universal access to primary healthcare possible.

APPENDIX: TRENDS IN HEALTH ODA: AN UPDATE

It is not possible to talk about the quality of aid without examining the quantity of aid being delivered. This appendix aims to give a snapshot of the quantity of aid from the five AfGH European donor countries to developing countries and to evaluate their performance with regard to ODA and health ODA.

The data contained in this appendix is taken from a report commissioned by AfGH to accurately calculate real aid transfers from the five AfGH countries⁶⁰. The main findings are summarised in table 5 of this appendix.

Methodology

In order to calculate ODA and health ODA as a percentage of total ODA, AfGH does not include expenses that do not make a difference to the lives of people living in recipient countries, such as administrative costs, the expense of housing refugees during their first year of asylum in the donor country, or debt that is written off from a country's balance sheet. All of these items are allowed to be classified as ODA according to OECD Development Assistance Committee (DAC guidelines), but do not represent real investments to build up the services and conditions required for human development in developing countries. Furthermore, the current practice of including debt relief in aid figures creates artificial 'bubbles' in official ODA statistics. The concept of real resource transfers represents a more realistic measure of overall donor efforts. In this way it becomes possible to accurately compare and evaluate the true ODA contribution of the five countries. A detailed description of the methodology applied is available on the AfGH website⁶¹.

⁶⁰ Performance of Economically Privileged Countries as Donors - Estimate of ODA Transfers to Developing Countries and Contributions for Health Promotion regarding Relevant Financing Mechanisms in the period 2007 to 2009. The Cases of: France, Germany, Italy, Spain and the United Kingdom of Great Britain and Northern Ireland, by Joachim Rueppel in cooperation with Sieglinde Mauder and Birgit Zuern, Medical Mission Institute, Wuerzburg, Germany.

⁶¹ <http://www.actiontracker.eu/sites/actiontracker.ttp.eu/files/Methodological%20Guidelines%20Monitoring%20ODA4Health%20fin.pdf>.

Table 5: ODA and health ODA contribution in relation to GNI of donor countries in 2007/8/9 (in %)

		ODA contribution in relation to GNI			Health promotion as % of total ODA contr. (in relation to real ODA transfer)
		Total ODA net	ODA for health		
		Year	Official figures	Real transfers	Disbursements
FRANCE	2007	0.38%	0.25%	0.042%	17.1%
	2008	0.39%	0.29%	0.043%	14.5%
	2009	0.47%	0.38%	0.041%	10.7%
GERMANY	2007	0.37%	0.24%	0.025%	10.2%
	2008	0.38%	0.28%	0.031%	11.2%
	2009	0.35%	0.31%	0.032%	10.2%
ITALY	2007	0.19%	0.16%	0.022%	13.9%
	2008	0.22%	0.17%	0.029%	16.4%
	2009	0.16%	0.15%	0.017%	11.7%
SPAIN	2007	0.37%	0.33%	0.036%	10.7%
	2008	0.45%	0.41%	0.047%	11.6%
	2009	0.46%	0.43%	0.053%	12.3%
UK	2007	0.36%	0.33%	0.061%	18.5%
	2008	0.43%	0.39%	0.060%	15.2%
	2009	0.52%	0.50%	0.076%	15.3%

ODA CONTRIBUTIONS IN RELATION TO GNI OF DONOR COUNTRIES IN 2009 (IN %)

a. Total ODA net⁶² in 2009 (real transfers)

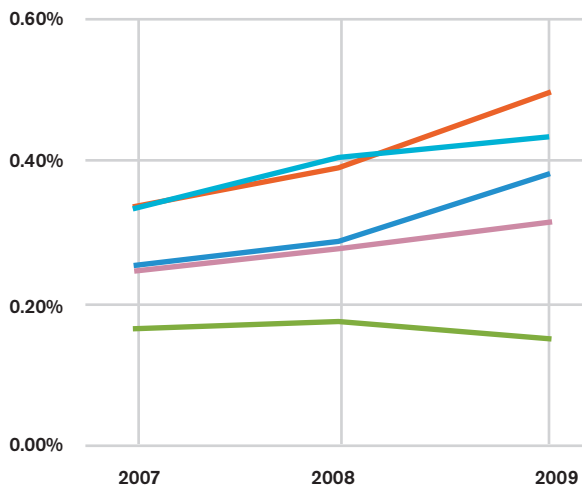
TARGETS⁶³

INTERIM TARGET
TO BE REACHED
BY 2010: 0.51%

TARGET TO BE
REACHED BY
2015: 0.7%



b. Total ODA Net 2007 – 2009 (real transfers)



The UK has now overtaken Spain as the largest contributor of real ODA in relation to GNI among these five countries. The only AfGH country that decreased the total real ODA in relation to GNI between 2007 and 2009 and therefore reversed progress in reaching the target is Italy. France and the UK made the most progress towards reaching the ODA target between 2007 and 2009 but the UK is the only country that looks likely to meet the interim target in 2010.

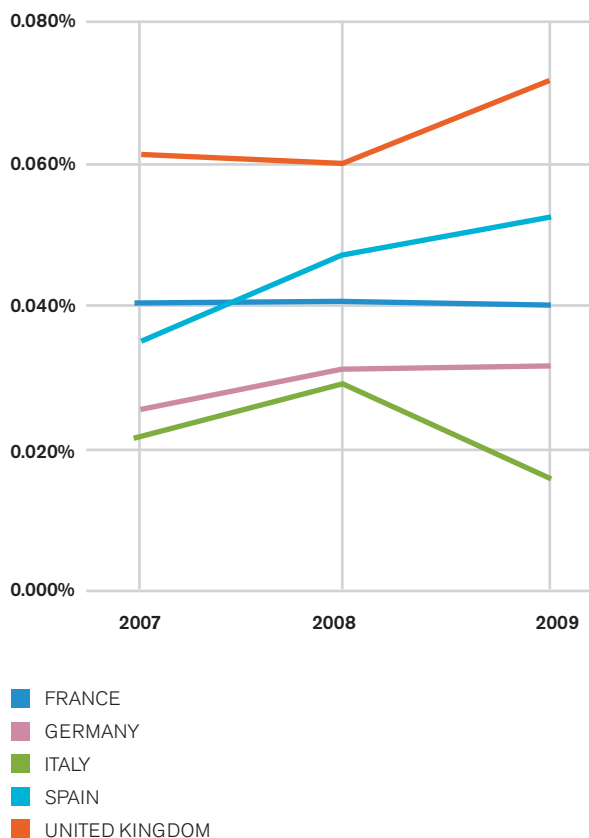
⁶² According to OECD-DAC definition this figure represents net disbursements i.e. less repayments of principal in respect of earlier loans.

⁶³ In March 2002, the EU set a collective target of reaching 0.39% ODA as a percentage of GNI by 2006. They reaffirmed this pledge in 2005 and went further, setting two new collective targets of 0.56% and 0.70% to be achieved by 2010 and 2015 respectively (with a minimum interim 2010 target for individual members of 0.51%).

c. ODA for health⁶⁴ in 2009 (disbursement)



d. ODA for health⁶⁵ 2007-2009 (disbursement)⁶⁶



In order to be on track to reach the WHO health target, countries need to have allocated 0.076% of their GNI to health by 2010⁶⁷. Therefore, only the UK is currently on track to meet the target. Both Germany and Spain made some progress on 2008 but France saw no change in its health ODA contributions in relation to GNI. Italy was the worst performer as the only country in which health ODA as a percentage of GNI decreased.

⁶⁴ In order to allow comparison with resource needs estimates, all aid activities which coincide with the definition of the Millennium Project for health funding are taken into account, whether they are currently registered under the health sector or other sectors; this definition includes the cost of running a health system offering essential medical interventions as well as interventions primarily provided outside the health system, such as preventing major diseases; on the other hand it excludes nutrition projects carried out by institutions outside the health system as well as activities related to population policy and management, such as work on census or migration.

⁶⁵ See footnote 60.

⁶⁶ Please note that figures given in the AFGH 2010 Policy Report have been revised in light of new information.

⁶⁷ Health ODA should represent 15% of total ODA. Thus 15% of 0.7% by 2015 is equivalent to 0.1%, while 15% of 0.51% is equivalent to 0.076%.

COUNTRY SCORECARDS

PROGRESS

FRANCE 



France has made a real effort to reach its pledges of 0.7% of GNI by 2015 and the interim pledge of 0.51% of GNI by 2010. Between 2007 and 2009, ODA (both official and real transfer) increased. However, there is still room for improving on health ODA, where amounts have remained more or less constant. In particular, France is the only country that did not increase its commitments to ODA for health in 2009.

GERMANY 



Germany has made very slow progress towards the ODA targets relative to other countries. Between 2007 and 2009, ODA real transfer and disbursement for health ODA in relation to GNI increased, and at the same rate.

ITALY 



Italy's record on development assistance is poor compared to the other four AfGH countries and in respect of its position as a G8 member. It is the only country that has allowed its ODA in general terms to decline and health ODA to decline at a proportionately higher rate. Between 2007 and 2008, Italy made small progress in that ODA (both official and real transfer) and disbursement of health ODA increased in relation to GNI. However, these have both drastically decreased, following an aid budget cut of 56% prior to the financial crisis and non-payment of €280 million to the Global Fund (the annual tranche of €130 million in 2009 and 2010, plus an additional €20 million pledged at the G8 Summit in 2009).

SPAIN 



Relative to its economic size, Spain has demonstrated real commitment to ODA. Between 2007 and 2009, both ODA official and real transfer and disbursement for health ODA in relation to GNI increased at a constant rate.

UK 



The UK has made strong headway so far towards the ODA targets. Official and real transfer ODA in relation to GNI increased between 2007 and 2009. Although commitments and disbursements for health ODA decreased in 2008, they increased again in 2009 and the UK is now the only country to be on track to meet the WHO target of 0.076% of GNI allocated to health aid by 2010.

FORECAST



2010 will see a decrease in French ODA due to the financial crisis. According to the Ministry of Finance, health ODA as a percentage of total ODA will further decrease in 2010, even if a new health commitment is made in 2010.



Stagnation of the German aid budget is expected from 2010 onwards due to the financial crisis. Severe budget cuts, including to health ODA, are expected from 2012-2014.



The trend towards lower ODA and health ODA is likely to continue into 2010 and 2011. It is expected that ODA real transfers in relation to GNI will fall to 0.13% by 2011. Since Italy has not paid its annual contribution to the Global Fund and no commitment has been made for 2011-2013, health ODA will similarly decrease.



Evidence suggests that Spain will not maintain the level of progress made so far, due to the financial crisis. Instead of a continuation of the same trend, evidence shows that health ODA is decreasing back to 2008 levels in 2010. During 2010, cuts have been made in multilateral support to health that will mean an even lower percentage in terms of real transfers. The forecast for 2011 for health ODA is a mere 0.022%, less than half of what was committed in 2010.



So far, the UK has held on to its commitments even in the face of the global economic downturn and a huge national deficit. ODA was one of the few areas protected from spending cuts undertaken as part of the UK Coalition Government's Comprehensive Spending Review in autumn 2010. It is anticipated that the percentage of GNI spent on health will continue to grow. The UK has also committed to pass legislation in 2011 putting the 0.7% target into law. There are, however, concerns that the Coalition Government will broaden the definition of development to include more expenditure lines within ODA figures than the previous Government. The Coalition Government has committed to respecting OECD-DAC definitions but not necessarily the even tighter definitions that the UK has followed in the past.

SUMMARY AND RECOMMENDATIONS

Due in large part to the global financial crisis, development budgets and health aid are likely to stagnate (in Germany) or be cut back (in France, Italy and Spain) in 2010 and 2011. Germany needs to ensure aid to health is protected as the ODA budget stagnates. France and Italy need to urgently review their ODA spending against the strong commitments they have made to health on the global stage, not least at recent G8 Summits. In Spain, the anticipated cuts to the global health institutions are a dramatic and embarrassing U-turn for a country that has led the way towards the ODA targets. The restructuring of aid modalities should not be allowed to result in a decrease in the total amount of ODA invested in health. Meanwhile in the UK, it will be important to monitor how ODA is calculated to ensure no decrease in the real amount of aid transferred.

CONCLUSION

The aid effectiveness agenda is alive and well in terms of its influence on decision-making, the mechanics of ODA and the search for better 'value for money'. But it needs to be healthier.

In several ways, the aid effectiveness agenda is having unintended consequences, or 'side effects', for health funding, civil society and the health MDGs, which are decidedly unhealthy and therefore undermining results.

Many of the symptoms can be treated by the widening of participation in budget planning processes and especially the greater involvement of civil society. An unanticipated outcome of the increased cooperation between governments and donors has been the adverse impact on donor and government relations with stakeholders, including Parliament and civil society.

Ministries of Finance are not necessarily the strongest champions of health and the health needs of the poor. Ownership, donor coordination and managing for results are all in danger of not delivering strong health outcomes, unless Ministers of Health, parliamentarians, CSOs and all relevant stakeholders are involved front and centre in the budget planning process. To this end, progress in developing tools and strategies such as JANS is a very encouraging development.

European donors need to urgently review their ODA health spending in light of the strong commitments made on the global stage. In particular, they can ensure that their investment in health yields visible and tangible dividends by taking the following three concrete steps:

- 1. Coordinate health aid better by providing an appropriate mix of funding mechanisms tailored to the needs of the local context as defined by national health plans.**
- 2. Directly support CSS to enable civil society to participate meaningfully in the development and implementation of all national health plans and related policies.**
- 3. Ensure managing for results is aligned with country efforts towards long-term goals, including HSS, universal access to primary healthcare and the attainment of the MDGs.**

GLOSSARY

Accra Agenda for Action (AAA)

The Accra Agenda for Action (AAA) was drawn up in 2008 and builds on the commitments agreed in the Paris Declaration. It contains the following main principles:

- Predictability – donors will provide three- to five-year forward information on their planned aid to partner countries.
- Country systems – partner country systems will be used to deliver aid, as the first option, rather than donor systems.
- Conditionality – donors will switch from reliance on prescriptive conditions about how and when aid money is spent to conditions based on the developing country's own development objectives.
- Untying – donors will relax restrictions that prevent developing countries from buying the goods and services they need from whomever, and wherever they can get the best quality at the lowest price.

Community System Strengthening (CSS)

Community Systems Strengthening (CSS) is an approach that promotes the development of informed, capable and coordinated communities and community-based organisations, groups and structures. CSS involves a broad range of community actors, enabling them to contribute as equal partners alongside other actors to the long-term sustainability of health and other interventions at community level, including an enabling and responsive environment in which these contributions can be effective. The goal of CSS is to achieve improved health outcomes by developing the role of key affected populations and communities and of CBOs in the design, delivery, monitoring and evaluation of services and activities related to prevention, treatment, care and support of people affected by HIV, tuberculosis, malaria and other major health challenges.

International Health Partnership and Related Initiatives (IHP+)

The International Health Partnership and Related Initiatives (IHP+) seeks to achieve better health results by mobilising donor countries and other development partners around a single country-led national health strategy, guided by the principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. Launched in September 2007, IHP+ aims to better harmonise donor funding commitments and improve the way international agencies, donors and developing countries work together to develop and implement national health plans. For more information, visit: www.internationalhealthpartnership.net.

Joint Assessment of National Strategies (JANS)

Joint assessment is a shared approach to assessing the strengths and weaknesses of a national strategy. The intention is that the assessment is accepted by multiple stakeholders and can be used as the basis for technical and financial support. Joint Assessment can be applied to a national health strategy (sometimes called the sector strategic plan); to a sub-sector strategy such as the national malaria strategy, or to the multi-sector AIDS strategy.

Paris Declaration on Aid Effectiveness

Endorsed on 2 March 2005, the Paris Declaration is an international agreement in which over 100 ministers, heads of agencies and other senior officials adhered to and committed their countries and organisations to continue to increase efforts in harmonisation, alignment and managing aid for results, with a set of monitorable actions and indicators. The main principles enshrined in the Declaration are:

- Ownership - developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.
- Alignment - donor countries align behind these objectives and use local systems.
- Harmonisation - donor countries coordinate, simplify procedures and share information to avoid duplication.
- Results - developing countries and donors shift focus to development results and results get measured.
- Mutual accountability - donors and partners are accountable for development results.

Results-Based Financing (RBF)/Management for Development Results (MfDR)

Results-Based Financing for health refers to any programme that transfers money or goods, either to patients when they take health-related actions (such as having their children immunised), or to healthcare providers when they achieve performance targets (such as immunising a certain percentage of children in a given area).

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LIST OF ACRONYMS

AECID	Spanish Development Agency
AfCoP-MfDR	African Community of Practice on Managing for Development Results
AfGH	Action for Global Health
AIDS	Acquired Immune Deficiency Syndrome
CBO	Community-Based Organisation
CCM	Country Coordinating Mechanism
CSO	Civil Society Organisation
CSS	Community Systems Strengthening
CSSM	Civil Society Support Mechanism
DANIDA	Danish International Development Assistance
DENIVA	Development Network of Indigenous Voluntary Associations
DFID	Department for International Development
EU	European Union
EC	European Commission
GAVI	Global Alliance for Vaccines and Immunisation
GBS	General Budget Support
GHI	Global Health Initiative
GNI	Gross National Income
G20	Group of 20
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
HSSP	Health Sector Strategic Plan
IHP+	International Health Partnership and Related Initiatives
IMF	International Monetary Fund
INGO	International Non-Governmental organisation
JANS	Joint Assessment of National Strategies
LGBT	Lesbian, Gay, Bisexual and Transgender
MfDR	Management for Development Results
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MP	Member of Parliament
NGO	Non-Governmental Organisation
ODA	Official Development Assistance
OECD	Organisation of Economic Cooperation and Development
OECD-DAC	OECD-Development Assistance Committee
PEFA	Public Expenditure and Financial Accountability
PEPFAR	President's Emergency Plan for AIDS Relief
RBF	Results-Based Financing
SBS	Sector Budget Support
SICD	Information System for Development Cooperation
SIDA	Swedish International Development Agency
SRHR	Sexual and Reproductive Health and Rights
SWAp	Sector-Wide Approaches
TTHATS	OECD Task Team on Health as a Tracer Sector
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organisation

Action for Global Health is a network of European health and development organisations advocating for the European Union and its Member States to play a stronger role to improve health in developing countries. AfGH takes an integrated approach to health, based on gender equality and women empowerment, and advocates for the fulfilment of the right to health for all. One billion people around the world do not have access to any kind of health care and we believe that Europe can do more to help change this. Europe is the world leader in terms of overall foreign aid spending, but it lags behind in the proportion that goes to health.

Our member organisations are a mix of development and health organisations, including experts on HIV, TB and sexual and reproductive health and rights, but together our work is organised around a broad approach to health. AfGH works to recognise the interlinkages of global health issues and targets with a focus on three specific needs: getting more money for health, making health care accessible to those that need it most and strengthening health systems to make them better equipped to cope with challenges and respond to peoples' needs.

In the lead up to the 4th High-Level Forum on Aid Effectiveness taking place in Busan, South Korea in December 2011, Action for Global Health's fifth annual report assesses the implementation of the Paris Principles by the EU and its Member States, and considers their impact on the health sector in developing countries. This report highlights progress and challenges in three key areas – coordination, ownership and managing for results – and sets out the concrete steps which must be taken if we are to see tangible results by 2015. The report also tracks the levels of aid for health, focusing specifically on AfGH countries, showing current and future trends.

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