

**DFID  
INFLUENCING  
IN THE  
HEALTH SECTOR**

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**DEPARTMENT FOR INTERNATIONAL DEVELOPMENT**

Working Paper 33

**DFID INFLUENCING  
IN THE HEALTH SECTOR  
A Preliminary Assessment of  
Cost Effectiveness**

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Full responsibility for the text of this report rests with the authors. In common with all independent evaluation reports and reviews commissioned by the Department for International Development (DFID), the views in this report do not necessarily represent those of the Department or of the people consulted.



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## **Abbreviations and Acronyms**

DALYS	Disability Adjusted Life Years
DFID	Department for International Development
EVD	Evaluation Department DFID
GFATM	Global Fund for Aids, TB and Malaria
GoN	Government of Nepal
GOI	Government of India
IDO	International Directors Office DFID
IHP	International Health Partnership (donors working collectively on national strategies for health in partner developing countries)
JFA	Joint Financing Arrangement (pooling of donor funds in Nigeria)
MDGs	Millennium Development Goals
NACA	National Action Committee for Aids in Nigeria
NHIS	National Health Insurance Scheme Ghana
NSMP	Nepal Safe Motherhood Project
ODI	Overseas Development Institute
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
RHC	Reproductive and Child Health Programme India
SAIC	DFID Staff Appointed in Country
SC	Scheduled Castes (as defined by the Indian Government)
SSMP	Support to the Safe Motherhood Programme Nepal
ST	Scheduled Tribes (as defined by the Indian Government)
UN	United Nations



## **Executive Summary**

- S1. The evaluation aimed to assess whether DFID's influencing and policy dialogue activities in the health sector provided good value for money. The core of the work involved six case studies:
- Global Fund for Aids, TB and Malaria (GFATM)
  - Zambia: Removal of user fees
  - Nigeria: Joint Financing Agreement ( improved donor collaboration on HIV and Aids funding arrangements)
  - Mozambique (human resources policy)
  - India (equity and access for impoverished castes and tribes and other poor groups)
  - Nepal (safer motherhood and safe abortion programmes)
- S2. An initial survey indicated that health advisers saw influencing as central to their work. More than 70% thought DFID gets good value for money or high returns from influencing efforts. Respondents thought effective influencing required: good communication, networking and an understanding of political drivers and incentives.
- S3. Influencing strategies were diverse and based on: lesson learning; evidence based approaches; leadership of the harmonisation agenda; and influencing through membership of global programmes and funds. Several of the case studies involved an influencing effort alongside a much larger programme of financial support to the sector.
- S4. In four out of the six cases, the policy change that DFID was trying to influence in partner Governments or organisations did actually take place, the main determinant being the level of political commitment by partners. DFID made a significant contribution to policy changes that took place, either directly or indirectly by working with the wider donor community. Key factors were:
- understanding political interests;
  - effective collaboration with other donors;
  - the quality and skills of DFID staff;
  - the flexible and rapid provision of technical assistance.
- S5. However, only 20% of respondents thought DFID was systematic in assessing opportunities and stakeholders. The case studies revealed that whilst the goals of the influencing efforts and programmes were clearly stated and understood by DFID teams, the specific outputs were not always explicitly articulated in strategy or project documents. In several case studies, the objectives and approach evolved in the light of the experience and the opportunities that arose. Only in the case of GFATM were policy objectives articulated publicly and reflected in a log frame.

- S6. Stakeholders also identified instances where DFID influencing had created tension amongst other bilateral donors and highlighted the risks of premature implementation of policy. Continuity of DFID staff was also a problem.

## **Value for Money**

- S7. The cost effectiveness of influencing was assessed through structured interviews with stakeholders and by assessing the resources used. Influencing costs varied between £300,000 - £600,000 per programme and were modest in relation to the potential benefits and in comparison to the level of financial aid being spent in the sector. More attention could have been given to specifying influencing objectives and assessing alternative approaches, for example, by looking at options for using local staff with relevant expertise instead of UK staff and consultants. The cost of DFID staff time should have been given more consideration.
- S8. Structured interviews with a range of non DFID stakeholders provided an assessment of DFIDs influencing:
- The majority of stakeholders we spoke to felt that DFID influence had been decisive for some of the key steps in the policy change process for at least 4 out of the 6 case studies (this represented a score of 6 - 8 out of a possible 10).
  - In all cases stakeholders felt that DFID had at least helped the policy change process and in some cases stakeholders felt DFID was the main driver.

Stakeholders also indicated that in the absence of the DFID influencing effort that policy would have taken longer to emerge and would have been less well formulated.

- S9. Health outcomes could not be attributed solely to DFID influencing. There is incomplete data that suggests an increase in utilisation of health facilities for deliveries and of skilled birth attendants in Nepal and an increase in safe abortion. If this is confirmed, it is likely to have contributed to the recent reduction in maternal mortality in Nepal. There are some improvements in a few Indian states and in Zambia there may have been an initial increase in utilisation followed by a decline.

## **Conclusion and Lessons**

- S10. Overall, the evidence suggests that in the case study interventions examined, DFID has contributed to changes in health policy undertaken by partner Governments and organisations and that these efforts were largely cost effective. This preliminary assessment of DFID influencing in the health sector also suggests several important lessons from the experience outlined in the case studies:

### ***Corporate Priorities***

- (i) Given the potentially high returns to influencing GFATM (and other international agencies with large health programmes), it could be cost-effective for DFID to allocate more resources to these efforts. This should be reviewed by DFID as the resources devoted to multilateral influencing are relatively modest in relation to potential returns. Such a move would be consistent with the new White Paper. DFID could allocate more resources in country programmes to pursue multilateral influencing agendas for example, to ensure value for money of Global Fund Programmes.
- (ii) The link between corporate and country programme influencing efforts is important and needs to be carefully managed. DFID needs to be more aware of the potential for such links to undermine established donor relationships in country programmes (where there is no consensus on the case for change) and the need to manage the raised expectations of partner Governments.

### ***Influencing Strategies and Approach***

- (iii) DFID needs to have a more systematic approach to choosing areas for influencing, setting objectives and defining outputs. Wherever possible the influencing objectives should be inserted in the logical framework of a broader health sector programme or project. In some cases a separate influencing project may be justified.
- (iv) The case studies suggest there are dangers of influencing Governments to adopt policies prematurely or ones which need to be better supported by evidence from the local context. DFID needs to continue to be sensitive to this, to ensure that advice is always offered in a balanced way and that opportunities to support local research or analysis to pilot new ideas or policies are taken.
- (v) Influencing new policy requires an evidence based approach but generating the evidence can take time and partner Governments can be impatient to proceed more quickly, even if the risks of failure are high. DFID needs to ensure influencing efforts are supported by international and national evidence of effective policy interventions and that the level of risk in adopting them is acceptable.

### ***Managing the Politics***

- (vi) Influencing by DFID has been most successful where it is facilitating partners to move in the direction that they have already broadly decided upon and which is aligned with domestic political incentives and interests. However new policy directions also have to be well planned, technically sound and cost effective. The Nepal and Zambia cases show there is a danger that donors can be used to meet a political imperative by a new Government or political party with insufficient attention being paid to possible constraints or adverse consequences from new policy.

- (vii) The case studies highlight the importance of understanding politics and incentives and using this to develop influencing tactics. DFID Advisers with Governance expertise, political analysis and influencing skills have a key role to play, as do DFID Staff Appointed In-Country (SAIC) staff who often have in depth knowledge of the local politics. DFID could usefully prepare operational guidance and examples drawing from these cases to help spread good practice and encourage more analysis of political drivers and incentives at sectoral level.

### ***Managing the Resources***

- (viii) A full quantitative cost effectiveness analysis of influencing is likely to remain impractical but more attention should be given to the costs involved and the alternatives that may be available, for example, to use more national consultants and SAIC staff. Some approaches are more resource intensive than others (for example a large international consulting team) and DFID should ensure that this can be fully justified by the potential returns.
- (ix) All influencing efforts should have a strategy that sets out the expected objectives, pathway of change and some monitorable targets<sup>1</sup>. DFID should assess the likelihood of success and potential impact in deciding to invest, especially where there is a high risk of failure and low returns. More attention needs to be paid to the cost effectiveness of the policies being promoted.

The evaluation suggests that in some cases, the planning of the influencing effort and thought given up front to strategy and prioritisation, was too small in relation to the effort and resources that were eventually expended. However planning also needs to be proportionate and elaborate strategies are not necessary when – as with some influencing work – the resources devoted are small and often a proportion of the time of one staff member.

- (x) The case studies indicate that influencing is by nature uncertain and that there is a need to remain flexible and ready to adapt to opportunities when they arise. DFID should aim to pick up unexpected developments early so that influencing objectives and approaches can be adjusted as required. Decisions to abandon the effort should not be seen as a failure if the obstacles are insurmountable.

### ***People and Incentives***

- (xi) The case studies confirm the critical importance of having the right people in country to influence effectively. Stakeholders want to interact with senior people able to represent their organisations effectively and with a team that offered a mix of international, local knowledge and skills. They also valued their flexibility and professionalism which is consistent with previous DFID evaluations<sup>2</sup>. There were concerns about lack of continuity and availability of staff in some partner countries.

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<sup>1</sup> A study by the Dutch Government has reached a similar conclusion on the need for a clear strategy. See “Playing Chess with Policy Makers”

<sup>2</sup> See for example the series of Country Programme Evaluations of DFID’s bilateral programme.

- (xii) The evaluation raises some important questions about possible trade offs for DFID staff involved in influencing. For example, the need to be responsive to Government priorities and reactive to political opportunities on the one hand, and, on the other, the need for a more structured and strategic approach.
- (xiii) Understanding the position of other development partners and ability to develop close working relationships with them has been a major factor in promoting effective harmonisation in several of the partner countries (e.g. Nigeria and Mozambique).



## Section 1 : The Evaluation Framework and Process

1.1 This report was commissioned by DFID's Evaluation Department. Its main purpose is as a contribution to the Health Portfolio Review, commissioned by DFID's Investment Committee, to assess the value for money of DFID's bilateral and multilateral investments in the health sector. Improving DFID's approach to measuring influencing is a key area of work for Evaluation Department (EVD), as agreed with the Independent Advisory Committee on Development Impact that decides on priorities for independent evaluation. EVD made a start with work in this area last year and expects to commission more work on tools and methods in 2010.

1.2 The focus of the study is the investment DFID makes in the health sector in advisory staff involved in policy dialogue and influencing partner governments and international partners. These interactions are often seen as one of DFID's key strengths and help to shape the policy and practice of partners towards development effectiveness and poverty reduction goals. The evaluation question to be examined is:

*“To what extent did DFID's influencing and policy dialogue activities in the health sector provide good value for money - and how could this be improved in future?”*

1.3 Measuring the impact of policy dialogue and influencing is a relatively new area for DFID's monitoring and evaluation systems. Most existing evaluations discuss influence to some extent and there have been a handful of studies which focus on it more directly, but none have set out to make a serious assessment of cost-effectiveness and impact. For this reason the consultants were briefed that:

- It would not be feasible to conduct a comprehensive assessment of the impact of DFID's influencing work across bilateral and multilateral investments in health in the time allowed for this work.
- The consultants should explore what was feasible and adopt a pragmatic and experimental approach to assessing cost effectiveness and impact.

And that:

- the key output should be a set of *illustrative examples* of typical influencing activities by DFID in the health sector, focusing on 6 case studies, together with *a preliminary assessment of the value for money of those examples*.

1.4 The work was supervised by a DFID team led by the Head of Evaluation Department with whom the methodology was agreed. Important contributions were made by Paul Spray, Head of Central Research Department and Jenny Amery, Head of Profession Health. The working hypothesis for the evaluation was that in the cases to be examined DFID would be more likely to be making a significant contribution to change in situations where they were working with

receptive partners and where they were able to effectively apply an evidence based approach to policy dialogue. This working hypothesis was tested in all the cases and the study also explored possible counterfactual scenarios (i.e. what might have happened without DFID engagement) through stakeholder interviews.

1.5 The evaluation process involved:

- a) Using a rapid outcome assessment method<sup>3</sup> to review a range of possible case studies involving “stories of change” prepared by DFID overseas offices and Departments.
- b) Undertaking a more in depth analysis of 6 case studies selected as a collection of examples spread across DFIDs bilateral and multilateral programme where documents could be accessed and interview programmes could be carried out.
- c) An electronic perceptions survey of DFID Health Advisory staff.
- d) A paper on developing new evaluation methods for future, more in depth, evaluations of influencing.

1.6 The case studies involved reviewing documentation and conducting up to ten key informant interviews with Government or donor organisations (both like-minded and non like-minded) and consultants involved in the process. A structured approach was used as set out in Annex 2. The interviews were triangulated and compared with documentary evidence and used to develop a case study to a consistent template. The case studies are set out in full in Annex 3 and cover:

- Global Fund for Aids, TB and Malaria
- Zambia: Removal of user fees
- Nigeria : Joint Financing Agreement (harmonised HIV and Aids funding)
- Mozambique (Human resources for health policy)
- India (Equity and access for scheduled castes and tribes and poor groups)
- Nepal (Safer motherhood-demand side financing and safe abortion)

1.7 The cost effectiveness and outcomes from the influencing efforts were assessed as set out below. The evaluators aimed to determine whether observed policy changes could be attributed in part to DFID whilst also examining the contribution from actions by Governments and other donors. Health outcomes could not be reliably attributed to DFID because of limited data and the methodological challenges of trying to trace the narrow contribution of influencing when so many other factors played such a big role. For each case study the approach included:

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<sup>3</sup> See [http://www.odi.org.uk/RAPID/Publications/RAPID\\_WP\\_266.html](http://www.odi.org.uk/RAPID/Publications/RAPID_WP_266.html)

- Gathering cost data and cost analysis of DFID staff time and other associated technical assistance (e.g. consultancy studies) used in the influencing effort.
  - Examining documents to establish whether DFID staff had considered alternative approaches or ways of carrying out influencing.
  - Using stakeholder interviews to assess the contribution of DFID to any policy change that had taken place and to score the overall effectiveness of DFID influencing on a pre-determined scale shared with the interviewees in advance.
  - Using secondary information where available to identify any changes in spending and service delivery levels or utilisation over the period of influencing. It was accepted that observed changes could not reliably be attributed to DFID or donor support.
- 1.8 The evaluation products include: the case studies (Annex 3), the survey (Annex 4) and the analysis of future options for evaluation (Annex 5).



## **Section 2: Influencing In The Corporate Context**

- 2.1 DFID's focus on policy influence and measuring its cost-effectiveness is not new. DFID's current White Paper explicitly calls for the organisation to tackle the challenge of becoming a global development driver addressing and engaging in policy dialogue at the global, national and local levels. Its focus on the Millennium Development Goals (MDGs) and the principles of the Paris Declaration<sup>4</sup> steer DFID towards multiple and inter-related policy spaces that require new competencies and skills to be handled effectively.<sup>5</sup>
- 2.2 A number of initiatives have been undertaken by DFID to help staff develop greater capability in influencing. This experience has been drawn on to help frame the current evaluation:
- (i) In 2006, DFID commissioned a consultancy to develop training in strategic influencing, strategic personal communications, and negotiation skills. This experience was used to develop the "RAPID" Outcome Mapping Approach which involves a systematic approach to planning influencing programmes. These methods have been applied in the current evaluation.
  - (ii) A DFID Strategy Unit brief<sup>6</sup> in March 2008 explicitly recognised the need to address uncertainty by continuously reviewing influencing objectives to ensure both that uncertainty is managed and that tipping points are identified. The study also found that DFID could improve resource allocation and prioritisation for influencing programmes by more systematically considering alternatives and comparing the costs involved with the expected outputs and outcomes. This evaluation seeks to establish the extent to which such systems are being utilised in health sector influencing work.
  - (iii) In 2007, DFID launched a project to pilot the use of new policy dialogue planning and monitoring tools based on the LogFrame tools employed by DFID. The pilots included teams based in HQ and countries. An evaluation of the project was commissioned by DFID and developed by Watson and Pierce<sup>7</sup> (2008). This suggested DFID's high staff turnover and weak stakeholder management systems affected its ability to build long-term relationships, understand stakeholders, and influence other actors effectively. Questions about these aspects were built into the current evaluation.

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<sup>4</sup> An agreement by the international donor community to set goals and targets to harmonise their development assistance and to reduce the burden on partner developing countries.

<sup>5</sup> As the experience of DFID's Latin American Department confirms, large spending programmes are neither a guarantee nor a condition of policy influence. DFID advisors and managers in that programme needed to engage in complex policy spaces or processes where political, corporate, social and cultural factors interplay.

<sup>6</sup> Measuring and Monitoring Influencing – What Can DFID Do? (DFID Strategy Unit Issue Identification Brief no 3 march 2008)

<sup>7</sup> Monitoring Policy Dialogue – Lessons from a Pilot Study (EVD report 692 by Sadie Watson and Juliet Pearce, PARC, Sep 2008)

- (iv) DFID’s International Directors Office (IDO) commissioned the Overseas Development Institute (ODI) in 2008 to undertake a study on DFID’s experience in influencing multilateral organisations to develop a practical guide or a set of recommendations to improve the planning, monitoring and evaluation of influencing initiatives<sup>8</sup>. The evaluation case study of GFATM provides an opportunity to examine the approach to international influencing currently being taken.

2.3 These studies have unearthed a number of influencing types and policy objectives commonly followed by DFID policy advisors (see below). The different types of influencing are explored further in the case studies and the overall influencing strategies used by DFID are set out in the next section:

Examples of influencing types	Examples of influencing objectives
<p>Personal relationships and contacts between DFID staff and other stakeholders.                      Joint analysis and agreement on problems and response.                      Formal Team based discussions across Whitehall, international donor meetings.                      DFID teams undertaking analytical work on policy options e.g. aid effectiveness.                      Formal dialogue in donor groups e.g. regular reviews of progress on harmonisation of donor programmes.                      Informal contacts and diplomacy.                      Communications strategy and programme.                      Speeches and public meetings.                      Budget support and expertise to countries and institutions that implement reform plans (UN system and country programmes).                      Leadership of donor dialogue at country level.                      Influencing global development assistance programmes and funds for example the Global fund for Aids , TB and Malaria.                      Bilateral country programme pilots for scaling up.                      Influencing the outcome of Multilateral negotiations like World trade organisation (WTO) negotiations.                      Using UK membership of G8, EU and UN Security Council to influence policy decisions.                      Prime Ministerial and Ministerial relationships with key decision makers                      Speeches, events and platforms.                      UK led “call for action”.</p>	<p>Open and improve the relationship with counterparts and their organisations.                      Develop common positions and policy across Whitehall.                      Influence the development and take up of new policy by donors.                      Increase public support for new policy.                      Take up of pro poor policy and more effective use of aid in partners.                      Encourage risk taking and adoption of new ideas by development partners and national governments.                      More effective international institutions having a bigger impact on poverty and global public goods.                      Mobilise political commitment and agreement to act on global public goods.</p>

## 2.1 Perceptions and Issues of Health Advisers

2.4 The 10-question survey of health advisors undertaken for this study confirms some of the findings and lessons emerging from the studies and initiatives mentioned above (see Annex 4). The perceptions of DFID Health Advisors (see Annex 4) can be summarised as follows:

- More than 50% of respondents think DFID spends comparatively little on influencing but gets very good value for money.
- Between 75-80% think that health advisors are critical to successful influencing in the sector.
- 75% think that corporate or departmental priorities drive influencing.

<sup>8</sup> DFID’s Policy Dialogue with Multilateral Organisations: Strengthening policy and practice: In 2008.

- More than 70% think influencing in DFID has implicit objectives and only 20% think DFID is systematic in assessing opportunities and stakeholders.
- The majority think effective influencing requires good communication and networking and an understanding of political drivers and incentives.
- Value for money could be enhanced by focussing on policy changes with the greatest potential impact and by flexibly financing evidence based studies.



## **Section 3: Influencing Strategy, Objectives and Approaches**

3.1 The case studies show that DFID had a variety of influencing objectives that fell into two broad categories:

### **A. Public policy objectives:**

- (i) The development of a new National Human Resources for Health Plan (Mozambique);
- (ii) The removal of user fees (Zambia);
- (iii) The implementation of safer motherhood policies including policies for demand side financing and skilled birth attendants (Nepal);
- (iv) Increased spending on programmes to assist disadvantaged groups (India); and
- (v) Introducing a Joint financing Arrangement (JFA) involving pooling of donor funds to support the National Action Committee for Aids or NACA (Nigeria).

### **B. Policies of development partners and other international organisations**

- (i) A change in GFATM processes to achieve greater harmonisation, alignment and predictability with existing in-country systems (GFATM);
- (ii) Mobilising additional resources from development partners and GFATM for the newly developed Human Resources Plan, strengthening coordination between development partners and the government, and bringing non-aligned development partners on board of a national Compact on Health (Mozambique);
- (iii) Developing interventions and mobilising additional funds from donors for programme targeting disadvantaged groups (India).

### **3.1 Articulating the policy objectives**

3.2 The goals of the influencing efforts and programmes were clearly stated and understood by the DFID teams involved but specific outputs were not always explicitly articulated in strategy or project documents. In several cases, the objectives and approach evolved in the light of experience and the opportunities that arose. In Mozambique, for example, support for the development of a new Human Resources policy was not initially articulated in a strategy document but subsequently a strategy was set out for the mobilisation of additional funds to cover the human resources financing gap. In this case, DFID responded to a formal requirement from the International Health Partnership (IHP) process to develop an influencing strategy.

- 3.3 Following an election in Zambia, DFID took advantage of an opportunity to influence the newly appointed Health Minister, who was a keen supporter of the idea of removing user fees. Originally, DFID had aimed to explore the possibility of user fees removal through the development of a pilot project and an inclusive process that would include the study of a number of health financing options. The influencing effort had been adapted in the light of the changed circumstance and was an opportunistic response to the emerging situation.
- 3.4 In Nigeria, by contrast, DFID specifically mentioned the setting up of the JFA as a policy objective in its project 'Support to the national response on HIV and AIDS'. As a consequence, specific resources were allocated and plans to achieve this objective were drawn up.
- 3.5 In the case of India, there was no written influencing strategy or systematic planning of the influencing effort because it was part of the design process of the much larger Reproductive Child Health programme-phase 2 ( RCH 2) programme. Supporting the development of new policy was an objective in the Nepal Safer Motherhood project (NSMP) and Support to the Safe Motherhood programme (SSMP) although the objective was set out in very general terms. DFID Nepal also recognised the political context was changing rapidly and that the uncertainty required DFID to remain flexible and ready to respond to emerging opportunities. A new Government also created an opportunity to influencing the introduction of free delivery services.
- 3.6 In the case of DFID's strategy towards GFATM, the policy objectives were clearly articulated and made public. These were communicated in a letter from the Secretary of State to the GFATM's Executive Director in August 2007 and in a Project Memorandum and Log frame for DFID's commitment of funds in October 2008.

### **3.2 Approaches**

- 3.7 Each case employed different strategies and approaches to achieve their influencing objectives. The full details are provided in the case studies but are summarised here:

(i) *Lesson Learning Strategies*

DFID Nepal explicitly aimed to develop new policies for safer motherhood by funding studies of cost constraints on access, analysing the options for new programmes and the cost of free delivery services. The NMSP and SSMP implemented service delivery improvements in rural areas and the Nepalese Government drew out the lessons learned from field experience to develop policy and programmes.

(ii) *Evidence Based Strategies*

In India, DFID focused on providing evidence about the lack of access to services by the poorest groups and by scheduled castes and tribes as an input into the RCH 2 design process. They worked closely with other donors and Government to develop options for interventions and to set targets for access. In

Zambia DFID had planned to support the Government by employing an evidence based approach to pilot removal of fees in selected Districts. However, a new Government wanted to proceed more rapidly and DFID then took the opportunity to provide advice on the experience elsewhere in Africa and to put forward the case for removing fees.

*(iii) Leadership of Harmonisation and Paris Agenda dialogue*

DFID played a leadership role amongst the donors in Nigeria by setting out a clear vision of change for the new national Aids organisation and selling the proposal to pool donor funds together for easier management. DFID funded design studies of the JFA-introduced experience from Malawi and elsewhere and facilitated the design work.

*(iv) Linking national and global policy processes*

DFID Mozambique followed an approach that linked a national policy process (the preparation of a human resources development plan) with a global policy process (the International Health Partnership) to mobilise development partners and their funds in support of the strategy. DFID used evidence from analysis, negotiation and lobbying to influence Government and donors (including influencing through the UN summit in 2008).

*(v) Influencing through Membership of Boards of Global Funds*

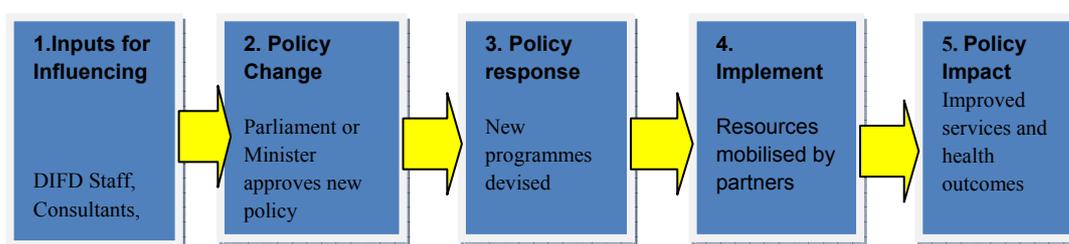
DFID influenced GFATM through its membership of the Governing body of the organisation and Policy and Strategy Committee. DFID HQ and staff in Geneva used direct contacts with the secretariat and links with advisers in country develop proposals for improving the quality of GFATM applications and implementation processes. Special studies were also carried out.

- 3.8 Overall, the case studies highlighted the key role that experienced sector managers, supported by a mix of economic, social development and Governance advisers, played in leading influencing strategies. Strong leadership and a multidisciplinary approach was essential to adapt strategies and tactics as DFID engaged with the various policy processes and responded to the challenges and opportunities that it faced.



## Section 4: Outputs from Influencing and Impact from Policy

4.1 This section will focus firstly on establishing whether the policy change that was being aimed for by DFID has actually occurred or not. Secondly, it summarises the evidence from the case studies about the extent to which the DFID influencing effort contributed to this change. Recognising that DFID's influence decreases as the process develops, the evaluators therefore examine stage 1 and stage 2 of the results chain shown in the diagram. What happens in subsequent stages 3 - 5 increasingly depends on action by the partners being influenced. The effects of DFID influencing therefore become subsumed in these processes. This section will set out the available evidence of the effects of new policy but recognising that any observed changes cannot be attributed directly to DFID.



### 4.1 Influencing Through People and Money

4.2 Several of the case studies involve a DFID influencing effort within the context of a much larger programme of financial support to the sector. The GFATM case study indicates that the decision to formalise the influencing objectives was taken simultaneously with one to provide an additional £1 billion of programme funding. In Nigeria the associated financial aid for pooled funding has been an important incentive in encouraging introduction of harmonised funding structures respectively in these countries. In Nepal and India the associated financial support through RCH2 and SSMP is helping to test out new ideas in the field as a basis for an evidence based approach to the development and take up of new policy.

4.3 The case studies also suggest financial aid is neither essential nor a guarantee of effective influencing. In Zambia the bilateral programme retains considerable influence through two health advisers but has no sector support. There are other examples reported to us such as Tanzania where DFID withdrawal has been even more complete and influencing is still being pursued through civil society (see box below).

#### Box 1: DFID Influencing In the Health Sector In Tanzania

DFID has withdrawn from the “overcrowded” health sector and no longer provides financial support or technical assistance nor does it have an in house health adviser. However DFID retains an influencing agenda about getting good quality information into the public domain. Support is being provided to Ifakara Health International to help them produce information for policy makers and the wider public about the performance of health services and different interventions. This will help increase public debate and the influence of civil society over Government policy and resource allocation.

## 4.2 The Influence of DFID on Policy Change

4.4 The six case studies in Annex 3 have systematically examined the influencing effort undertaken by DFID to achieve policy changes by partner Governments, other donors or by international institutions. The table below reveals whether the policy change that was sought has actually occurred and the steps that led to these changes:

Case Study	Change Objectives	Current Situation	Assessment
<b>GFATM</b>	<p>Greater harmonisation and alignment of GFATM in partner countries; greater predictability of GFATM funding; and improved value for money.</p> <p>Poverty focus and fit of GFATM with international architecture.</p>	<p>Streamlined grant processes; testing of national strategy approach to align GFATM support with country priorities; development of approach to joint donor assessments.</p> <p>VFM being pursued through pooled procurement and monitoring of commodity prices.</p> <p>Positive change by GFATM against several Paris harmonisation targets.</p>	<p><b>Policy change partially made.</b></p> <p>Influencing effort still underway.</p> <p>Some progress is being made against all DFID influencing objectives.</p>
<b>Mozambique</b> Human Resources for Health Policy	<p>Government adopting a Human Resources for Health policy; and the International Health Partnership Compact.</p> <p>GOM mobilises additional resources from US Government and GFATM and gets their commitment to join Compact.</p>	<p>Government has approved the HRH policy; sector Compact approved; the US and GFATM are yet to sign Compact.</p> <p>Some additional funds- US \$ 31million for health systems by GFATM; more funding from DFID , Belgium and Italy; US has shifted its focus to health systems.</p>	<p><b>Policy changes made with partial achievement of outcomes.</b></p> <p>Full mobilisation of resources for HRH yet to be achieved and position of GFTAM and US still to be decided.</p>
<b>Zambia</b> Removal of user fees	<p>Encourage an evidence based policy to remove user fees for basic health services.</p>	<p>User fees for rural health services were removed in Jan 2006.</p> <p>Supply side constraints persist with constraints on drug supplies, staffing and facilities.</p>	<p><b>Policy change made and outcome to be determined.</b></p> <p>Utilisation for some categories of population has risen but not others.</p>

<p><b>Nigeria</b></p> <p>Harmonised financing and planning in HIV and AIDS</p>	<p>Encourage Government and donors to develop and implement a Joint Financing Agreement.</p>	<p>JFA model endorsed by donors.</p> <p>National Action Committee for Aids (NACA) plans to sign JFA in 2009.</p>	<p><b>Policy changes partially made.</b></p> <p>Strong momentum has built up and trend is positive.</p> <p>Some donors have yet to agree to join JFA.</p>
<p><b>Nepal</b></p> <p>Safe Motherhood policies</p>	<p>Government adopting new policies addressing demand side financing; skilled birth attendants; and safe abortion.</p>	<p>New policies announced in all of these areas over 2005-8.</p> <p>Implementation of new programmes underway funded by GON and pool donors.</p>	<p><b>Policy changes made and positive trends emerging.</b></p> <p>Early results are promising with increased utilisation of facilities but too early to tell if fully successful. Increase in safe abortions.</p>
<p><b>India</b></p> <p>Equity and Access in RCH 2</p>	<p>Government and donors adopt strategy and programmes to increase access and service use by poor, scheduled castes and tribes SC/ST.</p>	<p>RCH2 design has adopted strategy and components to address the needs of poorest and disadvantaged.</p> <p>Interventions and programmes for poor and SC/ST being introduced.</p>	<p><b>Policy change made.</b></p> <p>Implementation is patchy and outcomes not yet clear.</p> <p>There are positive signs of increased utilisation by poor and SC/ST groups and of increased service provision.</p>

Source : Detailed case studies in Annex 3

4.5 The factors contributing to the observed changes are discussed in the rest of this section and set out in more detail in the country case studies. They reveal that the main determinant of a policy change is the political commitment of partner Governments. They also suggest that in the majority of the cases DFID made a significant contribution to the policy changes that took place, either directly or indirectly by working with the wider donor community.

### 4.3 The Politics of Policy Change

4.6 The case studies highlight the critical importance of understanding and aligning with political interests in partner countries and the incentives of donor partners. In all the country cases the main external condition making influencing possible was the opening of the political space to allow consideration of new ideas. New Governments in Nepal and Zambia were keen to introduce policies respectively for demand side financing and removal of user fees.

- 4.7 DFID was typically well positioned to support national champions and to respond to any political opening. In Nepal, DFID funded studies of cost constraints on access and helped the Ministry of Health to assess the financial consequences of new policies for Government. This helped persuade the Nepalese Treasury to adopt new policies. In Zambia, DFID provided advice based on experience of user fee removal elsewhere in Africa. In India, an evidence based approach was used to generate information on the lack of access by so called “Scheduled Castes and Tribes” (SC/ST) who have been designated by Government as qualifying for special assistance and the poor as a basis for assisting Government to develop new interventions and targets for service delivery to these groups.
- 4.8 The evidence base for some new policies promoted by DFID was limited and arguably needed more context-specific analysis. Some commentators in Nepal thought DFID and the donors had been used to meet a political imperative and that new policies and programmes on free delivery had been prematurely implemented. In practice, the Government of Nepal took the view that the risks were worth taking and DFID pushed for commitments to monitor and review in the light of experience. In Zambia, DFID initially promoted piloting of user fee removal and then cautioned against their excessively rapid removal. DFID advocated user fee removal but also argued that steps needed to be taken to ensure a supply side response was prepared to meet increases in demand. In both cases, DFID was unable to influence the Government to take a more cautious and planned approach although in Nepal they persuaded Government only to introduce free delivery services rather than introduce free services across the board.
- 4.9 There are other examples where DFID has responded opportunistically to situations where a political opening occurs. As the box shows, timely visits by HQ Advisers to advise Ghanaian politicians at the highest level seem to have made a contribution to decisions to include pregnant women in health insurance so that they have access to free health care.

**Box 2: Free Health Care for Pregnant Women In Ghana**

The DFID influencing effort involved provision of a small amount of advice at the Ghana Health summit and consultancy to Government on experience elsewhere. The President subsequently announced free membership of the National Health Insurance Scheme for all pregnant women services and cited DFID's influence. So far, 433,000 women have registered for free care. The situation will need careful monitoring to see if this leads to increased utilisation of maternal health services and improved maternal health outcomes.

**Source: Information provided by DFID Ghana**

**4.4 The Importance of Donor Collaboration for Influencing**

- 4.10 The GFATM case highlights the challenge and limitations of influencing in a situation where DFID is one among a number of stakeholders on a Board constituted of many and varied interests. The evidence suggests that in these cases, DFID influencing objectives and priorities need to be well thought through and pursued on a collaborative basis. Understanding the incentives and

positions of other stakeholders was key to the progress made in changing GFATM. A platform for influencing has been created by working to build coalitions and to find areas of common interest. Tactics can be adapted as the situation unfolds.

- 4.11 In the bilateral country programme case studies, the influencing efforts have mostly been pursued within the context of joint donor planning structures and coordination frameworks. In India this collaboration was particularly important in enhancing donor leverage and influencing the Government of India's (GOI) approach. GOI and donor partners thought the partnership arrangement worked very effectively and that differences of view had been constructively aired and addressed. In Nigeria, Mozambique, Nepal, and India non-likeminded donors such as the US felt able to move toward a more coordinated framework despite fundamental limitations in their capacity to adopt harmonised approaches.

#### **4.5 The Role of DFID Staff and Consultants**

- 4.12 All the cases point to the importance of DFID staff in carrying out influencing effectively. Government and donor stakeholders consistently underlined the critical role played by senior DFID programme and advisory staff who could undertake policy dialogue at a senior level with Ministers and formally represent the interests of their agencies within the donor group. They also highlighted the importance of combining knowledge of international good practice with local experience and a skills mix that covered finance and management as well as specialist and technical health areas. Lack of continuity of DFID and consultancy staff due to problems of high turnover were seen as a constraint in India and to a lesser extent in the other cases. Governments were also concerned about the demands on DFID staff which could sometimes affect their availability for consultation.
- 4.13 The country cases highlighted the strong incentives within DFID for country staff to address corporate priorities and to find opportunities to align DFID's interests with those of partner Governments to mutual benefit. The Mozambique and Zambian cases suggest this can reinforce divisions within the donor group when the rest of the donor community are not fully in agreement. In Mozambique some donor stakeholders remain unconvinced of the value of pursuing the IHP and the effort that went into it. In Zambia the donors remain divided on the merits of user fee removal and some feel more should have been done to ensure that the pre conditions were in place.
- 4.14 The flexible and rapid provision of technical assistance was seen as critical in several cases. The various instruments used such as study tours or visits by regional advisers were often influential in exposing decision makers to experience elsewhere; to the evidence about potential interventions; and the assessment of costs and benefits of policy options. A study tour to other African countries was an important factor in persuading Nigerian officials of the value of the JFA. Consultancy studies were undertaken to analyse the evidence and the policy options in Nepal, Zambia, Mozambique and India.

4.15 External consultants have mostly been used to carry out “one off” studies to generate analysis and data to support policy decisions. In the case of Nepal there has been a long term consultancy team embedded in the Ministry of Health without which implementation of improved services would have been very difficult. During the evaluation questions were raised about the sustainability of the model and the need to address longer term capacity constraints.

#### **4.6 Health Outcomes From Policy Changes**

4.16 The evaluation has used secondary data and reports to assess significant trends in service delivery areas and health outcomes related to the policy changes that have occurred. The information that the evaluators have collected is incomplete at best and reflects the total effort by Governments and donors in the sector. It is not possible to attribute health outcomes directly to the DFID influencing effort.

4.17 A summary of the limited available data in the case studies is provided in the table below. The partial nature of the data makes it premature to draw any firm conclusions but there are some signs of improved trends in utilisation of health facilities for deliveries and of skilled birth attendants in Nepal. There has also been an increase in safe abortions. Institutional deliveries seem to be increasing in some Indian states. In Zambia there may have been an initial increase in utilisation followed by a decline but the results of a major study currently underway are awaited. In this case it seems that the results of user fee removal are likely to vary by District and to require careful interpretation.

	<b>Health Service Delivery and Outcome Targets</b>	<b>Evidence and Trends</b>
<b>Zambia</b>	Increased availability and utilisation of health facilities and primary services in rural areas.	Increase in utilisation followed by fall. No change in utilisation by children but increase for older children and adults suggests some impact of fee removal. Big variations across Districts.
<b>Nepal</b>	Increased utilisation of safe motherhood services eg deliveries in facilities up by 2% a year.  Improvements in skilled birth attendance by 4% a year.  Increased use of safe abortion.	Facility deliveries have increased from 95,000 in 2004 to 148,000 in 2008.  800 SBAs trained but 80% of mothers still give birth without one.  212,396 safe abortions have been carried out.
<b>India</b>	Increased access and use of mother and child health services by Scheduled Castes and Tribes.  Contraceptive prevalence from 38% to 50%.  Deliveries by SBA from 30% to 50%.  Fully immunised children from 48% to 75%.	Systematic survey data is not yet available for SC/ST but mid term review shows.  Increased spend on innovative targetted services and more use by SC/ST.  Institutional deliveries up by 64% in Rajasthan and 35% in Madhya Pradesh 2005 - 8 for SC/ST.  Post natal care for SC/ST up by 10% and 67% respectively for the same states.

- 4.18 In the case of Nepal it is also useful to look at the broader context of national trends in maternal mortality. The case study highlights that there are many factors that have contributed to this outcome. The political commitment of the Government has been the overriding factor. The evidence also suggests that the DFID has been instrumental to the wider donor effort and that the substantial financial aid and technical assistance provided over the past decade has contributed to a big reduction in maternal mortality from 539 deaths per 100,000 births in 1996 to 281 in 2009.

#### **4.7 Influencing Effects on Global Institutions and the Donor Community**

- 4.19 The other three cases have focussed on influencing the performance of the Global Fund and promoting harmonisation and mobilising resources from non aligned donors in Mozambique and Nigeria. Each of these cases has demonstrated that DFID has had a positive influence on donor behaviour and resource use. The cases illustrate the substantial potential that exists to use relatively small amounts of DFID resources to enhance the effectiveness of resources provided by other donors in partner developing countries and help improve the performance and cost effectiveness of global institutions like GFATM. Specific influencing outputs so far are:

**GFATM:** DFID has influenced decisions made by the Board to test an approach that aligns GFATM funding requests with national strategies and priorities. There has been an increased commitment to the Paris declaration by GFATM as demonstrated by progress against the Paris targets. DFID has helped focus the organisation on cost effectiveness and value for money by encouraging greater attention to these issues and championing new market intelligence systems for drug procurement. This has now been agreed and will be funded by the United Nations. Such a system could generate substantial financial savings by monitoring and sharing data on the latest drugs and commodities prices and allowing grant recipients to source from the lowest cost suppliers. It will promote help greater transparency and change procurement practices

**Mozambique:** The Government has adopted a high quality human resources policy that addresses the most critical constraint in the sector and is a basis for mobilising resources from other donors. The introduction of the IHP was championed by DFID and this has created a single structure for Health Sector planning and donor involvement. As a result the behaviour of the US Government has changed with a conscious attempt to realign PEPFAR programmes worth US \$220 million a year and to avoid doing harm. Some additional funding has been mobilised but so far, this has been less than anticipated by the Mozambiquan Government. There are prospects for an additional US \$80 million from GFATM if Government's latest proposals are accepted.

**Nigeria:** The Government has adopted the plan developed by DFID for a Joint Funding Arrangement that would underpin the establishment of one plan for HIV and Aids that could be overseen and monitored by the National Action Committee for Aids. DFID has championed the approach and helped NACA win support from Government and the donors for the first pooled donor funding arrangement in Nigeria. This remains to be signed but if implemented, can be expected to reduce transaction costs to Government.

## Section 5: Assessment of Value for Money

- 5.1 Cost effectiveness analysis is commonly used in the health sector to assess the cost of averting ill health through a range of alternative interventions. By comparing the costs of these interventions and their health benefits in terms of Disability Adjusted Life Years (DALYS) decision makers can then select the approach offering the best value for money<sup>9</sup>.
- 5.2 The limitations on cost effectiveness analysis of health policy influencing in DFID are considerable. Assessing and attributing benefits is difficult and resources used are often not formally recorded unless the effort is sufficiently large to warrant it or has been projectised. Only in the case of GFATM was the influencing effort documented in project form with defined objectives, indicators and outputs with resource costs fully identified. In other cases, the resource costs for technical assistance or consultancies were often captured in DFID health projects or programmes but the DFID staff costs were not separately identified and included.
- 5.3 The overall cost of each influencing effort has been assessed and is shown below broken down into the main categories of resource cost involved:

Case Study	DFID financial support to the sector <sup>1</sup>	Influencing Cost £	DFID Staff used for influencing-Cost £	Other TA used for influencing-Cost £
Mozambique	38,000,000	305,000	137,000	168,000
Zambia	14,500,000	605,000	90,000	515,000
Nigeria	7,500,000	447,000	315,000	132,000
Nepal	23,000,000 *	442,000	64,000	378,000
India	245,000,000	317,000	28,000	289,000
GFATM	1,000,000,000**	345,000	261,000	84,000

1. Figures in column one show the total multi year funding planned by DFID and stretching over five or more years. The data is for financial aid only. The influencing costs in the other columns are related to DFID staff or technical assistance costs.

\* figure for Nepal is mostly financial aid but includes some consultancy costs.

\*\* represents long term plans to 2015. Actual spend in 2008/9 is expected to be £50 million.

It is clear from the analysis, that the resources consumed in the influencing efforts are significant but are also relatively modest in relation to potential influencing outputs and the down-stream health benefits that can result where Government and donors subsequently take action to implement policy changes.

- 5.4 The cost of influencing is also often only a small proportion of the development assistance funds devoted by DFID and donors to the sector. For example, in Mozambique they were just under 1%, and in Nepal 2% respectively of the financial aid being provided to the sector by DFID (see table above). To the extent that new policies improve the value for money of resource use in the sector, the potential impact of an influencing effort can be considerable.

<sup>9</sup> Using Economic Analysis to Inform Priority Setting and Resource Allocation in the Health Sector.

- 5.5 In the case of GFATM, a comparatively small amount of DFID staffing resources is influencing the way a very large financial commitment by DFID of £1 billion over 2008 - 15 and the much larger total GF funding is used. The annual cost of the DFID influencing effort amounts to only 0.009% of the total annual disbursements by GFATM.<sup>10</sup> In other words DFID spends around £9,000 a year on influencing the Global Fund for every £100 million of its programme spend. This relatively small amount was still able to achieve significant policy traction. Secondly, it highlights the way in which some DFID country programmes have actively aimed to influence the design and delivery of GFATM programmes. It is suggested that there may be potential to increase this effort and that this could offer high returns to the broader corporate influencing objectives.
- 5.6 The cost table also reveals the diversity of approach and that alternatives ways of influencing have been used with different resource implications. Whereas the India and Nigeria offices relied more heavily on in house DFID staff, the Nepal office adopted a model of contracting consultants. The Nepal influencing approach used a high level of consultancy resources because of its strongly evidence based and learning by doing approach and the need to address the limited capacity of the Nepalese institutions. Mozambique fell somewhere in between and Zambia was relatively low in resource use to begin with but, more recently, has allocated substantial resources to a systematic research based survey of the effects of removing user fees.
- 5.7 The costs of influencing also vary depending on whether DFID uses HQ based staff or staff in overseas offices. The case studies suggest the costs of DFID overseas staff can be double the cost of UK based staff because of the additional costs of living overseas which are met by DFID. However the case studies also show that overseas offices are using mixed teams of UK based and local staff which reduces their overall influencing costs and that national Governments (for example in India) seem to value the availability of senior UK staff. The evaluation suggests that the priority for DFID overseas offices is to ensure sufficient senior expertise is available in house so that partner Governments have the level of support they need and the confidence that their interlocutors have a good knowledge of DFID corporate and country policy. This will usually require a core team of home civil service staff. However within this framework, value for money can be enhanced by using national SAIC staff and specialist expertise from local consultants where appropriate. International consultants are likely to be the most expensive option but can be justified where specialist expertise or a technical assistance project is required.

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<sup>10</sup> The annual cost of influencing to DFID is estimated at between £140,000 to £200,000 per annum in the annexed Global Fund case study. Assuming an average annual cost of £170,000 (or US\$272,000 at current exchange rates of £1=US \$1.6), this annual spend would amount to around 0.009% of the annual spend of US \$3 billion by GFATM in 2008. A spend of US \$3 billion a year would be £1.875 billion at current exchange rates.

**5.1 The Impact of DFID Influencing**

5.8 Assessing and measuring the impact of DFID on policy change is a difficult task. The evaluators have used a qualitative approach based on using structured interviews with independent (i.e. non DFID) stakeholders that included questions designed to explicitly score DFID’s performance. We also explored possible scenarios that could have materialised if DFID had not provided the support.

5.9 The table below summarises the scoring given to DFID by a group of stakeholders for each case study. The evaluators recognise the limitations of the methodology including its subjective nature. We also acknowledge that practical constraints limited the sample size and it was not always possible to get individuals to respond. Although the results are not statistically significant, they nevertheless give an impression from Government and donor partners (like minded and non like-minded) of how effectively DFID contributed to the policy changes that came about. Each X in the table is a score given by the stakeholder that was interviewed:

**Table 1: Stakeholder Assessment of DFID Influence**

	Score 0	Score 1-3	Score 4-5	Score 6-8	Score 9-10	No Score Given
<b>Mozambique</b>			X	XX	X	XX
<b>Zambia</b>			X	XXXX	XX	
<b>Nigeria</b>				XXXX	XXX	
<b>Nepal</b>			X	XXXX	X	
<b>India</b>			X	XXXX		
<b>GFATM *</b>				XX	X	XXXX

\* A significant number of GFATM stakeholders did not give exact scores but their remarks suggested a score mostly in the range 4-5. Only the scores actually given are recorded in the table.

Notes : Each X is a score provided by a stakeholder against the following criteria:

- 0- No influence (the change would have happened anyway)
- 1-3 DFID had some limited influence
- 4-5 DFID influence has helped the policy change process but not in a decisive manner
- 6-8 DFID Influence has been decisive for some of the key steps in the change process
- 9-10 DFID has been the main driver behind the policy change process

5.10 The results show a distribution of scores toward the higher end of the scale for the bilateral programmes and some clustering around 6-8. The majority of the stakeholders interviewed take the view that DFID made a decisive contribution to at least some of the steps in the policy change process. This is borne out by the case studies which seek to examine the specific ways in which DFID contributed and where, and how, to specific decisions that were made by partner Governments and donors. This supporting evidence is set out in the annex and will not be repeated here. In the case of GFTAM, DFID was seen as one of several Board members advocating policy changes which has encouraged and enabled changes in procedures at the Fund but most stakeholders did not see DFID’s role as decisive.

- 5.11 It is noticeable that some stakeholders have given a markedly lower or higher score. The reasons given for the lower scores include views that Government was less open to influence than the donors (and DFID) generally thought. There was a recognition that this might lead to an over exaggeration of the influence that was actually brought to bear. Other stakeholders thought that DFIDs influence could only be assessed as part of a broader donor effort. In other words, DFID's influence alone was less significant than when viewing the contribution as part of a wider and more collective donor effort.
- 5.12 In the majority of cases the stakeholders thought that DFID had accelerated the adoption and implementation of new policy. They felt that in the absence of DFID the Government was likely to have proceeded with the policy change anyway but that they would have done so more slowly and without systematic consideration of the likely effects. In Nepal, Zambia and India, stakeholders said that DFID's support gave the policy credibility with their national Treasuries and with other donors. In Mozambique and Nigeria stakeholders thought DFID played a key role in persuading other donors to move toward a more harmonised and coordinated planning framework.

## **5.2 Improving Value for Money In Future Influencing Efforts**

- 5.13 Annex 5 considers how to improve value for money in health influencing efforts in future. It suggests achieving value for money requires a strategic assessment and choice between different potential areas of policy change. DFID could then concentrate influencing on the policy area with the greatest potential impact for poor people. Adopting a more strategic approach to influencing in future could have important benefits but the evaluation also suggests that DFID needs to balance this with maintaining responsiveness to political opportunities as they occur.
- 5.14 The annex suggests there are few examples of efforts to assess the cost effectiveness of policy influencing by donors in the health sector but there are examples of impact studies that seek to examine the health consequences of policy change by Government. The box describes a study currently underway in Zambia that could potentially throw light on the effects of the removal of user fees and indirectly provide valuable insights into the outcome of the earlier DFID influencing efforts. This kind of approach could be a possible way forward in more complex evaluations of influencing.

**Box 3: Process and Impact Evaluation of the removal of user fees in Zambia, Methodological Approach.**

Component 1: An **impact analysis** which will summarise and analyse available information on the impact of fee removal on attendance at primary care centres by the poor and vulnerable groups. It will also include a benefit incidence analysis to assess whether district health service spending has become more pro-poor over the time of fee removal.

Component 2: A **policy process analysis** which will document the process by which this reform took place and was implemented at national and district level.

Component 3: A series of **case studies of implementation and impact** at district level. These case studies will seek to understand the experience of health workers and communities of the effects of this reform, the manner in which it was implemented, and the other factors that have been influential upon the successful delivery of good quality health services to poorer groups.

5.15 The approaches that can be used in future also depend on the nature of the influencing effort and the specific outputs. All have their limitations but the following could provide simplified approaches for assessing value for money:

- (i) Cost or efficiency savings could be assessed where DFID aims to improve the efficiency and effectiveness of the UN and other international agencies like GFATM. For example, improving procurement systems may have identifiable cost savings or result in reduced drug prices that can be passed on to developing countries. The degree of behaviour change that was needed to justify the influencing investment by DFID could also be calculated (i.e. £ million improvement in efficiency is required to pay back the cost of the DFID influencing effort).
- (ii) Where DFID aims to promote increased harmonisation amongst donor partners it may be possible to directly quantify some of the cost savings (e.g. from reduced transaction costs for partner countries) or efficiency savings (e.g. from cutting out waste caused by duplication or overlap in health programmes). These cost savings or efficiency gains can be compared to the level of resources used in the influencing effort.
- (iii) Where DFID seeks to influence partner developing countries to improve the delivery of health services or to increase access to them, it is likely to be more difficult to identify and attribute the benefits. One possible approach would be to look at the total cost (i.e. of the influencing and incremental spending by donors and Government) of achieving the health outcome and compare this to the total outputs/ benefits. If these looked broadly acceptable then the influencing effort should proceed.
- (iv) Another possible approach in partner countries would be to focus on the influencing effort more directly. In this case the proportion of the total cost of a policy change accounted for by the influencing could be used to allocate a share of the total output or benefits to the DFID influencing effort. For example, if the influencing effort was 0.001% of the total cost of delivering the outcome, then 0.001% of the benefits/outputs would be allocated to the influencing effort.

Arguably it would be more realistic to add together the influencing costs and the incremental financial aid being spent by DFID before assessing the share of benefits/outputs from the particular health policy outcome.

5.16 The following section seeks to apply some of these approaches in the context of the case studies we have examined during the evaluation.

- (i) GFATM: The purpose of the influencing effort was to improve the value for money of the total funding being provided by that organisation. The second aim was to increase the quality and effectiveness of resource use by pushing for greater harmonisation of GFATM support in partner countries. A simplified analysis could compare the cost of the influencing effort to the value and size of the GFATM funds to be influenced. GFATM's total annual spend is around US \$3 billion compared to DFID's total annual influencing cost of just under US \$300,000. It would therefore require only a 0.01% increase in efficiency of the total being spent annually by GFATM to more than cover the projected cost of the influencing effort. If there was a 2% improvement in the efficiency or value for money of the annual GFATM spend this would generate potential annual benefits of US \$60 million. DFID also provides an annual commitment of financial aid to GFATM. DFID's total annual financial commitment amounts to only 7% of the total annual spend of GFATM and this allows influence to be exerted over a much larger resource.
- (ii) Nigeria: Joint Financing Arrangement. This influencing programme sought to establish a multi donor planning framework for HIV and Aids. All donor funding including the US President's Plan for Aids Relief (PEPFAR), World Bank, DFID and the Foundations (e.g. Clinton) have agreed that their funding and activities will be on-plan, with joint donor reviews and a commonly agreed reporting format. When fully enacted, there will be transaction cost savings to Government and donors in the form of reduced number of missions and avoiding the costs from duplicated reporting arrangements. Government can also identify and remove any duplication or overlap in existing HIV and AIDS programmes. For those partners involved in the pooling of funds there will be financial savings from procurement under one system within NACA. The total funding for HIV and AIDS that is affected by these changes is around US \$300 million per annum compared to an influencing effort of US \$715,200 (£447,000 at current exchange rates). It would require only a very small improvement (0.24%) in the efficiency of HIV spending by donors to exceed the cost of the influencing effort. The DFID influencing effort therefore seems to have offered value for money.
- (iii) In Zambia and Nepal the influencing effort aimed to remove cost constraints on access to primary health care and safe motherhood services respectively. In both cases it was possible for the evaluators to cost the influencing effort by DFID. The evaluation also established that at the time, the two DFID offices has modelled the total projected cost of implementing the specific policies for the two Governments concerned.

For example, in Nepal the modelling suggested that the cost of increasing utilisation of health facilities by pregnant women over a five year period to Government and donors was;

2008/9 - 2012/13	
US\$ million	
Cost of offering free delivery	22.90
Incentive payments	14.31
Incentives to health workers	5.38
<b>Incremental cost/policy</b>	<b>42.59</b>

Taken together the cost of DFID influencing the policy change (£442,000 or US\$707,000) and its implementation amounts to US \$43.3 million. This total cost can be compared to the outputs of the policy over the same 5 year period. The expected benefits were a rise in institutional deliveries from 25% to 43% of total pregnancies or an increase of 123,000 births taking place at a health facility<sup>11</sup>. The additional cost per institutional delivery was projected to be a relatively high US \$352 partly due to Nepal's difficult transport conditions.

Assessing the cost effectiveness of the immediate outputs from a specific policy change can therefore provide a useful indication of value for money. However, there are limitations and it is important to examine wider changes in the health system. In both Zambia and Nepal the expected outcomes of increased demand and utilisation for services depended on changes taking place in the rest of the health system for example improved drug supply, staff training and new equipment provision. The Zambia case study suggests that when these complementary changes did not happen, utilisation subsequently declined. A wider impact study is now being undertaken to examine the system wide effects.

- iv) In Mozambique DFIDs influencing effort was geared to assist Government to develop a new human resource policy that would identify the resources required to build the capacity to deliver effective health services. It later took a more ambitious direction by promoting the development of a compact under the International Health Partnership as a basis for the Government to seek additional resources for the sector from donor partners including the US Government. The analysis in the case study indicates that the cost of the influencing effort totalled US \$488,000 (£305,000) which can be compared to the benefits to

<sup>11</sup> These figures are taken from the analytical model prepared by DFIDN and DFID funded consultants

Mozambique of the additional financial resources raised. In practice the most significant benefit was the improved alignment of PEPFAR resources with Government priorities. As a minimum this will have reduced duplication of project support and done less damage to Government services for example by adopting consistent salary and hiring policies which reduced the drain of staff to PEPFAR projects. Since the PEPFAR resource flow amounted to US \$220 million then efficiency improvements or cost savings would only have to be 0.22% of this total to pay back the cost of the influencing effort. The case study also indicates that some donors committed additional funds as a result of Governments' strengthened case for additional resources in the sector. In themselves these amounted to US \$39 million from GFATM and Belgium alone and were far in excess of the influencing costs. This would seem to indicate that the influencing effort offered very good value for money.

- v) In India the DFID office worked with other donors to influence the design of the RCH2 programme to introduce measures that would encourage provision of services to Scheduled Castes and Tribes, women and poorer groups. Implementation involved the Federal Government encouraging States to mainstream efforts to address these groups across all aspects of their health services. Where specific interventions were developed they were mostly not separately costed and they largely emerged in an unplanned way as individual states experimented with innovative measures to improve access. Planned improvements in utilisation and access by the poorest are also attributable to general improvements in the quality of services as well as to the specific measures taken directly on their behalf. For these reasons it is not considered appropriate to attempt a separate cost effectiveness analysis of the influencing effort but rather to compare the anticipated overall increase in utilisation by SC/ST and poorer groups as a result of the planned spending on the programme as a whole by Government and donors. In practice this was the approach adopted and one that the evaluators endorse.

5.17 In placing renewed emphasis on cost effectiveness measures and value for money we need to be remain vigilante to the potential for this to lead staff toward "quick wins" where it is easier to assess and demonstrate benefits or to prefer pre planned approaches that can rule out experimentation and innovation. There is also a need to be more explicit about the approach to decision making that is being taken. Research suggests that decisions are made as much on the basis of past experience and intuition as they are on evidence. This tendency can be compounded when the evidence base is weak. ODI has been working with the International Department to develop an "information matrix" approach that requires the basis for decisions to be made more explicit.

## **Section 6 : Lessons, Conclusions and Recommendations**

- 6.1 The evaluation study reviewed six case studies of DFID influencing in the health sector. The results show that DFID has invested relatively modest resources in influencing policy change and that in the majority of these cases this has contributed to an outcome that the organisation was seeking. Key factors were:
- Understanding and aligning with political interests and the incentives of partners.
  - Collaboration with other donors by searching for common ground and interests.
  - Using senior experienced DFID staff with a range of policy, negotiating and technical skills and good practice knowledge.
  - The flexible and rapid deployment of technical assistance.
- 6.2 Influencing costs varied between £300,000 - £600,000 per programme and were small in relation to the potential benefits and in comparison to the level of financial aid being spent in the sector. Structured interviews also suggest that DFID is perceived as having been decisive for some of the key steps in the policy change process. Stakeholders suggested that without DFID support, policy would have taken longer to emerge and been less well formulated.
- 6.3 DFID could have been more systematic in considering the efficiency and effectiveness of influencing efforts. In particular, more attention could have been given to specifying influencing objectives and assessing different methods of achieving them, the chances of success and the likely impact. It should be recognised that in conditions of uncertainty, changes and adjustments may well have to be made as the influencing effort progresses.
- 6.4 Health outcomes could not be attributed to DFID influencing. However there is incomplete data showing an increase in utilisation of health facilities for deliveries and of skilled birth attendants in Nepal and an increase in safe abortion. These changes are likely to have contributed to the recent reduction in maternal mortality in Nepal. There are some improvements in a few Indian states and in Zambia there may have been an initial increase in utilisation followed by a decline. A fuller study of user fee removal is likely to be available soon.
- 6.5 Overall, the evidence suggests that in the case study interventions examined, DFID has contributed to changes in health policy undertaken by partner Governments and organisations and that these efforts were largely cost effective.



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## ANNEX 1: TERMS OF REFERENCE

### Terms of Reference for: A Preliminary Assessment of the Cost-Effectiveness of DFID's Influencing work in the Health Portfolio

#### 1. *Background and Context*

1. DFID is currently undertaking a Health Portfolio Review to assess the value for money of its bilateral and multilateral investments in the health sector. The review has been commissioned by DFID's Investment Committee which has oversight of major investments. An important objective of the review is to inform discussions with Treasury in the forthcoming Comprehensive Spending Review.
2. Part of the value for money assessment will focus in the normal way on DFID's bilateral investments (projects and programmes) and resources channelled through multilateral partners.
3. However, the focus of this particular study is the investment we make in the health sector in our advisory staff involved in policy dialogue and influencing partner governments and international partners. These interactions are often seen as one of DFID's key strengths and help to shape the policy and practice of partners towards development effectiveness and poverty reduction goals.
4. Measuring the impact of policy dialogue and influencing is a relatively new area for DFID's monitoring and evaluation systems. Most existing evaluations discuss influence to some extent and there have been a handful of studies which focus on it more directly, but none have set out to make a serious assessment of cost-effectiveness and impact.
5. Recent work includes studies commissioned by EVD, FCPD and the Strategy Unit:
  - a. Monitoring Policy Dialogue – Lessons from a Pilot Study (EVD report 692 by Sadie Watson and Juliet Pearce, PARC, Sep 2008)
  - b. Measuring and Monitoring Influencing – What Can DFID Do? (DFID Strategy Unit Issue Identification Brief no 3 march 2008)
6. Earlier studies for EVD include:
  - a. A 2004 review for EVD of DFID's Advocacy and Influencing Activities (EVD working paper no 1. Emma Spicer)
  - b. Changes in Strategic Influence: DFID's contribution to Trade Policy (EVD 644, Sep 2003, David Pedley)

There have also been examples in EMAAD and in DFID's work with multilaterals of decentralised evaluations which have looked at influencing, although not in the health sector, and older studies of influencing in health see for example 2002 study for HPD.

7. This relative sparsity of studies is partly because of the difficulty of measuring influencing and partly because internal incentive structures encourage a stronger focus on financial spend than the allocation of human resources for influencing work.

8. Influencing activities pose problems in specifying clear targets and indicators which are attributable and in measuring performance in the face of high levels of uncertainty about outcomes, while also providing the flexibility which is an essential component of influencing work. Confidentiality is also important because influencing tactics often need to be kept internal to DFID. Other agencies and organisations are struggling with the same agenda and some NGOs are more systematic in designing and monitoring influencing activities.

## 2. *Overall Aims and Key Question*

9. This study will address in a straightforward and preliminary way (given the tight timescales) the question:

To what extent did DFID's influencing and policy dialogue activities in the health sector provide good value for money – and how could this be improved in future?

***A comprehensive assessment of the impact of DFID's influencing work across bilateral and multilateral investments in health is not feasible or expected within the resources and time allowed for this work.***

## 3. *Outputs*

10. Instead, the key output is a set of ***illustrative examples*** of typical influencing activities by DFID in the health sector, focusing in 6 case studies, together with ***a preliminary assessment of the value for money of those examples.***
11. In order to achieve this, the following activities and suboutputs are expected:
  - A rapid assessment of tools and methods available and potentially suitable for measuring influencing in DFID's work in the health sector, drawing upon recent work for EVD.
  - Rapid document review and telephone/e mail discussions with a small number of DFID health advisers, to identify some of the main areas of DFID's policy dialogue and influencing work in the health sector and to identify key learning examples.
  - Carry out telephone and/or short electronic surveys of key stakeholders in up to 6 countries to assess in an structured, independent and confidential way the perceived impact of DFID's policy dialogue and influencing activities
  - This should involve asking stakeholders to assess for example:
    - How strategic was DFID's influence and was there a clear set of goals and approach?
    - How effective was DFID in gaining the trust of partners and building relationships?
    - What was the change in policy outcomes attributable to DFID's advisory staff engagement, compared with what might have happened through other donors or routes;
  - Given the sensitivities around influencing as an activity and the need to encourage honest and open participation and responses, it will be essential to use DFID networks and contacts in country to prepare the ground carefully for survey contacts.

The surveys must be carried out by a skilled and credible evaluation professional.

- Using the results of the telephone surveys and document review, carry out a preliminary analysis of the cost-effectiveness of typical activities compared with standard project type investments in services.
- Suggestions for how to assess value for money in influencing in future (i) for longer and more complex evaluations (ii) to update the HPR every 2 years, preferably in ways that can be built into DFID's regular reporting requirements.

#### 4. *Methods*

12. The methodological approach will be based around RAPID Outcome Assessment (ROA) and a 'most significant change approach' based on case studies. (see: [http://www.odi.org.uk/RAPID/Publications/RAPID\\_WP\\_266.html](http://www.odi.org.uk/RAPID/Publications/RAPID_WP_266.html))

13. For each case study:

- a. For each policy intervention develop a story of change that describes the changes in the policy behaviours (based on Outcome Mapping) of the key policy actors involved.
- b. For each intervention, cost DFID's inputs (health adviser time, technical assistance, pilot funding, strategic inputs, etc.) and if possible quantify and/or roughly estimate the change in health impacts consequent of the policy change.
- c. Identify, using telephone surveys (with all relevant stakeholders) and other evidence, the most significant changes in the change process –changes that the informants consider absolutely necessary for the final outcome of the policy process.
- d. Identify possible alternative scenarios where DFID's roles might have been different and where other facts might have played a role. Consider health impacts without the policy change, for example.
- e. Focusing on the most significant changes, and the different scenarios, use telephone surveys (with all relevant stakeholders) and other evidence to assess the relative contribution/importance of DFID's intervention on their outcomes.
  - i. *little or no influence (would have happened anyway or other actors factors were instrumental) = 0%*
  - ii. *highly influential (DFID's presence was a uniquely important determining factor) = 100%*
- f. Consider the difference that having/not having a DFID health advisor; or the type of support (GBS, health sector support, or projects) would have made; or using a consultant; or working through partners; and any other variables. This should include if possible a comparison of how the influencing might have been done in other ways and some consideration of relative cost-effectiveness of different approaches.

14. An alternative but similar approach would be to:

- a. identify key health policy areas where the DFID health adviser was engaged in dialogue with government with an influencing objective or strategy and where measurement is likely to be feasible and useful

- b. for each area, cost the DFID inputs (health adviser time, technical assistance, pilot funding, strategic inputs)
- c. use the telephone surveys and other evidence to identify subsequent changes in government policy on these topics
- d. if possible quantify and/or roughly estimate the change in health outcomes consequent of the policy change
- e. use the telephone surveys and other evidence to assess how far the government found DFID's dialogue, advice and influencing activities useful and how far they had an impact, compared with what would have happened anyway
- f. triangulate against views from key informants also contacted in other stakeholders such as donors, civil society, external policy commentators in academia
- g. make an assessment of how important DFID's influence, in percentage terms from
  - i. *little or no influence (would have happened anyway) = 0%*
  - ii. *highly influential (DFID's presence was a uniquely important determining factor) = 100%*
- h. use the percentage influence to pro rate changes in health outcomes and develop an estimate of cost-effectiveness by scaling the measure of impact by resources DFID invested.
- i. Use this measure and other relevant evidence to assess how cost-effective the activities were in comparison with other approaches and how it could have been improved.

## **5. Report**

15. To present and summarise the findings, the consultant is required to produce:
  - a. a short report (approximately 5-10 pages) to be written in plain English with a short executive summary
  - b. a short section (1-2 pages of text and tables) as a contribution for the overall HPR report and following the agreed format and style
  - c. more detailed annexes providing an audit trail on assumptions and sharing the data supporting the analysis
  - d. recommendations for further work on how influencing could be measured in future, using prospective evaluation methods and with longer planning horizons. [If necessary this can be developed separately and provided after the main deadline for the HPR work to timescales by agreement with DFID].

## **6. Relationship to HPR**

16. The purpose of the work is solely to feed into the HPR. It is not to provide an output for its own sake, although the learning on how to measure influencing will be useful to DFID and to EVD.
17. The emphasis of the work is therefore on:
  - a. providing value for money estimates that are convincing and credible to the Investment Committee and Treasury as key audiences.

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- b. The style of the report should therefore be quantitative and focused, rather than narrative and discursive, matching the approach used in other work for the Education and health portfolio reviews.
  - c. Delivering to the timescales determined by the overall HPR – it is essential that outputs are available by the end of June

## **7. *Management arrangements***

18. The work will be commissioned and managed by EVD, on behalf of the HPR team. Guidance will be provided by a small subgroup consisting of :
  - Nick York, Head of EVD (who will provide day to day supervision)
  - Jenny Amery, Head of Profession for Health
  - Paul Spray, Deputy Director Policy and Research
  - Julia Watson, Senior Health Adviser
19. An initial project inception meeting will be held 8 May, start up during week of 11 May with telephone conferences to provide updates every 2 weeks chaired by the head of EVD and a final meeting to discuss outputs in late June. An early meeting with country health advisers will be arranged and inputs from them will be sought as required.

## **8. *Timescale and resources***

20. The elapsed time allowed for the work 7 weeks, to start as soon as possible and be completed by end June. Resources negotiable in the region of 70 days total inputs provided by 3-4 skilled evaluation consultants.
21. Additional support will be provided from DFID, mainly through EVD and DFID health advisers in identifying information sources, designing the approach and making contacts prior to carrying out surveys. If possible, a DFID health adviser will be identified to work with the researchers and provide some limited inputs [up to 5 days] on approach and practicalities, in addition to inputs on the specific case studies.

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## **ANNEX 2: KEY INFORMANT INTERVIEWS**

**Subject:** *DFID Influence on Health Sector Policy and Programmes*

**Case Study:** *Country Name Inserted*

### **Questions for Government Partners and Donors**

The interviews are designed to feed into a series of six case studies being undertaken as part of an evaluation of DFID engagement in the development of the Health sector in partner developing countries.

The evaluators would like to hear about the sector experience in Mozambique with specific reference to the policy, strategies and programmes to address problems of capacity and human resources. The focus of the interview will be on the way donors engaged and specifically the role of DFID and its effectiveness in influencing and supporting the Government Sector programme.

The following questions are provided as a framework to guide the key informant interviews. The list of questions will be provided in advance of the interview and the evaluators will aim to work systematically through the questions to ensure there is a consistent basis for comparison across the case studies. The interview will last 60-90 minutes.

The case studies are designed to explore the changes in policy and improved services that sector partners (Government and donors) were seeking and how these came about. The aim is to assess the contribution that DFID made to the outcome by identifying specific interventions that were made, for example : to support processes or events in time (e.g. meetings or policy decision points); the provision of consultants to research particular issues; or provision of finance.

It would be very helpful if interviewees could consider the questions before hand and come prepared with evidence, examples and supporting information wherever possible.

### **Context**

1. What were the main challenges in the sector ?
2. What were overall objectives in the Health sector during the development of the current phase of the programme?
3. What were the priorities for action by Government and donors ?

### **Donor Engagement**

4. What role did Government envisage for donors and DFID ?
5. How effectively did the international community engage ?
6. Was the international community approach harmonized ?
7. Was it clear at the outset what objectives DFID was aiming for ?
8. How relevant and appropriate was the support provided by DFID ?

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## Outputs and Outcomes

9. What changes have taken place in the sector and how far have Government objectives been achieved? *NB these can include changes in policy, programme design or implementation including mobilising additional resources*
10. What has been the impact on health services and outcomes ? *e.g.more resources available to the sector from donors; better use of public resources by partner Governments on more cost effective or higher impact health interventions etc*
11. In what ways did DFID contribute to the achievements in the sector for example in the development of sector policy or the design and delivery of sector programmes ?
12. Were there any decisions by Government or changes that came about as a result of DFID's specific contribution ?
13. What specific actions by DFID can you point to that made a difference?
14. Overall, how far has DFID contributed to sector policy or programme design/delivery change? *NB Please choose a score in the range 0 (no contribution) to 10 (DFID was the main driving force behind the changes that took place)*

Score 0: No influence (the change was anyway going to happen in the same way).

Score 1-3 : DFID had some limited influence

Score 4-5: DFID influence has helped the change process to happen, but not in a decisive manner (other stakeholders were more instrumental).

Score 6-8 DFID influence has been decisive for some of the key steps of the change process.

Score 9-10 DFID has been the main driver behind the policy change process, from its initiation to its implementation.

## Cost and Cost Effectiveness

15. Do you consider that the contribution by DFID was an effective use of development resources and good value for money ?
16. In retrospect would you have liked DFID to have used its resources differently for the same objectives or for some other purpose entirely ?
17. What do you think would have happened if DFID had not engaged ?

## **ANNEX 3: CASE STUDY DRAFTS**

### **A: GFATM Influencing Case Study**

#### **1. Context**

- 1.1 The Global Fund to Fight AIDS, TB and Malaria (GF) was established in 2002 as a new funding channel that would scale up resources available for tackling the three diseases. It developed some new and different methods of doing business, including
  - requiring countries to establish a Country Coordinating Mechanism (CCM) that includes civil society and people affected by the diseases, as well as governments, NGOs and development partners. The CCM has to approve applications for grants and oversee implementation.
  - Offering grants on a rounds-based system – countries can apply for as much as they want and their applications are judged in a series of rounds.
  - The governance structure is a 20 member Board that includes the same types of constituencies as the CCMs, supported by a Secretariat in Geneva.
  - A system of ‘performance based funding’ where grants are initially approved for 2 years, and only extended if performance indicators and reporting requirements are met.
  - Encouraging grant applications from the private sector (mainly NGOs/civil society) as well as governments.
- 1.2 The GF has been successful in raising funds and allocating them. So far there have been 8 rounds of grants awarded, with a total value of \$15.9 bn committed and a total of \$7.8 bn disbursed.
- 1.3 The GF argues its model is country owned and demand led, because it is the countries that decide what and how much to apply for. However there are concerns among DFID and others (particularly from those working at country level) that the GF approach has been parallel to existing national structures and systems for health planning and for coordination with other partners. In addition, the GF requirements for reporting and accountability place an additional burden on countries and make it difficult to integrate and align the GF projects with existing systems.
- 1.4 In addition, some countries have successfully applied for an increasing number of GF grants, several in the same disease area, each with their own grant management requirements.
- 1.5 DFID wanted to bring about changes in GF processes to bring greater harmonisation and alignment with existing systems in country, greater predictability of funding for countries, and assure value for money. This is in line with DFID’s aid effectiveness agenda and in response to the high transaction costs of GF processes. Predictability is particularly important in the case of AIDS treatment, as once people are on treatment it needs to continue. This agenda also reflects the fact the GF is one of the largest sources of funding for health and

DFID therefore wanted to ensure that these resources were used in ways that support broader health systems development rather than narrow disease focussed programs.

- 1.6 Stakeholders in GF have varied views on these issues. For example, the USA (which is the most influential donor as largest funder of GF), has tended to support a disease focus. Civil society wants to see continued engagement of civil society and affected people at country level, who tend not to be closely engaged in national health planning and coordination processes.
- 1.7 DFID is a Board member of GFATM in a constituency with Australia. In addition DFID has provided funding to GF from its inception. A senior official (the UK Board Member) has been based in Geneva to facilitate links with the GF (as well as other agencies there), supported by staff in London and feedback from country level advisers. In 2007 DFID made a new commitment of up to £1 billion over eight years (2008/9-2015/16).

## 2. Influencing Strategy and Objectives

- 2.1 DFID had clear objectives in the area of increasing harmonisation and alignment, ensuring support worked in ways that supported health systems rather than competing with them, and encouraging value for money. These were articulated in a letter from the Secretary of State to the GF Executive Director in August 2007 and subsequently spelt out more explicitly in the development of a project memorandum and logframe for DFID's commitment of funds in 2008 (DFID, 2008a; DFID, 2009a).
- 2.2 The objectives set out in the project memorandum (dated October 2008) are:
  1. **Support for developing country systems, working with other donors**
    - A simple, achievable certification process is put in place for national plans such that a substantial number of countries successfully use their national health or disease plans as the basis for seeking support from the Fund.
    - The Fund aligns its systems and operations better with those of developing countries and donors.
  2. **Maximum value for money**
    - The Fund and Board members review the Global Fund's Comprehensive Funding Policy to determine whether the Fund can reduce its cash reserves (to release funds to finance good-quality projects).
    - The Fund helps ensure that developing countries get good value when buying medicines for HIV/AIDS, tuberculosis and malaria.
  3. **Better contribution to the global architecture of aid for health**
    - The Fund retains its focus as a financing mechanism targeting the poorer developing countries.
    - The Fund clearly articulates its position on health systems strengthening, and provides funding that dovetails increasingly well into national systems and support from other agencies.

- The Fund engages more actively at global and country level with endeavours to join up better with other agencies in support of country-led disease programmes and health system strengthening.
- 2.3 DFID's objectives and indicators for the GF are set out more explicitly in the logframe. The latest version of this includes indicators from the agreed key performance indicators of the GF and some additional DFID-specific indicators.
- 2.4 Whilst the messages were consistent with earlier influencing objectives and lines to take, this was the first time they were so clearly articulated and shared in writing, with the GF Secretariat and Board.
- 2.5 Some issues within this strategy have since been questioned, as DFID's policy evolves. One is the focus on poorer countries – whether it should be an objective to focus on low income countries rather than on where the diseases are prevalent, especially in view of the DFID line elsewhere that one role of multilaterals is to support development in middle income countries that DFID's bilateral efforts do not reach.

### **3. Design and Implementation Of Influencing Effort**

- 3.1 The logframe and project document set out the objectives and how progress towards these will be measured. They were developed with consultation within DFID but not based on an explicit analysis of the context or positions of other stakeholders (ODI, 2009). They do not set out the pathway or activities by which DFID expects to get to the objectives.
- 3.2 The primary mechanisms that DFID has for influencing GF are
- through its membership of the Board and Policy and Strategy Committee (PSC), working groups on specific topics and informal interaction with other stakeholders around these. This can include written exchanges, e.g. a letter to the Chairman of the PSC on ideas for strengthening GF's key performance indicators in early 2008 (DFID 2008b).
  - through contacts with the Secretariat on various issues, including for example the recent visit by the UK Board member to Mozambique with senior Secretariat staff to identify how GF support better fit with harmonised sector processes and become more predictable.
  - Through work at country level by DFID staff to improve the quality of GF applications and implementation, and by feeding back issues to the central level and the Board member.
  - Through studies to inform the debate. This included a study on financing and health system strengthening issues in global health partnerships in 2008, including a case study on the effect of global partnerships on country plans in Cambodia (Pearson, 2008).
- 3.3 The provision of a substantial financial commitment gave the opportunity to formalise the objectives (through preparing a project memorandum and logframe) as well as helping to give weight to DFID's position.

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- 3.4 The development of the International Health Partnership (IHP) was also intended to influence the behaviour and processes of the GF. The UK was the driving force behind setting up the IHP although other agencies take the lead in implementation. The UK made sure that the GF was a founder member of the IHP and has encouraged its involvement in IHP related initiatives.
- 3.5 DFID prepares systematically for each Board meeting by reviewing the documents and identifying a few key objectives for that Board meeting (DFID 2008c&d and DFID 2009b). DFID staff felt this has become easier with the agreement on explicit objectives, and the agreed lines and priorities are more consistent over time than in the past.
- 3.6 DFID also responds to emerging issues, e.g. the need to consider rationing resources as demand outstrips available funding, and the sustainability issues around antiretroviral therapy and other commodities. This illustrates that the influencing strategy needs to evolve over time.
- 3.7 The costs of influencing were not explicitly addressed. Implicitly costs may have been a factor in the decision not to have a health adviser allocated to the team working on GFATM and other global health partnerships when this role moved to GFDD, nor (so far) staff to support the Board member in Geneva on GF.

#### **4. Role of DFID In Policy Changes towards harmonisation, alignment and value for money**

- 4.1 The GF Board has made a series of decisions to streamline the grant processes and align them with country processes. This reflects the recognition from recipient countries and others that the multiple grants were too complex with high transaction costs. A review of grant architecture was undertaken and moves to streamline and align include:
- Agreed at the November 2006 Board meeting to pilot grant consolidation to simplify processes and achieve cost efficiency;
  - at the next Board (April 2007) agreed to allow flexibility to align grant periods with national strategy periods.
  - introducing a single stream of funding per disease per principal recipient (agreed November 2008) so recipients do not have to manage and report on multiple grants at the same time.
  - harmonising salary support with other donors was agreed by the Policy and Strategy Committee in September 2008.
- 4.2 All of these are ways to reduce transaction costs and hence should improve efficiency. DFID supported these reforms through its engagement in the Policy and Strategy Committee (PSC) (where such issues are discussed in some detail) and the Board (where decisions are made, typically with little detailed debate). Most external players said that DFID has been consistently supportive, although not a decisive player in these reforms. These predate the formal PM and logframe process.

- 4.3 In April 2007, the GF Board agreed to test an approach known as National Strategy Applications (NSAs); more details were agreed at the November 2008 meeting. This would allow countries to submit their national plan for the disease or the health sector for funding, rather than requiring the specific application form for GF. The idea was to reduce the work involved in applying for funds while also aligning the GF support with national plans. This was something that DFID had pushed for and was known to support, including through its engagement on the Board and PSC. There were mixed views from external interviewees on whether the NSA approach would have gone ahead without strong backing from DFID, but all agreed that DFID support and making the case for the approach had helped the reform to be accepted, alongside other core proponents. One interviewee felt DFID had led on the introduction of NSAs, since they reflect the approach promulgated under the IHP.
- 4.6 The NSA approach that is being tested is partial and on a limited scale. A ‘first learning wave’ of countries has been invited to apply with disease focussed strategies in 2009. DFID would like this extended to health sector strategies, which support the whole health system, in line with the IHP approach. The GF concluded it would be quicker and easier to start with disease strategies, given the related process on assessment of national health strategies being pursued under IHP auspices. Given the varied views about the NSA approach and the early stage of development of Joint Assessment processes, external interviewees did not think it likely that DFID could have had a greater influence in terms of getting support for health sector plans rather than disease focussed plans in the first wave of NSAs. Some interviewees have doubts about the impact of the move to NSAs and welcomed the cautious approach.
- 4.7 The idea of a joint assessment process has been taken forward in a Working Group under the IHP and GF has been an active participant in this. GF has used the early outputs of the working group in the assessment of first learning wave NSAs. Thus the GF is on track to apply the Joint Assessment (formerly known as certification or validation) of national plans, one of DFID’s objectives. DFID has influenced this indirectly through encouraging the approach and support to IHP. Externals said DFID’s catalytic role in IHP was known and the value it placed on engaging in IHP was communicated to the Fund, while it was also well recognised that DFID was leaving others to lead IHP.
- 4.3 One external interviewee argued that DFID had a catalytic role in getting the GF to engage with the OECD DAC and Paris Declaration, which was then adopted by the GF. DFID has encouraged the GF to measure its progress in meeting the Paris targets for harmonisation and alignment. The GF has assessed itself against these indicators in 2005 and 2007 and has now included a composite measure in its key performance indicators. The earlier influencing case study (ODI, 2009) notes this as a success of lobbying by DFID.
- 4.4 DFID has been active at country level in trying to make GF applications fit with national processes and harmonise with other donors. This was pursued actively in Mozambique where DFID supported the inclusion of GF funds in a pooled fund mechanism. The GF’s requirements for results reporting and financial management however did not fit well and it was agreed they would leave the

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pooled mechanism. DFID has worked at both central and country level with the GF to identify how the GF can adapt to fit better with harmonised processes in Mozambique, and these efforts were recognised by Secretariat staff.

- 4.8 On value for money, DFID has been working with the GF and others to agree on a shared approach to monitoring and sharing data on commodity prices. DFID helped to develop a project to develop a global market intelligence system that shares procurement data across the multilaterals, and UNITAID has agreed to fund it. DFID has contributed to this through technical staff (in PRD) convening the players and encouraging a dialogue on how they can best work together and GFDD staff engagement with UNITAID. This system has potential to achieve substantial savings in procurement through more transparent procurement and understanding of markets. This assumes the information it provides is acted upon by those setting budgets and doing procurement.
- 4.9 The external interviewees said that DFID was an active proponent of value for money in meetings and made useful contributions on this. Some cited their effective working with the USA and Japanese constituencies to control the size and costs of the Secretariat. Others said that DFID could be clearer in what it expects to see the GF produce in terms of demonstrating value for money, beyond basic administrative efficiency and commodity price related measures. For example, DFID has encouraged improved analysis of cost effectiveness analysis of GF financed activities in order to improve value for money, what sort of assessment was expected for country programmes. Several mentioned the sensitivity of the issue in the Board (some constituencies see it as a cover for reducing funding) and that there is scope to push harder to reduce waste and target resources to the most cost effective grants.
- 4.9 Overall the external partners welcomed DFID's contributions. The quality of DFID Board membership was commented on by several respondents (unprompted) including the intellectual calibre of staff and that they are well prepared for meetings. Their ability to explain and argue for concepts, apply experience and suggest practical solutions was welcomed by other Board members. DFID's influence was seen to stem from this and also (to a varying extent) from its substantial financial contribution, its long term engagement in the Fund, the feedback from country level that informs its comments, and wider development credibility.

## **5. Costs and Cost Effectiveness**

- 5.1 The interviews asked about the extent of DFID influence on the decision to go ahead with National Strategy Applications (NSAs), selected as an example of an important change in the Fund's architecture that should enable harmonisation and alignment. Two of the interviewees were unable to comment, not having been present in relevant meetings. The others are summarised below.

*Assessment of Effectiveness of DFID Influencing in GF decisions on NSAs*

Stakeholder	Score	Rationale	Without DFID Support
Board member 1	6-8	DFID was a key driver of the move to NSAs, and made the case for them skilfully so that others understood the benefits.	
Board member 2	4-5	Harmonisation, alignment and VFM consistently come from interventions by the UK, but UK role does not stand out on the NSA decision – combined effort of various Board members.	NSAs would have gone ahead unless DFID had actively opposed them.
Board member 3	4-5	UK has pushed for NSAs, alongside like minded donors.	NSAs would have happened anyway.
Board member 4	6-8	Consistent emphasis of DFID on harmonisation and alignment, helped to catalyse discussions on NSAs.	NSAs would not have happened without DFID support.
Board member 5	9-10	NSAs are the same agenda as the IHP and the UK is the driver of the IHP.	If other constituencies had supported NSAs strongly, then DFID would probably have agreed given the need to simplify GF mechanisms.
Secretariat staff 1	1-3	DFID provoked and facilitated early interaction of the GF with OECD on aid effectiveness. The GF then 'picked up and ran with it'. The need for change was clear from grant recipients and other Board members.	NSAs would have gone ahead anyway since on the Board's agenda and a priority to deal with multiplicity of grants.
Secretariat staff 2	6	Harmonisation and alignment often raised by DFID, including at country level.	

Ratings in italics are by the interviewer based on comments made.

5.2 The estimated costs of influencing and working with GF are set out in annex 3. This includes a small share of health advisers' time at country level, to reflect their engagement with the GF and the feedback they give to HQ on request. It also includes a share of the IHP team's time to reflect that one objective of IHP is to influence GF. Costs for staff inputs are estimated at £140,000 in 2007/8 and £121,000 in 2008/9. The studies on financing, systems strengthening and country impact of global partnerships cost £84,000; it is not clear that they had much influence, perhaps because of their timing – by the time they were competed, some decisions had been made. The substantial long term financial commitment to GF (up to £1 billion commitment made for 2008-2015) is also noted.

5.3 Given the level of GF expenditure, then if DFID's influence improve the quality and efficiency of expenditure this dwarfs the costs of influencing. For example, if the estimated total cost of DFID influencing is around £140,000 - £200,000 per year (excluding the financial contribution to the Fund), it would

need to improve efficiency of all GF spending by less than 0.01% annually to pay for itself. Or, if for example, the benefits from influencing value for money and harmonisation led to 2% efficiency savings overall, this would be some \$60 million efficiency gain compared to influencing costs of less than \$300,000 (on 2008 spend of \$3 bn). Arguably an increase in influencing expenditure could be justified on these grounds.

- 5.4 Even including the financial contribution by DFID of an average of £140 million per year, DFID has scope to influence the total spend of the full \$3 billion GF annual spending expected in 2009 while providing only 7% of the funds.

## 6. Outputs and Outcomes

- 6.1 There has been progress on the influencing objectives that DFID has set out, both before and since these were formalised in a logframe and project document. It is likely that reforms of this type would have happened without DFID engagement, but that DFID has helped to push forward the reforms and to ensure alignment with country systems. The NSA approach is an example where DFID was seen as influential in gaining agreement by other Board members, alongside like minded partners. This could lead to a fundamental shift in the way GF provides support, especially if the first learning wave goes well and convinces other key stakeholders it can address their concerns. The position of the USA government seems to be shifting towards supporting health systems, which is likely to be conducive to more wide ranging reforms in the Fund's processes and architecture.
- 6.2 Whilst the outputs of DFID influencing are starting to emerge, the logframe indicators were set with baselines using 2008 data, so it is not yet possible to show progress against these indicators.
- 6.3 The GF has monitored its performance against the Paris Declaration in 2005 and 2007 (GF, March 2009). Selected results based on a survey of countries (for 32 countries in 2005 and 54 in 2007) are shown below:

Aid effectiveness indicator	2005 results	2007 results	2010 Targets
Aid recorded on budget	15%	23%	85%
Grants aligned with country cycles	62%	62%	90%
Use of country financial management systems	39%	39%	59%
Use of country procurement systems	33%	56%	55%
Use of parallel project implementation units	16%	13%	5%
Actual/expected disbursements	90%	95%	95%
Aid recorded as scheduled	16%	30%	60%

Aid effectiveness indicator	2005 results	2007 results	2010 Targets
Support to program based approaches	74%	68%	66%
Joint missions with other donors	15%	14%	40%
Transparent and monitorable performance frameworks	100%	100%	100%
Grants aligned to national M&E systems	73%	82%	90%

- 6.4 Whilst some assessments can be questioned, there are some positive trends and areas for improvement have been identified. Innovations approved in 2007 and 2008 will start to feed into these results in the coming years. These should bring improvements in efficiency of resource use through lower transactions costs and better alignment with country systems. They will not necessarily lead to savings.
- 6.5 The proposed global market intelligence system looks likely to be funded by UNITAID. DFID was instrumental in setting up this mechanism for improving value for money. Since 45% of GF grants are used to purchase commodities, even small improvements in procurement prices and efficiency could result in massive savings. DFID is encouraging continuing attention to procurement prices through having in the logframe indicators of the median level and range of anti-retroviral prices.
- 6.6 The NSA approach is being tested. Whilst it is not all DFID might hope for in terms of support to national strategies, it is a start on adapting to a more aligned approach that should eventually contribute to strengthening health systems. The GF is actively participating in the IHP+ process including on developing Joint Assessments, which are intended to support a broader use of the NSA approach.

## 7. Conclusions and Lessons

- 7.1 Overall, DFID has played a positive role in encouraging reforms in GF processes and grant architecture to simplify and align its funding. External interviewees confirmed this and recognised there has been a consistent view from DFID in this area. DFID reinforced and helped to highlight concerns from recipient countries and to build consensus on responses. DFID worked alongside other partners with consistent views to address the issues in committees and in individual cases. The IHP has also helped maintain the pressure on GF for alignment and reforms.
- 7.2 On value for money, DFID is seen as having a clear interest and has encouraged measures such as better drug price information and review of grant budgets that will enhance efficiency. There were suggestions that DFID could do more, alongside other constituencies, to help the GF define value for money and encourage it to measure it in programs in more rigorous ways. It was also suggested that there needs to be mechanisms that enable and put pressure on recipients to be cost effective and economical, e.g. making sure drug price and other unit cost information reaches CCMs and is scrutinised, and taking unit costs into account in grant allocation. DFID and like minded partners could

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work with the Secretariat in these areas. The current funding context, with more demand for funds than money available, provides a good opportunity to step up the focus on value for money.

- 7.3 The feedback from external interviewees, especially fellow Board members, made it clear that DFID's contribution is valued and that the credibility of DFID's staff, especially the Board members, backed by sound analysis and experience from the ground, means that DFID is listened to. As a partnership with wide ranging constituencies, DFID (and others) cannot create changes alone, but DFID was seen as skilled in working with other partners where there is common ground to achieve consensus.
- 7.4 In comparison with the scale of resources provided by DFID to GF and particularly taking into account the scope to influence the total GF expenditure, (\$2.5 bn in 2007 and \$3 billion in 2008, rising in total and as a share of health aid), the costs of influencing are minor (some 0.009% of 2008 GF spend). Hence even if DFID could improve the efficiency of GF resource use by 0.1%, this would repay the influencing costs 10 fold.
- 7.5 Membership of the GF Board and committees and related informal contacts provide opportunities for influencing as does interaction at country level with the design and implementation of programmes. DFID should and does take advantage of these opportunities. This includes for example the involvement of PRD staff in the GF's new Market Dynamics and Commodities Committee. It may be worth considering whether a greater investment of DFID resources in influencing and improving practices of such global agencies is merited, given the scale of funding involved and the opportunities for participation in their governance. There are various models for this, including participation in committees, seconding staff and funding staff or consultant inputs.
- 7.6 Two Board members interviewed suggested (unprompted) that DFID should consider taking on chairmanship of one of the committees, as this provides additional influence and visibility, both in the work of the committee and in presenting the committee's findings to the Board. Whilst taking on such a role increases the workload and hence the costs of engagement, it should be justifiable if the committee is likely to influence important issues for DFID. It is clear from the interviews that substantive discussion on, and thus opportunities to influence, key issues and decisions take place in committees rather than the Board meeting itself.
- 7.7 One issue is how congruent DFID HQ agendas are with the remit and agenda of the country offices and how to ensure congruence between them. In the case of the GF, there seems to be clear interest at both levels to maintain the pressure on harmonisation and alignment, as advisers see the impact of non-aligned GF processes. There is less evidence of the value for money agenda being taken up at country level.
- 7.8 It may be worth considering whether DFID could play a greater role in influencing the impact of GF grants at country level. Given the large scale of GF funding compared to DFID's bilateral funds, improving value for money in design and implementation of GF grants could have considerable impact. Health advisers do engage in many countries, and in some cases have committed time or

resources to strengthen GF grant design. This could include technical support and strategic/related use of bilateral funds to enhance grant effectiveness. This point raised by some external interviewees, noting the lack of GF presence in country and that DFID has the capability to support strengthening of governance (e.g. administrative capacity, accountability, anti-corruption). One question is whether there are adequate incentives in place to encourage this role.

## **ANNEXES**

### **Annex 3\_A1. People interviewed**

DFID

GF Board

GF Secretariat

Board Observer

### **Annex 3\_A2. Source documents**

DFID, 2008a, Project Document for DFID's 2008-2015 Support for the Global Fund to fight AIDS, TB and Malaria, October 2008

DFID, 2008b, letter from Carlton Evans to PSC Chairman on Key Performance Indicators, 14 January 2008.

DFID 2008c, 17<sup>th</sup> Global Fund Board briefing – Objectives, April 2008

DFID 2008d, 18<sup>th</sup> Objectives for the 18<sup>th</sup> Global fund Board, November 2008

DFID, 2009a, Logframe (version revised2)

DFID 2009b, Global Fund Objectives, briefing for the 19<sup>th</sup> Board, May 2009

GF, 2007, Report of the Fifteenth Board meeting. GF/B16/2 et al

GF, March 2009, Results Report: Scaling Up for Impact.

ODI, 2009, DFID's Policy Dialogue with Multilateral Organisations:

Strengthening policy and practice, Draft report March 2009 (includes a case study on GFATM)

Mark Pearson, 2008, Cambodia case study, Health Resource Centre

### Annex 3\_A3. Estimation of influencing costs

**Table A DFID Staff time used on Influencing GFATM**

Staff Resources	Notes on time used on average on influencing	% FTE FY 2007/8	% FTE FY 2008/9
GFDD Deputy Director, UK	5% assumed	5	5
FCO Deputy Director, Geneva based	20% reported	20	20
A2s in PRD, UK	Reduced role of PRD as GFDD took on focal point role.	50	5
A2 GFDD Global funds Policy and Programmes Manager, UK		30	30
B1 GFDD Global funds Policy and Programmes Coordinator, UK		30	30
Country based health advisers (mix of A1, A2 and SAIC)	Average 2% of 16 people = 32% at average A2 grade plus 7% of the A2 health adviser in Mozambique = 39%	39%	39%
PRD IHP team 60% of one A2 and 20% of one A1	Say 25% of IHP team inputs allocated to GF	5% of A1	15% of A2 5% of A1

**Table B: Costs of Staff Used in Influencing (in £)**

	Unit cost per annum	Total cost for 2 yrs	Cost in 2007/8	Cost in 2008/9
Deputy Director, UK	£104,000	10,400	5,200	5,200
Deputy Director, Geneva based	£104,000	41,600	20,800	20,800
Health /HIV Advisers in countries	£ 120,000*	93,600	46,800	46,800
A2 Manager and advisers, UK based	£ 64,000	83,200	51,200	32,000
A1 Adviser	£ 80,000	8,000	4,000	4,000
B1 Coordinator, UK based	£ 40,000	24,000	12,000	12,000
Total	-	260,800	140,000	120,800

\* Unit cost for an A2 in Mozambique used as average for all country based advisers - salary, accommodation and other: £120,000 p.a.

**Table C: Other Resources and Inputs Used in the Influencing Effort (£)**

	<b>Total Cost £</b>	<b>2007/8</b>	<b>2008/9</b>
Consultancy study on GHPs Financing and HSS issues	£84,000		£84,000
Financial Aid directly associated with the influencing effort	Commitment of £1bn for 8 years with related logframe.		£50,000,000

## **B: Zambia Case Study**

### **1. Context**

1.1 Zambia's current health policy has been strongly influenced by reform processes introduced in the mid 90's and backed by the World Bank, IMF, USAID and DFID. These reforms aimed to make the system more service-delivery oriented and to improve its sustainability. Core features of the reforms were the decentralization of the health system and the introduction of cost sharing policies. The latter strategy pursued a number of objectives (UNZA 2005):

- To generate funds to cover part of the costs of running the health services.
- To facilitate the decentralization process and allow better localized, district-level control over cash flow by partially disconnecting the funding of health facilities from central services.
- To enhance ownership of the health systems by user communities.

1.2 Health outcomes experienced little improvement throughout the 1990's and early 2000's (UNZA 2005). The Zambian Health system faced a number of challenges, including the HIV/AIDS pandemic. Important investments were made in the HIV/AIDS sector, leading to a free access to ART policy which was instituted in 2005.

1.3 In 2005, the priority issues for the health sector were to improve the implementation of the user fees exemption policy, to decentralize the health system, to improve health workers' qualifications and motivation, and to strengthen the drug supply system. Health financing was seen as the key to all of these issues and became a major point of focus for donor groups and MOH. The donor's dialogue with the MOH was largely channeled through a Strategic Advisory Group (SAG), in which most key DPs as well as the MOH were represented. There was a growing consensus for the need to reform the health financing system and setup a social security fund, although there was little agreement on the best strategy with which to achieve this. The cost sharing policy was seen as a potential barrier to access, resulting in reduced service uptake as well as creating inequity across user groups. In a report commissioned by the MOH, and supported by SIDA and DFID, the University of Zambia conducted research into these difficulties which concluded that:

- There was no evidence that cost sharing increased the volume of resources in the health sector by an appreciable margin.
- There was no evidence to suggest that the Zambian health sector could achieve large enough financial injections from cost sharing given the microeconomic picture of the country.
- Cost sharing resulted in high costs of access to health provision and there was evidence of diminished policy emphasis on access (i.e. exemptions) for the poor within the conduct of a cost-sharing policy.

- However, several elements seemed to suggest that cost sharing could, and had, improved quality, access and health system functioning for the benefit of some sections of poor society.
- 1.4 At that time, support for the removal of user fees was not yet part of a formal set of corporate DFID policies. However, DFID policies were explicitly pro-poor and with a strong equity focus. Although the issue was still debated within DFID, support for the removal of user fees was already being promoted by a number of DFID staff. By 2006, as a result of earlier experiences in countries like Uganda, DFID moved to promote the removal of user fees and explicitly included mention of their support for this policy in the 2006 White Paper.
- 1.5 Aside from the growing consensus on the need to reform the health financing system, the other important contextual factors were political. 2006 was an election year in Zambia, and therefore offered political opportunities for pro-poor policy reforms. The new Minister of Health was appointed in April 2005 and proved an energetic leader, able to seize reform opportunities. Additionally, with the IMF and WB profiles damaged by their connection with the structural adjustment policies of the 1990's, a favourable political environment for alternative policies to be moved forward was created.

## **2. Influencing Strategy and Objectives**

- 2.1 The Minister of Health expressed her intention to remove health user fees to DFID Health and Governance advisors at a reception organised at the High Commission (3<sup>rd</sup> Oct 2005), and this marked an important turning point for DFID influencing strategy and objectives.

### **Phase 1 - Analysing the Health Financing System**

- 2.2 The incumbent cost-sharing policies were seen as an important, but not unique, barrier to access; and while DFID's policies were clearly pro-poor, it is not clear if, at this stage, DFID was specifically aiming a supporting removal of user fees. However, it was certainly supporting the emergence of alternatives to cost-sharing policies. The cost-sharing policy was largely questioned by a number of stakeholders, and there was a growing consensus within the SAG (Strategic Advisory Group, made of donors and with a MOH observer) that financing policies needed to be reformed to improve access to health services and equity.
- 2.3 At that time, the DFID influencing strategy shared with other DP (SIDA, and the Dutch Cooperation), was articulated as follows:
- Support the government to examine alternative options to the existing health financing policy.
  - Support the government to pilot user fees removal policies in a limited number of rural districts.
  - Support the government to learn from these evidences to shape implementation for health financing system reform.

- 2.4 This locally grounded evidence-based approach had already contributed to build consensus on the need for change. However, the second step of this strategy could not be effectively implemented : the MOH moved quickly to instigate popular reforms to the cost-sharing policy which necessitated DFID's moving the influencing process into a second phase.

### **Phase 2 - Advising the Minister of Health**

- 2.5 Immediately after her nomination in April 2005, The Minister of Health made a number of public statements criticising the cost-sharing policies as inequitable. She made her intentions to remove user fees clear to DFID Health and Governance advisors during a reception at the High Commission and DFID advisors mentioned that DFID was favourable to this policy orientation. However, they reminded the minister of DFID's commitment to the plans to pilot such a policy change in a few districts, in order to help shape such a policy reform to scale. The Minister preferred not to delay the reform and was seeking support for immediate implementation of the policy change.
- 2.6 DFID decided to support the Minister's intention, and shifted towards an approach to advise the MoH on the implications and prerequisites of such a policy change. This strategy isn't explicitly documented, but was implicitly articulated.
- Support Health Minister to champion policy change.
  - Share lessons learnt from international experiences with MOH.
  - Provide technical advice to the MOH on how to implement the reform.
  - Support the policy change at the highest political level.
  - Offer financial support to compensate for part of the extra costs.
  - Support thorough impact analysis, to help the GRZ learn from this Policy change and inform international debates.
- 2.7 This strategy proved realistic since the policy change effectively took place: the reform was announced in January 2006 and was implemented in April 2006, less than 7 months after the first discussions with the Ministry of Health. No interviewee doubted that DFID used an appropriate strategy to support the GRZ in the implementation of this rapid policy shift.

## **3. Design and Implementation of Influencing Effort**

- 3.1 DFID's objective was to help the MoH move forward with health financing reforms, in order to improve access and equity. In both phases there was no log-frame to detail short term influencing steps and success indicators.
- 3.2 DFID's initial plan (Phase 1) was to support the GRZ through an inclusive process, of which the pilot study would be the next step. This process had been openly discussed within the Strategic Advisory Group and SIDA and the Dutch

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cooperation shared a similar strategy to DFID. The research conducted to examine the health financing options was implemented by the University of Zambia, and co-funded by the MoH. The need for reform of the health financing system was already high on the MoH agenda. The pilot study to remove user fees in a limited number of districts was envisaged as the next step of the analysis process. This study was jointly led by the MOH and DFID (ToR Pilot July 2005).

- 3.3 However, the process had to be much accelerated after the Minister of Health made her intentions to move forward with the removal of user fees in Oct 2005. Most of what happened in Phase 2 wasn't planned in advance, and was therefore not budgeted for. The key planning period for Phase 2 happened very quickly after the first meeting on the 3<sup>rd</sup> of Oct. The plan shifted towards providing evidence from international experiences and informing the Minister about critical implementation challenges. From the beginning of the discussion, DFID made it clear to the Minister it would not support the MoH with extra basket funding, and reaffirmed its commitment to support the GRZ through General Budget support.
- 3.4 DFID was able to quickly react and adapt its strategy to the evolving context and could explicitly detail the support DFID was prepared to offer to the Ministry of Health 16 days after the first meeting (DFID information Note, Oct 2005). However, a number of stakeholders were left with the impression that this flexibility has been possible at the expense of risk assessment and engagement with partners.

#### **4. Role of DFID in Policy Change**

- 4.1 The health services user fees were removed in 54 out of 72 rural districts in Zambia. The Reform was announced to the parliament on the 9<sup>th</sup> of January 2005 and implemented from the 6<sup>th</sup> April 2006, only 6 months after this intention was discussed with the Minister of Health. The 2 key milestones in the policy change process and DFID's role were the discussion between the Minister of Health and DFID Head of Office the 19<sup>th</sup> of October, as well at the announcement of the reform by the President of Zambia the 9<sup>th</sup> of January 2008.
- 4.2 Until Oct 2005, DFID was essentially engaged in an open dialogue with the GRZ and the other CP to support the GRZ reform the Health System.
- 4.3 2004 - Oct 2005: together with the MoH and SIDA, DFID supported the study "Health Care Financing in Zambia: a study of the possible policy options for implementation" (Masiye 2005).
- 4.4 2005 – DFID supported the planning for a pilot study to remove user fees in 4 rural districts. This study was planned to last for an 18 month test period, starting early 2006 (ToR Pilot 2005).
- 4.5 DFID, SIDA, the Dutch cooperation, and Irish Aid formed a coalition of like-minded donors, supporting the emergence of health financing reforms towards

more equitable access to health services. Academic observers reported that this group was not advocating for specific policies but, rather, supporting the ongoing debates within the health sector. DFID was an important driver and contributor to these debates. Most stakeholders interviewed argued that the health sector financing reform process was inevitable and already in motion. The MoH was engaged in an iterative evidence-based policy process.

- 4.6 The important contributions from this first phase were:
- A. Effectiveness of the cost sharing policy to enhance community-ownership was explicitly criticised (Mogensen & Ngulube 2001, SAZA 2003).
  - B. The recognition across the sector that the cost sharing system was faced with serious shortcomings in terms of generating revenue for the sector:
    - *Low contribution to health system financing - User fees generated approximately 3% of total health income. In rural areas, the cost of collecting the income fees was estimated to be very similar to the income generated.*
    - *Inequitable barrier to access - Less than 1% of exemptions were made on the basis of low income, yet 67% of the population were living below the national poverty line. This showed that existing exemption policies were not effective.*
- 4.7 The period between Oct 2005 and January 2006 was the key period for shaping policy reform decision. DFID was heavily engaged in providing policy advice to the GRZ to help them work through the policy change design process.
- 4.8 There was proactive engagement of the Head of Office and DFID advisors in the reform process; DFID contracted a senior TA to share international experiences and highlight potential implementation issues, and arranged for F. Masiye, the author of the financing option study, to issue a policy oriented version of his report (Masiye 2005).
- 4.9 The ToR from the consultant was clearly oriented towards highlighting implementation issues and risks (ToR Consultancy 2005), important outputs of this consultancy were:
- A short report, based on international experience, identifying the benefits of user fee removal, potential risks and challenges and how they could be, or had been, mitigated (Yates 2005-1).
  - A short Implementation Issues paper that identified issues based on experience from elsewhere in Africa that need to be addressed if there is a decision by the Ministry to remove health user fees (Yates 2005-2).
- 4.10 Other key advice from the consultant to the Ministry Of health was to make sure this reform was led by the President. While causation cannot be sufficiently traced back to DFID's advice, the President made the announcement of the policy to Parliament and made this policy one of his key reforms in his re-election campaign.

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- 4.11 Other Development Partners were briefed by the consultant on the MoH's intentions during a Strategic Advisory Group meeting. They did not object, but there is little evidence of further attempts to engage them at this stage of the process. Some important donors for the sector (USAID, the WB) mentioned that, although they were consulted, the SAG didn't reach a consensus as to how best support the policy reform process.
- 4.12 The LSHTM was consulted to help estimate the expected costs associated with the implementation of a user fee removal policy.
- 4.13 Most of the dialogue during this intensive period happened on a bilateral basis between DFID and the MoH. DFID assumed the MOH was coordinating the discussion with other departments and encouraged the Minister of Health to seek commitment from the Presidency (DFID Note 2005). According to DFID, the Ministry of Finance was not engaged in dialogue at this stage of the process. A number of Donors, as well as MoH staff mentioned, when interviewed, that they were unhappy with the lack of consultation at district level before the policy decision was made.
- 4.14 During the 2005 Ministry of Health Annual Consultative Meeting (MHACM 2005), the Minister of Health announced her intention to abolish health services user fees. The Ambassador of the Netherlands, representing the Cooperation Partners, advised the Ministry to apply the policy in a phased manner, to alleviate the negative effect that the user fees removal policy would have on human resources, and availability of drugs and medical supplies. He also mentioned the need to reallocate resources to compensate for the revenue losses at health facility level.
- 4.15 On the 8th of January 2006, the removal of the user fees was announced by the President of Zambia to the Parliament.
- 4.16 **After January 2006:** DFID maintained an active role in supporting the government to design the implementation process.
- 4.17 The commitment from DFID to offer extra Budget Support to compensate for the expected costs in the health sector was confirmed shortly after the announcement of the reform by the President. DFID was engaged in a Poverty Reduction Budget Support (PRBS) policy and the extra support offered was at the level of 2.9M£/year additional PRBS for 5 years (notionally earmarked to the health sector for the first two years). In 2008, a decision was made to leave allocation to the health sector at the discretion of the Ministry of Finance.
- 4.18 After the announcement of the reform, the Ministry of Health set up a pilot committee, to which the Ministry of Finance was invited, to manage the reforms. DFID played an active role in this committee. Other development partners, with the exception of the HSSP project (USAID funded project) were poorly represented in the pilot committee.

- 4.19 The implementation of the reform began in April 2006 and resulted in immediate increases in utilisation rate (a figure of 30% is often quoted). The increased utilization, as well as the loss of revenue for health facilities, led to drug shortages at health facility level. The ongoing LSHTM impact study team (see outcome section) reports that a large share of this early utilisation rate increase was not sustained over time.
- 4.20 DFID brought back their consultant in May 2006 to advise on strategies to deal with consequences of increased utilisation. One issue that required work was the PRBS provided by DFID which had not been expanded to district level yet. A number of stakeholders suggested that at this stage of the process (once the policy had been announced) it could have been appropriate for the CP to provide longer term technical support to help design implementation plans. Other donors gradually shifted their programs and became engaged in supporting the government's policy implementation (USAID through HSSP).
- 4.21 DFID Zambia supported the Ministry of Health to undertake an extensive impact evaluation (2.5 years study by the University of Zambia, the LSHTM, and the University of Witwatersrand, Johannesburg, South Africa, 450,000£ budget). This study did not begin until 2008 but the LSHTM felt that it was essential to safeguard the robustness of the MoH policy and to the interpretation of the policy's outcomes. It was not possible to implement any baseline survey prior to the policy implementation.
- 4.22 The research was essential to understand the impact of the reform in Zambia and therefore to help refine the implementation of the health system reform. It will also contribute to inform a wider international audience about the impact of health fees removal reforms.
- 4.23 Overall DFID is perceived as having had a very prominent influence in the policy change process.

Stakeholder	Score	Rationale
Government 1	9-10	DFID has been the main DP driver behind this reform. Strongly instrumental in the decision and design process (both consultancy and commitment for financial support). DFID also very supportive in The Impact assessment phase, less so in the implementation.
HSSP 1 & 2	6-8	The Health Minister's role was critical. However, without DFID's support, can't see how the reform would have moved forward.
University of Zambia 1	9	The reform wouldn't have been implemented without DFID advisory, political and financial support.
University of Zambia 2	6-8	DFID played a key role at all steps, but other DPs were instrumental too, especially in supporting the evidence gathering process prior to the decision time.
Donor 1	6	DFID was influential, but the role of other partners was critical too (SIDA, Dutch Embassy). These would probably have supported the Gvt (maybe not in the same way) if DFID had not supported the policy reform process so strongly. The government was in the driving seat. The reform would still have happened without DFID support.
Donor 2	8	DFID played a (too) strong role in driving the process, but the role of the Minister has been decisive too.
Donor 3	9-10	DFID has introduced the idea, provided tech support, financial support and is funding the evaluation of the policy change
Donor 4	5-6	DFID has provided technical advice to the Minister of Health. It is not possible to say whether she followed DFID's recommendations. Want to think that DFID recommended her to follow a more inclusive approach, which she didn't.

4.24 Most stakeholders interviewed rated DFID's influence between 6 and 8 on a ten-point scale. They believed that DFID was by far the strongest supporter of the MoH during the policy change process, particularly between Oct 2005 and Jan 2006. Policy advice provided by the consultant and the extra Budget support were both acknowledged as important in this process, as well as the political support from the UK. Stakeholders who rated DFID's influence as lower on the scale felt that other development partners had played a larger role in laying the groundwork for the policy process (SIDA and Dutch embassy very active in Phase 1), but also very importantly that the shift to Phase 2 was essentially an initiative of the Minister of Health. Some donors rated DFID influence around 9. They argued that DFID was too strongly driving the policy change process.

4.25 It is hard to determine whether the policy change would have happened in the same way without DFID engagement. For some stakeholders, it would, at best, have been delayed. Others felt that the Minister of Health was determined to implement the policy change and would have moved forward with the reform with or without DFID's influence.

## 5. Costs and Cost Effectiveness

5.1 The below table synthesises the main costs involved or related to the DFID influencing effort.

<b>Position</b>	<b>% of time of the post spent influencing FY 2005/6</b>	<b>% of time spent influencing FY 2006/7</b>	<b>Same for FY 2007/8</b>	<b>Total Cost</b>
<b>Head of office (SCS)</b>	-	-	-	-
<b>Health/HIV Adviser</b>	15% (Oct 2005- March 2006) (144000*.15)	30% (144000*.3)	10% (144000*.1)	£79,200
<b>Social Development Adviser (HCS)</b>	7.5% (144000*.075)	n/a	n/a	£10,800
<b>Total DFID staff</b>				<b>£90,000</b>
<b>Purpose of the consultancy</b>	<b>FY 2005/6</b>	<b>FY 2006/7</b>	<b>FY 2007/8</b>	<b>Total Cost</b>
<b>Research UNZA (financing options)</b>	44,500			£44,500
<b>First visit Rob Yates</b>	17,500			£17,500
<b>Consultancy Masiye</b>	4,500			£4,500
<b>Research LSHTM</b>		£450,000		£450,000
<b>Total Consultancies and Research</b>				<b>£515,500</b>
<b>Health earmarked budget support</b>		£2,900,000	£2,900,000	£5,800,000
<b>General Budget support (From 2009)</b>	-	-	-	£8,700,000
<b>Budget Support</b>				<b>£14,500,000</b>

Note: Unit cost for Zambia- salary, accommodation and other allowances: £144,000 pa

5.2 The cost involved in direct influencing work looks relatively limited in relation to the importance of the reform: £156,500 for staff and consultancy costs, excluding the impact assessment research. The extra amount of budget support offered by DFID was obviously much more significant in financial terms. However, it is difficult to distinguish between the influencing elements of this additional Budget Support and its broader objectives in terms of support to the Zambian Government.

- 5.3 It was suggested that the reform of the user fees policy had not been implemented earlier due to concerns about financial sustainability and the capacity for the health financial system to cope with the increased demand (Masiye 2005, interview with UNZA, Musumali). The financial repercussions of the reform were a concern for the Ministry of Health, and DFID acknowledged them. A number of interviewees believed that the offer from DFID to compensate for part of the costs associated with the reform was instrumental in the Minister's decision to move forward with removal of user fees. Although the financial support DFID offered was untied to the reform, the fact that the financial consequences of the user fee removal were largely accepted as a constraints to the policy change supports the case for including the BS expenses in the influencing efforts costs.
- 5.4 Excluding the PRBS, the cost effectiveness of the policy advice activities was good. The resources spent in policy advice were relatively limited, and very well targeted. The LSHTM research will also help generate evidence for wider policy advice. Assessing the cost effectiveness of the Budget Support is much more complex. If this BS was largely attached to the reform, there are two relatively independent questions related to the cost effectiveness of the extra PRBS:
- *Was the amount appropriate to encourage the government in taking this decision?*
  - *Was the PRBS an effective tool to support the policy change implementation?*
- 5.5 The sequence of events suggests that the PRBS was important enough to encourage the Zambian government to confidently take the decision to implement policy change. Current available evidence is somewhat critical of the effectiveness of the extra Budget Support (ODI 2009). The extra PRBS disbursements to the GRZ were delayed, and there are identified issues with health facilities accessing flexible funds to replace revenue loss due to removal of user fees. The ODI study concluded that the PRBS had limited effectiveness in helping the GZR meet its sector objectives (p. ix Exec summary).

**The emerging picture to the cost-effectiveness question is therefore:**

- The DFID influencing work has been very effective
- The policy advice side was certainly very cost effective (both advisors' role and consultancy support)
- Extra Budget Support has been an effective way to support the policy decision process.
- The cost effectiveness of the Extra Budget Support in supporting the policy change implementation is beyond the scope of this study to assess, but there is evidence that it has not been as effective as the policy advice.

- 5.6 DFID's initial plan was to support the government to pilot a user fee removal policy in a few districts. Issues with the implementation of the policy change would have been highlighted by this pilot study. Most stakeholders are unhappy that the pilot reform wasn't implemented in a more phased approach (e.g. MoH, Dutch Cooperation), and feel that DFID should have strongly warned the minister of the potential negative effects.

- 5.7 The other position is to acknowledge that the leadership of the Minister of Health was the determinant factor for the policy change. In this perspective, DFID had to offer support adapted to the pace of the reform dictated by the GRZ. Acknowledging this scenario, it is not easy to imagine alternative ways in which DFID could have delivered effective and timely support to the GRZ. However, advisory support to the GRZ during the policy implementation process is often mentioned as a gap (MoH, UNZA).
- 5.8 At the policy level, the benefits of the DFID influencing efforts are clear: the user fees have been removed in the rural districts. A more impact oriented cost-benefit analysis of such a policy change would need to be based on the actual benefits for the users, which is beyond the capacity of this case study. The LSHTM-led impact research study will provide answers to these questions.

## 6. Outputs and Outcomes

- 6.1 DFID has been successful in terms of achievement of policy dialogue objectives: the government has removed user fees in rural districts, donor funded projects are now aligned (e.g. USAID HSSP funded project is supporting the implementation), and there are quite advanced talks to remove the user fees in urban districts. In terms of policy change, it is a clear success. What is more debatable is how much of this change can be attributed to DFID. Although DFID's role is clearly recognised as important, it must also be clear that the most crucial turning point was the Ministry of Health lead and commitment in making that policy change happen.
- 6.2 The results in terms of outcomes are currently being studied by a research project led by the LSHTM, in Partnership with the University of Zambia and the University of Witswatersrand.

### **Process and Impact Evaluation of the removal of user fees in Zambia, Methodological Approach.**

Component 1: An **impact analysis** which will summarise and analyse available information on the impact of fee removal on attendance at primary care centres by the poor and vulnerable groups. It will also include a benefit incidence analysis to assess whether district health service spending has become more pro-poor over the time of fee removal.

Component 2: A **policy process analysis** which will document the process by which this reform took place and how it was implemented at national and district level.

Component 3: A series of **case studies of implementation and impact** at district level. These case studies will seek to understand the experience of health workers and communities of the effects of this reform, the manner in which it was implemented, and the other factors that have been influential upon the successful delivery of good quality health services to poorer groups.

- 6.3 There is no validated result available yet. However, trends are emerging (LSHTM communication):

### **National level secondary data analysis**

- Significant increase in the utilisation rates for the >5years patients
- No significant increase in the utilisation for the < 5years
- Important variations across districts
- Initial peak of utilisation after the policy was implemented, but in several districts utilisation went down again.

### **District/facility-level case studies**

- Important outcome variations within and across districts and facilities but determinants for these variations are still not clear.
- The contribution of the fees to the flexible cash flow of the health facilities was significant, and loss of revenue has undermined many activities.
- Health workers seemed supportive of the policy change, but stressed the importance of sufficient staff, resources and drugs in the facility.
- An important financial barrier esp. for poorest seems to have been removed, but quality of care can be compromised
- Outcomes were looked at - both comparing charging and non-charging facilities (by definition, urban vs. rural) as well as within facilities before/after policy change (2005 - 2008).

### **Benefit incidence analysis and policy process analysis**

- Not yet undertaken or on the way

### **Overall (preliminary) conclusion**

- Variable outcomes of the user fees removal policies - both positive and negative. A policy to remove user fees is implemented in a wider health system, which relies on an adequate drug supply, innovative HR strategy, good financial management to improve access to quality care for all. Hence, this policy should therefore not been seen in isolation but as part of wider set of health reforms.

## **7. Conclusions and Lessons**

### **A flexible approach**

7.1 This case study in Zambia is a good illustration of DFID's flexibility and ability to change strategy. DFID has been a very reactive and supportive partner to the Minister of Health. DFID work in Zambia is also a good example of a comprehensive influencing cycle:

- DFID pro-poor corporate policies and some DFID staff supporting removal of user fees.
- Support for research aimed at informing evidence based policy change process.
- Technical Assistance to Minister when reform process accelerated.

- Political support to GRZ to back up reform process.
- Financial support to GRZ to support implementation.
- Support for thorough impact assessment in order to refine Nation Policies, inform international debates, a feed back to DFID corporate position.

### **DFID as a catalyser of the reform process**

- 7.2 It remains hard to tell if the policy change would have happened without DFID engagement. The Minister of Health's commitment to and interest in the reform was strong, and may have moved the reform forward anyway.
- 7.3 Nonetheless, the policy changes supported by DFID were implemented. DFID could quickly adapt its influence strategy and provide the best available technical advice to a Minister committed to engage in a pro-poor policy reform. Both the technical expertise and the financial support provided by DFID are pointed out by the stakeholders consulted as important elements that helped the MoH to shape and move forward with the reform. Whether or not its influence was an essential factor in the reform, DFID is clearly perceived as a strong catalyser of the process by most stakeholders.

### **Flexibility should not come at the expense of high risks**

- 7.4 There were risks that the desired impact would not be achieved. Other components of the health system needed to adjust for such a policy reform to achieve the enhanced utilization without compromising quality of care. Risks associated with slow adjustment of other elements of the health system, and the need to address them simultaneously, were highlighted by technical advice provided by DFID through their consultant. However, most stakeholders interviewed reported that the policy change process did not address these risks. A number of criticisms were also made of the policy change process itself:
- The policy change process was seen as being insufficiently participatory at all levels: The decision was announced prior to consultation with actors in the health system (MoH staff at district and central level, Development Partners). This criticism was made by all stakeholders interviewed.
  - Evidence from international experiences are not enough to tailor such a reform to domestic characteristics of the health system: a pilot was seen as necessary (MoH, LSHTM, WB, and USAID).
  - There were a number of priorities within the reform agenda for the health sector, including the strengthening of human resources and drug supply systems. Moving forward with this reform without addressing other issues was likely to have negative repercussions (MoH, Dr. Ngulube, and C. Musumali, the WB).
  - The strategic priority for health sector financing was to shift from a point of use payment towards a social security system. This priority wasn't factored in the reform process (C. Musumali, Dr. Ngulube).

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- 7.5 With DFID clearly being associated with the policy process, some of these criticisms are addressed towards them as having pushed for a policy that may have been prematurely implemented, with consequent implementation problems.
  - 7.6 Some criticism is directly addressed to DFID for not consulting enough with other Development Partners before deciding how to support the policy. Some like-minded donors who engaged with DFID in the earlier process (pilot study) expressed strong criticism towards DFID.
  - 7.7 Most importantly, the speed of the process meant that there was a lack of local evidence on the potential local impact and implications of the fee removal reform.
  - 7.8 These criticisms highlight the risks and trade-off in seizing the opportunity to promote change when there is strong political interest and a national champion that will address it. These risks and trade-off need to be more systematically incorporated in the design process.

#### **Supporting M&E early in the process**

- 7.9 DFID support of the LSHTM impact assessment study highlights DFID's accountability, openness to criticism and openness to learning attitude.
- 7.10 There are a number of possible methodological approaches to measure the impact of such a reform process (Mills et al 2008). Random allocation of individuals (or clusters) to control or intervention groups is regarded as the gold standard approach against which other designs are judged. There are a number of limitations to applying this approach. However, the minimum requirement for an impact assessment is to have a proper baseline before the implementation of the policy reform against which to measure change. Because of the absence of such a baseline, but also because the study began after the the policy implementation, the study is struggling with significant methodological issues.
- 7.11 It is important to plan and support M&E efforts so that they can begin as soon as possible along with such policy reforms processes. When policy changes so quickly, Real Time Evaluation approaches would help to capture key lessons.

## Documents Consulted

- 1) Whose Ownership - Which Stakes? Communities and Health Workers Participating in the Zambian Health Reform. Modensen & Ngulube, Urban Anthropology, Vol 30(1) pp 71-104 (2001).
- 2) ToR Pilot study – Analyzing the impact of suspending the cost-sharing for primary health care services in Zambia, July 2005.
- 3) Health care financing in Zambia: a study of the possible policy options for Implementation. ECON/UNZA, IHE, MOH, CBOH and DFID, August 2005
- 4) DFID information Note: Zambia: Potential removal of health user fees, 20th Oct 2005
- 5) UK Department for International Development’s support to the Government of Zambia in reviewing health user fee policy: 19 October Meeting, letter from DFID HZO to Minister, 2005.
- 6) ToR for a consultancy to provide information and technical expertise to inform policy related to cost sharing in Zambia, Oct 2005.
- 7) International Experiences in Removing User Fees for Health Services – Implications for Zambia, Rob Yates, 2005.
- 8) Implementation Issues for the Removal of User Fees in Zambia, Rob Yates, 2005
- 9) Minutes of the 2005 Ministry of Health Annual Consultative Meeting.
- 10) Estimating Anticipated Revenue Loss in Public Health Facilities due to removal of User fees in Zambia, Felix Masiye. Department of Economics University of Zambia, 2005
- 11) Removal of User Fees in Rural Districts in Zambia, Guidelines for the service utilization tracking system, December 2006
- 12) Notes on the Consultancy visit by Rob Yates on behalf of DFID Zambia, May 2006
- 13) The SAZA study: implementing health financing reform in South Africa and Zambia, Health Policy and Planning; 18(1): 31-46; 2003
- 14) Process and Impact Evaluation of the Removal of User fees in Zambia – Research Proposal, LSHTM - April 2007
- 15) What do we mean by rigorous health-systems research? Anne Mills, Lucy Gilson, Kara Hanson, Natasha Palmer, Mylene Lagarde DHPD, LSHTM, The Lancet 2008.
- 16) \* Sector Budget Support in Practice, Case Study - Health Sector, ODI 2009.

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## **C: Nigeria Case Study**

### **1. Context**

#### **Challenges to Aid Effectiveness in the Sector**

- 1.1 After 1999, the President of Nigeria took immediate leadership of the national HIV response and moved forward with two important decisions in quick succession: (1) he established the National Action Committee for Aids (NACA) in 2000 as the lead national agency to tackle HIV, and (2) he launched the National HIV Emergency Action Plan in 2001 (HEAP 2001-2004). A subsequent and much stronger strategic plan, the National Strategic Framework for HIV & AIDS (NSF, 2005-2009), was then developed as the “agreed HIV & AIDS action framework that provides the basis for coordinating the work of all partners”. In 2008, UNAIDS reports around 2.6M people living with HIV/AIDS in Nigeria.
- 1.2 From 2005, USG (PEPFAR) and the Global Fund started funding important HIV/AIDS programs (mostly focused on treatment) and quickly became key donors for the sector, as did the Clinton Foundation in 2007. By 2007, more than \$300 million was flowing to Nigeria for HIV annually, and by 2008, HIV financing had exceeded total annual ODA to the country. Most of the funding to the sector is earmarked to specific projects. The large size of the programs and the diversity of approaches and stakeholders make it difficult to harmonize in the sector. DFID, but also the WB, in particular began support for the Government of Nigeria and HIV/AIDS programs from much earlier on (2001 for the WB).
- 1.3 Harmonisation and alignment possibilities were constrained by specific difficulties around the complexity of Nigeria as a country. The difficulties most commonly reported were: large size of the country and of its population, the decentralized nature of the Nigerian administration system, and the thin capacities of some technical services.

#### **Alignment and Harmonisation Opportunities in the Sector**

- 1.4 In 2005, NACA was put under pressure to deliver when the President publicly announced the target of 250,000 people on anti-retroviral treatment (ART) within 18 months, for which the NACA would be accountable. NACA had to demonstrate results, and prove ability to lead and coordinate an HIV/AIDS sector almost entirely donor-funded.
- 1.5 This followed a significant period of strategic thinking to strengthen NACA’s vision, strategic approach and institutional setup. In 2004, DFID supported a “NACA reengineering workshop”, to help NACA deal with some of its institutional weaknesses and reshape its vision after its first few years of existence, and the quick evolution of the volume of Aid flowing to the sector and the growing number of stakeholders involved in the response. This workshop was followed up by a “reengineering study” (also DFID funded), which helped NACA to better articulate a strategy to deliver on their commitment to their mandate.

- 1.6 This was concomitant with international commitments on alignment and harmonisation in the sector. The Global Task Team Recommendations were published in June 2005, they were articulated around the “Three ones” principles, following the Paris Aid Effectiveness declaration commitments.
- One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
  - One National AIDS Coordinating Authority, with a broad-based multisectoral mandate.
  - One agreed country-level Monitoring and Evaluation System.
- 1.7 These commitments were formally adopted (domesticated) in Nigeria a few months after (November 2005). In line with some of the reengineering study recommendations, the domestication process proposed to strengthen NACA’s legal status and make it a Government Agency rather than a technical committee. NACA effectively became a Government Agency in 2007. NACA was perceived as a relatively strong and well equipped Governmental Agency. Leadership and vision of NACA’s ex DG (Dr. B. Osotimehin) is widely acknowledged nationally and internationally.
- 1.8 Despite a number of challenges to harmonisation and alignment in the sector, a number of elements were also assembled to allow for progress:
- Articulation of a strategic framework for the sector (NSF),
  - international commitments to aid effectiveness,
  - quick domestication of these commitments in the country,
  - a strengthened vision and institutional setup for NACA, and
  - a strong lead of political commitment from NACA’s DG.

### **DFID position and the emergence of the JFA idea**

- 1.9 Aid Effectiveness is explicitly part of DFID’s corporate agenda, and is acknowledged as such by Development Partners. Although a Joint Financing Arrangement (JFA) wasn’t formally a part of the recommendations by the domestic GTT, the above mentioned combination of strengths presented the ideal opportunity for DFID to introduce the concept of using a JFA to support NACA in achieving its mandate. The mandated aims were: providing leadership for the sector, promotion of more joined-up working through strengthened coordination, effective alignment behind the NSF, and the potential to significantly reduce transaction costs for NACA.
- 1.10 The JFA idea was introduced by a DFID Advisor in 2006 (power-point presentation to DPG – not retrieved) while she was seconded from DFID to the World Bank (April 2004 – Nov 2006). Although this idea was quickly adopted by the DFID, WB and CIDA country offices, it is worth mentioning that it was brought about by the DFID Advisor based on her previous experience of being involved in the development of a SWAP in the health sector in Malawi.

## 2. Influencing Strategy and Objectives

- 2.1 For DFID, supporting the setup of a JFA for NACA was a step towards its influencing objectives to (1) contribute to improved aid effectiveness in the sector and to (2) strengthen and support NACA's leadership and administrative capacity.
- 2.2 A JFA would allow a more coherent and coordinated dialogue between NACA and the Development Partners, as well as reduce the transaction costs to NACA by harmonising disbursement, procurement, financial management, audit, monitoring and reporting arrangements (JFA discussion paper, 2007). The JFA, which would facilitate the implementation of the National AIDS Priority Plan (NACA's Strategic Framework), was also seen as a tool to reinforce NACA's strategic planning. In the end, the JFA process would reinforce NACA's leadership, strengthening its institutional capacity. Therefore, one mark of success would be an increased explicit contribution from the Government of Nigeria to NACA's funding to ensure its institutional sustainability and movement towards the sustainability of the national HIV response.
- 2.3 JFA's vision and objectives are summarized in the box below (JFA discussion paper, 2007).

- Alignment with Nigeria's programming and budgeting cycle in support of national HIV priorities.
- Strengthen Nigeria's public administration and coordination capacities so that effective public sector management processes can be used to support the national HIV response.
- Demonstrate the effectiveness of evidenced based decision making based on the national M&E framework, using Results Based Measurement (RBM) performance information to inform national programming.
- Coordinate among DPs to provide harmonized support for the national HIV response and policy dialogue mechanisms, including CCM, and find strategies to reduce transaction costs (and avoid redundancy and overlap) inclusive of delegated cooperation agreements.

- 2.4 An important element of the strategy / tactics to support a JFA setup was to demonstrate its effectiveness first with like-minded donors, therefore attracting others to participate. The World Bank, CIDA and DFID quickly formed a group of like-minded partners, willing to pool their funds and support the setup of a JFA. An important opportunity to build a strong alliance was provided by the presence of a DFID advisor seconded to the World Bank to manage their HIV Aids program. The partnership of these 3 like-minded donors worked effectively from the very beginning of the process. Indeed, A few months after the JFA concept had been proposed by the DFID Advisor to the DPG, CIDA drafted a concept for the JFA to be presented to NACA, with the support of DFID and the WB.

- 2.5 Perhaps even more importantly, part of DFID's strategy to support the JFA setup was to quickly pass the lead to NACA and provide support to the initiative through the Development Partner Group (DPG). The JFA was to be aligned to NACA's Strategic Framework by supporting the costed version of this document (NCBW). This was facilitated by the strong leadership and political commitment of NACA's DG, who quickly took up the JFA idea and took ownership of it. DFID, in partnership with World Bank (-DFID secondee), then used the DPG forum to support the JFA process. The decisive period for building momentum for the JFA coincided with WB's chairmanship of the DPG, during which time they became a more strategic and cohesive group of development partners, with JFA as a core shared objective (2008-2009).
- 2.6 The other significant strategic / tactical orientation was to push for an early engagement of NACA's board and the Ministries of Finance (MoF) and Planning (NPC) in the JFA design process. Once NACA's DG picked up the idea, he quickly set up a JFA Task Team (first meeting in Feb 2007) in order to refine and operationalise the JFA concept.

### **3. Design and Implementation of Influencing Effort**

- 3.1 DFID's support of the setup of a JFA agreement was very explicitly formalised as part of its strategy for the sector. It was formally mentioned as an objective, in the logframe of its capacity building project to NACA, as early as October 2006 (and was therefore articulated beforehand) when the discussion with NACA and the other DP's had just begun. It is not clear if the design of the influencing approach was based on a systematic analysis of the context, the stakeholders and their interests. The costs involved had not been estimated when the objective was formulated. However, it was expected that the benefits of alignment and harmonization would not be easy to demonstrate. Indeed, previous experiences from other countries prove that such benefits (1) need time and committed support before they can be realised (2) are sometimes difficult to attribute to specific processes, and (3) that when the impact is measured as health outcomes it is potentially offering high value for money (low marginal investment compared to the potential influence), but that the actual influencing impact is very difficult to measure on these terms. This was therefore an influencing project with high risk of failure but important potential benefit - an advisor mentioned that one of the reasons why it was possible to make progress was DFID's willingness to take risks.
- 3.2 An important element of the design and implementation of the JFA design and implementation process was both its NACA leadership and its participatory approach in the implementation. The JFA Task Team was an instrumental tool, effectively managed, chaired by NACA but substantially supported by DFID (adviser and secondee). The quality of the consultancy provided to facilitate the process was highlighted by almost all interviewees as a determining success factor. Three qualities have been highlighted: (1) the consultant's expertise in supporting the JFA setup process, both as a result of involvement in the ECOWAS process and knowledge of the WB administration procedures which the other DP's were committed to align with (2) the quality of the consultant's facilitation skills, and (3) the consultant's neutrality and objective focus on systemic issues rather than HIV technical issues.

- 3.3 DFID influencing work was not only designed as a NACA oriented project, but was also aimed towards strengthening DFID’s advisory role within the Development Partners Group. DFID staff (advisor and secondee) played an important role in chairing the DPG, gradually making the JFA central to the DPG discussions. Their essential role in driving the process forward was acknowledged by both NACA, and other donor interviewees. This was possible as the DPG gained in strength during the same period that the JFA gained momentum.

## 4. Role of DFID in Policy Change

### Target Audience

- 4.1 NACA itself – NACA’s DG quickly picked up the JFA idea and envisioned the potential benefits to NACA: since it would help reinforce its institutional capacities, put coordination firmly within its remit, and offer better leverage to fulfil its mandate. However, NACA staff were concerned by a number of questions: the JFA idea was initially felt as part of the aid “jargon”, and needed to become operational; some were expressing doubts about the potential to actually reduce transition costs to NACA.
- 4.2 Development Partners – (apart from CIDA and DFID who initiated the JFA), the key Development Partners in the sector were: The World Bank, USG, The Clinton Foundation, and the Global Fund. Some Development Partners committed to the Paris Declaration expressed readiness to pool funds when there would be evidence of NACA’s capacity to administrate the JFA and reduced transaction costs. Others were and are not necessarily committed to pooled funding arrangements.
- 4.3 The three like minded partners attended all the JFA meetings. Although USG decided not to pool funds, a quite positive sign was their participation as deputy chair of the DPG. It helped the JFA to be accepted as central to the discussions.
- 4.4 The World Bank, being supportive of the Aid effectiveness agenda at corporate level, soon became a major partner. The dialogue with the WB was also facilitated by the fact that the HIV/AIDS advisors of the WB project had been seconded from DFID from at least 2004. Quickly, the main discussion points with the WB became focused on technical issues regarding the implementation and design of the JFA.

### Timeline of the Influencing Process

- 4.5 **Before 2006** - Some key background events
- 2000 - Appointment of a committed and charismatic project manager to head the World Bank HIV/AIDS project who later became the chairman, then the DG, of NACA.

- 2004 - DFID funded NACA reengineering workshop and study. The study highlighted the need for better donor harmonisation and alignment in the sector. It provided useful recommendations for NACA to establish a clearer vision and strategy with an organisational structure which would enable it to effectively deliver its mandate as the national coordinating body. This study is still acknowledged as a key step of the NACA institutional development process.
- 2005 – Domestication of the GTT recommendations in Nigeria.
- 2005 - DFID Advisor came to Nigeria from Malawi where she had been heavily involved in the implementation of a SWAP process and was therefore very familiar with the harmonization and alignment issues. A strategic partnership between DFID and the WB was already in place in the sector with a policy of having DFID seconded staff top-manage the WB HIV/AIDS programs. The DFID Advisor was seconded to the WB until November 2006.
- **End 2006 / Early 2007** – The introduction of the JFA idea
- 2006 – The DFID Advisor, as she was seconded by DFID to the WB, presented the idea of a JFA to fund NACA to the Donor Coordinator Group in 2006. This idea was very quickly accepted by DFID, CIDA and the WB, with varying levels of interest from the rest of the group.
- January 2007 - CIDA, with the support of DFID and the WB, drafted a concept for the JFA.
- January 2007 – NACA’s DG agreed to further examine the opportunity of moving forward with the JFA concept and put in place a task team to revisit objectives and draw up a strategy.
- February 2007 – Arrival of last DFID adviser seconded to World Bank, bringing fresh experience as lead partner in Malawi’s Health SWAP. WB and DFID Nigeria advisers form strategic partnership.
- February 2007 - Setup of the JFA Task Team, chaired by NACA, and attended by representatives of NACA board and other ministries, DFID, the WB, CIDA, USAID and UNAIDS. Monthly meetings were held throughout 2007 and 2008. The DFID / CIDA pairing were the key NACA supporters during this process, both financially and in terms of leadership and institutional commitment.
- Early 2007 – NACA chaired a selection board made up of the JFA Task Team members to select an international consultant to help facilitate the JFA development process. A consultant was selected by the board who had been involved in another JFA setup process (ECOWAS), and who had worked in the World Bank for many years previously and therefore had solid understanding of World Bank processes and procedures.

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- 2007 / 2008 - The actual JFA design process, facilitated by the consultant.
  - During 2007- the consultancy firm managing the HIV NGO JFA on behalf of Government and Development Partners in Tanzania gave a presentation on their mechanism, as part of the NACA Task Team mission to explore the range of JFA mechanisms that are in use across Africa.
  - Observation of different JFA models by NACA staff, NACA board and partners (UN and WB) – decided that they liked the Malawi Model and then started to think about how to make it fit with the Nigeria realities.
  - 2007 – Development of the NACA costed Bi-Annual Workplan by NACA.
  - March 2008 – Stakeholder workshop to share progress to date, and look at the challenges and opportunities going forward.
  - August 2008 - Study Tour (NACA staff, NACA board, DPs represented by DPG Chair) – the study tour confirmed it was the right way to go and confirmed they preferred the Malawi model. Crucial step to reach consensus.
  - As expected from the inception phase, the whole process took some time, with very regular NACA led meetings. However, it took a relatively short time to draft a JFA agreement (less than 2 years until a JFA was drafted), compared to other JFAs, the number of stakeholders involved, and the complexity of the Nigeria administrative setting.
  - During the whole period the support from DFID advisors, both seconded and within DFID, has been crucial, not only with the DPG, but also to provide direct support to NACA’s management of the JFA design process.

**Early 2009** – Most recent developments.

- Early 2009 – Change in NACA leadership and awaiting the World Bank Board approval of the Multi-Country AIDS Program 2 (MAP2). These two issues were mentioned as the main reasons for the current delay in signing the JFA (planned for late 2009).
- Late 2009 – significant step forward towards a stronger partnership between the WB and DFID, with the appointment of a single senior HIV/AIDS Advisor (DIFD) to manage the WB and DFID projects.

**NACAS’s perspective on DFID support**

4.6 NACA strongly acknowledged the key role of DFID in supporting the JFA through the following four angles:

**Discourse** – Getting the vision clear. The NACA reengineering studies, as well as DFID lead role in making the JFA idea central to the Donor Coordination / Development Group agenda were key elements of this discourse support.

**Information** – Sharing international experience. The study tour is a particularly good example of this component of DFID support. It proved to be a very positive experience for NACA and other government ministries to materialise the JFA idea and its potential benefits.

**Systems** – DFID’s financial support to NACA’s capacity (both physical and technical/organisational) was acknowledged as an enabling factor for NACA to move forward the JFA idea (time and resource consuming process to setup).

**Processes** – The JFA Task Team setting as well as the participatory approach of the JFA design phase were quite effective. UNAIDS also made important inputs based on experiences from other African countries.

### DFID effectiveness in supporting the JFA process

4.7 Stakeholder assessments of DFID influencing efforts were very clearly positive and the majority were scored in the range 6-8 and above (i.e. has been decisive for some of the key steps of the change process). A brief tabular summary is provided below:

Stakeholder	Score	Rationale
NACA 1	9	The JFA wouldn’t have been possible without DFID support. DFID’s support was essential to make what was a jargon become a tangible process. DFID not only funded the process but was a demanding member of the process.
NACA 2	6-8	Without DFID, the JFA would have been much delayed, but the partners were already committed to implement the GTT recommendations at country level. DFID capacity support to NACA was also important to move the JFA forward.
Donor 1	9-10	Without DFID financial and technical drive and commitment, it wouldn’t have happened. The WB wasn’t in a position to offer the lead.
DFID seconded to WB	7	DFID played a key role in driving the process. Also acknowledges the role of NACA and other committed DP.
UN 1 & 2	6-8	DFID played a key role in driving the process. Also acknowledges the role of NACA and other committed DP. Without other DP committed to pool, there is nothing to pool!
Donor 2	6-7	DFID played a key role in driving the process. Also acknowledges the role of other committed DP. Isn’t aware of how much funds DFID is committed to Pool, but other’s commitment significant too.
Donor 3	9-10	DFID staff, within DFID and the WB played an important role in driving the process. They effectively brought the JFA as a priority item within the DPG.

## 5. Costs and Cost Effectiveness

5.1 The resources invested by DFID to support the JFA setup are reported in the below table.

	Unit cost per annum	Cost in 2005/6	Cost in 2006/7	Cost in 2007/8	Cost in 2008/9	Total Costs
A2 HIV Advisor (HCS)	£ 202,000	15% 6 m = £15,150	35% = £70,700	40% = £80,800	40% = £80,800	247,450
A2 Secondee (HCS)	£ 150,000	n/a	15% = £22,500	15% = £22,500	20% 9m = £22,500	£67,500
<b>Total staff costs</b>						<b>£314,950</b>
International TA	£45,000	n/a	n/a	£22,500	£22,500	£45,000
Country Study Tour	£87,000	n/a	n/a	n/a	£87,000	£87,000
<b>Total project costs</b>						<b>£132,000</b>
<b>Total Influencing costs</b>						<b>£446,950</b>

- 5.2 These cost estimates illustrate the prominent role of DFID advisors in supporting the process. The cost effectiveness of the TA work appears to be quite good value for money as highlighted by the interviewees.
- 5.3 By comparison the indicative partner's (all incl.) contribution to the 2009 National AIDS Priority Plan (NAPP) amounts to USD 27M (JFA draft, annex 4). With each budget converted to an annual basis, the DFID financial contribution to the JFA process represents 0.53% of the total contributions to the NAPP. DFID influencing efforts therefore represent a limited percentage of NACA's budget and a much more limited share of the overall HIV/AIDS programs implemented in Nigeria.
- 5.4 In addition to these direct contributions to supporting the JFA process, £7.5 million has been committed in DFIDN's new HIV Programme 'Enhancing Nigeria's Response to HIV' (ENR) over 6 years, and will start flowing as soon as the JFA becomes operational.
- 5.5 The extra annual support committed by DFID represents around 7.5% of NACA's 2009 annual budget forecast (Draft JFA, annex 4), which isn't negligible. This commitment probably had some traction force as well as the advisory support.

## **6. Outputs and Outcomes**

- 6.1 A JFA agreement is drafted and has been reviewed by NACA, the WB, CIDA and DFID, who are committed to contribute to funding it. It should be signed in autumn 2009. Other key donors (USG, Global Fund, Clinton Foundation) will not pool in the first instance. However, other partners such as JICA are committed to examining the possibility of joining the JFA in its next tranches. The contribution of the WB, CIDA, DFID and the Government of Nigeria is planned to account for over 95% of NACA's funds in 2009. The JFA should therefore cover all NACA's costs.
- 6.2 An interesting outcome of the JFA process is the benefit to the current USG led compact process. The USG mentioned that the lessons learnt from the JFA would help them through the process, but would also influence the policy content orientations of the compact.
- 6.3 However, all HIV/AIDS programs should fall under the NSF, for which NACA is coordinating the strategy discussions. The long term vision is that further support for NACA's capacity building should allow NACA to have a strong coordination role and oversight of the whole sector and to effectively report back to the Federal Government of Nigeria.
- 6.4 The JFA was planned to be signed earlier in 2009, but it was delayed due to change in NACA leadership, as well as the WB Board approval of MAP 2.
- 6.5 The ex NACA DG is now the Federal Health Minister and has expressed support to the finalisation of the JFA, saying that the lessons learnt will inform better coordination in the health sector. This was of course, not a planned success of the JFA, but it is an important element that helps to guarantee the continuity of the leadership and political commitment from the Government of Nigeria.
- 6.6 It is obviously still not possible to assess the outcomes of the JFA with respect to its ultimate objectives. One of the key challenges will be for NACA to demonstrate that the JFA actually reduces transaction costs. Experiences from other countries show that this might not happen immediately. However, the JFA provides a framework for enhancing NACA's administrative capacity and coordination function, and is expected to allow for a stronger RBM of the national response. The outcomes should be later evaluated on those results and on the further buy-in of other Development Partners and well as of increased financial contribution from the Federal Government of Nigeria.
- 6.7 One of the objectives under the NAPP is to reinforce the NACA oversight, coordination and M&E for the sector. In the long term it should enable NACA to better track the sector outcomes. Clear linkages between outcomes to the JFA agreement are likely to be difficult to demonstrate.

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## 7. Conclusions and Lessons

- 7.1 The JFA experience highlights that influencing efforts can have a high risk of failure and some uncertainty about the likely benefits. In Nigeria there was no experience of joint funding and harmonised approaches to HIV and AIDS which made it difficult to predict whether Government would endorse the approach. It was also hard to know how many donors would engage and to determine the likely level of transaction cost savings or to measure other potential benefits including increased predictability and flexibility of financial flows. This experience suggests that a detailed Cost Effectiveness Analysis may not always be possible but there is still scope for a more basic approach – for example, to determine whether the costs of influencing are likely to be small in relation to the level of resources affected or to the perceived benefits in terms of reduced transaction costs or budgetary predictability.
- 7.2 Outcomes will remain difficult to measure in the future, but key outputs have also still to be delivered. Although there are good reasons to think that the JFA will be signed by the end of 2009, it is still not effectively the case.
- 7.3 In terms of process, the way towards the JFA has many characteristics of a success story. A number of **success factors** were identified by the interviewed stakeholders:
- A strong NACA leader: The ex NACA DG leadership has played a key role in making the vision clear and in driving the process. His strong leadership is acknowledged by all stakeholders interviewed.
  - DFID long standing commitment to support NACA: DFID positioned itself as a strategic partner for NACA long before the JFA process. The support to NACA institutional funding and capacity building (e.g. staff costs) was referred to as a binding element between NACA and DFID, opening channels for DFID to influence NACA.
  - Support from DFID to two key processes: the 2005 NACA reengineering study and the facilitation process to design the JFA (2007–2008). The quality of the consultant, as well as the appropriateness of the facilitation approach was highlighted as key by all stakeholders consulted. The ability for DFID to support these processes as well as NACA’s capacity with grant funding was seen as important.
  - Highly qualified DFID Advisors: they formed a strong collaborative partnership to drive the process forward on behalf of development partners. Both managing large HIV portfolios for their respective organisations, the partnership represented a critical mass of like minded partners. Both were experienced with well developed harmonisation and alignment processes from Malawi. Both had worked for the World Bank previously and were therefore knowledgeable of its systems, processes and corporate values, and both held DFID corporate priority of aid effectiveness personally. The World Bank also reported the consistently high quality of DFID staff seconded as HIV/AIDS advisors.

- 7.4 A number of lessons can be drawn from this case study:
- 7.5 This case study is a good example of a **strategic approach to influencing**:
- (i) It was part of a corporate agenda in support of Aid effectiveness, and seen as a step towards a longer term NACA capacity building process.
  - (ii) It built a positive relationship of trust with a national champion (ex DG), and supported him with technical advice to lead the process.
  - (iii) It was linked to significant investments in building the capacity of the institution to be influenced.
  - (iv) It was started with a small group of likeminded partners to show its effectiveness and therefore encouraged the involvement of others through DPG.
  - (v) It was relatively low cost compared to the NAPP forecast, but with enough funding to make the process effective.
  - (vi) It used a simple Logframe, with targeted and realistic objectives.
- 7.6 The **role of DFID health advisors** has been crucial in this story. Both understanding of the context and experience of a similar process in earlier assignments have been critical to their success in their roles.
- 7.7 The **partnership between the WB and DFID** has been critical too. Such JFA processes took longer in other contexts, and the fact that there was a very cohesive group of like-minded donors behind the JFA process certainly made it easier. The DFID advisors seconded to the WB have been instrumental in this, but also important was the long standing strategic partnership between the two organisations in Nigeria.

**People interviewed: Names removed.**

**Source documents**

- 1) Report to DFID on the project to improve the institutional and organisational functioning of NACA, CRISP, 2004.
- 2) Domestication of the Global Task Team Recommendations in Nigeria, 2005.
- 3) HIV/AIDS National Strategic Framework for Action (2005-2009), 2005.
- 4) Discussion Paper Development Partners Collaborative Mechanism (pooled funding): National Response to HIV/AIDS, 2007.
- 5) Design of a Framework for a Joint Financing Agreement (JFA) for the NATIONAL AGENCY for the CONTROL of AIDS (NACA), by Peter Watson 2007.
- 6) Joint Financing Arrangement between the National Agency for the Control of Aids, its Funding Partners and the Federal Government of Nigeria represented by the Ministry of Finance, 2009.
- 7) Joint Financing Agreement Update, Presentation to the Incoming DG, NACA, undated, 2009.
- 8) Terms of Reference of for the JFA section of the NACA Board study tour, The JFA Task Team, August 2008.
- 9) Approved Round 5 Workplan NACA-1, 2008.

## D: Mozambique Case Study

### 1. Context

- 1.1 Mozambique faces a health workforce crisis (only 1.26 health workers per 1000 population); among the bottom 5 ratios in the world. Only two thirds of the population is covered by health services. Less than half of all births are attended by skilled health workers. The Human Resources for Health (HRH) shortage is considered as the single greatest barrier to further MDG progress in Mozambique and it has been a priority of the Government of Mozambique (GoM) at least since 2005 when the issue was taken up by the Ministry of Health (MoH). Internationally the issue has received a great deal of attention. In response to the critical HRH shortages DFID and the Officer of the US Global Aids Coordinator (OGAC) have been working with various African countries to develop strategies and country level actions. Gordon Brown and President Bush have made joint announcements on the issue during 2008 –and HRH shortages were a key component of the UN high Level Event on the MDGs in September 2008.
- 1.2 In Mozambique, donors play an important role. Over 50% of the overall budget is funded by International Aid. On health, Mozambique is at the forefront in terms of alignment and harmonisation practices and has had a Sector Wide Approach (SWAp) since 2000. Before 1998, the sector was highly fragmented with donors providing aid on a project by project basis. Between 1998 and 2008 a number of common funds were set up and this pooled funding has increasingly become the preferred approach. During this period, three common funds for the health sector were in place.
- 1.3 In 2008, Sector Budget Support (SBS) for PROSAUDE II (that followed PROSAUDE I, one of the old common funds) became the only joint funding mechanism to the sector.
- 1.4 In this context, dialogue between development partners and the GoM is facilitated by a strong coordination structure operating at three levels:
  - i) The Sector Co-ordination Committee (SCC): It meets twice a year and is chaired by the Health Minister.
  - ii) The Joint Co-ordination Committee (CCC): It meets 8 times per year and is chaired by the Permanent Secretary of the MoH. Development Partners are represented by the Health Focal Point (and two vice focal points –one of them being the former focal point). DFID is the current focal point; the EC held the post before DFID. Focal point partners must wear ‘two hats’: that of their organization but also that of the development partners’ group.
  - iii) Working groups: They were established under the SWAp with terms of reference approved by the CCC. There are 10 working groups and one of them is the Human Resources working group (set up in 2005). Partners can chose to be members of various working groups depending on their interests, expertise and commitments.

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- 1.5 It is within the context of the Human Resources working group that the MoH took the decision to develop a National HRH Plan. The new completed plan was launched in September/October 2008 and aims to increase the ratio of health workers per 1000 population to 1.87 by 2015. It is expected that another decade will be necessary for Mozambique to achieve the ratio of 2.3 per 1000.<sup>12</sup>
  - 1.6 This case study describes the nationally led Human Resources for Health policy process that culminated with the development and launch of the National Human Resources for Health Plan. The International Health Partnership (IHP) process came into the picture in 2007 at the time when DFID's commitment for the human resources issue in Mozambique grew. This process links a national policy process with an international one.
  - 1.7 We have focused on the HRH process rather than the IHP one because it appears that the latter was used to improve the outcome of the former. Also, the HRH policy process provides an excellent opportunity to observe DFID's role in relation to that of many more development actors than in the IHP case. Finally, the HRH policy process also highlights the crucial role that formal collaboration spaces (among development partners and governments) play.

## **2. Influencing Strategy and Objectives**

### **The Human Resources for Health policy process**

- 2.1 DFID Mozambique had an explicit influencing objective and a focus on addressing the HRH gap: Programmes such as PROSANTE I and II, that DFID supported under the SWAp and common funding, included objectives to address the issue in a flexible way. However, no formal or systematically planned influencing programme or strategy was developed.
- 2.2 The explicit nature of DFID's influencing objectives is best illustrated by the recruitment of a human development advisor with appropriate skills for working on human resources and salary reform.
- 2.3 DFID also expected that promoting dialogue and funding the right studies would help the MoH to make case to the Ministry of Finance (MoF) for reviewing public sector salaries and increasing the health workforce. The HRH Plan and the GoM's support could also mobilise additional funds.<sup>13</sup>

### **The International Health Partnership process**

- 2.4 Along the way a new opportunity aroused. The IHP process offered a mechanism to encourage non-aligned donor partners (still providing vertical funding –namely the GFATM and the United States Government (USG) institutions including PEPFAR) to engage more directly with pooled funding and SBS and to contribute more resources. DFID also considered that this process could accelerate improvements in the health sector. Critical to this approach was the strong link between the country programme and DFID HQ.

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<sup>12</sup> Ministry of Health, 2008

<sup>13</sup> Interview

Policy process	Level	Objectives	Strategy
Human Resources for Health	National	A National Plan developed; Financed; and Implemented	A focus on evidence based support for the development of the National HRH Plan; and  Active encouragement to the research and development process within the working group and in direct collaboration with the MoH
International Health Partnership	International	A Compact that brings development partners and the GoM together;  High level support for the National HRH Plan; and  Additional funds to implement it	Active and direct negotiation with development partners in Mozambique to sign the Compact;  Coordination with the IHP process and DFID HQ for: high international profile for the HRH Strategy, lobbying of development partners in their capitals; and  Direct support to the GoM in its interaction with the international policy space including its presentation at the UN Summit in 2008

### 3. Design and Implementation of Influencing Effort

- 3.1 We must differentiate between two policy processes and DFID's strategies to influence them: the HRH policy process and the IHP policy process.
- 3.2 DFID did not develop a logframe for the influencing effort around the HRH policy process other than the original PROSAUDE logframe, which included an HR element. However, DFID did identify specific influencing objectives for various key policy actors like the USG/PEPFAR, GFATM, GAVI and The World Bank, as well as setting, along the way, the objective of leveraging additional funding from other actors as the IHP planning documents document.
- 3.3 This stakeholder or audience mapping was included in the IHP process planning.<sup>14</sup> The IHP bid indicates agency specific behaviour changes as well as the expected impact of those changes.
- 3.4 It is therefore important to note that the investments made in 'influencing' the HRH policy process were not all considered directly as influencing at the time - Mozambique needed an HRH strategy, and DFID and DANIDA decided paid for it.<sup>15</sup> Even if that increased their capacity to influence, the primary purpose was providing the necessary input to support the process, rather than to influence a process.

<sup>14</sup> DFID Internal Process for Accessing IHP catalytic funding: Mozambique, no date

<sup>15</sup> Email

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- 3.5 The IHP process, on the other hand, has been more about influencing other agencies such as GFATM and PEPFAR to respond in a more aligned way to nationally defined needs.
  - 3.6 The IHP was also an internationally led strategy. Whereas in the case of the HRH process DFID did not have to submit a strategy for approval, in the IHP process this was the case. To take advantage of the IHP, DFID Mozambique had to put together a formal strategy. In it, it made its influencing objectives explicit and formal
  - 3.7 Both initiatives were underpinned by DFID's intention of supporting an accelerated progress towards the MDGs with additional funds to the health sector. Unless there is a well functioning system, and the HRH plan is a key component of this, increased funding would be difficult to attract.<sup>16</sup>
  - 3.8 In the next section, both processes are further developed.

#### **4. Role of DFID in Policy Change**

- 4.1 The Human Resources working group included the main Health Partners like DFID, The World Bank, WHO, CIDA, USG, the Clinton Foundation, Irish Aid, GTZ and the GoM. The working group was chaired by the MoH and co-chaired by one of the development partners (first DANIDA, then the Clinton Foundation and now the WHO).
- 4.2 Originally, there was little interest for the working group but this grew over time.<sup>17</sup> The working group constitutes an important turning point in the way that development partners interacted with the GoM. Before the working group, it was expected that the GoM would coordinate its interactions with the various development partners. After it was set up, the responsibility to coordinate collaboration and policies on HRH fell on the working group itself.<sup>18</sup>
- 4.3 When the group was set up, there was draft HRH plan on the table waiting for approval. However, a change in government meant that the draft plan was never picked up. The GoM decided to abandon it and focus on the development of a new, more ambitious, plan (one of the main criticisms of the old draft was that it did not consider the health MDGs).<sup>19</sup>
- 4.4 DANIDA took the lead within the Human Resources working group and, with the MoH, developed the terms of reference for the development of the new plan. The background studies and the consultation that ensued were led by the Lisbon School of Tropical Medicine and with technical support from the WHO in Geneva. This was co-funded by DANIDA and DFID.
- 4.5 Here, DFID and the WHO in Geneva were able to collaborate. As a former board member of the Global Health Workforce Alliance and having worked in the EC, DFID's health advisor, Neil Squires, knew Mario Dal Poz and Norbert Dreesch, two WHO HQ staff charged with supporting the HRH plan

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<sup>16</sup> Email

<sup>17</sup> Interview

<sup>18</sup> Various interviewees

<sup>19</sup> Interviews

- development. This allowed DFID to collaborate with them. This engagement with the WHO and the strategy development process also included meeting the team at the Lisbon School of Tropical Medicine in August 2007.<sup>20</sup>
- 4.6 The developing process for the plan started in late 2007, after a long negotiation with the Institute, and culminated in September 2008 with the launch of the National HRH Plan at the UN Summit in New York.
  - 4.7 The process faced a number of problems.<sup>21</sup> First of all, the government treated the School as a consultancy and expected its team to deliver a complete plan; they, on the other hand, had negotiated a supporting role to the ministry's leadership. Additionally, the government resisted a broader consultation (including district managers). DFID played a key role in persuading the GoM to respond, take the lead and agree to broader consultation (even if this was not carried out to everyone's satisfaction). According to the Lisbon School of Tropical Medicine DFID behaved not just as a funder but as a technically expert partner. In the DFID health advisor, the School's team found someone who could contribute to their work.
  - 4.8 DFID also paid for a consultancy for the MoH to do the costing of the plan. This was intended to be the basis of a resource mobilisation exercise, both in terms of arguing for more funds to address healthcare shortages with Ministry of Finance, but also in terms of mobilising external funding.
  - 4.9 A validation of the costing of the plan was also funded by DFID (using the Resource Requirement Tool (RRT) developed by the WHO) as it was necessary for its inclusion in the Round 9 application for the GFATM.
  - 4.10 The overall process was facilitated by the Director of Human Resources at the MoH as chair of the Human Resources working group; but, according to some development partners involved in the working group, DFID's health advisor, who at the time was also the Focal Point for Health in the SCC, was another key figure in the process. He was able to help build and maintain the momentum. When other development partners insisted on focusing on changes in the GoM's processes and protocols, DFID searched for more practical solutions.<sup>22</sup> Some described him as a broker and a diplomatic operator who was able to advance the interests of all parties rather than only DFID's –as was expected of the Health Focal Point.
  - 4.11 It appears that due to the active role played by DFID and the good relationship that the health advisor was able to nurture with the MoH, the ministry eventually assumed the lead in the process once the plan had been completed.
  - 4.12 However, it is worth noting that it has also been suggested that the real 'star of the process' was the working group itself.<sup>23</sup> DFID may have played a leading role within the working group, but others played equally important parts. After all,

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<sup>20</sup> Email

<sup>21</sup> Interview

<sup>22</sup> The USG interviewees used a phrase to describe what DFID had been able to recognize: 'this dog won't hunt'. DFID recognized that the changes that many donors wanted to improve the Government's implementation of policies were not possible; instead DFID looked for changes that would more easily adopted.

<sup>23</sup> Interviews

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the working group had been operational on the HRH issue before DFID took it on as a policy priority.

- 4.13 This view also reflects the opinion of Dr. Mussa who saw DFID as a supporter of the GoM's own agency within the group.
- 4.14 The development of the plan coincided with the launch of the high level International Health Partnership in 2007 in London. DFID saw the IHP process as an opportunity to leverage additional funds from the international community as well as to increase the alignment between development partners that was necessary to see the National HRH Plan approved and implemented at the national level (various planning documents and interview and emails from Neil Squires).
- 4.15 A few of our interviewees have argued that DFID's support and facilitation of the process was in part motivated by the IHP process' own demands and timeframes. In other words, the research and consultation undertaken by the Lisbon School of Tropical Medicine might have been rushed to coincide with the IHP process and the New York event (see below).
- 4.16 Under the IHP process, DFID promoted the signing of a Compact between the GoM and all development partners in Mozambique. Initially, not all development partners were positive about this, according to our interviewees. Some, like the USG, 'simply do not sign anything'. Others like the EC and the WHO considered that the SWAp and the pooled funding that already existed were sufficient. However, DFID, and in particular its health advisor, 'wouldn't give up'. He negotiated with each development partner to ensure that the Compact would be acceptable to all of them.
- 4.17 Not all those involved see the IHP process and the Compact as value for money. As mentioned before, some development partners did not see any benefit, or added value, in signing the Compact; others considered that the interests behind the IHP (as other global processes) were political (driven by George Bush' and Gordon Brown's own global agendas); and others remained confused and felt disenfranchised by the process (some may have felt that the legitimate role of the working group was being challenged).
- 4.18 So, in the end, not all development partners signed the Compact. While they were all supportive of its principles (based on the Paris Declaration principles), only those who had already committed to the SWAp and pooled funding were able to sign. Others like the USG, the UN agencies, GAVI and the GFATM, only submitted letters of support to the principles of the compact and promised further coordination. They did not commit to any concrete actions.
- 4.19 Another opportunity to mobilize the resources that the very ambitious National HRH Plan required appeared in 2008. DFID approached Dr. Mussa (Director of Human Resources and Chair of the HRH working group) at the MoH with the intention of mobilising the GoM to raise the profile of the National HRH Plan at the UN's High Level Summit on the MDGs in New York, in September 2008. The event could serve as the perfect opportunity to launch the Plan, attempt to mobilise funds from the international community, and position Mozambique as a global leader on HRH.

- 4.20 Participation in the New York Summit was part of a call from Number 10 to identify possible opportunities of high profile successes.<sup>24</sup> If the National HRH Plan was presented in New York and the necessary funds were mobilised through international lobbying then this would constitute a clear success.
- 4.21 In Mozambique DFID worked directly with Dr. Mussa, with inputs from the Lisbon School of Tropical Medicine, to prepare the relevant documentation and presentations for the GoM to take to New York. PEPFAR paid for the production of many of the materials used through a local contractor and supported the participation of the GoM at the event.<sup>25</sup> This collaboration reflects both a close relationship between both development partners in Mozambique as well as globally.
- 4.22 Without this support, the government would have made a much lower-key presentation as it did not see the event as a priority or as an opportunity to engage the international community on the issue of HRH. DFID's and USG's efforts persuaded the President to personally engage in the process and be more vocal on health issues.
- 4.23 Upon their return from New York, the National Plan was launched in Mozambique in October 2008.
- 4.24 Globally, DFID lobbied, unsuccessfully, for more funds in the capitals of the various development partners in Mozambique as well as at the UN event.

## **5. Outputs and Outcomes**

- 5.1 The National HRH Plan provided 'the highest quality plan' that the MoH has developed, and one that all development partners are ready to back up.<sup>26</sup> The plan identifies three key strategic targets and indicates a clear schedule of activities to achieve them. This places the GoM in a much better position to mobilise the necessary funds and begin to implement the solutions for a problem the whole development community in Mozambique has identified as both urgent and critical.
- 5.2 Similarly, it offers the basis for new financing decisions of 'non-aligned' development partners like the USG; that has started considering how to better support the strengthening of HRH systems as called for by the National HRH Plan.
- 5.3 We must note, however, that some interviewees have mentioned that the plan was rushed through and that in some instances, there were certain doubts about the quality of the data. We have no further evidence of this. It has also been suggested that the process may have been accelerated to take advantage of the IHP process.<sup>27</sup>

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<sup>24</sup> Interview

<sup>25</sup> Interview

<sup>26</sup> Interview

<sup>27</sup> Various interviewees.

- 5.4 Some additional funds have been made available for the GoM to implement the National Plan; albeit, not at the level expected or desired by DFID and the GoM in the run up to the UN Summit:
- DFID has increased its funding for health systems as a result of the IHP process, and extended the time frame of funding to give longer term predictable funding. Financing to the health sector common fund has increased from £17m for 2007–2011, to £38m for 2007 - 2013.
  - The USG has not made more funds available but it has shifted the focus of its US\$220 million per year fund to address health systems –even infrastructure. Indirectly, the process provided an opportunity for the USG to become more aware of the need for a more aligned and harmonised way of working. Its interaction within the working group and other private discussions with DFID on the IHP process, for example, has led to better coordination and alignment between the two. At the time that this engagement was underway, PEPFAR was in the process of launching its 2009 Country Assistance Plan (CAP) and so was unable to incorporate many of the lessons drawn from the process. However, the planning process for the 2010 CAP is incorporating these issues and the USG is discussing them with the GoM; and PEPFAR, in particular, has positioned itself more closely to other development partners.<sup>28</sup>
  - The GFATM, a key policy audience for DFID’s and the GoM’s efforts, has not awarded new funding yet; although 8 projects totaling US\$31 million that focus on systems strengthening have been approved under Round 8. The recent application to Round 9 greatly draws from the plan and, if successful, it should deliver US\$80 million that would be aligned to it. However, it is yet not certain that the Round 9 application will be successful –and among the people interviewed there are conflicting opinions. If it is, it could be argued that the National HRH Plan and the Compact could make up for the shortcoming in past performance and the lack of a National HIV/AIDS strategy.
  - The Belgian cooperation has announced US\$8 million over the next 3 years, the Italian government has earmarked €2 million for supporting training institutions, and DANIDA is funding 3 technical advisors to help implement the plan.<sup>29</sup>
  - The Netherlands are considering an additional €5 million for 2010 and 2011 to fund the implementation of the National HRH Plan.<sup>30</sup>
- 5.5 In any case, a recent review of existing funds carried out by the Clinton Foundation has shown that there are sufficient funds for the next two years. If salaries, incentives, and expatriate doctors are excluded, the aggregate partner support is \$47.7 million (this exceeds the indicated need for 2009 (\$36.6 million). This view is shared by the MoH. The analysis has also provided a clearer map of the resources that are available and how they are being spent. The representatives from both the GoM and development partners expressed that this mapping exercise was extremely useful to promote coordination.

<sup>28</sup> Garrido, PI, I. Lewis, J. Campbell and N. Squires (2009)

<sup>29</sup> Interviews .

<sup>30</sup> Email

- 5.6 In the process, DFID also learned how to better engage with the USG. For example, it became clearer to DFID that their development partners could only develop annually plans and were, therefore, unable to make commitments beyond that timeframe: pooled funding is out of the question.
- 5.7 Some have suggested that the failure to attract more funds for the plan constitutes an important setback and that the GoM felt let down by the development partners that egged it to join the IHP and invest in raising the profile of its National HRH Plan. A certain degree of disaffection with the IHP process exists; and this is illustrated by the recent decision by the GoM to miss the annual IHP meeting Mali in June 2009. Whether there was a boycott of the event or it found it difficult to mobilize on time, it certainly suggests that the process is not at the top of the government's agenda.
- 5.8 Interviewees agree that some disappointment was expressed in the beginning, when it became clear that the efforts to present the plan in New York had not delivered as soon as it was expected. Nonetheless, the GoM understands that this is a long term process and that the implementation of the strategy (which includes securing the necessary funding) has just started.<sup>31</sup>
- 5.9 Some development partners do feel that the effort invested in following the IHP and signing the Compact in particular do not represent good value for money. And the process was perceived by some as being politically led (rather than driven by DFID's proven and trusted technical expertise) and unclear (even though their national governments and HQs had signed up to the IHP at the global level). It is possible that DFID assumed that their development partners had been informed of their capital's commitment to the IHP. Uninformed and unable to make decisions in the same way that the more decentralized DFID structure allows country teams, other development partners felt that sometimes DFID came across too hard on them.
- 5.10 More consultation could have helped to address this resistance and work for a more robust consensus, because, in the end, those who at the beginning of the process had not joined pooled funding did not sign the Compact either. DFID wanted GFATM to send a very supporting letter but they submitted a rather more neutral version. However, GFATM did recognise the changes that DFID and GoM had been looking for –and these needs have been reiterated by DFID and the Minister of Health.<sup>32</sup>
- 5.11 Our assessment of the influencing outcomes of this policy process suggests the following:
- The National HRH Plan was effectively developed and it is supported by all donors and the GoM. It could have been more inclusive and taken longer to satisfy various dissenting voices but overall this is not considered to be an important issue.
  - The IHP process and the signing of the compact had positive consequences that have not been communicated to all development partners (e.g. better working relations with the USG) but the process itself, the asymmetry of information between DFID's and others in relation to their responsibilities

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<sup>31</sup> Interviews

<sup>32</sup> Emails, Suggested Text for Global Fund Letter on the Mozambique Health Compact, and Bland and Robinson 2008

towards the IHP, and even DFID's influencing style, could have created a certain degree of resistance among development partners. Crucially, it has not yet delivered significant additional resources, with much depending upon the implementation of recommendations made by the innovative financing task force, which was launched at the UN MDG call to action, and will result in concrete recommendations being made to the G8. Therefore, the final judgement on whether the IHP process has positioned Mozambique to tap into any additional resources cannot yet be made.

- The participation of the GoM in the UN Summit in New York did not deliver the expected outcome of further resource mobilization. However, the process launched in New York is still running. If additional resources are not mobilised, then arguably, the efforts put into mobilising Mozambique for the UN summit could be considered to have been a step too far in the process that could have had negative consequences regarding DFID's image among the GoM and its development partners.

5.12 Finally, with the costed National HRH Plan and the Compact, the development community in Mozambique finds itself with a clearer plan and commitment than it had before.

## 6. Costs and Cost Effectiveness

- 6.1 To address the cost effectiveness of the intervention we considered the cost of the influencing effort in light of the policy outcomes achieved.
- 6.2 Overall costs between 2005-2009 of the process are (for detail see Annex 3):
- Staff: £137,000 –the main staff costs are those associated with the Senior Health Advisor (20% of his time in this process); and this was complemented by 5% of the time of an HIV/AIDS advisor.
  - Other resources: £17,568,430 (and only 168,430 for research, technical support and meetings; excluding Financial Aid directly associated with the influencing effort)
- 6.3 Staff and research resources constitute 1.7% of DFID's Financial Aid associated to the influencing effort.
- 6.4 There is consensus that the studies and the support provided were of high quality and that the 'best people for the job' were chosen. DFID and other development partners found the right balance between the need to provide rapid responses and the quality of the work.
- 6.5 None of the people interviewed could suggest any alternative strategies that would have been more effective in achieving the development of the HRH plan. Even with the benefit of hindsight, the HRH policy process is deemed to have developed as well as it could have been.
- 6.6 In the case of the IHP process and the Compact that is considered by some as not cost effective we would argue that, according to the USG, the engagement at the heart of the process did lead to a better and closer collaboration between non-alignment development partners and the government. This, however, is an

outcome that has remained private – so other development partners are not fully aware of this outcome. We consider that this new relationship is a good value for money outcome of the influencing effort.

- 6.7 On the issue of the New York Summit, there seems to be a consensus among the non-DFID interviewees that at best it was unfortunate and at worst it was damaging DFID's relationship with the government and with its development partners. Arguably, DFID Mozambique took a chance. But this might have backfired; unless, DFID can show that it is committed to continue supporting the process and, as argued by two of our interviewees, accepts part of the responsibility of what happened.
- 6.8 When asked to estimate the relative contribution that DFID made to the HRH process (to develop the National Plan), some interviewees offered the following verdicts:

Stakeholder	Score	Rationale	Without DFID Support
Donor 3	<b>No rating</b>	All donors and the GoM played the role they had in the SWAp coordination structure. DFID was able to play a leading role but it was supported by the smaller contributions that others made.	
Consultants	<b>No rating</b>		Without DFID the HRH process would have been slower and the government would not have taken the lead (eventually)
Donor 1	<b>5-7</b>	DFID carried out the financial costing of the National HRH Plan, it was able to mobilize qualified expertise at short notice, and was able to mobilize its alliance with the USG both globally as well as nationally. This was very useful in persuading the USG to provide more support through the MoH other than through vertical funds. However, without the health partners group and the working group there would have been no process for DFID to engage in or a new plan.	
Government 1	<b>6-8</b>	DFID played a key role in designing the compact and within the human resources working group, it pushed to get more out of all players and it was a very close partner of the MoH. As a partner, DFID's approach was to offer the GoM the necessary resources and options to make the best possible choices. The technical assistance that they provided was cost effective and the best available.	
Donor 2	<b>6-8</b>	DFID has been decisive for some of the key steps of the change process. DFID, and Neil Squires in particular, has been the most visible donor. Neil Squires was able to separate DFID's interests from those of the government and of other donors because he understood the politics of the process and knew how to deal with a complex challenge.	
Donor 4	<b>9-10</b>	In particular because DFID drove the National HRH Plan process and the successful negotiation of the compact	

- 6.9 In conclusion, DFID is considered, by those who offered an assessment, as a key driver of change in this process –but not the only one. And its success was highly dependent on existing collaborative mechanisms.
- 6.10 On the IHP process, on the other hand, there is consensus that DFID was the leading development partner. One interviewee with close links to the GoM offered a 10 rating (even though the outcome of the IHP process was not equally highly valued).

## 7. Conclusions and Lessons

- 7.1 In our view DFID’s influencing efforts represent good value for money.

Influencing effort	DFID associated spend	Total Pledged (government and donors)	Total additional funds raised by influencing effort
£305, 420	£38 million	£396 million (approximately)	£194 million (including £147 million from the USG that have been better aligned)
£305,420 (2007 to 2009)	£38 million (2007-2011)	If salaries and incentives are not considered the aggregate partner support is \$47.7 million –this exceeds the indicated need for 2009 (\$36.6 million).  Financing gap for the HRH Plan is still US\$594.5 million over the next 7 years	£21 million (DFID from 2011 to 2013)  US\$ 220 million better aligned to support health systems.147  US\$31 million for 8 GFATM projects in the current round. 21  US\$8 million (Belgium for 2009-2012). 3.5  €2 million (Italy for training institutions) 1.6  TA support for the MoH (DANIDA 2009-2012)
		The anticipated total expenditure on human resources for health would increase from 129.5 million USD in 2008 to 158 million USD in 2009, 175 million USD in 2010, 209 million USD in 2011, 242 million USD in 2012, 273 million USD in 2013, 310 million USD in 2014 and 350 million USD in 2015.	<b>Possible:</b> The Netherlands are considering an additional €5 million for 2010 and 2011 to fund the implementation of the National HRH Plan.  Round 9 of the GFATM includes US\$80 million that would be aligned to the RH Plan.

			Additionally, Mozambique's participation in the IHP process and the UN Summit could support the mobilization of additional funds for Health Systems global –to up to US\$1 billion.
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7.2 There are a number of conclusions that can be drawn from this case study:

- 1) DFID did not initially consider the HRH policy process as an influencing project. However, it is clear that along the way, DFID invested significantly in driving it forward.
- 2) DFID was able to join an existing policy process and contribute to it because there was a working collaborative structure (the working group). In fact, when DFID says that it responded to a request from the GoM it is important to highlight that that request was articulated through the working group. The importance of the working group and, hence of its members, must not be underestimated.
- 3) DFID was not the only actor with a policy agenda.
- 4) DFID was not just influencing a policy outcome on HRH but also the policy positions and behaviours of other development partners. It was also influencing the relationship between DFID and them, as well as between development partners and the GoM. There are, therefore, multiple influencing objectives.
- 5) This particular policy process was heavily influenced by research based evidence –for which there was a strong demand. Evidence helped to set the agenda, define the problem, identify policy options and is now helping to implement the National HRH Plan.
- 6) The GoM was a key agent of the process. Both development partners and the GoM were working towards the same goals. However, when the MoH did not take the lead the process slowed down.
- 7) Through the working group, the main policy actors were able to design a policy process with clear entry points for all development partners to engage with. This reduced transaction costs for both partners and the GoM.
- 8) Even though this was a nationally driven process, international processes played an important role and might have had negative consequences for the terms of the national process.
- 9) DFID benefited from an experienced and well connected health advisor but mostly from its ability to allow the advisor to be responsive to the changing policy environment.
- 10) A number of unexpected and unintended outcomes have emerged: some positive (like the improved relationship with the USG), others negative (like the apparently tense relation between DFID and other development partners).

A number of lessons may be drawn from this case study:

***The role of the working group and national policy actors***

- 7.3 The technical working group emerges as the most important policy space in this story of change. While DFID's role was critical in driving the process forward, and this was greatly aided by its strategic and flexible approach, the technical working group offered a sustainable (and consistent) reference point for all development partners and the GoM. It provided a space for debate, reviewing progress and providing technical inputs into the research and planning process.
- 7.4 The working group also highlights the role played by the GoM. In policy influencing initiatives it is important that donors do not forget that no matter how influential they are, they are never as influential as the national government and those legitimately charged with policy making and implementation.

***The role of the health advisor***

- 7.5 All the interviewees have described the role of DFID's health advisor as crucial. He has been described as a broker of deal, a facilitator, a smooth operator able to relate to all development partners and the government. He has also been described by the GoM as a true partner; a personal friend. He led a process, even when he was not officially in charge, by being proactive, dynamic and responsive.
- 7.6 The value of his contribution to the process can be best illustrated a comment from Dr. Mussa from the MoH who, when asked whether DFID's Funds were more important than the role of its staff in 'influencing change': 'when someone like to help you [like he does] this can compensate for no funding'.
- 7.7 In future initiative, health advisors must be supported so that they are able to 1) develop context specific strategies and 2) drive the process in the interest of development outcomes. Political interests, that may affect DFID HQ decisions, should not intercede in national level policy process –in particular when DFID takes on responsibilities on behalf of other development partners.

***The role of evidence and expertise***

- 7.8 DFID contributed to the process by funding highly relevant research and expertise. Without it, it has to be said, maybe of the milestones of the process would not have been possible to achieve. However, the interviewees have painted a picture in which DFID's contribution complimented the work of others in the technical working group. DFID was able to take the lead partly because it had more flexible resources, a better understanding of the process and what were the necessary inputs, strong links to its headquarters and therefore a better global perspective, among other things.
- 7.9 In any case, the process was highly dependent on the quality of the evidence produced. Development partners funded research that helped design the plan, cost it and validate it. This research fed directly into the plans but also provided evidence that was used by the GoM in for the launch of their strategy at the UN Summit in September 2008. President Armando Guebuza quoted the findings of the studies in his speech.

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- 7.10 Research undertaken by others has also been important. The mapping exercise carried out by the Clinton Foundation, for example, has helped development partners, and in particular the USG, focus their own strategies.
- 7.11 In this sense, it is important to consider the added value that DFID's contributions had on the activities of the working group and its other members. Arguably, without the working group DFID might not have been able to identify the right entry points and its contributions might not have been sufficient.

***The unintended consequences of engaging globally***

- 7.12 A possible downside of the process is the suggestion that some development partners might have felt confused about why the IHP was relevant to their work at the national level, the way that the Compact was negotiated, and the funding expectations that were raised around the IHP process and the New York meeting.
- 7.13 Some have argued that the IHP and the Compact represent a waste of resources that could have been used to focus on improving the GoM's capacity to implement the plan with the existing resources (which, according to the Clinton Foundation's mapping, are sufficient to begin with).
- 7.14 In fact, it is important that global policy processes and their operators take into account the consequences that their demands for inputs and participation have on national policy processes and their policy actors.

***When does the story end?***

- 7.15 If the case study had been reviewed in early 2009, the significance of the failure to mobilize new funds after the New York Summit may not have been even considered. A few months later and still short of funds, this issue has become more significant. In a few months, however, it is possible that new funds will become available and that DFID's contribution to the process will be seen as a success –even by its current critics.
- 7.16 It is important that we be careful about the effect that deciding on the 'cut-off' date for an evaluation will have on the perceived cost-effectiveness of an influencing strategy. Change is a complex and long term process; there is an inherent danger in measuring the value for money of strategies that may still need years to mature.

## Annexes D

### Annex D\_1: People interviewed or consulted: Names removed.

### Annex D\_2: Source documents

Bland, S. And A. Robinson, (2008) *Global Fund Mozambique Discussion*

Campbell, J. and B. Stilwell (2008) Mozambique: Taking forward action on Human Resources for Health (HRH) with DFID/OGAC and other partners Final Report 30 May 2008

DFID (un-authored), Briefing Note: the International Health Partnership: Preparation for Lusaka (provided by Neil Squires)

DFID (un-authored), DFID Internal Process for Accessing IHP catalytic funding: Mozambique (provided by Neil Squires)

Garrido, PI, I. Lewis, J. Campbell and N. Squires (2009) Taking Forward Action on Human Resources for Health: Positive Synergies in Mozambique, Manuscript for the WHO Bulletin

Global Health Workforce Alliance and Results for Development Institute (2008) Resource Requirements for Human Resources for Health in Mozambique, Report for DFID DRAFT

GWha FTF Secretariat (2008) Human Resources for Health Resource Requirement Tool, Global Health Workforce Alliance and Results for Development Institute

Ministry of Health (2008) Addressing the Health Workforce Crisis in Mozambique: A call for Support

National Directorate of Human Resources, (2008) National Plan for Health Human Resources Development: Sufficient and Competent Health Workers for Expanded and Improved Health Services for the Mozambican People Ministry of Health, Maputo

PEPFAR Support in Human Resources (provided by Neil Squires)

Proposta de Modelo: Compacto de Moçambique, Compromisso de Intenções

Sixpence, J. (2008) ODM's podem ser atingidos se cada um cumprir suas promesas, Domingo, 28 setembro

Squires, N Suggested Text for Global Fund Letter on the Mozambique Health Compact (provided by Neil Squires)

Squires, N. (19 December 2008) Increasing DFID PROSAUDE funding from the original commitment of £16.4m for the period 2007-2011, to £38.4m to reflect DFID's IHP commitments, Memo to Jane Rintoul, Policy Forum, HD Team

Squires, N. (no date) PEPFAR does and GFATM needs to Support HRH in Mozambique Power Point Presentation

Visser-Valfrey, M. and M. Bibi Umarji (forthcoming) Sector Budget Support in Practice: Case Study Health Sector in Mozambique Overseas Development Institute Draft

## Annex D\_3: Table of influencing costs

Table A DFID Staff time used on Influencing Programme: Mozambique

Staff Resources	% of time of post used on average each year on influencing effort	% of time of the post spent influencing FY 2005/6	% of time spent influencing FY 2006/7	Same for FY 2007/8	Same for FY 2008/9
Grade of post					
1.Head of office (SCS) - UK based		0	1	2	2
A1 Health Adviser UK based		0	0	20	20
A2 Health/HIV Adviser UK based		0	20	5	5
A3 – Policy Officer SAIC		0	5	5	5
B2 SAIC			5	5	5

Table B Staff Used in Influencing: Cost Calculation

Staff	Unit cost per annum *	Total Cost	Cost in 2005/6	Cost in 2006/7	Cost in 2007/8	Cost in 2008/9
SCS Head of Office	£ 140,000 (all costs, including housing flights, salary etc)	£8,400		(Calculated as 0.02 x £140,000) = 2,800	(Calculated as 0.02 x £140,000) = 2,800	(Calculated as 0.02 x £140,000) = 2,800
A1 Health Adviser (UK)	£ 140,000	£84,000		(Calculated as 0.02 x £140,000) = £28,000	(Calculated as 0.02 x £140,000) = £28,000	(Calculated as 0.02 x £140,000) = £28,000
A2 Health/HIV Adviser (UK)	£120,000	£36,000		0.2 x £120,000 = £24,000	0.05 x £120,000 = £6,000	0.05 x £120,000 = £6,000
A3 Policy Officer SAIC	£ 33,000	£4,500		(Calculated as 0.05 x £30,000) = £1,500	(Calculated as 0.05 x £30,000) = £1,500	(Calculated as 0.05 x £30,000) = £1,500
B2 SAIC	£28,000	£4,200		0,05 x £28000 = £1,400	0,05 x £28000 = £1,400	0,05 x £28000 = £1,400
<b>TOTAL</b>		<b>£137,100</b>				

\*the unit cost figures should be available from the Departmental Finance Officer. They can provide average annual salary costs plus other costs for each grade

**Table C: Other Resources and Inputs Used in the Influencing Effort (£)**

	<b>Total Cost £</b>	<b>2005/6</b>	<b>2006/7</b>	<b>2007/8</b>	<b>2008/9</b>
Consultancy for study on Health Strategy Design	£89,066				£89,066
Consultancy on Health Strategy – Costing (75 working days contract)	£35,930			£35,930	
Consultancy on Summarising and Marketing of the PNDRHS (Health Strategy)	£1,216				£1,216
Consultancy on Finalisation and Harmonisation of Health PAF	£6,118				£6,118
Consultancy for study	£1,294				£1,294
Technical Assistance-Advisers					
Meetings and Events: HD advisor participation at IHP Inter-ministerial in Geneva	£2,488				£2,488
Meetings and Events: Ministry of Health Senior staff participation at Wilton Park Conference – Maternal, new born and child mortality: meeting on the MDGs	£6,356				£6,356
Meetings and Events: Ministry of Health Senior Staff (including the Minister) participation in the high level summit in New York	£13,033				£13,033
Meetings and Events: HD trip to UK in October 2008?	£3,701				£3,701
Meetings and Events: HR meeting in Maputo – Accomodation and other costs for Paulo Ferrinho and Norbert Dreesch	£1,354				£1,354
Meetings and Events: HIV advisor and Minister of Health participation at IHP launch in UK	£6,500			£6,500	
Meetings and Events: Joint GFATM/DFID/UNAIDS/WHO Mission Dinner	£714				£714
Financial Aid directly associated with the influencing effort eg extra sector budget support linked to the policy change	£17,400,000			£10,400,000 (£3.7m in Jul 07 and £6.7m in Mar 08) <sup>33</sup>	£7,000,000
<b>TOTAL</b>	<b>£17,567,770</b>				

<sup>33</sup> Mozambique FY is the calendar year, therefore, whilst £10.7m for health was allocated from DFID FY 2007/8, from a Mozambique FY perspective, DFID's contribution was £3.7m in 2007 and £6.7m in 2008.

## **E: India Case Study**

### **Influencing Equity and Access Policy and Programmes**

#### **Reproductive Child Health - RCH2**

##### **1. Context**

- 1.1 In the late 1990s it became clear that despite earlier efforts to improve maternal and child health in India, the decline in infant mortality had stagnated and maternal mortality remained very high at 407/100,000 live births. Regional, caste and gender based disparities remained as deep seated as ever with the poorest and most disadvantaged failing to get access to improved services. India was not expected to achieve the MDGs for reducing child and maternal mortality.
- 1.2 After a two year design process, the National Rural Health Mission (NRHM), was launched in 2005 with its flagship element the Reproductive and Child Health Programme (RCH2) . Government of India (GOI) aimed to provide accessible, affordable, quality health care to rural populations. RCH2 would o increase accountability to local people, decentralise, focus on those with the worst health outcomes, monitor against standards, foster innovation, provide flexible funding, and strengthen cross-sectoral efforts to address the social determinants of health.
- 1.3 RCH was a very large programme of US \$ 8.9 bill and most of the funding was provided by the Government of India itself. The World Bank and DFID funded 8.4% of the cost through a pooled funding arrangement and another 5.6% was provided outside the pool by the same donors plus the European Commission and USAID. The financial commitment by DFID was £ 245 million of financial aid over 2005-20010 and £ 5 million technical assistance, making it the largest donor.
- 1.4 Although equity is part of the rhetoric of the NRHM , specific action to focus resources on the poorest, or to reduce barriers to service access was not well conceived at the outset. DFID therefore aimed to influence the design of the RCH2 programme to ensure there was a clear strategy and well defined programmes that would ensure that services would provide access to the poorest and most disadvantaged groups.
- 1.5 This case study therefore seeks to focus on the outcome of the efforts by DFID to influence the design of RCH 2 and the extent to which policy dialogue and related support through research and consultancy was able to ensure that concrete programmes to target disadvantaged groups were included in RCH2. It will also examine the results of the implementation efforts so far.
- 1.6 The primary objective of the influencing was to bring an equity focus into the planning and provision of health services – by reducing financial, geographical and service based (e.g. discrimination) barriers to accessing health care by the poorest (ie Below Poverty Line-BPL) and by scheduled castes and tribes(SC/ST). In India, Scheduled Castes (Dalits, earlier known as "untouchables" below the

*varna* hierarchy) Scheduled Tribes (Adivasis, indigenous peoples) and religious minorities (particularly Muslims) are at the bottom of the social ladder. These groups suffer the burden of multiple disadvantages and have the lowest levels of human development indicators such as education, health, poverty and other social rights. The mortality rate of Schedule Caste/Tribe children is 30% higher than children born in other families.

- 1.7 The main stakeholders were the Ministry of Health and Family Welfare, the Department of Women and Child Development and an extensive donor group including the World Bank, DFID, EC, USAID, UNFPA, UNICEF and WHO.

## 2. Influencing Strategy and Objectives

- 2.1 By 2002, through commissioning papers on poverty among Dalits, Adivasis and Moslems, DFID had begun to identify the social exclusion of poor and disadvantaged groups as a major constraint on poverty reduction in India. The country strategy provided an overarching strategic framework for action across the bilateral framework and on specific sectoral programmes and projects. The aim was to address equity and access issues in all DFID programmes including the health sector and in RCH2. DFID aimed to assess the impact of programmes on the poorest and marginalised groups and how equity and access issues could be more effectively addressed in future.

- 2.2 There was no specific written influencing strategy to address equity and access issues in the DFID programme but an approach to influencing evolved over time in three main ways :

- Promoting a public dialogue in India on social exclusion issues using emerging evidence about the condition of poor and disadvantaged groups set out in national survey data disaggregated by SC/ST and gender.
- Engaging with GOI in programme design processes that could explore how to improve the targeting of public services and DFID support on the poorest and most disadvantaged groups
- Supporting advocacy, lobbying and research into social exclusion issues by civil society and piloting of new approaches to service provision by NGOs

- 2.3 DFID engaged on RCH2 as an entry point for promoting inclusiveness and giving the poor access to the benefits of growth. In engaging in the health sector through RCH DFID saw the potential to overcome problems of financial exclusion and discrimination in the provision of health services. Interviews with DFID staff suggest the aim became to influence the RCH2 design by :

- Ensuring the RCH programme had a strategic focus on overcoming the barriers to access by disadvantaged groups
- Including specific interventions in the design of RCH services that would enable improved access for the poor and disadvantaged and more equitable distribution of the benefits

- Developing an approach to monitoring and evaluation with indicators that would identify whether the poorest and most disadvantaged were benefitting.
- 2.4 DFIDs expected outcome was increased focus of spending by GOI and donors on approaches specifically to assist disadvantaged groups including ring-fenced budget line items and special programmes for example to offer free delivery services for poor women or to reduce travel costs and out of pocket expenses.
- 2.5 By 2005, these objectives were aligned with GOIs new national policy priorities and were highly relevant to the development needs of the country. It was anticipated that if RCH2 could be better targetted on the poorest groups this would begin to provide practical ways of addressing GOIs long standing concerns with lack of progress on health and social outcomes.

### **3. Design and Implementation Of Influencing Effort**

- 3.1 The design of RCH2 was undertaken through a collective donor effort in a partnership led by the Government of India. The donors recognised that the financial support they could provide was only a fraction of the total programme cost and that they were in effect supplementing a programme resourced largely by GOI. Through their collective influencing effort they intended to support GOI in promoting a “paradigm shift” from a rigid centralised planning approach to a decentralised state and district level planning and stakeholder process.
- 3.2 As part of this process the donors aimed to elaborate the design of RCH2 to enable GOI to include innovations such as sector wide decentralised planning with a special focus on the poor and marginalised as well as in a range of other areas including new partnerships with the private sector and community based organisations. DFID , the World Bank and UNFPA provided financial support in a flexible way through pooled funding to enable GOI to try out innovative schemes and arrangements that would not have been possible within the framework of their own financial arrangements.
- 3.3 The effort by DFID to address equity and access issues in the design of the RCH2 design was part of a much broader design process. There was no attempt to projectise the influencing effort or to develop a separate log frame for the equity and access aspects of the design. This was appropriate since the donors needed to focus on the wider planning framework that covered the entire design process. The range of issues considered was very wide and included : programme management, fiduciary risks and financial controls, selection of a cost effective package of mother and child services, public private partnerships.
- 3.4 DFID had well established relationships with the main Government stakeholders and donors but did not systematically assess their position and power in relation to equity issues or plan how to leverage changes in their position. There was no influencing plan as such. DFID took a pragmatic approach based on generating data and information on excluded groups and undertaking studies, including on equity and access in health services, as a basis for policy dialogue and technical discussions with Government and donors.

- 3.5 DFID and the donors focussed on identifying key people within MoH to share new ideas and proposals in an opportunistic way. Design processes also created opportunities to share ideas with wider audiences including state officials. Donor attention was almost exclusively taken up in discussions with Government and little effort was made to work with other opinion formers e.g. there was only limited engagement with civil society, apart from discreet DFID association with well-known activists as an informal sounding board, and the private sector.
- 3.6 DFID entered the design phase of RCH2 recognising that it was a new departure based on a multi donor sector wide programme approach. DFID knew this would mean a significant effort and commitment of staff time. The cost of the DFID design team was not explicitly assessed but it was clear that DFID realised the substantial commitment that was being made and the opportunity costs involved. There was a design budget to meet the costs of associated consultancies.

#### 4. Role of DFID In Policy Change

- 4.1 The significant policy change was confirmed when the final RCH2 programme document including equity and gender components was approved by GOI in early 2005 . It represented a new direction for GOI from the 1997 programme and included a number of aspects which were designed to specifically address the needs of the poor and most disadvantaged groups<sup>34</sup> :
- A pro poor focus with a specific chapter on addressing gender, equity and access for SC/ST and women at state level . This included an emphasis on :
    - enhancing capacity so that States can direct resources to poorer and disadvantaged groups.
    - establishment of baselines and indicators to measure and monitor inputs to poorer groups and the health impact .
    - stimulating demand and access through participatory approaches to planning and service delivery
    - demand side financing including simple voucher schemes for poor households
    - reducing the cost of care by providing reliable services free to the poorest groups including cost exemption schemes
    - making services more responsive and accountable to the communities served for performance

and

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<sup>34</sup> See Chapter 2 National Programme Implementation Plan RCH Phase 2 , Programme Document, Government of India 200.

- A more demand led and bottom up approach to planning both urban and rural with participation of poorer and disadvantaged groups
  - State, District and Ward plans that address equity and gender issues
  - A progressive increase in flexibility in financial and human resource allocation to the states to respond to the needs of the worst off
- 4.2 The interviews and documentation suggest that the adoption and launch of the new RCH 2 programme in 2005 was a significant change in approach from RCH1 which had started in 1997 and had helped GOI move from a target based fertility reduction programme towards a broader range of RCH services. However it failed to address the capacity constraints in the health system . Slow financial transfers and weak planning and management at State level resulted in persistently high MMR and IMRs.
- 4.3 Only the World Bank supported RCH1 with other donors supporting parallel projects in family planning (USAID, UNFPA and UNICEF). The EU supported a Health and Family Welfare Development Programme over 1998-2005 which responded to GOIs increasing interest in decentralisation, adoption of public-private partnerships and the reform of the system. Interviews suggest that the EC support created a useful foundation for RCH2 by developing ideas and approaches to effective decentralisation , performance based funding, capacity building and public private partnerships.<sup>35</sup>
- 4.4 The change in Government in 2004 created the opportunity to confirm a new approach in the sector. There was a greater stress on the importance of a better functioning health system and for urgent action to address the gross inequality and conditions faced by the poorest members of society. GOI then launched a rural health mission to raise the quality of health services with a focus on the less well performing states of the North and North East and on the rural poor.
- 4.5 The DFID influencing effort continued when GOI asked donors to sign up to the newly announced Common Minimum Programme to deliver 10<sup>th</sup> plan targets and the MDGs for infant and maternal mortality. DFID did so and was one of the first to join the design process for the planned comprehensive programme in health, which explicitly drew on equity approaches developed for the RCH2 programme.
- 4.6 The RCH2 design process took two years (2003-2005) and was led by the MOHFW with the aim of moving toward a sector planning framework within a multi donor funding arrangement. The donors formed a Development Partners Group to examine the options for managing, financing and implementing such a programme . This quite quickly became a collective effort in partnership with Government as MOHFW started to attend the donor meeting .
- 4.7 The design process took a long time because of the need to accommodate the interests and views of large number of stakeholders and because of the complexity of the programme. The donors allocated work according to their

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<sup>35</sup> See Support to the Family Welfare Programme in India and the EC-India Country Strategy Paper Draft Dec 2004.

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comparative advantage. DFID chaired the group on equity and access issues and worked in this area with EC, USAID and UNFPA. There was a lot of discussion before a donor consensus emerged. Interviews with other donors suggest that DFID also played a key role in Chairing the wider donor group on a rotating basis and in the work that was undertaken on financial management and fiduciary risk.

- 4.8 By leading the sub group on equity and access issues, DFID was able to consolidate and pull together the available evidence on SC/ST and other disadvantaged groups and to undertake new studies where needed. USAID had previously funded the India National Family Health Surveys which generated data on the condition of disadvantaged groups and their access to services. This data became an important tool for analysing the level of inequity in access to health services and its effects on the health of poor and disadvantaged people. It was used to demonstrate the power of collecting data disaggregated by social class, caste and tribe.
- 4.9 DFID built a consensus within the donor group and persuaded MOHFW of the need to build information collection and monitoring and evaluation of the impact on the poor and disadvantaged into the RCH2 programme. DFID funded a social equity and access to health study in 2003 which considered the constraints affecting the SC/ST, women and the poorest groups. The design process also involved consultation and dialogue with stakeholders from the Indian states and the donor group were involved in workshops which set out the case for collecting disaggregated data and for direct interventions to improve access for the poorest.
- 4.10 Interviews with GOI and donor stakeholders<sup>36</sup> suggest that DFID Social Development Advisers played a prominent role in formulating principles for community monitoring. They also supported the donor dialogue with MOHFW over the integration of baseline indicators and systems to monitor the utilisation of services by poor and disadvantaged groups. The MOHFW were keen to triangulate available data from the sectoral DHMIS and the national surveys within RCH2. The design process also involved making proposals for interventions such as performance funding for states and health facilities that targetted services on the poorest and for reducing the transport and cost barriers to access.
- 4.11 Other donors recognised that DFID had expertise and knowledge concerning equity issues. This derived from earlier efforts in 2002 by DFID to lay the groundwork by building up networks in the NGO community and later working with them and other donors like UNICEF on social exclusion including by supporting “social equity audits” of development programmes post-tsunami.<sup>37</sup>

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<sup>36</sup> This point was made by MOHFW and several donor partners.

<sup>37</sup> Interview and Minute June 9<sup>th</sup> 2009.

- 4.12 Donors such as USAID were also aware of the equity issues and had funded the national surveys which had highlighted the lack of service provision to poor and disadvantaged groups. DFID joint funded the 2005 national survey that produced the first national data disaggregated by caste, tribe, gender and religion.
- 4.13 The World Bank had a more technical approach but were also concerned with assessing social impact especially on indigenous people. Interviews suggested that the Bank team was initially lukewarm about the need for such a strong focus on disaggregating data on access to health services by disadvantaged groups but became persuaded by the design work carried out by DFID.
- 4.14 The interviews with the *MOHFW* and other donors suggested the following key ways that DFID brought influence to bear :
- Having a senior and experienced team that was devoted to the design process was a major positive factor. It was important to have senior staff capable of leading and representing the donors when required and carrying out dialogue with GOI at the highest level. The team had a good balance of international and local knowledge and a mix of management, financial , health and more specialised skills. Continuity of staffing was a critical factor and was achieved earlier in the process, though less so later on.
  - Providing responsive and rapid funding of supporting studies through technical assistance support was crucial in maintaining momentum. Around 21 studies were undertaken in all for RCH2 and few of the donors could provide support as easily as DFID. DFID was equally important in engaging and supporting studies in other key areas of the design process including programme management and financial systems.
  - Promoting stronger links between RCH2 and the States : GOI interviews suggested that DFID's presence in some States provided useful insights and contacts which informed the RCH2 design process but also later during implementation allowed the national programme to be followed through at state level in other DFID programmes. DFID staff stated that reduction of health disparities is a core objective of DFID state programmes . In West Bengal DFID has encouraged the allocation of state resources **to poorest districts** where majority of poor/excluded people reside. In Orissa, a health **equity plan** has been developed and is being implemented. With DFID support and influence, Orissa and West Bengal have also developed **integrated Nutrition Plans** to meet the nutrition and health demands of excluded groups. Madhya Pradesh is in the process of developing a similar plan.
- 4.15 As the current Chair of the development partners forum for the RCH programme DFID secured an agreement for a gender and equity study as part of the mid term review of the programme. This has highlighted achievements and shortfalls (see section 6)

## 5. Costs and Cost Effectiveness

5.1 Stakeholder assessments of DFID influencing efforts were positive and the majority were scored in the range 6-8 (ie has been decisive for some of the key steps of the change process). A brief tabular summary is provided below:

### Assessment of Effectiveness of DFID Influencing in RCH 2

Stakeholder	Score	Rationale	Without DFID Support
Government 1	6-8	Most flexible donor . Speedy and high quality TA was critical to design. Difficult to separate DFID influence from the collective effort.	
Government 2	6-8	Decisive influence. Quality of senior staff and ability to lead the process across all aspects of design. Flexible TA was key to undertake studies and as was money to help implement the programmes.	Without DFID the design would have been very different and less well targeted.
Donor 1	4-5	DFID part of a collective effort and change mainly led by GOI. Donors overestimated their influence.	
Donor 2	6-8	Considerable influence . DFID could draw on earlier work and its experience at State level	RCH2 would have gone ahead anyway but with less emphasis on equity and access issues
Donor 3	6-8	Very influential on the whole design process. Good leadership, helped distil principles and operationalise concepts	Unlikely that donors would have collaborated so effectively

5.2 The design team for RCH2 as a whole was 5-6 DFID staff including senior programme managers, Health, Governance, Social and Economic Advisers. Those involved in addressing the equity and access issues were a sub set of this group. The DFID staff inputs and the cost of studies associated with the influencing effort are shown in detail in annex 2. The total influencing cost over 2003-5 was £ 317,000 of which the vast majority (£ 289,000) was DFID staff cost and the rest was spent on consultants (£ 28,000).

- 5.3 Alternative ways of achieving the same output from the design effort were not considered. From the outset DFID assessed that a group of senior DFID staff would need to be devoted to the design work backed up by specialist consultants as required. In principle, it would have been possible to rely more on Indian institutions and expertise to support a wholly GOI led process, but unlikely that it would have enabled the re-focusing on equity and access issues. It was one reason why DFID worked so closely with an Indian consultant for the equity and access study and worked with Indian civil society to engage with MOHFW in 2005 to develop the model for community based monitoring and triangulation of data. The EC told the evaluators that this is a model they are now trying to develop.
- 5.4 Feedback from GOI interviews was categorical that the donor partnership model used for the design of RCH2 was appropriate and had been a very effective way to interact with MOHFW. There was a need to explore the options and issues in an open way and the requirement was for a dialogue with representatives who understood what their organisations could accept. Design was more than just a technical process and the arrangements had offered good value for money.
- 5.5 In the absence of the support provided by DFID the RCH2 programme would have proceeded as planned because it was very high priority for the Government of India. Most stakeholders have argued that the design would have been less well targeted on the poorest and most disadvantaged groups.

## **6. Outputs and Outcomes**

- 6.1 The evidence from interviews and documents demonstrates that reducing disparities has become a priority of the RCH2 programme. Arguably this was one of GOI's objectives from the outset but the collective donor effort during the design of RCH2 was clearly a significant factor in operationalising an effort to tackle the problems of access to health services by disadvantaged groups. The final programme approved and launched by GOI contained indicators for SC/ST and included some specific interventions as well.
- 6.2 The implementation record is patchier. States have yet to systematically utilise disaggregated data (it is collected only at facility level and not yet used for planning services) or to set up financial performance incentives for achieving utilisation targets at District level for SC/ST. However a number of direct interventions have been tried and there has been an unexpected bout of innovation at state level to try out new schemes to reduce barriers to access by disadvantaged groups. This "learning by doing" approach has been encouraged by national Government and the donors and states have been encouraged to share experience of good practice between themselves.
- 6.3 During implementation DFID has continued to work with the Government to:
- undertake special social group disaggregated analysis of health outcomes using national survey data;

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- set performance measures and develop strategies to tackle disparities in health outcomes at national and at state level;
  - further develop health monitoring systems including revisions to the Health Information System to track service utilisation by disadvantaged groups.
- 6.4 Interviews and mid term review documents show that the RCH2 programme has led to State Governments giving higher priority in their Programme Implementation Plans (PIPs) to improving access and utilisation by marginalised groups through :
- more rural health facilities and better services with more deliveries in health centres at district level;
  - demand side financing : providing financial incentives to offset the high opportunity costs of seeking care for example by using the national cash incentive scheme (ie the JSY<sup>38</sup>);
  - helping indigent families to negotiate care by accompanying them to care facilities;
  - improved service availability geographically to the poorest areas within states;
  - Increased numbers of poor and disadvantaged groups accessing services;
  - more spending on poor and disadvantaged groups.
- 6.5 Innovations have been introduced including mobile health services for tribal populations in Madhya Pradesh, Rajasthan and Gujarat; food for women and attendants (Madhya Pradesh, Gujarat and Andhra Pradesh). Partial data is available showing changes in key indicators for some states. In Rajasthan institutional deliveries for SC/ST have increased by 64% over 2005-8 and SC/ST women receiving post natal care have increased by 10% over the period. In Madhya Pradesh the increases were respectively 35% and 67% over the same period.<sup>39</sup>
- 6.6 Survey and monitoring data is incomplete and it would be premature to draw any firm conclusions about whether access and health status has improved for SC/ST/BPL groups and women. There are some encouraging signs but more systematic surveys and data collection will be needed before a clearer picture emerges. There is also anecdotal evidence of continued obstacles to improving access for SC/ST from field trips made by some stakeholders.

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<sup>38</sup> JSY is the Janana Suraksha Yojana which is a scheme which offers free maternal and delivery services for SC/ST/BPL

<sup>39</sup> "Equity and Gender": Power Point Presentation from the MTR : RCH 2 Design and Beyond Findings from the MTR 2008.

## 7. Conclusions and Lessons

- 7.1 The preparation and design of RCH2 was a new approach to the delivery of health services that later found ready support from the new Indian Governments' political imperative to address the needs of the rural poor and previous failures to make progress against health related MDGs. The design work drew on the experience of earlier efforts by the EU to strengthen health systems and capacity and GOI were open to new ideas that could be presented within the framework of the Development Partners Group. Influencing a large national programme was difficult for donors. Government had a clear vision and ready access to the resources required and was becoming more ambivalent toward donor support.
- 7.2 In this context, DFID was able to play an important influencing role as part of the collective donor effort not just in the area of equity and access but also in the programme management, financial arrangements and other aspects. Some stakeholders found it difficult to differentiate the DFID contribution from that of the donor group as a whole. However the majority of the feedback suggests DFID played a substantial role in leading analytical work on equity and access issues and drawing out from this the policy and programme implications. The role in high level dialogue and presentation to senior officials of national and state Government was critical in persuading GOI of the need to develop indicators and interventions related to the uptake of services by the poorest and most disadvantaged.
- 7.3 There are several important lessons to be drawn from this experience :
- (i) The political relationship between Government and donors can limit the potential for influencing. The careful effort to build relationships with GOI under the design phase created the possibility of influencing some aspects of GOIs emerging programme. DFID and the donors took advantage of this to influence the direction on equity and access. But several stakeholders suggested that subsequent delays in donor funding<sup>40</sup> of RCH2 has reduced their influence during implementation.
  - (ii) Even in a fast growing developing country with a growing pool of national expertise, there can be an important role for Senior DFID staff (UK based and SAIC) in engaging directly with Government in considering policy and programme options and approaches. In India Government was receptive and recognised the value and skills of the senior team devoted to the design process by DFID.
  - (iii) The ability of DFID to flexibly and rapidly finance studies at critical stages of the design process was important to progress the design as planned and created opportunities for DFID to influence the options and approaches adopted
  - (iv) Collective efforts can maximise donor influence where there is close collaboration between development partners. Stakeholders found it difficult to separate DFIDs influence from that of other donors and

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<sup>40</sup> Caused by linked disbursements delayed by Bank procurement concerns.

thought the close collaboration was the foundation of the successful partnership with MOHFW. Only EC supported the agenda of addressing social exclusion in access to health services at an early stage, although there were supportive individuals in other agencies. The level of agreement on structures (a rotating Chair and regular meetings with sub groups) and willingness to share work according to areas of capability was key.

- (v) Unexpected events can create greater opportunities for influencing . The implementation phase of RCH2 illustrated how innovation took place at State level in India and created a wide variety of efforts to address equity and access issues. DFID and the donors have seized the opportunity to document these and to encourage State officials to share good practice, which was an agreed strategy at the latter end of the design process. This illustrates the potential to continue the influencing of policy and practice during implementation and to facilitate the spread of new ideas.

## Annex E\_1. individual names removed

## Annex E\_2: India Case Study : Influencing Costs

Table A DFID Staff time used on Influencing Programme

Staff Resources	% of time of post used on average each year on influencing effort	% of time of the post spent influencing FY 2005/6	% of time spent influencing FY 2006/7	Same for FY 2007/8	Same for FY 2008/9
Grade of post					
A1 Health/HIV Senior Regional Adviser UK based	5-15 % from 2003-2007	15	5	10	5
A1/2 Health/HIV Adviser based in country	10 -30 % from 2003-2009	25	5	20	20
A1 Senior Social Development Adviser (HCS) UK based in country	20-50 % from 2003 -2007	30	30		

Table B Staff Used in Influencing: Cost Calculation

	Unit cost per annum *	Total Cost	Cost in 2005/6	Cost 2006/7	Cost 2007/8	Cost 2008/9
Staff						
A1 Health Adviser At £ 182,000	£ 182,000	£ 63,700 (£27,300+£9100+£18200+£ 9100)	27,300	9,100	18,200	9,100
A2 Health /HIV Adviser (HCS) at £ 166,000	£ 166,000	£ 116,200 (£ 41,500+£ 8300+£ 33200 + £ 33200)	41,500	8,300	33,200	33,200
A1 Social Development Adviser (HCS) At £ 182,000	£ 182,000	£ 109,200 (£ 54,000 + £ 54,000)	54,600	54,600		
Total		£ 289,100	123,400	72,000	51,400	42,300

**Table C: Other Resources and Inputs Used in the Influencing Effort (£)**

	<b>Total Cost £</b>	<b>2005/6</b>	<b>2006/7</b>	<b>2007/8</b>	<b>2008/2009</b>	
Design phase: Consultancy for study on Mainstreaming Equity and access into the RCH programme	7,000 (2003-04)					
Consultancy for study during MTR	15,000				15,000	
Consultancy on disaggregated data analyses	6,000					
Sub total	28,000					

Cost of DFID Consultants was £289,100 and DFID staff time was £28,000

**Total influencing costs were £317,100**

## **F: NEPAL Case Study**

### **Nepal : The Nepal Safer Motherhood Project (NSMP) and Support to the Safe Motherhood Programme (SSMP)**

#### **Background**

- 1.1 Nepal remains one of the poorest countries in the world with one of the highest maternal mortality ratios. In 1996 there were around 539 per 100,000 live births which put Nepal on a level with some African countries.<sup>41</sup> At that time it was inconceivable that Nepal could reach the MDG target of reducing maternal mortality by three quarters by 2015.
- 1.2 The root cause of high maternal mortality in Nepal is the low status of women. Social norms routinely under value and disempower women especially the poorest. Women from certain castes and tribes also suffer discrimination.
- 1.3 The advent of multi partyism in 1990 led to a decade of political instability and a Maoist led uprising but during this period there was a continuous evolution of policy in the health sector.
- 1.4 The 8<sup>th</sup> five year national health plan 1992-97 and the second long term plan 1997-2017 focussed on primary health care services (including family planning and immunisation) . A high priority was attached to improving district level services and to extend coverage and improve access to the 90% of Nepalese living in rural areas.

#### **1. Context**

- 1.5 The Nepal Safer Motherhood project (NSMP) was implemented over 1997-2004 in support of Government efforts to improve maternal health. The main Government stakeholder was the Family Health Division of the Ministry of Health. The project focussed on improving midwifery and basic emergency obstetric care including improved infrastructure, equipment and staffing at hospitals and clinics. There was also an effort to improve access through social mobilisation and emergency funding for transport.
- 1.6 The NSMP was funded by DFID and was intended to provide a basis for developing models for service provision and also for systematically exploring the constraints on access. The aim was to feed District learning and experience into central policy making and programme design.
- 1.7 There is now a Health sector programme or SWAP which involves 12 donors providing coordinated support in diverse forms but under a single planning framework led by the Nepalese Government. DFID and the World Bank provide financial support to the SWAP.

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<sup>41</sup> Nepal Demographic and Health Survey 1996.

- 1.8 The successor to NSMP called the SSMP commenced in late 2005 . SSMP has 8 components and built on the experience and evidence generated by the earlier project. The objectives are to improve health systems and service delivery. DFID's current commitment to the SSMP is £23 million (40% is technical assistance and 60% in financial aid). In 2007/8 SSMP financial aid accounted for 37% of the national safe motherhood budget. This makes it one of the largest programmes of maternal mortality support by DFID anywhere in the world. NSMP and SSMP aimed to develop new policies in a number of areas and this case study considers three: increasing demand through financial incentive payments, safe abortion and the Safe Birth Attendant policy.

## 2. Influencing Strategy and Objectives

- 2.1 Interviews with Nepalese stakeholders suggest that from the outset, DFID's support for improving safe motherhood in Nepal has consistently followed an approach based on :

- Explicitly aiming to develop new policies and programmes based on evidence of the challenges faced and operational experience.
- Targeting immediate service delivery improvements in rural areas.
- Learning lessons from operational field experience about what worked.
- Encouraging scaling up of service provision in the light of the experience.

The 2004 synthesis evaluation<sup>42</sup> highlights how the lesson learning and evidence based approach was used first to demonstrate how to mobilise resources effectively to improve maternal care and then as a basis for scaling up and extending these services.

- 2.2 Both the NSMP and SSMP had explicit policy influencing objectives but these were couched in very general terms. DFID support to NMSMP was intended to influence Government and to: “contribute to safe motherhood policy and programme development”. The measure of success was to be “at least three examples of influencing policies or programme development” at the end of the project. In SSMP there was a commitment to achieve “at least 4 central level decisions made and/or policies developed based on needs and/or evidence”. The key Government stakeholder was the Family Health Division of the Ministry of Health.
- 2.3 DFID and the donors adopted an approach to influencing policy that was based on supporting GON in researching the nature of the constraints, reviewing international experience and practice, generating local evidence through experience and then considering appropriate policy responses. This evidence based approach mean that the influencing strategy was based around demonstrating to Government what worked and through a process of lesson learning to arrive at a suitable approach which could then be used as a basis for policy.

<sup>42</sup> Synthesis of Final Evaluation Findings from the Nepal Safer Motherhood Project 2004

- 2.4 A good example of the approach was the development of “demand side financing” which involved the use of financial incentives to overcome cost constraints on access and to encourage take up of services. In the case of safe abortion policy DFID funded consultants focussed mainly on existing international evidence to argue for new legislation and drew up proposals at an early stage.<sup>43</sup>
- 2.5 Another important aspect of DFID influencing was the effort to encourage movement by Government and donors towards a more coordinated and harmonised approach in the sector. In the 1990s Government was very cautious about the development of a Sector Wide Approach. Donor support was overlapping and duplicatory . Interviews with Government and donors suggest that DFID was instrumental in promoting a more comprehensive planning framework for the sector.

### **3. Design and Implementation Of Influencing Effort**

- 3.1 The broad approach to influencing was articulated in the project and programme documents but there is no evidence that DFID drew up a more detailed influencing strategy and plan. There were broad areas where specific policy changes were anticipated but there was no attempt to plan out an expected pathway for future changes or to identify the main stakeholders, their interests or their current position. There was no documented plan to use leverage on specific parts of Government or individuals to encourage specific changes in position, decisions or behaviour.
- 3.2 The course of the conflict was a major source of uncertainty which required a flexible approach which could react to opportunities and events as they unfolded. Interviews and documentary evidence suggest that DFID and the donors laid the technical groundwork by assessing options and evidence to facilitate Government decision making and operated in an opportunistic way at a political level by seeking to influence politicians and key decision makers when opportunities arose.
- 3.3 DFID's approach was ambitious but realistic. The relationship with the Ministry of Health had been built up over a decade and was soundly based. As an institution it was already developing a culture of evidence based approach to policy development and there was a strong technical support team in place. These factors made it more likely that a systematic and well planned approach could persuade key Government decision makers to introduce soundly based policy and programmes.
- 3.4 Both the NMSP and SSMP were subject to an overall economic appraisal which considered the cost effectiveness of the health services to be supported by the programme. The costs of the policy influencing effort were not examined separately because this was seen as an integral part of the overall programme of

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<sup>43</sup> Interview evidence provided by the UK funded consultants Options and corroborated by Government stakeholders.

support. DFID Nepal staff time and resource costs for influencing were also not assessed and the opportunity costs of staff time were not systematically considered.

#### 4. The Role of DFID in Policy Change

- 4.1 During the ten year period of DFID support, GON policy on maternal health had a clear strategic goal to reduce maternal mortality by improving access to higher quality services.<sup>44</sup> However the specific policies and programmes that could deliver this goal were being developed and evolved in partnership with the donor community.
- 4.2 There were three major external drivers or enabling factors that assisted this process. Firstly, the political turmoil in the country created huge pressure to address the health needs of the rural poor and created political space for introducing new policy and for firm action. Secondly, the Ministry of Health in Nepal was committed to a research led approach . Thirdly the there was a shift by donors from an uncoordinated project based approach toward a sector planning framework.
- 4.3 From the outset, high level political support was a key ingredient in prioritising maternal health and pushing new policy. Technical direction from the Department of Health Services (DOHS) was also important in delivering better quality services, new policy and programmes. DOHS set up a research Committee in 1998 specifically designed to generate an evidence base and to draw on international experience. Interviews suggest that DFID positioned its consultants provided under NSMP to facilitate this process. A dedicated research advisory post was also provided under SSMP.
- 4.4 In 1997 the NSMP donors operated in a projectised and ad hoc way with informal coordination and considerable transaction costs. GON were initially resistant to change but eventually approached DFID to help develop a sector planning framework under SSMP. Government and donors acknowledge the catalytic role that both DFID and the World Bank subsequently played in promoting a more sector based approach and establishing harmonised structures and pooled funding in the move towards the SSMP.<sup>45</sup>
- 4.5 During interviews the Government of Nepal stakeholders told the evaluators that donors had made a major contribution to improving maternal health care in Nepal by :
  - helping to try out new models of safer motherhood service provision in a few Districts and then supporting their scaling up
  - systematically examining the factors constraining access and utilisation
  - developing options for new policy and programmes to address the constraints

<sup>44</sup> See for example the Safe Motherhood Neo natal Health Plan SMNHP 2002-17.

<sup>45</sup> Interviews with GON Ministry of Health and USAID.

- 4.6 The NSMP initially focussed on providing selected Districts with support for improved infrastructure and equipment at health facilities. New models for delivering improved emergency obstetric care were developed and tested particularly in remote areas. There were also efforts to provide 24 hour cover and to improve obstetric care, facilities management and midwifery skills. District based plans were drawn up to increase access including community level emergency funding for transport. Improved services were scaled up and rolled out across the country in phase 2 and support has continued under SSMP.
- 4.7 Important examples<sup>46</sup> of areas where GON has introduced new policies related to specific aspects of maternal health care are :
- overcoming financial barriers to health
  - a new law and services in the area of safe abortion
  - the new policy framework on skilled birth attendants
- 4.8 The documentary record and interviews suggest that a political opening occurred in 2004 when a new coalition Government wanted urgent action to improve the status of women. DFID took the opportunity to influence the new Minister of Health by funding consultancy studies and research into the financial barriers faced by pregnant women in accessing skilled birth attendants and emergency care.
- 4.9 A DIFD funded study in 2004 confirmed that the high cost of accessing emergency obstetric care was a major barrier to utilisation of maternity services by pregnant women. The results showed 51 % of those delivering in hospitals had to borrow to meet the cost of attending health facilities (including transport to facilities, user charges etc). Home births were also incurring significant costs which discouraged mothers from seeking support from skilled birth attendants.<sup>47</sup>
- 4.10 The results of the analysis were considered by GON and a decision was made to introduce new financial incentives that would encourage health staff to attend pregnant women in their homes and would reduce the financial barriers for women that wished to give birth in health facilities. These so called “demand side financing” arrangements started as the Maternal Incentives Scheme (2005) and later evolved into the Safe Delivery Incentive Programme SDIP (2007) and finally into the AAMA programme.
- 4.11 Initially the first Maternal Incentives Scheme (MIS ) focussed on incentive payments to skilled birth attendants (SBA) and to pregnant mothers but the former proved problematic.<sup>48</sup> Subsequent arrangements under the SDIP were changed to remove the direct payments to SBAs and instead offered an incentive payment to the health facility as a whole against agreed service delivery targets. Payments to pregnant mothers continue under the AAMA programme that is being substantially funded from DFID financial aid.

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<sup>46</sup> Support to the Safe Motherhood Programme Strategic Issue Paper 15 Nov 2007.

<sup>47</sup> Cost Study 2004 quoted in Synthesis of Final Evaluation Findings from the NSMP Oct 2004. See also Coping with the Burden of the Costs of Maternal Health Jo Borghi et al April 2004.

<sup>48</sup> Incentives paid to SBAs de motivated other health workers.

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- 4.12 The AAMA programme has two elements: free institutional delivery care (launched in 2009) ; and the existing cash incentive arrangements. AAMA provides :
- Incentives to women : A cash payment after delivery at a facility.
  - Free delivery services: A payment to the facility or institution for the provision of care. This covers the cost of all required drug, instruments and emergency obstetric care.
  - Incentives to health workers for home delivery :This was originally in SDIP and is being phased out.
- 4.13 DFID funded consultants helped the Ministry of Health to develop and launch the MIS and SDIP financial incentive schemes under the SMMP. A special Committee was established in the MOH and the DFID funded studies were used to generate programme options and to set out the costs for the Ministry of Finance.<sup>49</sup> DFID argued for a more cautious piloting of the new arrangements with careful monitoring. However, Government subsequently introduced the new national policy in 2005 and donor financial support has been provided through the NSMP and later through the basket funding mechanism.
- 4.14 Fresh elections in 2006 created more momentum for action . Following the launch of the International Health Partnership in September 2007 a visit by a DFID Health Adviser from HQ created an opportunity for high level policy dialogue. DFID staff met with the Minister of Health and the Parliamentary Health Advisory Committee to discuss the options and potential impact of removing health user fees. The DFID local office were cautious about free health care across the board and subsequently carried on the dialogue and pushed for free delivery services to be the main focus. The DFID Adviser and consultants helped examine the options and provided projections of the costs up to 2015. Free delivery services were announced in January 2009. DFID stressed the need for careful monitoring.
- 4.15 Some donors interviewed during the evaluation are of the view that the incentive schemes were rolled out too fast because of political pressure to do so. Other commentators have also highlighted that political expediency to ensure the policy was adopted quickly may have meant there was inadequate preparation for SIDP<sup>50</sup>. Some donors also took the view that the later introduction of free delivery services was an example of the donors being used help meet populist demands for free services and that this posed risks if the system was unable to respond to the increased demand. However GONs stakeholders rejected this view on the grounds that it was necessary to take risks to overcome the severe cost constraints on accessing services.
- 4.16 There was also political interest in addressing the safe abortion issue and GON took advantage of the changing political and social context to introduce new legislation. National evidence was used to demonstrate that unsafe abortion was

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<sup>49</sup> Ensor et al “ What Drives Health Policy Formulation: Insights from the Nepal Maternal Incentives Scheme” Health Policy 2008.

<sup>50</sup> BMC Health services research : Tim Powell Jackson et al The Experience of Districts in Implementing A National Incentive Programme to Promote Safe Delivery in Nepal March 2009.

a significant cause of maternal death. A review of global learning was carried out which together with pre existing WHO guidelines, formed the basis of the new policy and guidance. DFID and GTZ provided substantial support to the process through advocacy and also through financing the Secretariat of the national technical committee for implementation of Comprehensive Abortion Care. NSMP and now SMMP have also financed GON abortion services.

- 4.17 GON interviews suggest that the focus on Skilled Birth Attendants (SBA) in Nepalese maternal health programmes started through dialogue between Government and WHO in the 1990s. The DFID funded NSMP helped GON to develop local experience and evidence based on efforts to improve SBA skill levels and to develop adequate referral systems and emergency obstetric care.<sup>51</sup> The SMMP also provided expertise to elaborate the SBA policy and in service training strategy introduced in 2006 and 2007 respectively. Support was provided for in service training and to ensure all new medical and nursing graduates qualified as SBAs.
- 4.18 Stakeholders are positive about the role played by DFID . Government valued the technical support role played by DFID funded experts in drawing up specific policy proposals and options or helping with draft legislation. DFID advisors and experts were seen to play an important advocacy role by communicating and disseminating experience and supporting public speeches, debates and internal GON discussions.
- 4.19 GON stakeholders emphasised that the direction of policy change was set by Nepalese Ministers and that external assistance by DFID and other donors had facilitated and not led the process. These policies would have been implemented anyway but additional support accelerated the process <sup>52</sup>. The financial aid provided was also useful in allowing Nepal to introduce new financial incentive schemes.
- 4.20 Donors also highlighted the role of DFIDNepal and the lead adviser in building support for a sector based approach. GON also had concerns about the limited contribution to capacity building and the need to pay more attention to developing GON staff.

## 5. Costs and Cost Effectiveness

- 5.1 The DFID influencing efforts drew on staff resources from the local DFID office and from a consultancy team . Annex 2 sets out the total resources used for the policy influencing related to overcoming financial barriers to access and work on safe abortion. The total estimated cost of DFID staff time and consultancy costs for basic research, formulation of policy options and design and monitoring of interventions over 2004/5 to 2008/9 was £ 441,609 made up as follows :

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<sup>51</sup> Op cit Strategic Issue Paper no 15.

<sup>52</sup> This point is also made in the paper “What drives Health Policy Formulation” : Insights from the Maternal Health Scheme Ensor et al 2008.

- A DFID office team including the Head of Office, two senior UK based advisers and a local SAIC adviser (£63,609)
- Management and advisory inputs from the consultants team (£135,000)
- Periodic, one off consultancy studies (£243,000)

- 5.2 The level of resources reflect the approach used including building up local evidence and experience and trying to synthesise the results with international experience to provide high quality advice. This required an intensive use of local and international consultancy resources in a close working relationship with GON. DFID staff costs were relatively modest (around 15% of the total) but were engaged strategically to identify the political opportunities and broker between technocrats and politicians. DFID staff also helped to ensure that convincing international and national evidence was systematically brought to bear and that it was carefully communicated to key decision makers and the public. They used high profile ways to advocate new ideas for example to give speeches advocating new policy approaches or lobbying Nepalese Ministers. DFID has also supported the donor group and used its role as Chair to establish common ground around free services.
- 5.3 The documentation suggests that DFID decided to use consultants as offering the only viable option for the “learning by doing “ approach used. There was a conscious decision to feed back lessons from the operational experience directly into national policy making. The consultants also had to provide support to national structures with limited capacity. This was an intrinsically resource intensive approach. There was also a concern to adopt a mix of national and international staff though this was as much to make use of local knowledge and culture as it was any specific concern to achieve value for money. DFID pursued a competitive tendering process to ensure that value for money was achieved
- 5.4 It is conceivable that DFID could have used more in house staff time as an alternative to using some of the international consultancy staff but in practice the scope for this was limited . The role of the consultants was different and was more engaged in the details of strategy and policy development whereas the DFID team had a more intermittent and strategic involvement in policy dialogue with senior GON personnel and Ministers.
- 5.5 Stakeholders judged DFID support positively and said that it had influenced changes in policy and helped introduce new programmes. GON and donors scored the contribution by DFID between 5-8 out of 10 in terms of the results of the influencing effort.
- 5.6 GON stakeholders stressed the role played by the careful evidence based approach which allowed the DOHS to make a strong case for specific policies and to argue the case with the Ministry of Finance for resources. Donor stakeholders were also positive although some stated that DFID should have listened more to alternative donor views and perspectives especially on free health services. The scoring and assessment by stakeholders are summarised in the box :

Stakeholder	Score	Rationale	Without DIFD Support
<b>Government 1</b>	<b>6-8</b>	The demand side financing schemes depended on DFID TA and financial support working together. This was a major new initiative. DFID was critical in rolling these programmes out.	Unlikely that GON would have introduced the incentives schemes.
<b>Government 2</b>	<b>6-8</b>	The main effect of DFID support was to empower the MOH to make the case for free delivery services and for other payments to cover transport costs etc	
<b>Government 3</b>	<b>6-8</b>	DFID influence was decisive . The evidence was produced through consultancies which allowed us to formulate demand side financing policy.	Implementation would have been slower without DFID. GOM needed expertise and financial resources
<b>Donor 1</b>	<b>9</b>	DFID has been the main influence in relation to free delivery charges and to early policies on incentives	
<b>Donor 2</b>	<b>8</b>	DFID was very influential in persuading GON through advice and consultancy. DFID took a lead when few other donors were involved	Unlikely that GON would today have progressed policies in EOC, SBA and care of new borns
<b>Donor 3</b>	<b>6-8</b>	DFID has used an evidence based approach and advocacy to stimulate change. This has been an important trigger for action by the Government.	The safe delivery incentives scheme would have moved much more slowly and struggled without DFID support. It was accelerated several steps forward.
<b>Consultant</b>	<b>5</b>	The changing political environment mainly created the conditions for new policy. DFID helped facilitate this.	The Safe Abortion policy would not have happened without DFID and GTZ

- 5.7 GON and donor partners thought that in the absence of DFID it was likely that much slower progress would have been made in developing a sector planning framework and a harmonised approach. Policy changes were thought likely to have happened anyway but less quickly and that new programmes would have been less well designed and effective. Other donors could have taken on DFID's role but they may have been unable to provide technical assistance in the same flexible way.

## 6. Outputs and Outcomes

- 6.1 Maternal mortality is declining in Nepal. Survey results<sup>53</sup> show a reduction from 539 per 100,000 live births in 1996 to 281 in 2009 which is a remarkable turnaround in the situation from only a few years ago. There are multiple factors contributing to success including high level political support, increased contraceptive use, better education as well as improved transport. The progress made coincides with the substantial effort by GON and donors to improve policy, access and services. Donor provision of expertise and additional funding (50% of total spending on safe motherhood) has undoubtedly been a factor in this improvement but any more direct attribution to specific factors or programme components is not feasible.
- 6.2 The successful development of a nationally led sector programme with evidence based policies and programmes has leveraged increased funding to Safe Motherhood both from GON and donors. GON stakeholders suggested resources had increased by a factor of ten over the decade. DFID and the World Bank have together played a prominent role in this success.
- 6.3 DFID policy influencing objectives have been met in the terms that they were originally set i.e. new policies have been introduced in several areas targeted by NSMP and SMMP. It is harder to say whether the policies themselves are having the intended impact. However available evidence shows :
- Following the introduction of incentives facility deliveries increased from around 95,000 in 2004/5 to 148,000 in 2007/8. Since SIDP was introduced in 2005 attendance by trained health workers has increased from 20% to 30% of mothers and utilisation of facilities has increased from 14% to 15.8% of mothers.<sup>54</sup>
  - The introduction of the safe abortion law and the provision of service capability has together allowed 212,000 women to receive safe services and 80% accepted a post abortion contraceptive method.
  - Over 800 SBAs have been trained and the supply of trained personnel is growing rapidly. Trained SBAs are more often available but it is still the case that 80% of Nepalese women give birth without one.

<sup>53</sup> Improvements in Maternal Health In Nepal – Further Analysis of the 2006 Survey Prakash Dev Pant et al May 2008.

<sup>54</sup> Figures taken from Ensor et al op cit Health Policy 2008 and from Options consultants.

- 6.4 These results are encouraging but need to be treated with a fair degree of caution. Incentive schemes are relatively new and in the absence of more rigorous impact studies it is not possible to be definitive that demand financing policy and programmes are the cause of increased utilisation. There have also been some negative effects in the earlier programmes from perverse incentives that arose from de motivation of facility staff who did not receive incentive payments.<sup>55</sup> Some of our interviews also suggested that facilities still demanded payment even though official policy was to offer a free service.

## **7. Conclusions and Lessons**

- 7.1 DFID has a well established relationship with GON and is regarded as a major contributor to the efforts over the last decade to improve Safe Motherhood services. DFID expertise and technical support has had a significant influence over GON policy and programmes in all of the policy areas examined in the current evaluation. DFID influence and leadership appears to have been greatest in the area of demand side financing. GTZ contributed to the work on safe abortion policy and other donors were also engaged on the SBA policy.
- 7.2 The influencing model adopted has been resource intensive and used both consultancy and DFIDN staff time. Nevertheless, GON stakeholders are clear that this represented good value for money. Earmarked pooled funding has also been critical for financing specific programmes and activities to deliver services and introduce new programmes.
- 7.3 There are ongoing challenges around sustainability. Stakeholders voiced concerns about the need to address the longer term institutional and capacity building needs in the sector. There is also a concern that any reduction in technical assistance or earmarked financial funding could reduce DFID influence and make it difficult to sustain the current approach.

### ***Political context***

- 7.3 The political crisis in Nepal created conditions that prioritised state action to improve the status of women and specifically to address the problem of maternal mortality. The relationship that DFID and other donors had built up positioned the international community well to take advantage of an alignment of interests. Political awareness and ability to identify champions and support those interests pushing for change has been crucial to the progress made in Nepal. DFIDN was pro active in taking opportunities to lobby Ministers and to present the case for new approaches.
- 7.4 The Nepal experience underscores the need for DFID sector staff to actively assess the political context and its likely effects. The existence of political space for action and the response by the donors can be key determinants of whether an influencing effort succeeds or fails. There can also be trade -offs to be made in

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<sup>55</sup> Nepal Safe Delivery Incentives Programme Veronica Walford Sept 2008.

the specific policy options and this was apparent in the design of some of the incentives schemes where politicians were initially keen to have broader coverage. Risks of “political capture” are also considerable and DFID needs to be more alert to this.

### ***Linking Policy and Practice***

- 7.5 The influencing model used by DFIDN sought to link policy formulation with field practice and international experience. The approach has been resource intensive because specific policy areas required considerable effort to research, gather evidence, consider options and develop operational plans. Careful monitoring was also required. This rational evidence based approach has ensured policy makers have been well informed.
- 7.6 The readiness of the DOH to adopt this approach was critical to its success. Feedback from GON confirms that the having proposals grounded in evidence has been an important factor in strengthening DOHs case for more resources within GON. DOHs influence has therefore been strengthened.
- 7.7 The link between policy and practice also helped highlight the need to address additional demands on health services arising from financial incentives policies and safe abortion. DFID and the World Bank have helped Nepal to ensure that the capacity of the system can respond.

### ***Working with Other Donors***

- 7.8 There has been real progress with harmonisation and donors worked collectively toward common goals to influence policy change in areas like safe abortion. Non pooled funding donors retain a projectised approach but have are actively involved in sector policy dialogue.

### ***Role of DFID Staff and Consultants***

- 7.9 DFID advisers have engaged in a strategic way in policy dialogue and have had the benefit of good local knowledge of the political structures and personal contacts in the sector built up over a period of years. The fact that the lead adviser was formally working in the Ministry fostered working relationships. There have been benefits from staff continuity and long term residence in Nepal.
- 7.10 The Consultancy team provided a mix of international and Nepalese staff and have become embedded institutionally within DOH . GON welcomed the flexible way in which resources could be provided for a mix of strategic, policy and technical assignments. There are on going concerns about the need to give greater priority to capacity building and training of Nepalese staff both in the Ministry and in the management of Health facilities.

ANNEX F\_1: removed.

ANNEX F\_2 : NEPAL : DFID resources used on Influencing Programme

Staff Resources	% of time of post used on average each year on influencing effort	% of time of the post spent influencing FY 2005/6	% of time spent influencing FY 2006/7	Same for FY 2007/8	Same for FY 2008/9
Grade of post					
1.Head of office (SCS) - UK based	1%			1%	1%
A1 Health Adviser UK based	10%	10%	10%	10%	10%
A1 economic adviser		5%			
A3 SAIC health adviser	20%			20%	20%

Table A DFID Staff Used in Influencing: Cost Calculation

	Unit cost per annum *	Total Cost	Cost in 2005/6	Cost in 2006/7	Cost in 2007/8	Cost in 2008/09
Staff						
SCS Head of Office	£ 160,000	£ 3,200 (calculated as 0.01 x 2 x £ 160,000)			£1,600	£1,600
A2 Health Adviser UK	£ 120,000	£ 48,000 (calculated as 0.1 x 4x £ 120,000)	£12,000	£12,000	£12,000	£12,000
A1 Economic Adviser	£ 64,188	£ 3,209 (calculated as 0.05x1 £ 64,188)	£ 3,209			
A3 Health Adviser SAIC	£ 23,000	£ 9,200 (calculated as 0.2x2x £ 23,000)			£ 4,600	£4,600
<b>Total</b>		<b>63,609</b>	<b>15,209</b>	<b>12,000</b>	<b>18,200</b>	<b>18,200</b>

## Annex F\_2

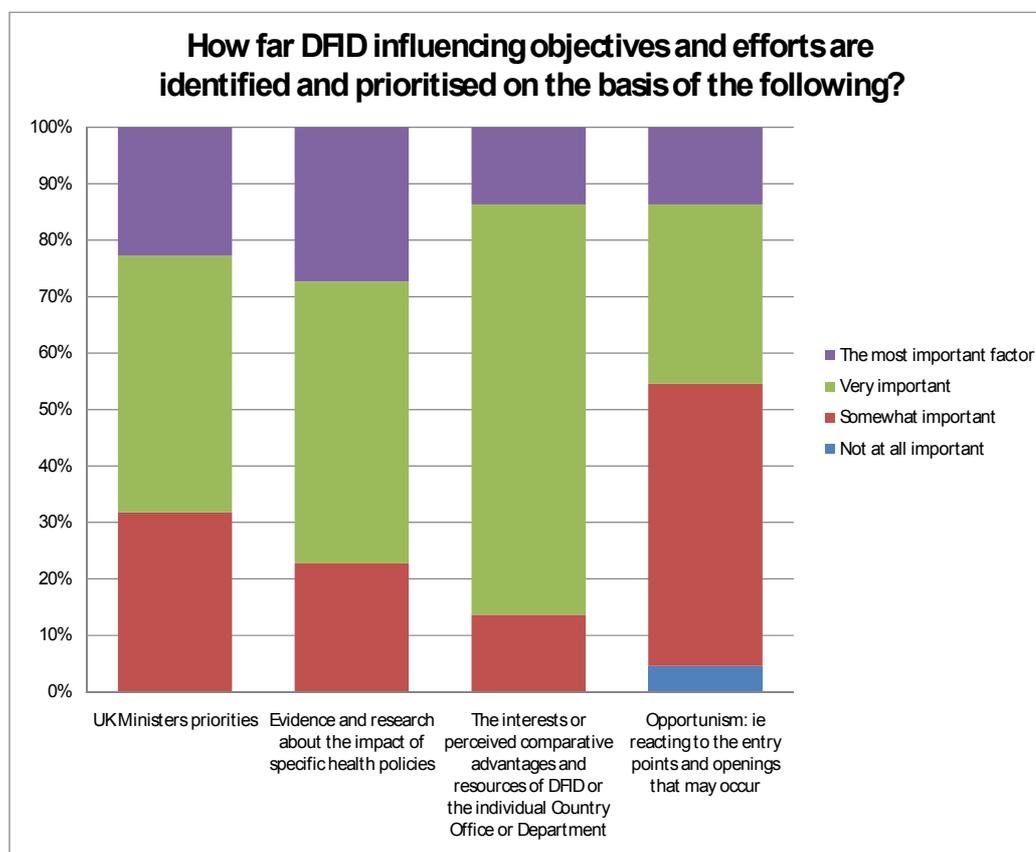
Table B: DFID Funded Experts Supporting Influencing Effort

	2004/5	2005/6	2006/7	2007/8	2008/9
Cost Constraints on Access Study	50,000				
International consultants- SMMP team leader and technical lead	27,000	27,000	27,000	27,000	27,000
AAMA Adviser		7,000	14,000	5,000	17,000
0.5 of a national adviser				6000	7,000
Process evaluation of SDIP (ICH London)			13,000	53000	3,000
Ensor design study for AAMA				28000	
Monitoring	8,000	8,000	8,000	8,000	8,000
<b>TOTAL</b>	<b>85,000</b>	<b>42,000</b>	<b>62,000</b>	<b>127,000</b>	<b>62,000</b>

Spend on DFID staff was £63,609 and on consultants was £378,000  
Total Spent by DFID on Influencing (Table A plus Table B) was £441,609

## ANNEX 4: PERCEPTION SURVEY

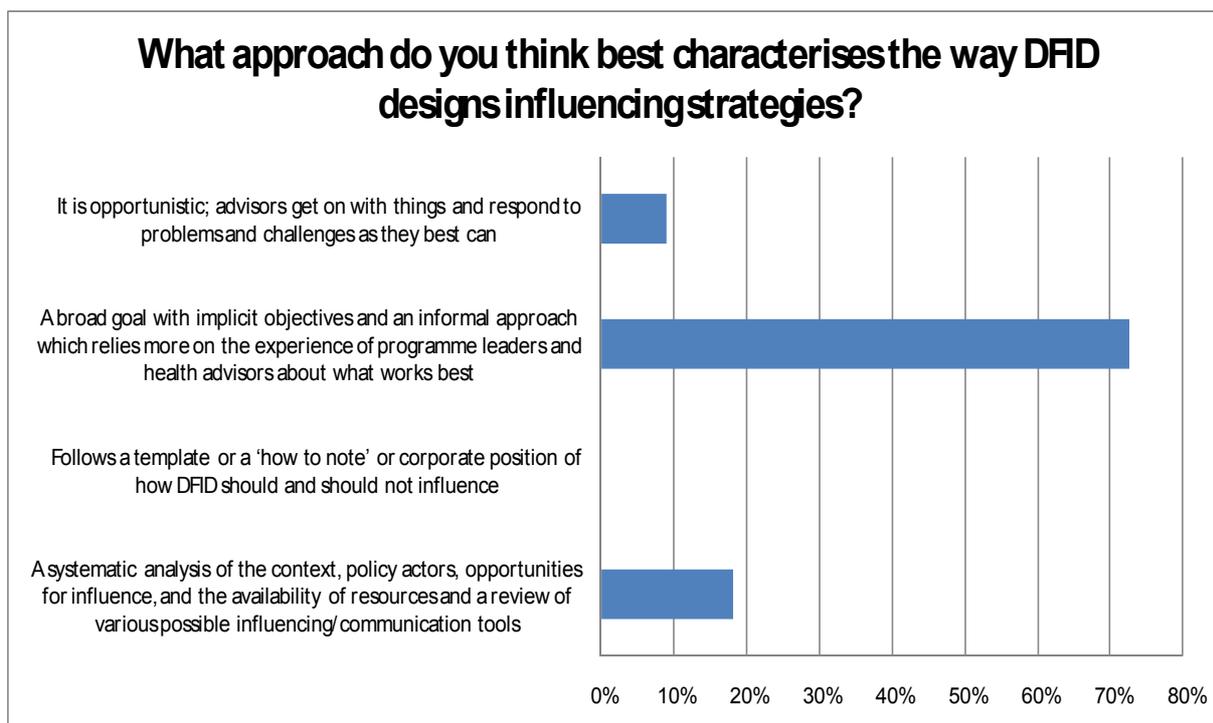
### Question 1



Other:

- Wider influence on DFID; for example, the U.S and some NGOs are critical
- Experience: we tend to do what we are used to doing
- The priorities and ways of working expressed by each individual country in which we operate
- Leadership from one or two influential advisers
- Work with International and local NGOs and civil society groups is very important

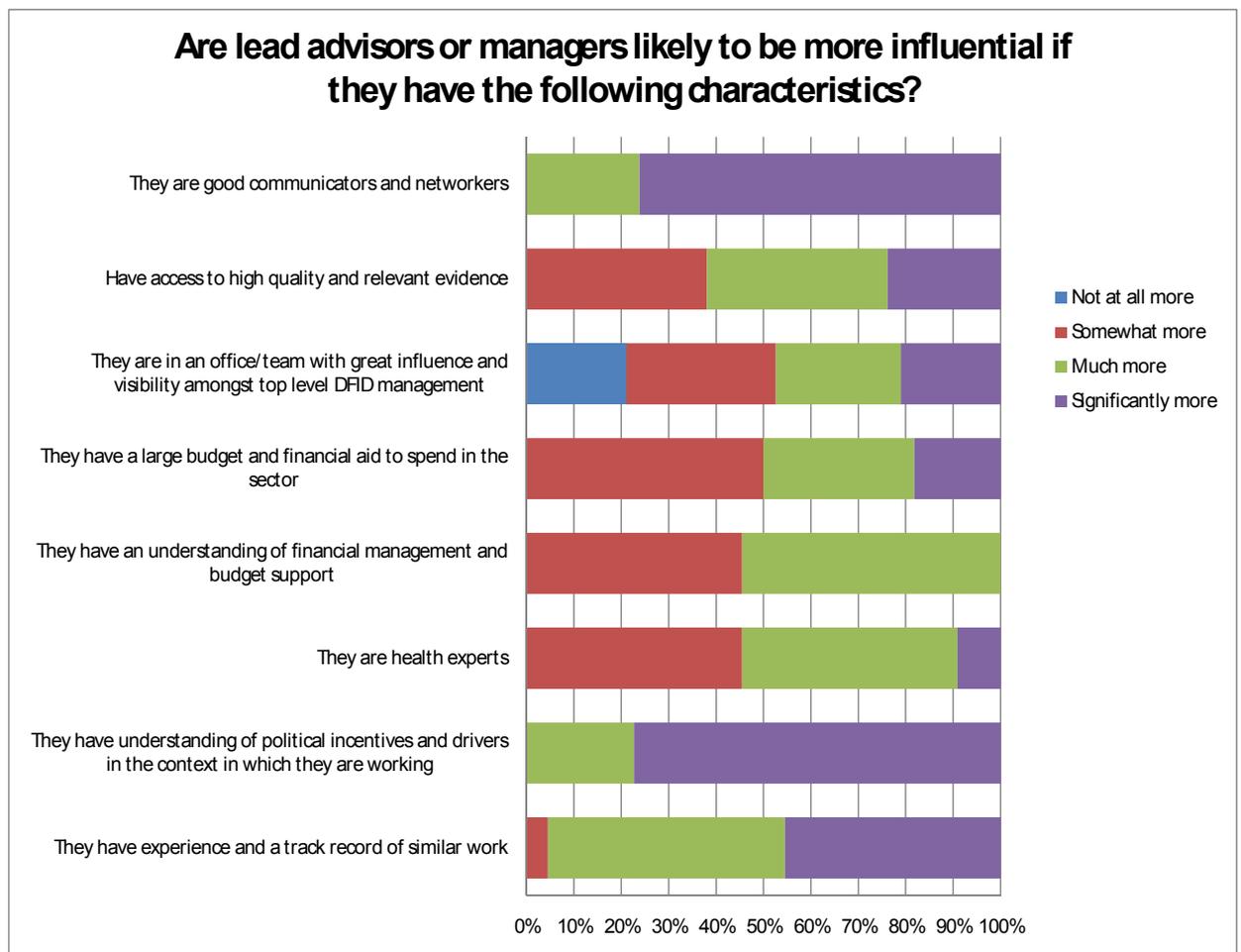
## Question 2



Other:

- The approach is a combination of 'a systematic analysis of the context' with the experience of health advisors

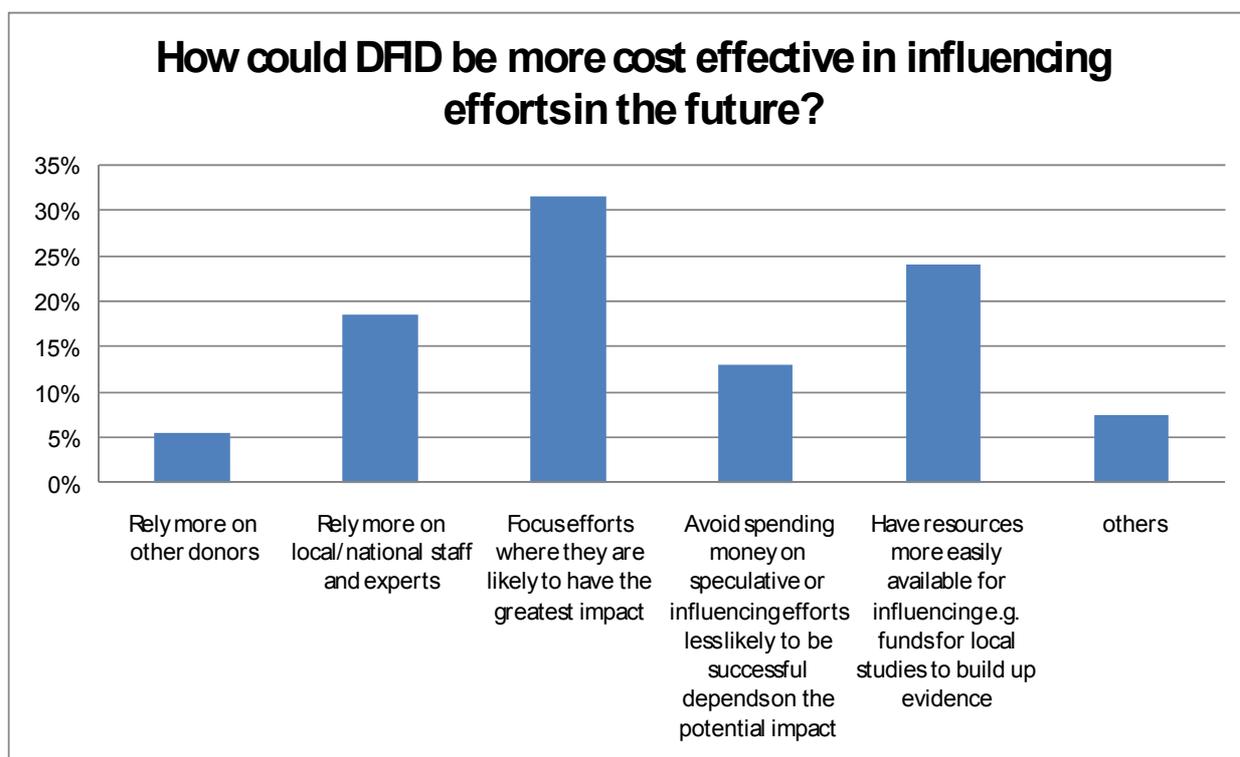
### Question 3



Other:

- Head of Office characteristics make a huge difference – they can support or crush policy influencing
- That they understand country context
- That they have influence with political leaders
- They are likely to be significantly more influential if they have excellent interpersonal and negotiating skills

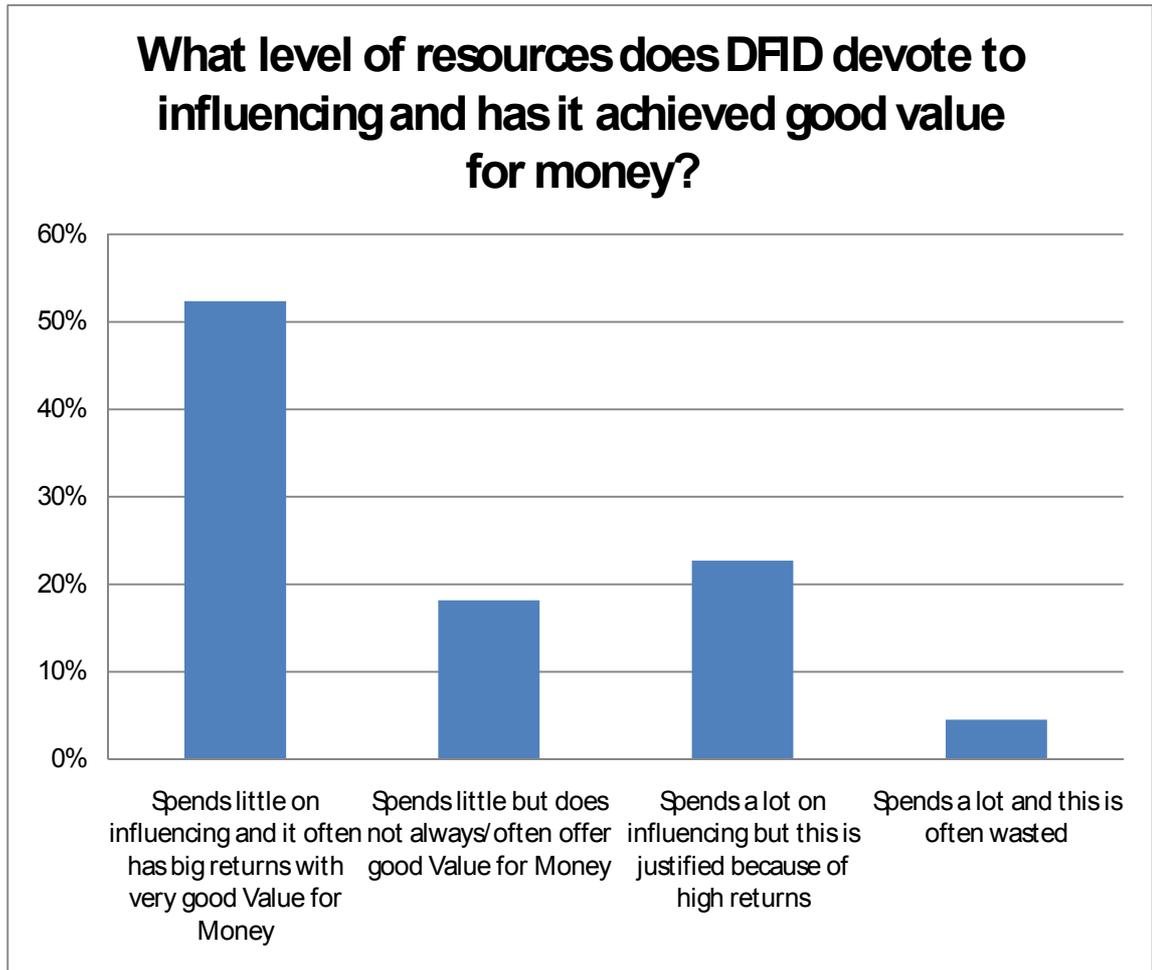
## Question 4



Other:

- Need to recognise amount of time advisers spend influencing. This is not in most PMFs
- Recognise the value of its health cadre and the skills its staff bring to bear on the influencing strategy - ensure they have sufficient time to devote to this agenda
- Pay more attention to what works and what doesn't work and ensure DFID speaks with one voice. Senior management in particular needs to pay more attention to country offices and professional experts and balance this with the demands of Ministers and UK politics
- Senior management could be more supportive by turning influencing successes into policy positions

Question 5



### **Question 6**

How appropriate and relevant to the needs of developing countries are DFID's Policy Objectives in the Health sector?

**80%**

### **Question 7**

How efficient, flexible and adaptable is DFID in managing and implementing influencing activities?

**62%**

### **Question 8**

How important is the role of health advisors in guaranteeing the success of a policy influencing strategy?

**80%**

### **Question 9**

Is DFID a leader in the donor community in developing and advocating new policy areas and approaches in health policy?

**75%**

**Other comments:**

- It is sometimes the rapid reaction to a question or a personal example that gives us influence - and less the large budgets or systems strengthening we give. Stories should be honest in focusing on that also: Trust, friendships and chance encounters.
- One area where we have been very influential in recent months is in encouraging the provision of health services free at the point of delivery. One example of this was in Ghana in May 2008, where a relatively short (2 weeks total) but focussed intervention involving a senior health adviser, the Head of Office and the Secretary of State resulted in the President of Ghana introducing free services for pregnant women in July. By the end of the year 433,000 pregnant women had registered for free services and there has been a surge in the number of supervised deliveries. The overall cost of the internal technical assistance was around £2,500.
- I think cost-effectiveness is very difficult to measure. Those of us that influence do it as a part of our job, not easily separated from other tasks.
- In China, DFID has completely transformed Government policy on HIV and AIDS by careful accompaniment, presenting the best evidence, and joining Ministry of Health colleagues in high level negotiations with the Public Security Bureau and other national and provincial level officials. If DFID had been heavy-handed, [this would not have worked]. By using an incremental and supportive approach, DFID made a huge difference.

## ANNEX 5: WORKING PAPER

### Background Paper: Cost Effectiveness of DFID’s Influencing Activities

By Mark Pearson and Yasmin Hadi

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### 1. Introduction

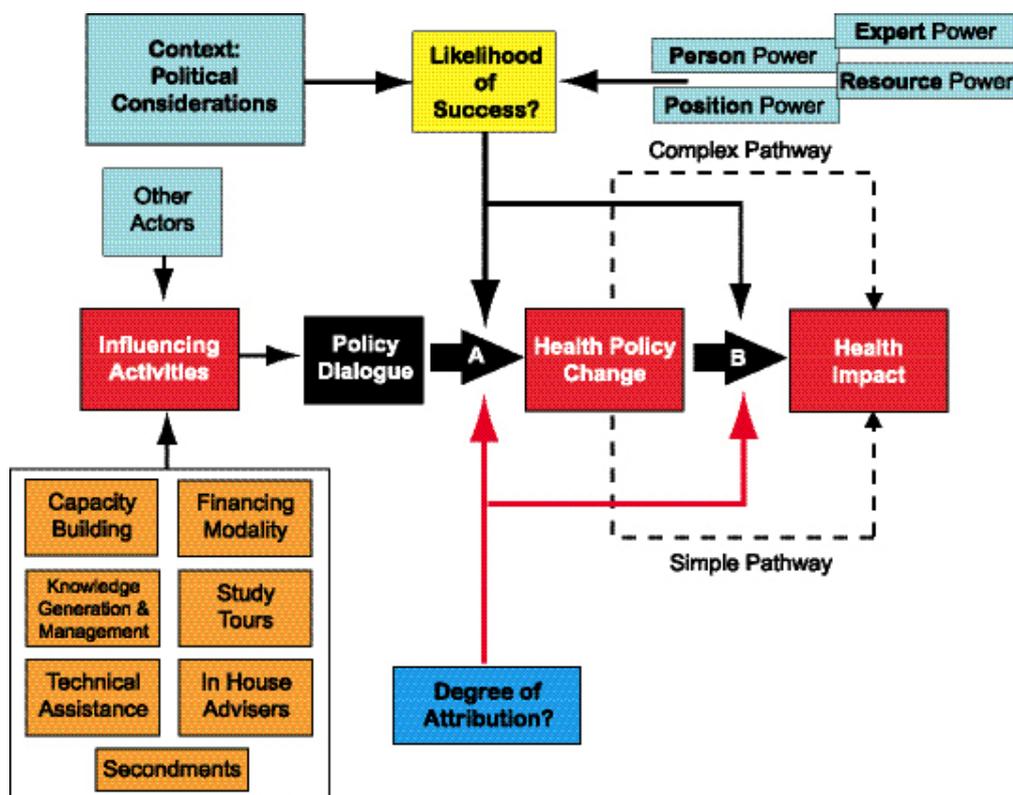
This short paper attempts to summarise the literature on the cost effectiveness of efforts to improve health outcomes through efforts to influence health policies. It also looks at options for improving analysis of the cost effectiveness of such activities. Full ToRs are at **annex 1**.

It should be noted upfront that many of the issues raised are not specific to the health sector. Specific issues related to health include – the major role played by global initiatives and multilateral agencies, the complex causal pathways and weak evidence based for health systems activities and the degree of fragmentation and harmonisation challenges this poses in the sector. Together these features mean that influencing can play an extremely important role in achieving sector objectives but also making the assessment of such effects increasingly challenging.

### 2. Framework for Analysis

The basic framework used in this paper is set out in Figure 1 below. It illustrates the possible role that policy dialogue – supported by a number of approaches (study tours, advisory inputs, research findings, technical assistance or secondments etc) might play in influencing behaviour change. It also shows that other actors may also be carrying out similar activities – indeed in many cases DFID’s influencing activities are carried out *through* other partners.

Figure 1: Schematic – Impact of Influencing Activities on Health Outcomes



Arrow A shows the link between influencing activities and health policy changes.

The likelihood of successful policy impact depends on a number of factors. The local context and, in particular, the political rationale for policy changes is often the key factor though policy dialogue may also play a role. The extent to which this is the case depends on DFID's ability to maximise its influence through harnessing its key strengths (position power – its presence on relevant Boards etc, resource power – its provision of financial support, expert power – its sound technical knowledge of “what works” and person power – its network of trust partners)..Attribution is an important issue – and is, in effect, impossible to resolve satisfactorily.

Arrow B shows the link between changes in health policies and health impact. In principle, this could be measured in terms of health outcomes or even DALYs. Again, a large number of variables will affect the extent to which impact is achieved; attribution remains an important factor.

The schematic also illustrates the fact that in some cases the pathway between the health policy change and expected health outcome is quite simple – in others it is far more complex. At one extreme might be a clinical intervention in which a research finding (a randomised control trial) demonstrates the superior cost effectiveness of a particular health intervention which is subsequently translated into a change in clinical guidelines (the policy change) which results in people in need of treatment getting better treatment than they would have otherwise (the health impact – measured in DALYs saved).

In other cases the pathway is far more complex. The influencing efforts might be focused on a multilateral or global health partnership with the results achieved being very diffuse (through a range of country programmes) often with long time lags. Equally, the intervention may be a complex systems reform where it is more difficult to tie outputs to outcomes (how does a better health information system lead to better access to key services?)

### ***3. Cost Effectiveness: To what extent should it guide the approach?***

Measuring cost effectiveness in the context of influencing activities raises a number of issues. First of all it is useful to distinguish between the cost effectiveness of the influencing activities themselves and the cost effectiveness of the interventions resulting from the policy changes which result from them.

In the case of the latter cost effectiveness may not be a valid objective and there may be other, more appropriate, ones. In practice cost effectiveness is often only a relatively minor consideration in resource allocation decisions with other factors such as the burden of disease, country preferences and equity often assuming greater importance. Nonetheless, cost effectiveness can still be a useful benchmark against which impact might be measured (it gives some indication of how much health impact is being given up by focusing on other goals. Although CEA does have its shortcomings (see Pearson 2008) there are useful, existing, international benchmarks against which the outcomes of policy changes resulting from DFID influencing activities might be judged. The WHO CHOICE project, (<http://www.who.int/choice/en/>) and **annex 2** for example, provides regionally based estimates of the cost effectiveness of a range of interventions. Although local cost factors might need to be considered the fact that the project finds huge differences between the cost effectiveness of different interventions suggests that the differences are likely to be real and applicable in all settings.

In the case of influencing activities cost effectiveness probably is a valid objective. It would be reasonable to ask whether the various inputs to the policy dialogue process are well balanced and likely to achieve results at the right cost. Essentially, did DFID advisers have the right ammunition for any policy dialogue and was this achieved at the lowest possible cost. (Could the same results have been achieved at lower cost?). However, the approach needs to be applied with a number of caveats:

Firstly, there are questions about feasibility. Some of the influencing inputs are relatively easily quantifiable – the cost of study tours or research for example. For others such as adviser’s time is less easy as certain tasks may be aimed at multiple objectives.

Secondly, where possible influencing outcomes are “all or nothing”, where potential benefits are huge or where a minimum, but typically unknown, level of effort is required to achieve a policy “tipping point” one would question whether a rigid application of cost effectiveness analysis is sensible. In such cases it might be better to over invest “just to be on the safe side”.

Third, it is also worth noting the bounded nature of any assessments of cost effectiveness. DFID is not completely free to allocate resources between possible influencing inputs. Advisory inputs are limited – the question is, therefore, one of how

best to use *existing* advisory inputs. The question of whether more advisory inputs is required is not simply a technical question – but needs to be viewed in the light of current constraints on staff costs.

Finally, the potential for long term and diffuse impacts also raises the question of the timeframe adopted and the degree to which only direct benefits are measured. The narrower the approach – the more likely benefits are to be under estimated

The next section considers a number of issues which affects the possible role for cost effectiveness analysis and builds on a number of the points made here.

#### ***4. Issues of relevance to the debate about cost effectiveness***

##### **4.1 Weak incentives to deliver proven cost effective approaches**

**Strong incentives to develop new and innovative approaches.** Whilst sustained improvements in health outcomes may require complex systems reforms significant progress can also be made by simply adopting existing, proven approaches more widely. An international working group on child mortality declared in the Lancet that: "application of what we know can reduce child mortality by two-thirds." The tendency of the donor community is often to focus on new solutions before fully realising the potential of existing ones.

##### **4.2 A weak evidence base – a failure to use what is there - and a slow response to the developing evidence base**

**The evidence base on what constitutes cost effective health policy is extremely weak.** Medical interventions are relatively easy to appraise given that outcomes tend to be uni-dimensional and processes and context are relatively unimportant. Even so , relatively few health interventions have been subject to gold standard double blind randomised controlled trials (RCTs) – and in many cases the results of those that have are applied in settings where the results might not be applicable (for different targets groups e.g. children rather than adults or in different settings). Indeed, some of the literature is even beginning to question whether RCTs are adequate.

There is even less evidence where more complex health policy and systems issues are involved. The user fee example is a case in point. Although DFID advocacy efforts in Ghana drew heavily on experiences from Zambia and Nepal the LSHTM researchers assessing the evidence base in Zambia suggest that “a recent systematic review ..... has highlighted the scarcity of robust evidence around the various consequences of introducing, removing and changing the levels of fees for health care in Africa’s health systems (Lagarde and Palmer 2006). In particular, the policy changes in Uganda and

South Africa have not been comprehensively evaluated”. Its preliminary findings on impact in Zambia are nuanced with positive but also negative effects and a clear recognition that key complementary actions are also required to make the policy succeed. Indeed, much of the case against user fees is built around the fact that having user fees is bad rather than that getting rid of them makes it better.

Health systems research – although seen as essential – is often seen to lack rigour – which tends to reduce its credibility. To a degree this is inevitable due to the multiple dimensions of performance and inability to use approaches such as RCTs. This emphasises the importance of systematic reviews which try to capture and synthesise the available evidence taking account of quality as part of the process.

More generally greater scrutiny of the evidence base in health in recent years has also revealed the many underlying weaknesses and it is now recognised that the quality of evidence is often extremely poor. The King’s Fund for example found that the evidence base for social programmes in the UK “is the result of haphazard and unrelated decisions by funders and researchers, so acting only on what has been shown to work could greatly reduce the scope for activity, and inhibit creativity and risk-taking”.

The key test here would be whether it is *reasonable* to assume – on the basis of available evidence – that a particular policy makes sense and that where there are some doubts than these should be fully reflected in any influencing messages given. This finding is consistent with that of the King’s Fund which suggests that much social policy in the UK is not strongly evidence based but is driven more by “informed guesswork and expert hunches, enriched by some evidence and driven by political and other imperatives” (On this basis the approach in Ghana appears reasonable – as it does identify some of the risk factors – the key question here is more about whether the approach is being oversold as the benefits suggested in the briefing note are extremely ambitious). Here a distinction might be made between influencing activities which try to change Government policies with activities which try to influence how a policy Government is committed to is actually implemented. The suggestion would be that promoting a change in policy requires a higher burden of proof.

**DFID needs to proactively seek out opportunities to build the evidence base – it would appear such opportunities are often being missed.** Where alternative innovative approaches are being adopted in a particular setting DFID should attempt to promote the harmonisation agenda by advocating for joint reviews. (In DR Congo EU has introduced performance based funding in some provinces, World Bank results based financing in others and DFID a no user fee policy in others. This would seem an ideal setting for a common review to find out what really works and why)

**Advocacy messages need to be simple – evidence is not:** There is often a (rather patronising but perhaps realistic?) view that messages need to be extremely simple to get policy traction. This raises the question as to whether the message being conveyed remains sound once largely stripped of its caveats and nuances.

**The need for flexibility in both use of instruments but also in terms of the message:** In addition to flexibility over the influencing instruments used it is also important that there is flexibility in the underlying message as more knowledge becomes available.

**The evidence base on what is cost effective influencing is almost non-existent** (see section 5)

### 4.3 Methodological questions

**Influencing activities are not always focused on immediate changes in policy**

The HPD Influencing study (Mundy et al 2003) (see **annex 3**) concluded that much of DFID's influencing activities are more about developing a shared understanding of key issues rather than aimed at any change in behaviour. The extent to which any new principles agreed as part of this process are applied are likely to be difficult to track and diffuse in nature. An overemphasis on the need to identify plausible pathways up front and for the activities to deliver immediate results could potentially lead to too much time and effort being spent on downstream, service delivery related, themes likely to have relatively little, but at the same time, relatively identifiable, impacts. Equally – sound influencing efforts may not bear fruit because of the prevailing political situation which create barriers to policy change. The key issue here is more one of understanding these barriers and tracking any changes with a view to potentially revisiting the issue at a later date when the context is more conducive.

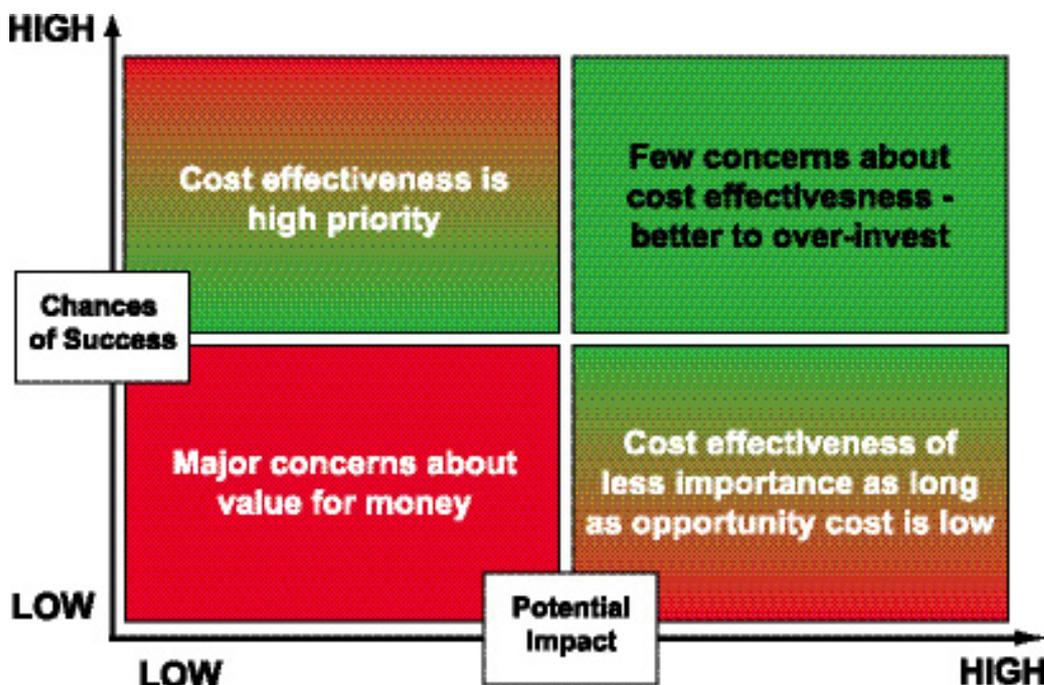
**The risk of taking an unduly narrow focus:** Focusing purely on the immediate objective of an influencing activity may mean wider systems effects are ignored. For example, increasing access to specific services may actually result in declines in other types of services – strengthening public services may also have knock on effects for private provision. The net impact may be positive or negative but either way – a narrow approach may only give a partial picture. (This is becoming increasingly important given the current shift towards performance based funding – with donor money being used to incentivise health workers to provide certain services – often at the expense of others)

**How to account for “deals”** In some cases influencing may involve other stakeholders doing things they really don't want to do but are willing to do so because they get something in return. (e.g. UK and French contributions to IFF and UNITAID). This being the case a true assessment of UK influencing would need to consider the overall impact of multiple, often unrelated, policy changes. (i.e. comparing the costs and benefits of DFID involvement in IFF and UNITAID as a single package)

**There are strong disincentives for actors to reveal their true preferences or views:** It will often be in the interests of consultants to overplay their role (they get more work), academic organisations to underplay the availability of systematic evidence (they get more work) advisers to over attribute impact (they get more kudos and get things moving) and other development partners to overestimate DFID's influence (to show they are an open, responsive organisation and perhaps also to create the impression that DFID may owe them something in return). Few would admit this – Pisani 2008 is an exception – readily admitting that UNAIDS manipulated HIV/AIDS statistics and evidence to build the case for a stronger HIV/AIDS response.

**The need to weigh relative importance with chances of success:** The table below shows some of the key dimensions which might also influence how DFID's influencing capacity might be deployed. Basically, it suggests that it might make sense to “over invest” where the potential health impact is greatest and where chances of success are reasonable. Given the low marginal costs and potentially huge benefits cost effectiveness should not be a major concern (a similar argument would be does it really matter if a measles immunisation programme is a bit inefficient – it will still be orders of magnitude more cost effective than say investment in anti retroviral therapy). Where likely impact remains high but chances of success low, cost effectiveness still remains a rather marginal issue – as long as costs are reasonable and opportunity costs

i.e. other opportunities, remain limited. Where potential impact is low issues of cost effectiveness issues might warrant greater attention. Where advisers are typically trying to achieve influence in a range of areas such a mapping might provide a useful framework for deciding how to allocate scarce advisory time and monitoring progress. This might also help identify situations in which DFID takes on too many influencing objectives (DFID, 2002a; Blackburn and Rodriguez-Carmona, 2002).



The strong suggestion from this is that influencing does not have to be particularly effective to be cost effective given what are often low marginal costs and high potential benefits. At the same time influencing is high risk and that one might expect a high failure rate. This should be considered a fact of life and not necessarily an indication of poor performance – at the same time there is a risk that limited resources are spread too thinly – suggesting that it may be better to risk over investing in a smaller number of areas where potential gains are great – than achieving a lot of successes in areas of marginal relevance.

#### 4.4 The importance of the specific policy context

**Building a strong case for a particular policy change from scratch is likely to be expensive. The marginal costs of influencing activities on top of this may be quite small:** Ensor et al ascribe the successful conclusion of their work on the Safe Motherhood Programme in Nepal to credible research work (the main cost) being disseminated through a variety of routes – punchy briefs, presentations and one to one meetings. The key conclusion from this would be to pick your targets well, ensure the delivery of a technically sound piece of research and then employ a range of approaches to spread the message. The study also suggested the importance of working with people close to the decision making process and also identifying possible ‘champions of change’ at an early stage. This finding would also suggest that whilst the marginal costs may be low if an effective case has been built up – research, groundwork to sensitise potential allies – significant time and resources might be needed to build such a case from scratch.

**Strategic approaches or opportunism (or both)?** A related question on the issue of focus might be whether the right policy issue was addressed given the objectives in mind. The aim of DFID's policy on user fees is to reduce financial access barriers and encourage access by the poor. Another, possibly more effective, approach might have been to have lobbied intensively for Governments to reallocate more of their resources to primary health care (i.e. focus on the 95% or more of public spend that is not accounted for by user fees). DFID might also, for instance, also have spent more time addressing/trying to counteract the German push for social health insurance. Such approaches might have led to nothing so would not necessarily have improved the outcome. The point, though, is DFID advocacy on user fees was pretty opportunistic – the process was kick started by the Ugandan Government – taken forward by an energetic, highly motivated DFID adviser – supported by the DFID health team on the basis that “we have to start somewhere”. Should it, and should the process in future be one in which the office corporately decides which its priorities are in terms of health financing? (To note: in terms of health financing DFID health strategy talks about improving aid effectiveness and removing user fees but says little of nothing on the choice of primary financing mechanisms nor issues of resource allocation (perhaps a reflection of the fact that strategies tend to reflect what is going on than what is needed??))

#### 4.5 Further Observations

**There are “win win” cases. *Being influenced also has its advantages*** DFID recently approved support of £50m for neglected tropical diseases (NTDs). This was seen as a payoff by DFID for concessions made by the US Government in trade talks. Investment in NTDs is amongst the most cost effective use of funds in the health sector (DFID should have done this anyway!). Either way the dialogue between Governments has resulted in major gains for HMG – in terms of two outcomes that would not have taken place otherwise.

**Reconciliation of influencing with country ownership:** The Ghana experience raises questions about attribution and the potential conflict between country ownership and influencing. The head of office talks about “Government has decided to own this decision rather than it appearing as another donor driven intervention” but then that “the President in making the announcement cited DFID's role in enabling this policy change to happen as the key determinant”.

**When to influence? First best and second best approaches:** Analysis of how the Global Fund could become more aligned is clearly a key outstanding question. It also raises the question, though, of whether earlier more effective or more intensive influencing efforts could have avoided many of the problems currently faced e.g. through the establishment of a Global Fund for Health rather than one focused on the three diseases. Probably not given the situation at the time but it does raise the question as to whether influence is being used “to make the best of a bad job” rather than make a good job in the first place.

**Constraints within DFID:** There are likely to be trade offs between DFID's human resource policies and its influencing activities. Influencing skills are not necessarily the foremost consideration in recruitment decisions – posting decisions are not based on a systematic analysis of the fit between an adviser's influencing capacity and the types of influencing needed at country level and turnover of staff often means people move on

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before they are at their most influential. In terms of skills development – influencing skills may receive relatively little priority as opposed to other areas such as updating technical knowledge.

### ***5. Specific Literature on Cost Effectiveness of Influencing***

The literature on the cost effectiveness on influencing is scarce – in fact there is little consensus on what influencing and advocacy actually mean. The literature, as it exists, tends to focus on questions of what works and why (effectiveness) rather than on issues of cost effectiveness. The only documented case of a cost benefit analysis actually being carried out which relates the costs of influencing with the ultimate outcome is that for Shell (Clarke 2008). However, even in this case it would appear that alternative approaches were not considered and the approach was a rather simple financial analysis (reflecting Shell’s commercial focus) rather than an overall analysis of benefits on society as a whole (a more complex analysis but one that DFID would be more interested in).

Other approaches described include approaches which assess selected experiences try to map the pathways of change in a sample of cases (Tear Fund, CIDA, CAFOD). The Citizen’s Advice Bureau, on the other hand, tries to projectise its campaigns and adopt a more systematic approach (though the resource implications are not known).

In principal, there would be nothing preventing DFID going down a similar route with advisory time assigned to different activities including influencing (e.g. by adopting a timesheet type approach to use of staff time – as consultancy companies do). Watson and Pearce found that managers in DFID based on pilot studies tended to “make these decisions implicitly as they prioritise staff time against competing priorities, however, this is not always done on the basis of a transparent analysis” and that staff struggled to allocate time to particular uses.

The need for a clearer link between the proposed benefits suggested as part of an advocacy/influencing programme and ultimate results. The Ghana user fee campaign has successfully support a change of policy – it remains to be seen whether the benefits “promised” by DFID actually materialise. The adoption of a more systematic link for some examples would help focus attention on the links between policy changes and outcomes but might also counteract any tendency to oversell any reforms.

In terms of systems wide impact of the global health initiatives Biesma et al<sup>56</sup> concludes that “speculation rather than systematic review of evidence characterizes current understanding of this major shift towards disease-specific funding, and its impact on health systems in recipient countries” although this is changing e.g. with the publication of the Global Fund evaluation. There is, on the other hand, greater consensus on the framework for assessing systems impact – facilitated by work of the

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<sup>56</sup><http://heapol.oxfordjournals.org/cgi/content/full/24/4/239/T3>.

Health Metrics Network. One of the key constraints in this area has been the lack of consensus on who should lead on health systems strengthening issues – WHO or the World Bank.

The literature on the impact of health systems interventions is developing (see for example World Bank HNP discussion series and WHO Alliance on Health Policy and Systems Research websites (see **annex 4**) as sources of what is available in terms of syntheses of health systems research and Health Metrics Network in terms of indicators of progress in terms of health systems development

## **6. Possible Recommendations**

Watson and Pearce found that though there are “some examples of good practice in policy dialogue planning within DFID.....the systems and tools used vary, and valuable lessons are not being systematically captured” and found “little evidence that teams are reviewing and evaluating this type of work”.

**Recommendation 1 would be for DFID to adopt a more systematic approach by projectising influencing activities where feasible.** This might include an initial appraisal of the proposed influencing approach (along the lines of a project memorandum). This would help ensure some form of strategic overview and analysis of alternative approaches (e.g. whether user fee abolition is the best way of addressing access barriers?). It could also consider the probability of different outcomes assessing their likely probability and possible impact (this assessment could be updated as part of the monitoring process to help give senior managers some perspective on whether favourable outcomes are more likely and why) It might also require a detailed critical analysis of the quality of the evidence and its relevance to the setting in question (this task could perhaps be out sourced to an appropriate academic institution).

The log frame can be a useful tool for this although the need for regular updating of the log frame as part of the monitoring process may represent a change of mindset but is, in principle, feasible. At the same time it will be important to document any changes in the approaches and targets and continually refer back to the original expectations, (Currently changes in log frames are poorly documented and given revisions it always appears that outcomes are successful as the log frame is typically adapted to what is achievable. This is particularly important where influencing is concerned as the success rate may actually be low and early decisions (to give up) may be appropriate.

Where causal pathways are simple it should be possible to try and link outputs to changes in access to health services and make more direct judgements on value for money. However, Kitson et al<sup>57</sup> suggest that even where the causal pathways appear

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<sup>57</sup> There has been a shift away from the traditional notion that getting evidence into practice is straightforward. Until relatively recently the spread of evidence was seen as a linear and technical process at the level of the individual, and was described as changes in clinicians' behaviour in line with evidence based guidelines [1]. Now there is widespread recognition that guideline implementation, and evidence implementation more generally, requires whole system change implicating both the individual and organisation ([2,3]).

simple and the evidence base overwhelming, behaviour changes are not automatic. It would still be important, therefore, to map the assumptions and risks which might interrupt the pathways. Where the policy effects involve more complex processes it will be increasingly important to map out the expected causal pathway – again with specific assumptions that can be tested over time.

Such approaches should certainly applied where the inputs are high or where expected benefits are large. There is less of a case when inputs are low and in cases where the approach is truly opportunistic perhaps representing a particular window of opportunity which could not have been foreseen beforehand. Even where this is the case it would again in principle be possible to map out expected benefits. Along similar lines Pearce and Watson suggest that “the extent of the analysis and planning for a particular policy dialogue process should be proportionate to the ambition of the objectives of the process and the novelty of the situation for DFID”.

One problem with the logframe approach is that the approach ends when activities have been completed. Given that the anticipated benefits (many of which will occur *after* the influencing activities have ended) form the basis of the project activities there would be no automatic assessment of whether any approach had been oversold or not. Whilst it is not possible to evaluate everything it does raise the question as to whether a Project Completion Report might be delayed and include a review of whether benefits have materialised or are likely to do so

### **Recommendation 2: reviewing existing methodologies**

At appraisal stage DFID needs to consider value for money (rather than just cost effectiveness) and thus consider possible trade offs with other policy goals e.g. equity when looking at ultimate outcomes. Where support is of a downstream nature it should be possible to try and quantify impact in terms of cost per DALY. For more upstream interventions what is probably most important is a thorough institutional appraisal to provide some reassurance that the desired changes are likely take place and some key indicators to give some indication of potential impact (which can ideally be measured as part of Government’s routine monitoring systems). Sensitivity analyses might be quite helpful to show the degree of behaviour change which would be needed to justify an investment. e.g. a conclusion that “DFID’s investment of £1m would be recouped if UNPFA’s procurement unit is able to reduce unit costs by x% which analysis suggests is achievable and when less tangible benefits are added this seems to offer good value for money”. Another possible approach might be to incorporate influencing activities into financial aid programmes as they are often linked as in some cases it might be possible to compare the share of total benefits with the share of costs down incurred through influencing. A similar approach might be necessary when DFID is only one amongst a number of other agencies trying to influence an outcome. This might require a subjective judgement of the relative role played by DFID and would run the risk of overestimation as suggested in earlier sections. More complex approaches (along the lines of the GBS evaluation) could be used in exceptional cases where the results are of particular interest to DFID but could not be used widely due to their resource implications.

Appraisal might also include a more explicit statement of the expected causal pathway e.g. strengthened UNFPA procurement – reduced unit cost of delivery and more effective technical support to countries – increased availability and management of resources at country level – more resources at the facility less and less stock outs –

greater utilisation of health services. The degree of uncertainty might also be better reflected by setting out the range of possible outcomes - i.e. to suggest whether the approach in question is “either/or “i.e. success/failure or whether there is a range of possible outcomes – to give an idea of the level of risk involved.

At the design stage it would also be useful to focus explicitly not just on the size of potential benefits but also on risks/chances of success and also on the extent to which benefits are likely to be immediate/long term or direct/indirect. The risk is the DFID could miss major opportunities if it focused only in areas where benefits are high, up front and direct as might be the case otherwise. This paper also suggests that scarce advisory input is best used assessing the cost effectiveness of influencing approaches where the chances of success is high but the potential impact is relatively low. Assessing potential impact is likely to involve a combination of using available research and possibly commissioning work in country.

Other measures might include:

- ensuring alternatives are considered more systematically at the outset and not as an after thought (as is often the case at present?)
- an assessment of opportunities for future lesson learning at the programme design stage.

**Recommendation 3:** To promote a **more forward looking approach** DFID might give more thought to identifying future influencing targets. To enable early preparatory work to get going – e.g. by commissioning work, devoting time to scenario analysis at retreats etc. It should also consider the relative role for a strategic approach to certain issues and allowing a more opportunistic approach in certain settings. Given that the costs of influencing are often low and the potential benefits high the issue will often not be how to improve cost effectiveness but how to reduce the failure rate. More detailed analysis of failures might therefore be helpful

**Recommendation 4:** Continuing efforts to **strengthen the knowledge base**. This might include a range of activities:

- commissioning health systems research in neglected but important areas (expanding the current evidence base) ,
- supporting efforts to carry out systematic reviews of existing evidence,(making better use of the existing evidence base)
- promoting measures to help get research into practice<sup>58</sup> (making better use of the existing evidence base). This could involve DFID actually funding such measures – alternatively it could pass this responsibility on to the research community but build this more strongly into design
- considering mechanisms to allow country advisers to carry out operational research (to help validate international findings which may not be proven in a local setting)

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<sup>58</sup> Despite a growing awareness that getting evidence into practice is a complex, multi-faceted process, there remains a lack of knowledge about what methods and approaches are effective, with whom and in what contexts. Kitson et al.

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- specific reviews on the cost effectiveness of different instruments aimed at influencing – e.g. study tours where there are fears about poor cost effectiveness
  - proactively seeking ways of promoting better coordinated health systems research at the design stage – more harmonised approaches e.g. multi donor review of systems strengthening approaches in DR Congo

**Recommendation 5: Strengthening advisory capacity** to undertake effective influencing activities. This might include a number of activities including:

- more intensive training on influencing – e.g. getting advocacy specialists to advise DFID and drawing on successes from other sectors like climate change (to strengthen person power)
- more systematic posting policy linking skills to needs (are public health specialists the best influencers? Do particular posts require different types of skills?)
- minimum posting lengths to maximise influencing outputs (and possibly including greater use of local staff who have the added advantage of better awareness of context). Selective use of HQ staff where they add value.
- strengthen continuing professional development of advisory staff (to strengthen expert power)
- better capture of best practices and lessons learned from field and better knowledge management and dissemination of these *within* DFID.

### **Annex 1: Terms of Reference**

1. review and summarise relevant literature assessing cost effectiveness of efforts to influence health policy
2. set out the range of options for donors and DFID to improve their appraisal of cost effectiveness of:
  - the effort and resources used to effect a given policy change
  - the link between the policy change influenced by DFID and the effects from implementing the policy
3. The main focus of the work is on ways to link influencing with for example observable shifts in public spending, utilisation , service quality etc in partner countries so that in future DFID can more systematically measure the effects of its influencing on policy change and the results of that policy.
4. The report should provide recommendations and proposals on how DFID could improve its analysis of cost effectiveness of influencing and its ex post assessment of what has been achieved

<b>Element</b>	<b>Implications for DFID</b>
Resource Power	Likely to be maintained/increased as DFID aid budget increases – more rapidly than other key donors?
Position Power	Likely to decrease as role of other development partners grows e.g. South Africa, India
Expert Power	Need to commission high quality policy systems based research  Strengthen/make more space for continued professional development for staff
Person Power	Mechanisms to recruit the right people – ensuring greater fit between adviser skills and context requirements - keeping staff in post longer/more use of locally recruited staff

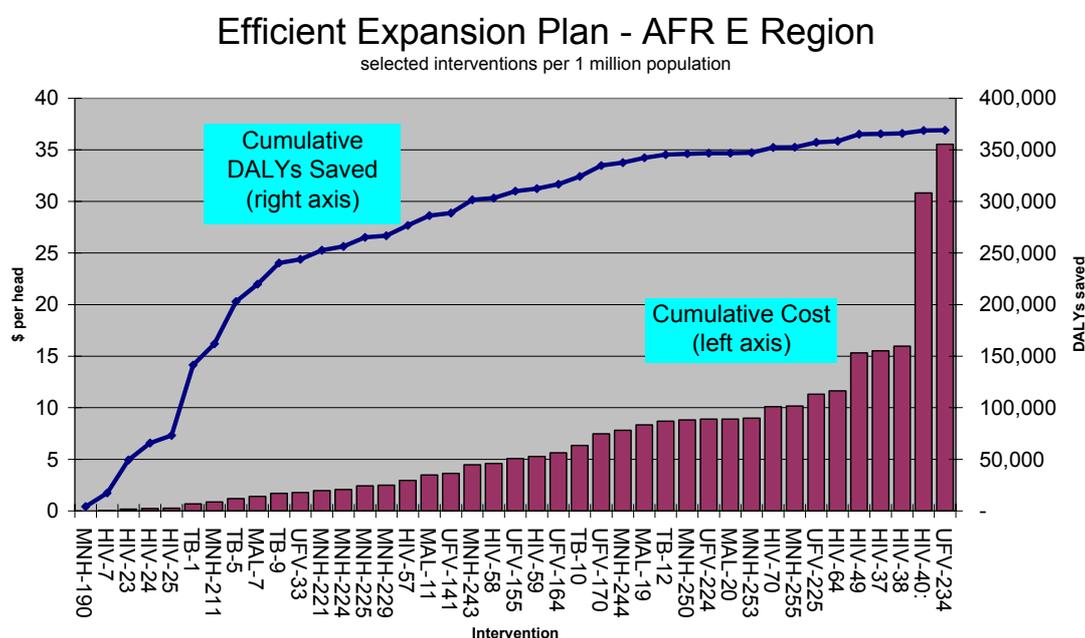
## Annex 2: WHO CHOICE model – a benchmark for appraising cost effectiveness

The following section takes real data from the WHO CHOICE<sup>59</sup> model and outlines what constitutes an efficient use of resources based on the assumptions it uses and considers the implications of adopting less optimal approaches

### What is an efficient expansion plan? (the most efficient use of resources)

The table below shows the **efficient expansion plan** (adding interventions according to their marginal cost effectiveness) for 5 diseases (HIV/AIDS, malaria, TB, childhood diseases, maternal and neonatal health) for incremental spending on health in AFR E<sup>60</sup> region.

It shows that as we move from left to right we move from the most cost effective interventions (in this case community-based case management for neonatal pneumonia) to the least cost effective ones (in this case adding CFGM<sup>61</sup> to Vit. A Suppl., Zinc Suppl., ORT & CM (@95%) + Measles vaccination (@95%). This is reflected in the fact that as the total expenditure increases the *additional* health gains tend to decline. Spending \$5 per head saves 300,000 DALYs per 1 million population, saving \$10 per head saves around 350,000 DALYS whilst spending \$35 per head (with most of the increase accounted for by moving from simple HAART with DOTS to HAART plus with DOTS) adds very little more in terms of benefits. In short, there are **declining returns** as investment increases.



<sup>59</sup> The CHOICE model uses regional estimates of costs and the strength of evidence on effectiveness is variable.

<sup>60</sup> Botswana, Burundi, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Uganda, United Republic of Tanzania Zambia, Zimbabwe.

<sup>61</sup> Improved complementary feeding through nutrition counselling and providing nutrient dense food for all underweight children 6-12 months old identified through growth monitoring and promotion (CFGM).

### ***Annex 3: Best Practice – HPD Influencing Study***

Best practice suggests that the most successful influencing strategies:

- Set explicit outcomes and have clearly identified objectives
- Have a clear influencing strategy, which includes clear tactics for influencing activity – i.e. “path of influence” mapped out.
- Select and combine from the variety of influencing channels and instruments available, focusing on relative merits of different approaches and using different approaches for different issues, as appropriate
- Prioritise influencing effort and resources at the most impactful points of leverage. Carefully consider where specific inputs and resources should be focused, based on priorities.
- Identify and map the current position and motivations of all decision-makers / stakeholders and carefully chose influencing targets. Consider the people to be influenced and an approach devised based on what is already known about these targets.
- Recognise and build on strengths where credibility exists – e.g. technical understanding, experience of governance / structures, personal relationships, expert knowledge and credibility of available consultants, in-country knowledge, social capital relationships and so forth
- Take into account the imperfect aspects of the wider environment, planning for and anticipating change. Objectives to be realistic and flexible enough to be able to respond to this. Ongoing review of the context with continuous planning and re-shaping of intended path of influence.
- Collaborate with stakeholders, building and working with likeminded groups and strategic alliances as appropriate. Consider sharing tactical activities and therefore collective time resource with likeminded organisations and individuals, including other donors.
- Have a realistic timeframe

#### ***Annex 4: Example of Systematic Reviews – WHO Alliance for Health Policy and Systems Research***

<a href="#">Audit and feedback – Does providing healthcare professionals with data about their performance improve their practice?</a>
<a href="#">Caps and co-payments–What are the impacts of policies regarding direct patient payments for drugs?</a>
<a href="#">Conditional cash transfers–Do conditional cash transfers improve the uptake of health interventions in low and middle-income countries?</a>
<a href="#">Contracting out – Does contracting out services improve access to care in low and middle-income countries?</a>
<a href="#">Distribution – Which interventions increase the proportion of health professionals practising in rural and underserved areas?</a>
<a href="#">Educational meetings – Do continuing education meetings and workshops improve professional practice and healthcare outcomes?</a>
<a href="#">Guideline dissemination – Which clinical guideline dissemination strategies improve professional practice?</a>
<a href="#">Immunization coverage – Do parent reminder and recall systems improve the rates of routine childhood immunisations?</a>
<a href="#">Integration – Does integration of primary healthcare services improve healthcare delivery and outcomes?</a>
<a href="#">Lay health workers – Do lay health workers in primary and community health care improve maternal and child health?</a>
<a href="#">Nurse practitioners – Do nurse practitioners working in primary care provide equivalent care to doctors?</a>
<a href="#">Outpatient referrals – Do educational, organisational or financial interventions improve outpatient referrals from primary to secondary care?</a>
<a href="#">Outreach visits – Do educational outreach visits improve health professional practice and patient outcomes?</a>
<a href="#">Pay for performance – Does pay-for-performance improve the quality of health care?</a>
<a href="#">Preventive services – Do educational, organisational or financial interventions improve the delivery of preventive services in primary care?</a>
<a href="#">Private for-profit sector – Can working with private for-profit providers improve utilization and quality of health services for the poor?</a>
<a href="#">Risk sharing – Does risk sharing mechanisms improve access to health services in low and middle income countries?</a>
<a href="#">Specialist outreach – Do specialist outreach clinics in primary care and rural settings improve care?</a>
<a href="#">Traditional birth attendants – Does training traditional birth attendants improve health behaviours and pregnancy outcomes?</a>
<a href="#">User fees – Does user fees have an impact on the access to health services?</a>

## DFID STATEMENT OF PURPOSE

DFID, the Department for International Development: leading the British Government's fight against world poverty. One in six people in the world today, around 1 billion people, live in poverty on less than one dollar a day. In an increasingly interdependent world, many problems – like conflict, crime, pollution and diseases such as HIV and AIDS – are caused or made worse by poverty.

DFID supports long-term programmes to help tackle the underlying causes of poverty. DFID also responds to emergencies, both natural and man-made.

DFID's work forms part of a global promise to:

- halve the number of people living in extreme poverty and hunger
- ensure that all children receive primary education
- promote sexual equality and give women a stronger voice
- reduce child death rates
- improve the health of mothers
- combat HIV and AIDS, malaria and other diseases
- make sure the environment is protected
- build a global partnership for those working in development.

Together, these form the United Nations' eight 'Millennium Development Goals', with a 2015 deadline. Each of these Goals has its own, measurable, targets.

DFID works in partnership with governments, civil society, the private sector and others. It also works with multilateral institutions, including the World Bank, United Nations agencies and the European Commission.

DFID works directly in over 150 countries worldwide, with a budget of some £5.3 billion in 2006/07. Its headquarters are in London and East Kilbride, near Glasgow.

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