

## Helpdesk Report: Different Funding Modalities for Health

Date: 28<sup>th</sup> June 2011

**Query:** What is the evidence on providing health funding support through unearmarked sector budget support as opposed to disease specific funds or programmes?  
Are there specific outcomes that can be attributed to different funding modalities?  
Are there any outcomes (or outputs) that can be linked to the way support is provided including sustainability or institutional strengthening?  
Is one way or the other way better or worse for outcomes?

**Enquirer:** DFID UK

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### 1. Overview

The World Bank and GAVI Alliance (2010) note that there is no specific evidence on the effectiveness of budget support for immunisation programmes. Assessment of the values of budget support for immunisation financing includes:

- Increased predictability of financing though support is at risks where there is conditionality.
- Whether support is equitable depends on the extent to which budget support will be allocated towards activities and programmes to improve the plight of the poor and to reduce poverty.
- Budget support is expected to reduce the transaction costs of dealing with the financial and programmatic reporting and audit requirements of each individual donor separately.
- Budget support is thought to be a sustainable mechanism as it creates a sense of ownership of the national plan and of financing of the health sector.
- Budget support from development partners is usually matched with government financing of the sector (and of the programme) and would contribute to self-sufficiency.
- Given that planning, budgeting, and monitoring of use of budget support are integral to sector coordination, this will contribute to greater accountability.

Williamson et al. (2008) find the deployment of uncoordinated project aid in many sectors has contributed and continues to contribute towards a vicious circle, compounding poor sector

governance. They suggest a balance of sector-based aid and general budget support. They suggest better dialogue at sector level and avoiding projects and common funds. The incentives within donor agencies and recipients also need to be addressed. Ultimately, the likelihood of reform relies on political support and technical leadership within government. This is very difficult for the donor community to influence.

SWApS can be important in making sector budget support (SBS) work. SWApS have been found to be successful in putting tools and processes in place for improved sector coordination but made only modest achievements of national health objectives (Villaincourt, 2009). The sequencing of efforts to develop and use local skills and systems can mitigate the risks of delayed implementation and a weak results focus.

Global health partnerships can result in a 'brain drain' of individuals best placed to provide national technical and managerial leadership. The International Health Partnership and related initiatives (IHP+) aims to address these issues at both a global and country level. Grant (2009) argues that the IHP+ needs a robust SWAp at country level to meet its ambitious targets.

In section 3, some points are pulled out from an in-depth case study of sector budget support in Mozambique (Visser-Valfrey and Umarji, 2010). The authors find some positive contributions of SWAp procedures and that sector budget support will consolidate positive impacts.

The ODI and Mokoro (2009) case study on SBS in Zambia concludes that SBS in the health sector in Zambia has not had a significant effect in meeting the objectives of partner countries and cooperating partners. This is mainly because SBS has not been extensively implemented in Zambia, so the experience has been very limited, with only small amounts of funding channelled through SBS over a relatively short period of time. Issues related to the design of SBS, delays in disbursements and budget transparency have caused significant problems. As a result, it is unsurprising that the experience of SBS so far has not been very positive, however if these problems are resolved, SBS still has the potential to be effective in supporting the achievement of health sector goals.

Evaluation of The Global Fund to Fight AIDS, Tuberculosis and Malaria (2010) finds:

- collective efforts have resulted in increases in service availability, better coverage, and reduction of disease burden
- health systems in developing countries will need to be greatly strengthened if current levels of services are to be significantly expanded
- equity is not always reflected in grant performance
- the performance-based funding system faces considerable limitations at country level
- the partnership model has opened spaces for the participation of a broad range of stakeholders
- country coordinating mechanism (CCM) have been successful in mobilising partners for submission of proposals. However, grant oversight, monitoring, and technical assistance mobilisation roles remain unclear and substantially unexecuted. The CCMS' future role in these areas and in promoting country ownership is in need of review.

A 2005 evaluation of the effects of the Global Fund (GF) on reproductive health in Ethiopia and Malawi finds successful mobilisation of resources but challenges in using funds efficiently and effectively. Improvements have been made in increasing actor involvement. Focus on three diseases has not been beneficial to broader health systems strengthening and other health priorities have been overshadowed. Opportunities that have arisen to strengthen health systems while implementing GF activities have often been missed, as in the case of the drug procurement system in Malawi.

The GAVI Alliance focuses on immunisation provision. Evaluation has found that:

- GAVI's basic programmatic approaches and the development of tools to support countries' financial planning was a key source of innovation in Phase I.
- Co-financing has supported country ownership, but it has contributed relatively little to financial sustainability and changes to the policy have been a cause of confusion at the country level.
- GAVI's choice of vaccines and its basic funding model – despite its contributions to tools and country approaches – has had a negative impact on country financial sustainability.
- The flagship programme has accelerated introduction of life saving vaccines and immunisation outcomes.
- Financing vaccine technologies has been successful and sustainable.

A report on Currency Transaction Levy-for-health is referenced in section 5. This has some useful discussion on the pros and cons of budget support and other funding mechanisms.

## **2. Budget support and sector wide approaches (SWAps)**

### **Immunization Financing Toolkit, Brief 10: Budget Support**

The World Bank and GAVI Alliance, 2010

[http://www.who.int/immunization\\_financing/tools/Brief\\_10\\_Budget\\_Support.pdf](http://www.who.int/immunization_financing/tools/Brief_10_Budget_Support.pdf)

Increasingly, the global health community is moving away from direct project assistance for health and towards sectoral or general budget support. This is in response to the perceived failings of classical project support. Projects often suffer from slow and delayed implementation, high transaction costs, and limited sustainability. They also tend to undermine government structures and processes. Projects are designed to respond to the preferences of donors rather than national priorities. This undermines ownership and the setting of national priorities, and compromises the sustainability of project results. (See Brief 8: Development Project Assistance).

In the case of sectoral and general budget support, immunisation resources fall less and less under the purview of national immunisation programme managers (as is the case with project assistance) and increasingly under the control of the ministry of health or the national treasury. It is therefore important to ensure that programme needs are adequately prioritised within the national strategic plan and budget. This has been a challenge for national programmes as they introduce new vaccines, particularly since they are outside of the national planning and budgeting framework (i.e. they are off-budget). Efforts need to be made to ensure the evidence base for the introduction of new vaccines, to facilitate adequate policy dialogue on priority setting, and to roll these resource requirements into annual or multi-year budgets to the extent possible. Greater advocacy between ministries, parliamentarians, and donor agencies may help in this regard.

Budget support has contributed to greater policy alignment and harmonisation of development aid. General budget support has been linked to increases in pro-poor development expenditures, and reduced earmarking of government budgets. General budget support has also been an effective instrument in strengthening public financial management and improving transparency and accountability. By increasing needed expenditures, budget support has helped to expand service delivery. An additional expected benefit of budget support is reduced transactions costs. There is no specific evidence on the effectiveness of budget support for immunisation programmes. Recent reviews of the effectiveness of SWAp mechanisms in improving health outcomes have found both strengths and areas for improvement. Sector programming is becoming better integrated within the budget planning process and there is improved diagnosis of barriers to service utilisation. There is also

evidence of closer links between policy and implementation. However, SWAp mechanisms explicitly require ministry of health leadership and, in some contexts, limited capacity coupled with high turnover of leadership and weak relationships with the ministry of finance has made this difficult. SWAp coordination has led to better planning and budgeting of the sector but vertical health initiatives still operate outside of these mechanisms to a large extent and this could potentially undermine gains. There is also a lack of information on the health impact of SWAp mechanisms. Broad participation in SWAp mechanisms has been limited in some cases, particularly in civil society. Weaknesses in monitoring systems persist and some donors are unable or unwilling to provide funding through government systems. In addition, budget support may increase the leverage of donors over national health policy since they participate more actively in planning, budgeting, and monitoring of the national health strategic plan.

Assessment of the values of budget support for health and immunisation financing include:

- Budget support can increase predictability of financing through multi-party planning and budgeting of health sector priorities. If budget support is conditional on achievement of targets, there is some risk that disbursements will be less than commitment levels.
- Whether support is equitable depends on the extent to which budget support will be allocated towards activities and programmes to improve the plight of the poor and to reduce poverty.
- Budget support is expected to reduce the transaction costs of dealing with the financial and programmatic reporting and audit requirements of each individual donor separately. The initial costs of establishing coordination mechanisms may be high in terms of time and effort, but these should decrease over time.
- SWAp mechanisms require significant investment in time and coordination – both in the initial stages and for continued maintenance.
- Budget support is thought to be a sustainable mechanism as it creates a sense of ownership of the national plan and of financing of the health sector.
- Budget support from development partners is usually matched with government financing of the sector (and of the programme) and would contribute to self-sufficiency.
- Given that planning, budgeting, and monitoring of use of budget support are integral to sector coordination, this will contribute to greater accountability.

### **Building Blocks or Stumbling Blocks? The Effectiveness of New Approaches to Aid Delivery at the Sector Level**

Williamson T et al., Research project of the Advisory Board for Irish Aid, 2008

<http://www.odi.org.uk/resources/download/1526.pdf>

In the continuing search for ways to provide more effective aid, donors have committed themselves to making greater use of government systems and harmonising the way aid is delivered. Donors who agreed to the Paris Declaration on Aid Effectiveness in 2005 are free to choose their own modality, as long as they progressively shift towards those that use government systems in full.

Programme-based approaches have been developed with these principles in mind. While such approaches accommodate all modalities, direct budget support and debt relief provided to recipient governments are those best suited to the use of government systems. Yet, donors are hesitating to move decisively towards these modalities, even in contexts where programme-based approaches have been well established by the adoption of sector-wide approaches (SWAPs) and national poverty reduction strategies (PRSs). Instead, they continue to use either project arrangements or intermediate modalities, such as common, pooled or basket funds. The justification usually offered is that recipient country systems are

too weak for a shift to sector or general budget support (GBS). Common funds (CFs) are presented as 'transitional' aid modalities by means of which donors can help strengthen country policies and systems while ensuring that aid funds are well spent.

This working paper analyses the effectiveness of different aid modalities and the coordination mechanisms associated with programme-based approaches at the sector level. It draws from three case studies, covering the education sector in Tanzania, the water and sanitation sector in Uganda and the health sector in Mozambique, and also from the broader literature.

The report finds the deployment of uncoordinated project aid in many sectors has contributed and continues to contribute towards a vicious circle, compounding poor sector governance. Six reasons for this are listed.

The principles of country ownership, alignment with country policies and systems and improved coordination embodied in the new aid paradigm are largely well conceived, and have the potential to deliver a break from the vicious circle of aid ineffectiveness. However, to date, traditional behaviour in aid delivery remains prevalent. To achieve this the report suggests:

- A balance of sector-based aid and general budget support
- Delivering better aid and better dialogue at the sector level
- Avoiding using projects and common funds in support of service delivery wherever possible.
- Addressing the incentives within donor agencies and recipients.

Changes in aid and donor behaviour have delivered some improvements in domestic policies and systems, however, this has failed to deliver a decisive shift from past ineffectiveness, and the vicious circle of aid ineffectiveness is likely to continue. This paper asserts that the aid paradigm has the potential to deliver this decisive break. A key finding is that common funds can act as stumbling blocks rather than building blocks in strengthening service delivery. A more decisive shift in aid modalities towards budget support, plus a change in donor behaviour, is required to break out of this circle.

However, a key constraint is the incentives within recipient and donor agencies which perpetuate the circle of aid ineffectiveness. Recipient incentives can be addressed by a shift in aid modalities towards Direct Budget Support. This increases the importance of changing the incentive structures within donor agencies to deliver against the new aid paradigm.

Ultimately, the likelihood of reform at the sector level relies on political support and technical leadership within government. This is very difficult for the donor community to influence.

### **Do Health Sector-Wide Approaches Achieve Results? Emerging Evidence and Lessons from Six Countries**

Vaillancourt D, Independent Evaluation Group, World Bank, 2009

<http://siteresources.worldbank.org/EXTWBASSHEANUTPOP/Resources/wp4.pdf>

This study distills evidence from six countries (Bangladesh, Ghana, Kyrgyz Republic, Malawi, Nepal and Tanzania) to address four questions regarding SWAps in the health sector:

1. Were the anticipated benefits of the *approach* realised?
2. Were the objectives of the national health strategies and programmes of work (PoWs) achieved?
3. Did the *approach* facilitate the achievement of national health objectives?
4. In what ways did channeling support through a SWAp affect the World Bank's efficacy?

Findings on benefits and achieving objectives:

- The report finds health SWApS have been largely successful in putting in place critical tools and processes for improved sector coordination and oversight.
- All SWApS made some headway in improving the harmonisation and alignment of development assistance, albeit with some shortcomings.
- Health SWApS have been only modestly successful in achieving improved sector stewardship.
- In most of the six countries, national health objectives were only modestly achieved under the SWAp.

How did the approach facilitate the achievement of health objectives?

- PoWs that set specific, prioritised, phased, and ambitious-but-feasible targets and that assessed the political economy of reforms were more likely to achieve their objectives.
- The strength of local capacities and systems used for common implementation arrangements determined the pace and efficiency of PoW implementation.
- Country experience has revealed three dimensions of partnerships formed under SWApS that can enable – or undermine – the achievement of results: who is in the partnership; the main functions of the partnership and how effectively they are carried out; and how the partners interact.
- The predictability, flow, and use of health sector resources – both domestic and external – have affected the efficacy and efficiency of PoW implementation.

Lessons learnt:

- The adoption and financial support of a PoW based primarily on the collaborative process for its preparation and/or its strong national ownership alone are not sufficient to ensure optimal health sector performance and outcomes.
- The sequencing of efforts to develop and use local skills and systems can mitigate the risks of delayed implementation and a weak results focus.
- Incentives, whether through rewards, sanctions, and/or pedagogical interventions, can strongly and positively affect a SWAp's results focus.
- The effectiveness of SWApS at the local level can be improved through better management of local political economy issues and strengthening technical, strategic decision-making, and service delivery capacity of health districts and facilities.

### **SWApS in the 21<sup>st</sup> Century**

Grant K., HLSP, 2009

Not available online.

SWApS proposed a new way of working, and although many development agencies signed up to the principles, many individuals found the change from a project approach challenging. Progress in implementation apart from a few countries such as Ghana has been slow.

Two other striking features of international support to the health sector in low income countries over the last two decades added to the inefficiencies of fragmented bilateral aid. The first is the rapid and continuous introduction of new global initiatives for technical and financial support – often before previous ones have been tested and evaluated. The second is that most of these ideas originate in Geneva, Washington, New York or the head quarters of bilateral donors – in contrast to thirty years ago when many of the ideas were developed and written up in Africa and Asia.

The adoption of the Paris Principles in 2005 gave recognition both to the issues to be addressed and the principles in resolving them. However new global initiatives still continue to be approved and donor behaviour continues to be schizophrenic – providing financial

support to Global Health Partnerships (GHPs) while supporting governments at country level to cope with the fragmentation that results.

A recently emerging issue is that the expansion of the global health partnerships has resulted in a 'brain drain' of those individuals best placed to provide national technical and managerial leadership. The International Health Partnership and related initiatives (IHP+) aims to address these issues at both a global and country level but there still remains a lot of work to do. This paper argues that the IHP+ needs a robust SWAp at country level to meet its ambitious targets.

The recent focus on new financial initiatives through the innovative financing taskforce, for example, the support to health systems strengthening through GFATM and GAVI and the discussions on a new joint funding platform for health system strengthening are again likely to risk further separating further technical and funding work streams at country level. A robust SWAp at country level will be needed to enable these initiatives to be effective.

Effective involvement of the non-state sector needs to be a key task of the new generation of SWAps. While there is now general recognition of the major role the private sector (both not for and for profit) plays in delivering health care to the poor, SWAps to date have not involved private providers in a way that will improve quality and value for money. Indeed one challenge is that governments are less willing to commission services from NGOs than development partners used to be when using a project approach.

The paper not only argues that using a SWAp at country level is needed now more than ever, but also sets out some of the lessons learnt. One clear lesson is not to be purist. The approach must be sufficiently inclusive to allow different agencies to use different funding modalities while signing up to the broader national health framework. Another is to recognise that building national capacity particularly for financial systems and management may take longer than originally thought: partners need to be realistic in assessing the overall management capacity and not be overly concerned by any need to provide interim support.

There is a risk that the SWAp becomes another "planner's dream", marked by a quest for coherent and consulted policies, actionable plans, robust and reliable financial management systems, with evidence pouring out of smart monitoring systems and donors aligning happily behind the bandwagon. This would set the goalposts so high that actual implementation becomes a remote possibility. Dealing with complexity by constructing a grand system with fixed norms, standards, checklists and measuring points is not the way forward.

The second risk is the polar opposite of the first. It lies in the dangers of adopting an approach that assumes that chaos is all-pervasive and continuous, and that all that can be done is to keep things basic and simple by way of an unprincipled, unguided 'muddling through'.

Between these two extremes is the promising middle ground for what this paper calls 'SWAp+', which recognises the complexity, accepts the disorder, and evolves a strategy for dealing with both. This is a demanding and difficult option but shows most potential, and would involve:

- Moving beyond the aid effectiveness agenda in SWAps and adopting a sector development perspective as the basic point of departure, recognising that sectors and SWAps do not start from scratch.
- Adopting an explicit political economy perspective on the sector; developing greater understanding of the stakeholders (including donors) and the wider context in which the sector operates; recognising the fundamental political nature of sector development processes; and understanding the drivers and constraints to change.

- Adding a consistent actor/stakeholder perspective on SWAps and sector programmes, asking not only what is in it, but also who are involved and who does what.
- Strengthening managerial inputs in the process – stronger “management from the top” from domestic authorities, coupled with better “management from below” from donors.
- Focusing on results in a basic, common sense, practical way in processes and arrangements related to SWAps and sector development.

The paper argues that it will be through adopting a realistic, pragmatic, coordinated SWAp+ approach that the very substantial resources now available for health can be used to the greatest effect to improve health and reduce poverty.

### **Improving the Results Focus in Health Sector Wide Programming**

Pearson M, HLSP, 2010

Not available online.

This paper aims to shed light on the issue of how to improve the results focus of health sector wide programmes in South Asia focusing on how to align and structure financing to maximise results. The key findings are summarised below:

- Terminology is extremely confusing and terms like Performance Based Aid (PBA), Results based aid or Results based financing (RBF) are used as if they were equivalent, which they are not.
- The evidence base on results based approaches remains extremely weak: well designed studies and piloting is required.
- All programmes have a certain degree of results orientation. It is how results are defined and whether satisfactory indicators can be identified to reflect the results focus.
- While the choice of indicators matters, the key to designing a successful results oriented programme is to develop a clear understanding of the incentive structure faced by key stakeholders and underpinning the programme.
- The main problem is not the fact that there is too much focus on process indicators in result frameworks. It is ensuring that a results focus is used at all stages but particularly that sector coordination arrangements allow for real dialogue on how results can be improved.
- Financial incentives are only one of a number of incentives, and if Government are truly committed to achieving the desired results it is difficult to see what further financial incentives will do.
- Where performance based payments are involved, definitions should be precise and the rules of the game need to be clear.
- A realistic sector programme based on a good diagnosis of the problem and a good understanding of sector bottlenecks is a key precondition, as is the existence of effective mechanisms that enable dialogue between government and donors on whether results are being achieved or not, and why.
- There is no perfect performance framework. In searching for one donors often encourage overelaborate and ultimately extremely burdensome frameworks. What is needed is simple, measurable indicators that everyone can understand and apply.
- The understandable failure of many programmes to deliver often elicits an inappropriate response by donors (withdrawal of funding/use of parallel funding) rather than reappraise targets and supporting capacity development.
- RBA/RBF mechanisms remain one sided – penalising failure but not rewarding over performance. Rewarding performance is difficult for donors to manage – they face competing demands which can undermine an intended results focus.

- Paradoxically rapid introduction of results based approaches might be easier in fragile, post-conflict situations – though it needs to be combined with parallel efforts to build national capacity.
- Attribution will remain next to impossible as RBA/RBF approaches will, quite rightly, tend to be implemented as part of a package that may involve other donors and other reforms.
- Shifting to a results focus will shift emphasis away from fiduciary assessments to assessing the ability of M&E systems to measure progress.

### 3. Sector budget support in practice, ODI and Mokoro

#### **Sector Budget Support in Practice, Case Study, Health Sector in Mozambique**

Visser-Valfrey M & Umarji MB, ODI, 2010

[http://mokoro.co.uk/sites/default/files/documents/SBSIP%20Mozambique%20Health%20Case%20Study\\_31\\_07\\_10.pdf](http://mokoro.co.uk/sites/default/files/documents/SBSIP%20Mozambique%20Health%20Case%20Study_31_07_10.pdf)

The overall purpose of the study is to draw together experience of sector budget support (SBS) to guide future improvements in policy and practice by partner countries and donors. The additional objective of this case study is to assess the lessons from experience to date in the health sector and to provide the Government of Mozambique and donors with guidance that will help them improve the design and implementation of SBS in future.

Points on the nature of sector budget support:

- Key development partners (DPs) provide external support in the context of the sector-wide approach (SWAp), which was put in place in 2000.
- The transition to SBS from the fragmented project support which characterised the sector in the mid 1990's has taken place over a decade. A number of common funds (CF) were progressively introduced and an increasing share of donor funding is provided through CF, now largely reflected on-budget.
- Until 2008, three common funds were in place in the Health Sector (the Provincial CF, the CF for Drugs, and PROSAUDE I). In 2008, the first two were merged into PROSAUDE II which became the only joint funding mechanism to the sector.
- For PROSAUDE II, funding is provided in two distinct ways – as internal or external budgetary funding. Donors concerned about funding through the State budget being 'lost' to the overall budget at the end of the year, can use a system by which funds are marked at the outset by donors as external funds.
- SBS is channelled via the Single Treasury Account, and the majority uses government procurement accounting and audit systems, governed by the new public financial management system (SISTAFE) law.
- SBS does not use government cash management arrangements and instead, when funds are disbursed by SBS donors they are transferred to spending agencies.
- Disbursements are based on overall 'satisfactory performance' of the sector against agreed indicators.

It is too early to say what the specific effect of the SWAp is. However, the CF and associated SWAp procedures that preceded SBS made the following overall positive contributions:

- The dialogue and coordination structures associated with the SWAp facilitated the development of a single policy and implementation framework for the sector (the PESS), costing of this plan, and development of a single monitoring framework (the PAF).
- These SWAp structures have led to inclusiveness of partners in policy dialogue through a structured process for discussion which includes the Joint Annual Review process.

- Clearer policies and the SWAp processes facilitated improved alignment by partners with government and sector planning and budgeting processes.
- Harmonisation among donors on policy, financial management, procurement, monitoring and evaluation and use of government systems has strengthened those systems and enhanced confidence in them.
- There has been progressive improvement in budget execution in the sector due to the introduction of e-SISTAFE – this was accelerated as common funds used e-SISTAFE.
- CF have allowed for an increasing volume and share of external sector funding to appear on-budget and have increased discretionary funding for the PESS, contributing to government ownership. Flexibility is likely to improve as conditionalities and earmarking by donors continues to decrease.
- Combined, this means that CF resulted in increased funding of operational inputs, such as medicines, and infrastructure for service delivery.
- CF have facilitated some additional decentralisation of funding to provinces, increasing capacity, confidence, and stakeholder participation at provincial and district level.
- The combination of SWAp coordination structures and the use of common funds have resulted in a gradual reduction in transaction costs for the Ministry of Health (MoH).

Progress has been made in a number of areas:

- Other plans co-exist with the PESS, fragmenting the policy environment.
- Insufficient progress has been made on key policy decisions, and on establishing clear sector priorities which can guide decision making at central and decentralised levels.
- The comprehensiveness of resource allocation is undermined as vertical funding continues to increase, much of which was off budget and not aligned to the PESS.
- Decentralisation of planning and implementation is weak namely for the external part of the investment budget. Central management of CF resources reinforces this.
- On-budget, CF have distorted the structure of resource allocation by channelling significant volumes of operational inputs via the investment budget.
- Issues related to poor predictability of funding have affected the government's planning and implementation capacity. Confidence among partners is still weak in some respects.
- A disproportionate time in the dialogue has been spent on CF issues. Little attention was paid in the dialogue to the downstream systems for service provision, the incentives faced by service providers, and accountability for service provision.

SBS in support to PROSAUDE II is likely to consolidate the positive impact of the SWAp and CF. However, it has failed to address many of the weaknesses:

- The allocation of SBS funds continues to be highly centralised, with only a quarter of funding allocated to provinces. Furthermore, SBS remains separately identifiable in the investment budget, and this continues to distort resource allocation. Whilst the intention of the MoU was for SBS to fund both the recurrent and development budget, the practicalities were not worked out. Further progress is undermined as vertical project funding continues to increase. The inclusion on-budget of more donor projects is positive, but efforts to get big 'vertical funders' (GAFTM, the World Bank) to be part of PROSAUDE II have failed for now.
- The SWAp dialogue has remained preoccupied with the design and management of SBS. Vertical funds have also taken up time. A disproportionate time of the dialogue is spent on PFM. As a result, other core service delivery issues remain inadequately addressed in the dialogue.

PROSAUDE II provides positive indications of progress. A large number of donors have joined in the common funding arrangements and committed to supporting the SWAp and to providing SBS. There has also been significant improvement in the proportion of discretionary funding provided, dialogue has been streamlined, donor coordination has improved, and there is evidence that this has impacted on various aspects of sector policy, management and monitoring and evaluation.

Moving forward, key issues regarding the mechanisms for funding service delivery need attention:

- The success of SBS will depend to a significant extent on getting the financing channels for service delivery right so that resources may be used in the most effective and efficient way. Addressing the aforementioned challenges and ensuring funds will be channelled to and accessed by decentralised levels to improve service delivery is crucial.
- SBS would be more effective in supporting financing delivery if SBS inscribed as internal funding was allocated to the recurrent budget, and specifically to existing budget lines on service delivery. In this way, the SBS would no longer be traceable. Furthermore, given the fact that the recurrent budget is increasingly reliable, those donors that can provide non-traceable SBS should elect for the funding to be inscribed as internal funds.
- Success of SBS will also depend on further progress by DPs in bringing aid to the sector into PROSAUDE II. This involves letting go of vertical projects and initiatives (a number of partners are moving in this direction) and increasing funding to PROSAUDE as confidence grows. It will also involve developing further confidence in monitoring systems which will allow partners to have some of the information/security which they are still getting through their project portfolio. For DPs there continues to be tension between the official commitment to more aligned means of funding and the reality of being held accountable for results.
- The increase in vertical funding is an important concern and should be a point of action moving forward – at country level and globally at the headquarters of agencies which are as of yet unable to join PROSAUDE II. As PFM, monitoring systems, and confidence all increase, conditions should allow for these partners to join. Alternatively, reluctant vertical funders may be more willing to join if they can play a key role in strengthening the systems that are currently preventing them from participating in PROSAUDE II.
- Donors are focusing strongly on the success in addressing public financial management issues as this is what they are ultimately held accountable for. A less than favourable audit in 2010 would represent a significant setback to progress whereas a lack of progress on key outcome indicators is perceived as potentially less damaging. The ‘incentives’ for DPs need to be reviewed so that SBS does not become skewed as a result of an excessive focus on mechanisms.

An equally important group of non-financial inputs needs addressing, key issues being:

- The focus of the overall dialogue and review processes need to be reoriented towards addressing the key challenges to effective and efficient health service delivery. Sector institutions, and systems for service delivery, must be more prominently on the agenda.
- Capacity constraints emerge throughout this study as a key concern. Efforts will need to be made to ensure that funding is brought on board to pay for the additional expenses.
- Attention to the provision of technical assistance and capacity building alongside SBS funding to strengthen downstream delivery, and central management and monitoring of service delivery.

- The development of stronger systems for accountability for service delivery at lower levels, and not just via SWAp arrangements

### **Sector Budget Support in Practice, Case Study, Health Sector in Zambia**

ODI & Mokoro, 2009

<http://mokoro.co.uk/sites/default/files/documents/SBSiP%20Zambia%20Health%20Case%20Study%20-%2026%2011%2009-1.pdf>

The nature of sector budget support in Zambia:

- The EC and DFID are the only cooperating partners (CPs) who have provided support to the health sector through SBS.
- The EC was previously providing resources to the MoH basket funds, but began SBS in 2006 as a pilot with EUR 10 million allocated to the Health Human Resources Plan (HRP) under the 9th EDF.
- The EC was previously providing resources to the MoH basket funds, but began SBS in 2006 as a pilot with EUR 10 million allocated to the Health Human Resources Plan (HRP) under the 9th EDF.
- The second tranche was only EUR 3.57 million as it was judged by EC headquarters that the required targets had not been met.
- Part of DFID GBS funds were earmarked to health and then non-traceably earmarked to assist in financing the elimination of user-fees. DFID committed to give an additional US\$5 million for health to their GBS commitments over five years (2006-2010). Funds were disbursed into the Treasury account in the MoFNP, with a reporting requirement that DFID should be given evidence that the funds had been transferred to the MoH.
- In 2007 the MoH decided to roll DFID funds into the district grant, with instructions that 4% of the grant should be spent on items that user-fees would have paid for, so districts were free to choose how to spend the funds.
- Although there has been very little SBS, this study is timely as levels of SBS are expected to rise in the near future, as more CPs move to SBS in response to the government of Zambia's statement that general and sector budget support are its preferred aid modalities.

The overall conclusion of the study is that SBS in the health sector in Zambia has not had a significant effect in meeting the objectives of partner countries and CPs. This is mainly because SBS has not been extensively implemented in Zambia, so the experience has been very limited, with only small amounts of funding channelled through SBS over a relatively short period of time. Issues related to the design of SBS, delays in disbursements and budget transparency have caused significant problems. As a result, it is unsurprising that the experience of SBS so far has not been very positive, however if these problems are resolved, SBS still has the potential to be effective in supporting the achievement of health sector goals.

There are two main reasons why the contribution of SBS to sector systems, processes and service delivery have been less than expected. These are delays in disbursement and budget unpredictability, which are a result of the requirement for traceability without additionality of SBS funds, which was not explicitly resolved during the design phase. Additionality of SBS funds is to a certain extent unimportant as SBS funds from both the EC and DFID had no additionality conditions; therefore it was at the discretion of the Ministry of Finance and National Planning (MoFNP) whether the Ministry of Health (MoH) budget would increase as a result. Given that it is very difficult to prove additionality anyway, particularly when the medium term expenditure framework process does not function well. What is more important is to ensure that at the very least there is a credible and transparent budget allocation system with an agreement on the level of health sector funding on an annual basis. In addition,

budgetary funding supported by SBS should be disbursed via the usual cash management procedures, and should not be based on SBS specific disbursements from CPs. A clear understanding of this was not reached between the central bank, MoFNP and MoH before the move to SBS.

### **Sector Budget Support in Practice, Good Practice Note**

Williamson T & Dom C, ODI, 2010

<http://www.odi.org.uk/resources/download/4732-english.pdf>

This report include the following sections:

- An overview of good practices in the design and implementation of SBS
- The pre-requisite for effective SBS
- Diagnosing the key challenges in service delivery
- Identifying and implementing actions to improve service delivery (with SBS in mind)
- Strengthening reporting and the monitoring and evaluation of service delivery
- Design and implementation of SBS inputs (with improving service delivery in mind)

### **Sector Budget Support in Practice, Synthesis Report**

Williamson T & Dom C, ODI, 2010

<http://www.odi.org.uk/resources/download/4733-english.pdf>

This is the synthesis report for a study on Sector Budget Support (SBS) in Practice for the Strategic Partnership with Africa (SPA).

Programme-Based Approaches (PBAs) to aid delivery are a central pillar of the drive to improve aid effectiveness. PBAs involve the provision of coordinated development assistance in support of locally owned policies and strategies. General Budget Support (GBS) is used as a modality for supporting poverty reduction strategies at the national level, and has received substantial attention. However, in Sub-Saharan Africa aid in support of sector programmes has overtaken GBS as the most significant family of aid modalities supporting PBAs. Sector PBAs are commonly referred to as Sector Wide Approaches (SWAs). SBS, alongside Common Basket Funds, are the two main modalities associated with support to SWAs.

SBS is therefore an aid modality which donor agencies are increasingly using to support African countries to achieve their policy objectives at the sector level. The purpose of this study is to draw on the experience from the provision of SBS in ten sectors in five different countries to guide future improvements in the use of SBS by partner countries and donors.

### **Making sector budget support work for service delivery: wider policy implications**

Williamson T, Dom C & Booth D, ODI, 2010

<http://www.odi.org.uk/resources/download/4737-english.pdf>

This is the third in a series of three ODI Project Briefings based on a study of Sector Budget Support in Practice for the Strategic Partnership with Africa (SPA). It builds on the overview and good practice recommendations provided in the companion briefings by considering the wider policy implications of the study.

Key points:

- Incentives are the key to what sector budget support (SBS) does well and what it does badly.
- Strengthening service delivery incentives will involve substantial multilevel efforts by SBS donors and partners.

- These efforts must address the underlying causes, rather than the symptoms, of weak incentives.

### **Sector Budget Support in Practice**

<http://www.odi.org.uk/work/projects/details.asp?id=1013&title=sector-budget-support#resources>

This site has links to all outputs of the ODI/Mokoro Sector Budget Support in Practice review, including ten country/sector case studies in education and other sectors and three short briefing papers.

## **4. Disease specific programmes**

### **The Five Year Evaluation of the Global Fund**

Global Fund, 2010

<http://www.theglobalfund.org/en/terg/evaluations/5year/>

The synthesis report discusses the following findings:

- The Global Fund, together with major partners, has mobilised impressive resources to support the fight against AIDS, tuberculosis and malaria.
- Collective efforts have resulted in increases in service availability, better coverage, and reduction of disease burden.
- Health systems in most developing countries will need to be greatly strengthened if current levels of services are to be significantly expanded.
- The Global Fund has modelled equity in its guiding principles and organisational structure. However, much more needs to be done to reflect those efforts in grant performance.
- The Performance-Based Funding system has contributed to a focus on results. However, it continues to face considerable limitations at country and Secretariat levels.
- The Global Fund partnership model has opened spaces for the participation of a broad range of stakeholders. This progress notwithstanding, existing partnerships are largely based on good will and shared impact-level objectives rather than negotiated commitments or clearly articulated roles and responsibilities, and do not yet comprise well functioning system for the delivery of global public goods.
- As the core partnership mechanism at the country level, country coordinating mechanism (CCMs) have been successful in mobilising partners for submission of proposals. However, in the countries studied, their grant oversight, monitoring, and technical assistance mobilisation roles remain unclear and substantially unexecuted. The CCMs' future role in these areas and in promoting country ownership is in need of review.
- The lack of a robust risk management strategy during its first five years of operation has lessened the Global Fund's organisational efficiencies and weakened certain conditions for the effectiveness of its investment model. The recent work to develop a comprehensive, corporate-wide risk management strategy is a necessary step for the Global Fund's future.
- The governance processes of the Global Fund have developed slowly and less strategically than required to guide its intended partnership model.

### **Effects of the Global Fund on Reproductive Health in Ethiopia and Malawi: Baseline Findings**

Schott W, Stillman K, and Bennett S, The Partners for Health Reform *plus* Project, 2005

[http://pdf.usaid.gov/pdf\\_docs/PNADF197.pdf](http://pdf.usaid.gov/pdf_docs/PNADF197.pdf)

This report is part of the Systemwide Effects of the Fund (SWEF) research initiative, which aims to assess the effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) and the activities it supports on reproductive health and family planning programmes in Ethiopia and Malawi. The main research objectives are to consider the effects of GF activities on the policy process, human resources, the public/private mix, and pharmaceutical and commodity procurement and management with relation to reproductive health and family planning services.

Findings are that reproductive health players have not participated extensively in GF planning processes, and GF activities are not integrated with reproductive health, family planning, or other preventive care services. Health workers have increased responsibilities with GF activities and work in resource-constrained environments.

In Ethiopia, health workers are shifting out of the public sector in search of better working conditions at NGOs, bilateral aid agencies, and international organisations, and, in Malawi, there is evidence of resource shifts away from community health programmes like reproductive health and family planning in favour of activities related to the three focal diseases of AIDS, tuberculosis, and malaria.

While both public and private facilities offer reproductive services, they are available in almost all public health facilities, but in fewer private facilities. The number of private NGOs has grown, while the involvement of the private non-profit sector remains limited. Systems for commodity procurement and disbursement have improved in Ethiopia, while fewer improvements to the system have occurred in Malawi as GF activities have been implemented.

In order to bolster reproductive health and family planning services in future GF activities, reproductive health advocates and providers should make a case for integrating services for these focal diseases with reproductive health and family planning, and become more involved in the planning process for GF activities.

The report concludes that the GF has mobilised substantial resources and released them to a greater number of players in an effort to combat HIV/AIDS, TB, and malaria. With the surge in funding brought about by GF comes opportunity to scale up efforts to improve health, as well as challenges in absorbing funds and using them efficiently and effectively.

Improvements have been made in areas such as increasing the actors involved in service provision, enhancing infrastructure, and increasing availability and capacity of health services. The GF, however, has also led to an increasing focus on the three focal diseases, rather than increased attention to broader health systems strengthening. As a result, existing health system challenges have been overlooked in many cases, and to some extent, other health priorities have been overshadowed. Opportunities that have arisen to strengthen health systems while implementing GF activities have often been missed, as in the case of the drug procurement system in Malawi. Furthermore, significant issues of sustainability remain.

While the CCM and other GF-related planning mechanisms may not currently provide a forum for discussions of integrating GF activities with reproductive health and family planning services, they may not be averse to considering new ideas on ensuring better coordination of GF-supported activities with other non-focal services. If appropriate to the national contexts, GF activities can be successfully integrated with other basic health services such as preventive care, family planning, and childhood immunisation, thus potentially increasing the impact of GF-supported interventions. Country-level stakeholders must weigh the potential

benefits and risks of integrating services and determine if it makes sense within the national context to advocate for integration.

### **Second GAVI Evaluation**

GAVI Alliance, CEPA LLP,

[http://www.gavialliance.org/resources/GAVI\\_Second\\_Evaluation\\_Report\\_Final\\_13Sep2010.pdf](http://www.gavialliance.org/resources/GAVI_Second_Evaluation_Report_Final_13Sep2010.pdf)

This evaluation report makes the following conclusions on a global level:

- Despite a fair wind, GAVI has attracted funding to immunisation that probably wouldn't have occurred in its absence.
- A big area of financial added-value has been through International Finance Facility for Immunisation (IFFIm), where GAVI's role has been unique.
- GAVI's role in the ongoing implementation of the Advance Market Commitment (AMC) pneumococcal pilot is also identified as a significant achievement.

Report findings on national level include:

- GAVI's basic programmatic approaches and the development of tools to support countries' financial planning was a key source of innovation in Phase I.
- Co-financing has supported country ownership, but it has contributed relatively little to financial sustainability and changes to the policy have been a cause of confusion at the country level.
- GAVI's choice of vaccines and its basic funding model – despite its contributions to tools and country approaches – has had a negative impact on country financial sustainability.

Findings on programmatic value include:

- There is strong evidence that GAVI's flagship programme, New and underused Vaccines Support (NVS), has accelerated countries' introduction of life saving vaccines and immunisation outcomes – which might not have happened in its absence.
- However, it has not contributed to a reduction in vaccine prices – as originally anticipated – with serious implications for country affordability and sustainability.
- GAVI is unique in financing associated vaccine technologies through its injection safety programme, which has clearly been successful and sustainable – although waste management remains an issue.
- GAVI's focus on health system bottlenecks in countries through its Health System Strengthening (HSS) window is deemed necessary for increasing coverage, but there are several issues in relation to the effectiveness of its delivery model, and the dilution of GAVI's focus and its comparative advantage.
- The Immunisation Services Support (ISS) programme has also received 'mixed' feedback. Although generally regarded as being highly innovative, the impacts achieved and scope for sustainability are less conclusive.
- The Civil Society Organisation (CSO) support programme has been slow to take off on account of some fundamental design and implementation issues.

### **Reviving Dead Aid: Making International Development Assistance Work**

Negin J, Lowy Institute, 2010

<http://www.lowyinstitute.org/Publication.asp?pid=1355>

This document reports on a malaria case study from Ethiopia.

Globally, malaria causes almost 250 million cases of illness and more than one million deaths each year. In Ethiopia, there is malaria in approximately 75% of the country covering 50 million people and malaria is the leading cause of morbidity nationally. Tens of thousands of children died each year from malaria. In 2005, 2% of households owned an insecticide-treated bed net but, in 2007, the government, supported by donors, committed to improve malaria control. By January 2008, more than 20 million bed nets were delivered increasing coverage of at-risk children by 1500%. At the same time, Ethiopia rolled out its health extension worker programme which saw 30,000 women mobilised – two per village – to provide health education to communities and to deliver basic medications when needed. This dramatically expanded access to anti-malaria drugs. As a result of this simple plan, the number of children who die from malaria has been halved in just three years. The case of Ethiopia demonstrates the profound impact of the delivery of well-known simple yet effective techniques. The Ethiopia story is not one of innovation or creativity as much as thinking at scale and implementing what is known to work.

## 5. Papers on different funding modalities for health

### **Aid for Better Health – What Are We Learning About What Works and What We Still Have To Do? An Interim Report from the Task Team on Health as a Tracer Sector**

OECD/DAC, 2009

<http://www.oecd.org/dataoecd/25/54/45014642.pdf>

The main findings and messages emerging from this report:

- A great deal of activity has been directed towards making aid for health more effective, and much has been achieved.
- While results are ultimately what matter, the most measurable progress is at the level of globally-agreed frameworks for delivering on commitments, new forms of co-operation and dialogue, and world-wide multi-stakeholder initiatives designed to address some of the complexities of the aid architecture.
- Improvements in aid management, both generally and in relation to health, are slower than they should be, and are uneven.
- The underlying challenges to make aid for health more effective involve moving to a more realistic political economy framework that creates pressure to deliver on commitments.
- Creating alliances across and among partner country governments, donors, global programmes and other players requires not just greater political drive, but also a sound and evidence-based technical discussion on what has to be done in terms both of broad strategies and of specific measures.
- The underlying challenges to make aid for health more effective involve moving to a more realistic political economy framework that creates pressure to deliver on commitments.
- Creating alliances across and among partner country governments, donors, global programmes and other players requires not just greater political drive, but also a sound and evidence-based technical discussion on what has to be done in terms both of broad strategies and of specific measures.
- Experience in health shows that aid effectiveness principles overlap and are mutually-reinforcing.
- Prioritising practical aid effectiveness measures is challenging and is at least partly country-specific. But one of the most important lessons from health is that a sound sector strategy, embedded in a broad national strategy and linked to financing through a medium-term expenditure framework and annual budget, reviewed regularly by stakeholders, is needed not just for government's management of development, but as a means for inducing best-practice behaviour change among donors.

- Active effort is needed to find ways of combining the resource mobilisation effort with keeping the number of players manageable, especially in countries with limited state capacities.
- Even where there is progress, the mechanisms are not always in place for accurately monitoring what is being done.

Even where there is progress, the mechanisms are not always in place for accurately monitoring what is being done. DAC reporting is valuable and continuously improving, but is limited to particular indicators and depends on donor inputs. Initiatives such as that of the International Health Partnership, IHP+ Results, are aiming to bring complementary information, but they are at early stages of development, and in any case partial in coverage and support. In respect of the monitoring surveys of IHP+ Results, a good start is being made, but coverage is incomplete for a mix of reasons relating both to staff shortages and doubts that some players have over the initiative. It is notable that survey returns from partner countries are limited, so that the first year's data will mainly profile donors only.

There is emerging evidence that donors and recipients have taken steps to review progress towards aid effectiveness commitments (see for example Vietnam's 2007 Independent Monitoring Report on Implementation of the Hanoi Core Statement, or the 2008 UK Progress Report on Aid Effectiveness). However, at the sector level few assessments of progress towards aid effectiveness at the individual country or donor level have been undertaken. A notable exception is the Ghana Ministry of Health's Review of Development Partners Performance for 2008.

While monitoring progress towards aid effectiveness is essential, it is important to remember that the end objective is development. The success of commitments such as the Paris Declaration therefore depends not only on recipients and donors implementing the agreed to changes. More important is that these changes should result in an acceleration of development, by for example freeing up government time through the reduction in transaction costs or leading to a more comprehensive, coordinated and context-appropriate development strategy.

Tracking the impact of aid interventions facilitates managing for development results (discussed in section 7), holds donors and recipients to account for their commitments, and provides the evidence base needed to raise awareness about progress and continuing bottlenecks. However, causalities are multi-factorial and not one-to-one, making a robust link between a specific intervention and health outcomes in the target community difficult to assess. Where the impact can reasonably be determined, the focus on measurement needs to be balanced with at least as much effort being dedicated to ensuring that management systems are in place to put into effect the lessons thus generated.

In some cases, the impact of interventions in the health sector can more easily be assessed than in some other sectors. For example, in contrast to education where many of the benefits of universal schooling are not achieved until students enter the labour market, in health donor provision of anti retro-viral medication has a near-term and direct impact on patients. Similarly, aid money used to increase coverage of DOTS (Directly Observed Treatment, Short-course) treatment is proven to lower the rate of tuberculosis, a leading cause of mortality in many countries.

Although it is difficult to link the impact of donor assistance to development outcomes, recent health improvements in aid-recipient countries are a positive indication. For example, in developing countries the under-five mortality rate per 1,000 live births decreased from 103 in 1990 to 74 by 2007. Progress is also evident at the country level. Thailand has experienced a 33% decline in HIV prevalence among young adults and 41% among injecting drug users, as well as an increased survival rate from ARVs. China has increased DOTS coverage and subsequently has achieved a 38% decline in tuberculosis prevalence and tuberculosis

mortality. Following a large-scale bed-net distribution and ACT (artemisinin combination therapy) roll-out, Rwanda has shown a 64% decline in child malaria cases and a 66% decline in child malaria deaths. Several other African countries demonstrate equally impressive achievements in the reduction of malaria. Donors are also working to assess the impact of their assistance. DfID, for example, reports that in part due to the support it provides to India's National Reproductive and Child Health Programme's Sick Newborn Care Units, there has been a marked decline in newborn deaths (DfID, 2009). Similarly, it is reported that by the end of 2008 GAVI Alliance support – including immunising approximately 192 million children against hepatitis B, 42 million against haemophilus influenzae type b and 35.6 million against yellow fever – has averted 3.4 million premature deaths. However, increasingly 'partners are recognising that attribution of health gains to support provided by particular donors is not only unfeasible [...] but also counterproductive' (WHO, UNICEF, World Bank, 2009, State of the world's vaccines and immunisation, 3rd ed.).

While information is improving, data are still unsystematically gathered and evidence on results is incomplete. Similarly, while anecdotal evidence of the impact of aid effectiveness on results is emerging - for example WHO et al (2008) report that in Mali — improvements in harmonisation and alignment among health partners are correlated with health sector gains — more systematic information and analysis is needed. To further show the collective impact of aid on results, as well as the link between aid effectiveness and health impact, evidence of the impact of health aid towards meeting the MDGs is currently being gathered. This workstream, which is led by the Global Fund, will culminate in a report based on country case studies for 2010.

### **CTL-for-Health/FTT-with-Health: Resource-Needs Estimates and an Assessment of Funding Modalities**

Baker BK, Action for Global Health and International Civil Society Support, 2010  
[http://ec.europa.eu/health/eu\\_world/docs/ev\\_20101013\\_rd05\\_en.pdf](http://ec.europa.eu/health/eu_world/docs/ev_20101013_rd05_en.pdf)

This document proposes a funding model for health. It then discusses how to distribute funds raised.

The pros and cons of budget support:

Questions about the intermediate “destination” of funding must be addressed. Proponents of sector budget support, general budget support, and other pooled financing mechanisms at the country level argue that such pooled funding increases government ownership and control, aligns with government budget cycles, and eases public finance management. With pooling, the government knows its total resource envelope and can plan and spend accordingly. If existing government capacity to handle pooled funding is less than desirable, then proponents argue that governments should receive technical assistance to build durable public sector management capacity. Proponents argue further that the alleged incapacity of governments to manage pooled funding must be weighed against its less-than-perfect alternative: the inefficient, convoluted, duplicative, and uncoordinated mechanisms of finance administration orchestrated by donors.

Critics of pooled financing directly to governments admit these potential benefits, but focus as well on historical analysis of some governments' poor planning, inefficiency, corruption, and incapacity to even spend as planned or to monitor and account for the actual flow of resources. Critics worry that most governments neglect important health needs and/or vulnerable populations and that some governments persistently refuse to grant resources to NGO/CBO/FBO organisations for community level health-related activities. A related concern about pooled funding mechanisms from a civil society perspective is that of governance – civil society feels that government-controlled pooled financing modalities have often been planned and implemented without the participation and oversight of civil society. In sum, critics fear that donor funds get put inside a black box and then disappear both in terms of

tracking and performance outcomes. They have evidence that government-controlled resources do not reach the local level (as little as 20%), where health programming is most needed, and thus that direct funding to CBOs might have a larger payment.

Finally, some critics have noted that there is a silver-lining to donor-controlled projects- or programme-financing, namely that it stays off the books (in terms of the country's public budget) and thus is not subject to IMF-mediated macroeconomic constraints. These IMF prescriptions limit overall government spending on health and may contribute to so-called substitution or subadditionality effects whereby governments decrease their health spending in proportion to donor aid for health.

The pros and cons of the following are also discussed:

- The Global Fund to Fight AIDS, Tuberculosis and Malaria
- GAVI
- World Bank
- UNITAID Medicines Patent Pool Initiative
- European Commission Millennium Development (EC MDG) Contracts
- The International Health Partnership and related initiatives (IHP+)

There is a table comparing the benefits of focussing funds on health systems or specific disease focus (p40).

Benefits of health system focus:

- More consistent with new focus on comprehensive primary health at WHO, in European countries (especially Scandinavian), and US Global Health Initiative.
- More consistent with stated goals of developing country partners to strengthen health systems more broadly to be able to respond to local epidemiological needs and priorities.
- Serves as a platform to emphasize need for increased and better-trained human resources for health.
- Allows simplified support for national health plans through health sector or general budget support (contested).
- Likely to increase country-ownership and stewardship of WHO Joint Health System Strengthening Platform (HSS).
- More likely to result in better integration of services and more robust and durable primary health care service delivery.
- Can direct resources to less sexy health systems needs – labs, health information, procurement and supply, health sector planning/management, etc.
- Can increase attention to health facilities needs, transportation infrastructure, etc.

Benefits of priority disease focus:

- Better able to draw on mobilised health movements, especially those consisting of infected patients and affected communities.
- More effective at mobilising demand from affected constituencies.
- Better messaging that mobilises political support and sways decision-makers.
- Results in sharper focus, speedier and more results-based implementation, and ultimately greater accountability.
- Greater potential for learning and dissemination of best practices.
- May result in a greater focus on service quality.
- Global Health Initiatives are already a fact on the ground and can be used for diagonal strengthening of health systems and service integration with related health needs including maternal and child health, sexual and reproductive health, and even neglected diseases.

## **A Joint Evaluation of General Budget Support 1994-2004**

OECD DAC Network on Development Evaluation

[http://www.oecd.org/document/51/0,3343,en\\_21571361\\_34047972\\_36556979\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/document/51/0,3343,en_21571361_34047972_36556979_1_1_1_1,00.html)

This page has links to a synthesis report, different thematic reports, country reports, briefing papers and presentations on general budget support evaluation.

## **Towards Equitable Financing Strategies for Reproductive Health**

Standing H, IDS, 2002

[www.ids.ac.uk/download.cfm?file=wp153.pdf](http://www.ids.ac.uk/download.cfm?file=wp153.pdf)

This paper examines the impact of different financing regimes on the delivery of reproductive health services in low and middle-income countries. Financing is an important entry point for examining the impact of health sector reforms on reproductive health. It is likely that different financing regimes have different implications for access to reproductive health services. Health systems are increasingly funded from a multiplicity of sources and through a wide range of fiscal mechanisms. The effects of these changes in modes of financing on reproductive health services are not well understood.

The paper explores three issues:

First, it looks at the broad trends in health financing in low and middle-income countries and how they relate to the provision of reproductive health services. At international level, these include transfer mechanisms, such as project and programme aid, social funds and the growing influence of verticality in multilateral funding strategies. At national level, these include cost recovery measures such as fees, pre-payments and insurances, as well as safety nets.

Second, it asks whether and how the balance has shifted between collective and individual responsibility for reproductive health and what are the implications for outcomes. There has been an increasing trend towards use of the private sector, even by poor people, as public sector health provision has come under strain. Rising costs of medical care also mean decreasing access to services, particularly for the very poor. To what extent have changing financing modes shifted the cost burden of reproductive health related conditions towards the end user?

Third, it considers what kinds of monitoring, oversight and advocacy can be undertaken nationally to improve the financing and implementation of effective reproductive health care. Several methodologies have been developed which could potentially be adapted to monitor reproductive health spending, such as National Health Accounts and Women's Budgets. It notes their advantages and limitations.

## **6. Aid effectiveness**

### **Is Harmonisation and Alignment Improving the Effectiveness of Health Sector aid?**

Lewis D, Dickinson C, Walford V, HLSP, 2010

Not available online.

This report outlines the approaches to improving effectiveness of health sector aid:

- SWAps
- General budget support and sector budget support
- International Health Partnerships (IHP+)

- Harmonisation and Alignment of Multilateral and Bilateral Partners working in AIDS

Evidence that these approaches are improving the effectiveness of health sector aid and delivering better health outcomes is limited. It is intrinsically difficult to measure the impact of particular measures such as improved coordination. Furthermore, health outcomes are determined by many factors within and beyond the health sector, making attribution difficult. In particular, it is unclear how to separate out the impact of aid practices such as having a SWAp or more aligned aid, from the impact of the health strategies and policies followed, and the adequacy of financing and implementation capacity. Anecdotal evidence of the impact of aid effectiveness on results is emerging e.g. WHO et al (2008) report that in Mali “improvements in harmonisation and alignment among health partners are correlated with health sector gains,” but more systematic data on the impact of approaches and tools that have been developed to increase harmonisation and alignment in the health sector is needed to provide an overall assessment of progress.

The report discusses effectiveness under the following question headings:

- How far has harmonisation and alignment and a results focus been implemented in the health and AIDS sectors?
- Has the quality of health plans and strategies improved, and the extent of national ownership?
- Is H&A improving the efficiency of resource use in the health and AIDS sectors?
- Are there greater incentives and better systems for demonstrating results?
- Has plan implementation improved, and are more resources available for priority services?
- Has the availability, quality and coverage of health services increased?
- Have there been improvements in health status?

### **Evaluation of the Implementation of the Paris Declaration, Phase 2**

OECD, 2011

<http://www.oecd.org/dataoecd/5/37/48113803.pdf>

The overall purpose of this evaluation is to assess the relevance and effectiveness of the Paris Declaration and its contribution to aid effectiveness and ultimately to development effectiveness.

The second phase comprises 22 country level evaluations which were designed within a common evaluation framework to ensure comparability of findings across countries while allowing flexibility for country specific interests.

This Evaluation – even with its wide and deep participation – is still necessarily selective. It cannot claim to provide the last word in assessing the effects of the Paris Declaration or pointing the way ahead for aid effectiveness. But the Evaluation has found that almost all the 56 commitments in the original Declaration – reinforced by the priorities adopted at the Accra Forum – have been and remain highly relevant for the improvement of development cooperation. That brief list of balanced commitments from 2005, deeply rooted in experience, has sometimes been lost from sight with the focus on broad principles, restricted indicators or emerging trends. But the commitment to aid reforms is a long-term one, and these clear original undertakings – which have attracted such unprecedented support – are neither fully implemented nor yet outdated. They still set the standard for the Busan High Level Forum and beyond.

### **Aid and Budget Transparency in Mozambique, Constraints for Civil Society, the Parliament and the Government**

The Informal Governance Group and Alliance 2015, 2010

[http://www.eurodad.org/uploadedFiles/Whats\\_New/Reports/Aid\\_Budget\\_Transparency\\_in\\_Moz.pdf](http://www.eurodad.org/uploadedFiles/Whats_New/Reports/Aid_Budget_Transparency_in_Moz.pdf)

Poor information affects in particular the health sector where aid is extremely fragmented in different projects. It is hard to budget without a clear idea of how much money will be available and aid commitments are not always delivered upon. The Global Fund, which is the largest donor to the health sector, in 2007 for example only disbursed 54% of its aid during the last month of the year, making it impossible to spend in that year. The United Nations practice of designing transversal programmes in various sectors, including health, makes it hard for the Ministry to know how much money is available.

When aid is reflected in the budget and in national financial management systems, it is easier to plan for and monitor. Yet nearly half of all aid money coming to the government does not use government budgetary execution, reporting or procurement procedures and two-thirds does not use government audit procedures. This makes it all but impossible for the government, parliament or civil society to monitor clearly how this money is being spent.

### **Learning from Experience? A Review of Recipient Government Efforts to Manage Donor Relations and Improve the Quality of Aid**

Menocal AR & Mulley S, ODI, 2006

<http://www.odi.org.uk/resources/download/1372.pdf>

Since the late 1990s, a new paradigm of effective aid has emerged, that, at least in principle, is based on the concepts of country ownership, partnership, and mutual accountability. These principles are embraced in the *Paris Declaration on Aid Effectiveness*, which includes a series of commitments from both donor and recipient countries to improve the quality of international development assistance. Donors have come to recognise that recipient country ownership is essential to the effectiveness of aid and development efforts. It has become increasingly evident that ownership of specific policy measures or programmes, and good governance in general, can only be achieved if recipient governments begin to take a more proactive role in determining how aid is allocated and managed.

Nevertheless, to date there are relatively few examples of recipient governments taking a lead in their relationships with donors. This is perhaps not surprising given the asymmetry of resources, power and capabilities which characterises most of the links between donors and recipients. This paper reviews the efforts of five countries seen as relatively successful examples of recipient-led aid policies and donor management. These countries are Afghanistan, Mozambique, Tanzania, Uganda, and Vietnam. On the basis of their experiences, this paper also suggests some general lessons as to the conditions that may enable recipient governments to take the lead in establishing aid policies and managing relations with donors.

Five enabling conditions are identified and discussed:

- Supportive macroeconomic and growth environment
- A history of open and frank engagement between donors and recipients that promotes mutual trust and confidence
- Commitment to reform and/or strengthen public institutions (especially regarding public financial management – PFM – and within that the budget)
- Strong political will and commitment by the recipient government to lead on the development agenda and own the development process
- ‘Mutual accountability’ mechanisms

## **Making the Most of the Money? Strengthening Health Systems through AIDS Responses**

Druce N & Dickinson C, HLSP, 2008

[http://www.hlsp.org/LinkClick.aspx?fileticket=4G\\_xupkPwy4%3D&tabid=1698&mid=3353](http://www.hlsp.org/LinkClick.aspx?fileticket=4G_xupkPwy4%3D&tabid=1698&mid=3353)

Despite growing consensus about the opportunities and need to use disease-specific funding to strengthen health systems, evidence about how this can be done remains limited. Based on experience at country level, and on HLSP's approach to health systems development, this paper presents good practice principles to support health systems strengthening. In addition to harmonisation and alignment efforts, these include: building the health sector response to HIV as a whole; investing in a common understanding of health systems among all stakeholders; and the need for effective technical support.

## **Aid Effectiveness for Health, Towards the 4<sup>th</sup> High-Level Forum, Busan 2011: Making Health Aid Work Better**

Action for Global Health, 2011

[http://www.actionforglobalhealth.eu/fileadmin/AFGH\\_Intranet/AFGH/Publications/2011\\_Policy\\_Report\\_-\\_Aid\\_Effectiveness\\_for\\_Health/AFGH\\_FINAL\\_WEB\\_.pdf](http://www.actionforglobalhealth.eu/fileadmin/AFGH_Intranet/AFGH/Publications/2011_Policy_Report_-_Aid_Effectiveness_for_Health/AFGH_FINAL_WEB_.pdf)

Ensuring that development cooperation is effective has never been more important as the international community seeks to reach the 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 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
- Ownership
- 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.

## **7. Additional information**

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