HEART
HEALTH & EDUCATION ADVICE & RESOURCE TEAM

Helpdesk Report: Different Funding Modalities for Health - Update

Date: 7th February 2014

Query: This is an update on the 2011 report which responded to the following questions: What is the evidence on providing health funding support through unearmarked sector budget support (SBS) as opposed to disease specific funds or programmes? Are there specific outcomes that can be attributed to different funding modalities? Are there any outcomes (or outputs) that can be linked to the way support is provided including sustainability or institutional strengthening?
Is one way or the other way better or worse for outcomes?

The update is results from a rapid search highlighting recent SBS evidence and documents on other aid instruments as they arose.

Content

SECTION A: Update

A1. Overview

Key findings:

- Sector budget support has generated some impressive results in the health field in the East Africa context (The Independent Commission for Aid Impact, 2012).
- A previous helpdesk review (Holley, 2012) finds evidence showing the benefits of budget support and deeming it cost effective.
- EC sector budget support contributed significantly to financing staff retention schemes, but data available do not permit a precise statement of impact (Particip GmbH, 2012)

- An ODI evaluation (Tavakoli, H. & Hedger, E., 2010) shows negative effects on resource allocation of switching from General Budget Support (GBS) to a Health SWAp.
- Peters et al. (2012) find SWAps have contributed to the development of robust national health policies and transparent expenditure frameworks as well as strengthening institutional capacity, though levels of success vary widely.
- IBRD/World Bank (2013) finds positive impact for results-based financing.
- Country specific resources including reviews and evaluations of aid impact in Malawi, Kenya and the South Pacific region can be found in section A6.

A2. Budget support effectiveness

The Management of UK Budget Support Operations
Independent Commission for Aid Impact (2012)
http://www.oecd.org/derec/50359937.pdf

The value for money of budget support is determined by the overall efficiency of public spending on poverty reduction. Many factors can influence this, from the quality of budget processes to the accuracy of national statistics. The quality of national procurement systems is an important factor. There is evidence from case study countries that funds transferred from the national budget down through sub-national government to local service delivery units (e.g. schools and health centres) often suffer substantial losses, due to excessive layers of bureaucracy. This can significantly undermine the value of national development expenditure and therefore of aid funds provided via the national budget.

In the East Africa context, budget support has led to an unprecedented expansion in development expenditure and the scope of basic services. This has generated some impressive results, particularly in the health field.

Cost Effectiveness of Budget Support and Technical Assistance for the Health Sector
Holley, C. (2012) HDRC
http://www.heart-resources.org/wp-content/uploads/2012/01/Cost-Effectiveness-of-Health-Sector-Support-Strategies-January-2012.pdf

This HDRC (now HEART) helpdesk report shows that there have been many reviews highlighting the benefits of budget support and deeming it cost effective. It has been said to provide many benefits, including enabling partner governments to increase expenditure on priority areas, provide more services, particularly in health and education, increased the capacity of partner governments to plan and deliver services effectively and to develop better poverty-focused policies, strengthen their financial management systems and good economic management.

Technical assistance has been written about as an idea of the past and shown to be ineffective and costly by many. It is seen as relatively expensive, and this has been exacerbated by tied aid. However, there are different approaches, with some being more cost effective than others, there has been a trend towards arrangements where donors pool their funds for technical assistance to improve coordination and encourage country leadership. It is often said that reliance on Western providers results in high costs, but some studies have noted that local providers are not always significantly cheaper, particularly in Africa.

A3. Sector wide approaches (SWAps)

Sector-wide approaches (SWAps) in health: what have we learned?
Peters, D.H., Paina, L. & Schleimann, F. (2012) Health Policy and Planning, 2012; 1-7

http://heapol.oxfordjournals.org/content/early/2012/12/11/heapol.czs128.full.pdf+html

SWAps have contributed to the development of robust national health policies and transparent expenditure frameworks as well as strengthening institutional capacity, though the levels of success vary widely. Government stewardship of donors and local stakeholders as well as their political will to implement health strategies also vary highly. Although SWAps are geared towards consensus building policy changes at the national level, in the face of urgent global health concerns, notably the HIV epidemic, donors often by-passed SWAp arrangements through global health initiatives intended to address international priorities. Yet, a key to sustaining global health initiatives is how well they can be integrated into national health systems, a task requiring a return to SWAp principles. Despite shortcomings, SWAps have remained a popular approach for supporting alignment, harmonisation and improved accountability between donors and country governments, increasing predictability of aid and reducing fragmentation. The future of SWAps will depend on stronger government oversight and innovative institutional arrangements to support health strategies that address the need for both targeted initiatives and stronger health systems to provide a wide range of public health and clinical services. For development assistance to be more effective, it will also depend on better discipline by donors to support national governments through transparent negotiation.

Effectiveness of sector-wide approaches in fragile contexts
Lucas, B. (2013) GSDRC
http://www.gsdrc.org/docs/open/HDQ1031.pdf

This GSDRC helpdesk report synthesises reviews that have been undertaken to assess the effectiveness of working through a Sector Wide Approach (SWAp) in fragile contexts, specifically focusing on health and education SWAps and decentralised contexts. It finds that there is no consistently strong evidence that sector-wide approaches (SWAps) have been effective at achieving development outcomes in fragile contexts. Available evidence is mixed, partly because of the uniqueness of each country's context. SWAps are generally considered to be most appropriate in relatively stable low- and middle-income countries, with national political leadership and institutional capacity considered to be prerequisites. However, there is some evidence that if given sufficient time, a mature SWAp can contribute to stabilisation and state-building processes. Processes of decentralisation can either enhance or undermine state-building objectives depending on context. This report presents brief summaries of a selection of health and education sector reviews completed within the last four years, covering a range of fragile and conflict-affected states in Asia, the Pacific, and Africa.

Do Sector Wide Approaches for health aid delivery lead to 'donor-flight'? A comparison of 46 low-income countries
Sweeney, R., Mortimer, D. & Johnston, D.W. (2014) Social Science and Medicine, Volume 105, pp 38-46
http://www.sciencedirect.com/science/article/pii/S0277953613007181

This paper utilises a uniquely compiled dataset of 46 low-income countries over 1990–2009 and a variety of panel data regression models to estimate the impact of health SWAp implementation on levels of health aid. Results suggest that amongst 16 especially poor low-income countries, SWAp implementation is associated with significant decreases in health aid levels compared with non-implementers. This suggests donors are not indifferent to how their contributions are allocated by recipients, and that low-income countries considering a SWAp may need to weigh the benefits of greater control of aid allocations against the possibility of reduced aid income.

Aid effectiveness in Malawi: options appraisals and budget support
Tavakoli, H. & Hedger, E. (2010) ODI
http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/5800.pdf

This Project Briefing examines an attempt by the Overseas Development Institute (ODI) to develop and apply a framework to enhance measurement of the net benefits of different options for DFID aid delivery in Malawi: an options appraisal. It looks at why DFID has strengthened its economic appraisal and summarises the methodology and findings from Malawi. Finally, it considers the implications for operational practice and gives recommendations for the design of options appraisals in the future.

The results show the net effect of switching away from General Budget Support (GBS) on the overall volume of budget resources allocated to priority areas of the poverty reduction strategy, expressed as a proportion of planned DFID expenditure. The 'base case' option of continuing GBS is preferable, marginally, to the other two options (Health SWAp and Water and Irrigation Programme). Switching to those options would have a net cost in terms of changes in priority spending, and shows a rating that is 'moderately negative'.

This does not mean that GBS is without challenges, but that providing GBS produces incremental gains over and above the possible alternatives. The expectation is that GBS would result in more resources for priority areas of the MGDS after accounting for transaction costs, leakages in the general budget and the interest costs of domestic borrowing.

It is important to note that the analysis draws a distinction between net benefit streams for which there is a good evidence base (termed 'Category A'), and those where a higher degree of judgement ('Category B') is needed. If 'Category B' estimates are excluded the preferred options become the Health SWAp and the Water and Irrigation Programme.

There is a trade-off in the appraisal methodology between the basic credibility of a comprehensive analysis that includes all assumed costs and benefits and the rigour and reliability of including only those costs and benefits that can be properly measured. This study attempted to follow the second approach, and it became clear that the assumptions used in the model are critical to the overall results.

The most significant benefit comes from the influence of donors on government spending allocations, inherent in GBS. By focusing primarily on quantifiable benefits and trying to avoid implausible assumptions, the model relies on a small number of factors to measure effectiveness. Marginal changes in these assumptions can have a significant impact on the net benefits of the different approaches. This focus on quantifiable results produces only a partial analysis of the net benefits of GBS and risks producing a skewed assessment that may be an unreliable guide for policy decisions. More work is needed, therefore, to understand better and explain more fully the assumptions underlying the analysis.

A4. Aid effectiveness

How Much Does Aid Effectiveness Improve Development Outcomes? Lessons from Recent Practice
Killen, B. (2011) Busan Background Papers
http://www.oecd.org/dac/effectiveness/48458806.pdf

Health has been studied in detail from the point of view of aid effectiveness. Findings here – ranging from early work on Sector-Wide Approaches (SWAPs) in the 1990s to the findings of the High Level Forum on the Health MDGs and Working Party on Aid Effectiveness's task team on Health as a Tracer Sector – have underlined the importance of the Paris principles for delivering development outcomes. Ownership (particularly in the form of strong health sector plans linked to the budget and medium term expenditure framework); alignment

(especially through support for countries' health systems) and predictable long-term finance in particular have emerged as key factors in supporting better health. Two examples from evaluations in Tanzania show how effective support to country led-strategies and capacity development reduces child mortality.

Child mortality rates in two large rural districts of Tanzania have fallen by more than 40 per cent over five years following a unique 10-year project carried out by a team of Canadian and Tanzanian researchers and health workers. The Tanzania Essential Health Interventions Project (TEHIP) provided health planning teams in the districts of Morogoro and Rufiji with the tools, strategies, and funding increases of US $1 per person per year to improve on-the-ground health care delivery. The key was focusing not on how much was spent on health care, but on how it was spent. By ensuring that limited resources were spent on the diseases that caused the greatest harm, that the right medicines were available at the right time, and that health personnel were trained to treat patients effectively, the project has proven that a country-led integrated approach to managing a health system is key to improving community health.

The Health Metrics Network (a donor institution hosted by WHO) invested in some of the poorest districts, to support planning, management and strengthening of health information systems with community involvement. This aid for effective country health systems has contributed to a 50% reduction in child deaths between 1997 and 2006.

The Impact of Official Development Aid on Maternal and Reproductive Health Outcomes: A Systematic Review

Taylor, E.M. et al. (2013) PLOS One
http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0056271

Progress toward meeting Millennium Development Goal 5, which aims to improve maternal and reproductive health outcomes, is behind schedule. This is despite ever increasing volumes of official development aid targeting the goal, calling into question the distribution and efficacy of aid. The 2005 *Paris Declaration on Aid Effectiveness* represented a global commitment to reform aid practices in order to improve development outcomes, encouraging a shift toward collaborative aid arrangements which support the national plans of aid recipient countries (and discouraging unaligned donor projects).

We conducted a systematic review to summarise the evidence of the impact on MDG 5 outcomes of official development aid delivered in line with Paris aid effectiveness principles and to compare this with the impact of aid in general on MDG 5 outcomes. Searches of electronic databases identified 30 studies reporting aid-funded interventions designed to improve maternal and reproductive health outcomes. Aid interventions appear to be associated with small improvements in the MDG indicators, although it is not clear whether changes are happening because of the manner in which aid is delivered. The data do not allow for a meaningful comparison between Paris style and general aid. The review identified discernible gaps in the evidence base on aid interventions targeting MDG 5, notably on indicators MDG 5.4 (adolescent birth rate) and 5.6 (unmet need for family planning).

This review presents the first systematic review of the impact of official development aid delivered according to the Paris principles and aid delivered outside this framework on MDG 5 outcomes. Its findings point to major gaps in the evidence base and should be used to inform new approaches and methodologies aimed at measuring the impact of official development aid.

Thematic evaluation of the European Commission support to the health sector
Particip GmbH, (2012)

http://ec.europa.eu/europeaid/how/evaluation/evaluation_reports/reports/2012/20121217-health-new-vol-i_en.pdf

This evaluation provides an independent assessment of the European Commission's (EC's) past and current support to the health sector by looking at the relevance, efficiency, effectiveness, impact and sustainability of the EC support provided. It also assesses the coherence of EC health support with other EC/European Union (EU) and donor policies and activities, as well as the specific EC added value within the health sector.

The evaluation assesses every aid modality used in the health sector, including Sector Budget Support (SBS) and General Budget Support (GBS), as well as funds channelled through multilateral organisations or global initiatives, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) or the Global Alliance for Vaccines and Immunisation (GAVI).

Although actual attribution of impact is difficult, the EC has contributed to progress in the health sector. Three key themes that emerge from the evaluation have limited its impact: (i) the persistent under-resourcing of the health sector by beneficiary governments, (ii) the human resource (HR) crisis in health, and (iii) the need for better health technical capacity in EUDs.

Impact is difficult to assess, but there is no doubt that overall, EC health assistance contributed to progress towards health MDGs, not only in the particular areas of maternal and child health and HIV/AIDS, but also more broadly in terms of promoting better health outcomes, especially among the poor. By contrast, EC impact in health care finance and in HR has been modest.

Health care finance is ultimately the responsibility of governments and all the EC can do is to provide technical and, through policy dialogue, encouragement. With a few exceptions, it is difficult to see hard evidence that EC SBS and GBS resulted in increased resources for the health sector. Regarding the closely-related area of health sector public financial management, there is evidence of EC capacity building, but less evidence of tangible improvements.

On sector budget support:

- EC sector budget support contributed significantly to financing staff retention schemes, but data available do not permit a precise statement of impact.
- Policy dialogue related to sector budget support was extremely successful in Egypt in promoting the primary health care model, with positive impacts on family planning and MNCH.

The selection by the EC of aid modalities and channels was made on the basis of a relatively good analysis of the health sector and of partner country needs and capacities, although this was weaker in the earlier period of the evaluation. EC aid delivery modalities were adapted well to the national context in recipient countries and this trend has improved over the evaluation period and was accompanied by an increasingly thorough analysis of the different dimensions of the health sector in partner countries. In terms of delivery modalities, this evolution has corresponded to more use being made of budget support especially sector budget support, although its use is still at a relatively low level compared to other sectors. There is no strong evidence on a significant positive impact of budget support on national health expenditures and on budget processes at both central and decentralised levels. There is, however, evidence that SBS has resulted in increased levels of capacity building support for health, including all EC financed SBS and in some instances GBS. On the other hand, SBS or health-related GBS lending has not led to comprehensive improvements in budgeting and policy processes, but there have been some notable contributions by the EC.

Where there have been achievements, the development of medium-term expenditure frameworks and sector strategies is the most common, but there is mixed evidence of consistent results in strengthening of policy processes or enhancing PFM. There was also limited success in improving policy based resource allocations, through SBS or GBS.

The Impact of Official Development Aid on Maternal and Reproductive Health Outcomes: A Systematic Review
Taylor E et al. (2013) PLoS ONE; 8(2)
http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0056271

Background: Progress toward meeting Millennium Development Goal 5, which aims to improve maternal and reproductive health outcomes, is behind schedule. This is despite ever increasing volumes of official development aid targeting the goal, calling into question the distribution and efficacy of aid. The 2005 Paris Declaration on Aid Effectiveness represented a global commitment to reform aid practices in order to improve development outcomes, encouraging a shift toward collaborative aid arrangements which support the national plans of aid recipient countries (and discouraging unaligned donor projects).

Methods and Findings: A systematic review was conducted to summarise the evidence of the impact on MDG 5 outcomes of official development aid delivered in line with Paris aid effectiveness principles and to compare this with the impact of aid in general on MDG 5 outcomes. Searches of electronic databases identified 30 studies reporting aid-funded interventions designed to improve maternal and reproductive health outcomes. Aid interventions appear to be associated with small improvements in the MDG indicators, although it is not clear whether changes are happening because of the manner in which aid is delivered. The data do not allow for a meaningful comparison between Paris style and general aid. The review identified discernible gaps in the evidence base on aid interventions targeting MDG 5, notably on indicators MDG 5.4 (adolescent birth rate) and 5.6 (unmet need for family planning).

Discussion: This review presents the first systematic review of the impact of official development aid delivered according to the Paris principles and aid delivered outside this framework on MDG 5 outcomes. Its findings point to major gaps in the evidence base and should be used to inform new approaches and methodologies aimed at measuring the impact of official development aid.

A4. Results-based aid

Results based aid and results based financing: What are they? Have they delivered results?
Pearson, M. (2011) HLSP
http://www.hlsp.org/LinkClick.aspx?fileticket=tdqKrWX321Q%3d&tabid=2288&mid=4442

Emerging lessons from experience to date suggests that:

- It is extremely important to focus on the right interventions and results.
- Results based funding is not a simple solution to concerns about attribution.
- We need to ensure that approaches involve payment for results rather than payment by results.
- We need to ensure a higher degree of consistency with the principles of aid effectiveness.
- We need a good understanding of the incentives faced by agents.
- We need to be cautious in assuming benefits are sustainable.
- We need to closely monitor impact on equity.

- Results based approaches do not remove risks – they just change their nature.
- The approach does not necessarily remove the need for 'targets' – but just changes the way they are applied.
- We need to build up the systems and promote a culture which support a greater results focus and more effective reporting and monitoring arrangements that involve both principals and agents.

Results-Based Financing for Health
IBRD/World Bank (2013)
http://siteresources.worldbank.org/INTAFRICA/Resources/AHF-results-based-financing.pdf

This background paper on RBF in Africa was part of the basis for discussion during the the *Africa Health Forum 2013: Finance and Capacity for Results*. The paper shares some of the operational results starting to come in from Health Results Innovation Trust Fund (HRITF) pilots.
Key messages:

- Over the past five years, Results-Based Financing (RBF) for health has been extensively tested in Africa as a promising approach to work towards Universal Health Coverage.
- RBF approaches are achieving good results; increasing coverage as well as quality of services while targeting resources to vulnerable populations.
- A well-designed RBF programme can strengthen core health system functions, increasing value for money and accountability of the health system.
- In many countries the design of RBF programmes has included removing user fees, thus improving financial access for essential health services.

Review of major Results Based Aid (RBA) and Results Based Financing (RBF) schemes
Pearson, M., Johnson, M. and Ellison, R. (2010) HDRC
http://www.heart-resources.org/wp-content/uploads/2012/05/271866_UK-Review-Major-Results-Based-Aid-and-Results-Based-Financing-Schemes_Report.pdf

"Managing for results" is a key component of the Paris Principles of Aid Effectiveness. The lack of a results focus is seen as a major reason why past aid efforts have yielded disappointing results.

Key messages from the review include:

- It is important first to take a step back and ask "are we targeting the right results?"
- RBA/RBF schemes do deliver the intended results but that is not necessarily enough
- Attribution is generally not possible
- It is unknown whether RBA/RBF schemes offer value for money or will continue to deliver results
- Conditionality doesn't always help
- Results on RBA/RBF schemes promoting equity are mixed.
- Good design is very important

In conclusion, RBA/RBF schemes have a role to play but are no panacea. However, measurement is not always possible. This review recommends that DFID should adopt a positive but cautious stance. Schemes need to be tailored to local circumstances.
They should be well prepared, well designed, piloted and carefully monitored and then modified as and when any unexpected effects become apparent. RBF appears to work better for simple interventions which are provider led and where latent capacity exists.
Complementary actions will usually be required.

A5. Recent research on funding modalities for health

Global health initiative investments and health systems strengthening: a content analysis of global fund investments
Warren, A.E. et al. (2013) Globalization and Health, 9:30
http://www.biomedcentral.com/content/pdf/1744-8603-9-30.pdf

This study shows that a substantial portion of Global Fund's Round 8 funds was devoted to health systems strengthening. Dramatic skewing among the health system building blocks suggests opportunities for more balanced investments with regard to governance, financing, and information system related interventions. There is also a need for agreement, by researchers, recipients, and donors, on keystone interventions that have the greatest system-level impacts for the cost-effective use of funds. Effective health system strengthening depends on inter-agency collaboration and country commitment along with concerted partnership among all the stakeholders working in the health system.

The health systems funding platform and World Bank legacy: the gap between rhetoric and reality
Brown, S.S., Sen, K. & Decoster, K. (2013) Globalization and health, 9:9
http://www.biomedcentral.com/content/pdf/1744-8603-9-9.pdf

Global health partnerships created to encourage funding efficiencies need to be approached with some caution, with claims for innovation and responsiveness to development needs based on untested assumptions around the potential of some partners to adapt their application, funding and evaluation procedures within these new structures. We examine this in the case of the Health Systems Funding Platform, which despite being set up some three years earlier, has stalled at the point of implementation of its key elements of collaboration. While much of the attention has been centred on the suspension of the Global Fund's Round 11, and what this might mean for health systems strengthening and the Platform more broadly, we argue that inadequate scrutiny has been made of the World Bank's contribution to this partnership, which might have been reasonably anticipated based on an historical analysis of development perspectives. Given the tensions being created by the apparent vulnerability of the health systems strengthening agenda, and the increasing rhetoric around the need for greater harmonisation in development assistance, an examination of the positioning of the World Bank in this context is vital.

From Millennium Development Goals to post-2015 sustainable development: sexual and reproductive health and rights in an evolving aid environment
Hill, P. S. Reproductive Health Matters, 2013; 21: 42
http://www.sciencedirect.com/science/article/pii/S0968808013427374

Using research from country case studies, this paper offers insights into the range of institutional and structural changes in development assistance between 2005 and 2011, and their impact on the inclusion of a sexual and reproductive health and rights agenda in national planning environments. At a global level during this period, donors supported more integrative modalities of aid – sector wide approaches, poverty reduction strategy papers, direct budgetary support – with greater use of economic frameworks in decision-making. The Millennium Development Goals brought heightened attention to maternal mortality, but at the expense of a broader sexual and reproductive health and rights agenda. Advocacy at the national planning level was not well linked to programme implementation; health officials were disadvantaged in economic arguments, and lacked financial and budgetary controls to ensure a connection between advocacy and action. With increasing competency in higher

level planning processes, health officials are now refocusing the post-2015 development goals. If sexual and reproductive health and rights is to claim engagement across all its multiple elements, advocates need to link them to the key themes of sustainable development: inequalities in gender, education, growth and population, but also to urbanisation, migration, women in employment and climate change.

A6. Country-specific resources

Perceptions of government knowledge and control over contributions of aid organizations and INGOs to health in Nepal: a qualitative study
Giri, A. et al. (2013) Globalization and Health, 9:1
http://www.biomedcentral.com/content/pdf/1744-8603-9-1.pdf

Background: Almost 50% of the Nepali health budget is made up of international aid. international NGOs working in the field of health are able to channel their funds directly to grass root level. During a 2010 conference, the Secretary of Population stated that the government has full knowledge and control over all funds and projects coming to Nepal. However, there are no documents to support this. The study aims to assess government and partner perceptions on whether Government of Nepal currently has full knowledge of contributions of international aid organisations and international NGOs to health in Nepal and to assess if the government is able to control all foreign contributions to fit the objectives of Second Long Term Health Plan (1997–2017).

Results: While Ministry of Health and Population leads the sector wide approach that aims to integrate all donor and international NGO contributions to health and direct them to the government's priority areas, questions were raised around its capacity to do so. Similarly, informants questioned the extent to which Social Welfare Council was able to control all international NGOs' contributions. Political tumult, corruption in the government, lack of human resources in the government, lack of coordination between government bodies, convoluted bureaucracy, and unreliability of donor and international NGO contributions were identified as the main reasons for difficulties in aid integration.

Conclusions: Despite its commitment to coordinate and control development assistance to the health sector, and its leadership position of the Sector Wide Approach, complete knowledge and effective coordination of all international contributions remains a challenge and is hampered by issues within the government as well as among External Development Partners and international NGOs.

In Sweet Harmony? A Review of Health and Education Sectorwide Approaches (SWAps) in the South Pacific
Vaillancourt, D. (2012) World Bank
http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Results___Evidence/HAE__results___lessons/SWAp_PacificStudy.pdf

Main findings include:

- With the exception of Samoa Health, aid effectiveness objectives and indicators under the SWAps are more implicit than explicit, making it challenging both to define and to measure success.
- Anticipated benefits of the SWAps reviewed have been partially achieved to date.
- There is uncertainty about whether sector performance and outcome objectives will be achieved under ongoing SWAps by the end of their program periods.
- The analysis of country experience has pointed to factors under the SWAps that may have undermined their ability to achieve national sector objectives, especially in the

initial years. A learning-by-doing process is ongoing, and this study's findings point to the opportunity for further improvements.
- There is a need for further exploration of the business models of the Development Partners supporting the SWAps (the four which jointly produced this study) to assess the extent to which they are efficient and effective in meeting the needs and demands of countries implementing SWAps.

Impact Evaluation of the Sector Wide Approach (SWAp), Malawi
Pearson, M. (2010) HDRC
http://www.heart-resources.org/wp-content/uploads/2012/02/Impact-Evaluation-of-the-SWAp-Malawi.pdf

This review responds to a National Audit Office request for further work to assess the impact of the health Sector-Wide Approach (SWAp) in Malawi. Malawi has been a relatively strong performer in terms of health outcomes for many years. Since the early part of the decade, key health indicators such as infant and under five mortality rates have been better than average for least developed countries. This raises the question as to whether the SWAp is sustaining or even accelerating those gains or whether such progress is being made in spite of the SWAp. There are some suggestions that the rate of improvement is declining (suggesting that perhaps easier gains have been made, that the SWAp is performing less than ideally or that external factors are responsible).

Good progress has certainly been made during the SWAp period, although Malawi is unlikely to achieve the Millennium Development Goals health targets; it may achieve the U5MR but is well off-track to achieve the Maternal Mortality Ratio target. This is perhaps not surprising as it was recognised at the outset that the Programme of Work was resource-based rather than needs-based and provided for too few resources to achieve the MDGs. In practice, more resources have been made available than was anticipated.

The SWAp process has undoubtedly had serious weaknesses, which largely reflect the low level of national capacity, but also declining commitment (according to a recent World Bank review) which means that the process is less developed than in many other SWAp countries. This might suggest that the question "Has a SWAp been tried?" may be just as relevant as "Has the SWAp worked?"

Third Annual Output to Purpose Review (OPR) of DFID Support to the Delivery of Essential Health Services (EHS), Kenya
Putney, P.J. (2010) HDRC
http://www.heart-resources.org/assignment/third-annual-output-to-purpose-review-opr-of-dfid-support-to-the-delivery-of-essential-health-services-ehs-kenya/

The leadership and technical capacity of the Ministries of Health continues to be strengthened with support from EHS that is transparent, integrated, flexible and strategic, supporting a transition to a SWAp (Sector Wide Approach). The relationships between EHS staff and their counterparts at the central, provincial, district and community levels are a key element in the success of the programme.

Other noted successes include:
- scaling up and expanding activities
- improved working relationships
- improvement in clinical skills and confidence as a result of training
- community units better informing women and their families

Some technical recommendations include:

- the most successful interventions should be analysed so that best-practice can be replicated
- Maternal Death Reviews should continue to expand and improve
- routine review of all “near misses”/complications, stillbirths and neonatal deaths should be made a requirement at all facilities
- increased incentives for community health workers
- development of concrete IEC (Information, Education and Communication) strategies

Aid alignment: a longer term lens on trends in development assistance for health in Uganda
Stierman, E., Ssengooba, F. & Bennett, S. (2013) Globalization and Health, 9:7
http://www.biomedcentral.com/content/pdf/1744-8603-9-7.pdf

Over the past decade, development assistance for health (DAH) in Uganda has increased dramatically, surpassing the government’s own expenditures on health. Yet primary health care and other priorities identified in Uganda’s health sector strategic plan remain underfunded. Using data available from the Creditor Reporting System, National Health Accounts, and government financial reports, trends in how donors channel DAH and the extent to which DAH is aligned with sector priorities were examined. Despite efforts to improve alignment through the formation of a sector-wide approach (SWAp) for health in 1999 and the creation of a fund to pool resources for identified priorities, increasingly DAH is provided as short-term project-based support for disease-specific initiatives, in particular HIV/AIDS. These findings highlight the need to better align external resources with country priorities and refocus attention on longer-term sector-wide objectives.

Vertical funding, non-governmental organizations, and health system strengthening: perspectives of public sector health workers in Mozambique
Mussa, A. H. (2013) Human Resources for Health, 11:26
http://www.human-resources-health.com/content/11/1/26/abstract

This paper explores the perspectives and experiences of key Mozambican public sector health managers who coordinate, implement, and manage the myriad donor-driven projects and agencies. It concludes that the Ministry of Health attempted to coordinate aid by implementing a “sector-wide approach” to bring the partners together in setting priorities, harmonising planning, and coordinating support. Only 14% of overall health sector funding was channelled through this coordinating process by 2008, however. The vertical approach starved the Ministry of support for its administrative functions. The exodus of health workers from the public sector to international and private organisations emerged as the issue of greatest concern to the managers and health workers interviewed. Few studies have addressed the growing phenomenon of “internal brain drain” in Africa which proved to be of greater concern to Mozambique’s health managers.

Aid for health in times of political unrest in Mali: Does donors’ way of intervening allow protecting people’s health?
Paul, E. et al. (2013) Health Policy and Planning, 2013
http://heapol.oxfordjournals.org/content/early/2013/11/06/heapol.czt082.short

This article describes and analyses how donors in the health sector reacted to the political unrest in Mali. It shows that despite its long sector-wide approach experience and international agreements to respect aid effectiveness principles, donors have not been able to intervene in view of safeguarding the investments of co-operation in the past decade, and of protecting the health system’s functioning. They reacted to the political unrest on a bilateral basis, stopped working with their ministerial partners, interrupted support to the health system

which was still expected to serve populations' needs and took months before organising alternative and only partial solutions to resume aid to the health sector. The Malian example leads to a worrying conclusion: while protecting the health system's achievements and functioning for the population should be a priority, and while harmonising donors' interventions seems the most appropriate way for that purpose, donors' management practices do not allow for reacting adequately in times of unrest. The article concludes by a number of recommendations.

SECTION B: Pre-2011

B1. Overview

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

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

Williamson et al. (2008) find the deployment of uncoordinated project aid in many sectors has contributed and continues to contribute towards a vicious circle, compounding poor sector governance. They suggest a balance of sector-based aid and general budget support. They suggest better dialogue at sector level and avoiding projects and common funds. The incentives within donor agencies and recipients also need to be addressed. Ultimately, the likelihood of reform relies on political support and technical leadership within government. This is very difficult for the donor community to influence.

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

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

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

contributions of SWAp procedures and that sector budget support will consolidate positive impacts.

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

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

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

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

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

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

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

B2. Budget support and sector wide approaches (SWAps)

Immunization Financing Toolkit, Brief 10: Budget Support

The World Bank and GAVI Alliance, 2010
http://www.who.int/immunization_financing/tools/Brief_10_Budget_Support.pdf

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

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

Budget support has contributed to greater policy alignment and harmonisation of development aid. General budget support has been linked to increases in pro-poor development expenditures, and reduced earmarking of government budgets. General budget support has also been an effective instrument in strengthening public financial management and improving transparency and accountability. By increasing needed expenditures, budget support has helped to expand service delivery. An additional expected benefit of budget support is reduced transactions costs. There is no specific evidence on the effectiveness of budget support for immunisation programmes. Recent reviews of the effectiveness of SWAp mechanisms in improving health outcomes have found both strengths and areas for improvement. Sector programming is becoming better integrated within the budget planning process and there is improved diagnosis of barriers to service utilisation. There is also evidence of closer links between policy and implementation. However, SWAp mechanisms explicitly require ministry of health leadership and, in some contexts, limited capacity coupled with high turnover of leadership and weak relationships with the ministry of finance has made this difficult. SWAp coordination has led to better planning and budgeting of the sector but vertical health initiatives still operate outside of these mechanisms to a large extent and this could potentially undermine gains. There is also a lack of information on the health impact of SWAp mechanisms. Broad participation in SWAp mechanisms has been limited in some cases, particularly in civil society. Weaknesses in monitoring systems persist and some donors are unable or unwilling to provide funding through government systems. In addition, budget support may increase the leverage of donors over national health policy since they participate more actively in planning, budgeting, and monitoring of the national health strategic plan.

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

- Budget support can increase predictability of financing through multi-party planning and budgeting of health sector priorities. If budget support is conditional on achievement of targets, there is some risk that disbursements will be less than commitment levels.
- Whether support is equitable depends on the extent to which budget support will be allocated towards activities and programmes to improve the plight of the poor and to reduce poverty.

- Budget support is expected to reduce the transaction costs of dealing with the financial and programmatic reporting and audit requirements of each individual donor separately. The initial costs of establishing coordination mechanisms may be high in terms of time and effort, but these should decrease over time.
- SWAp mechanisms require significant investment in time and coordination – both in the initial stages and for continued maintenance.
- Budget support is thought to be a sustainable mechanism as it creates a sense of ownership of the national plan and of financing of the health sector.
- Budget support from development partners is usually matched with government financing of the sector (and of the programme) and would contribute to self-sufficiency.
- Given that planning, budgeting, and monitoring of use of budget support are integral to sector coordination, this will contribute to greater accountability.

Building Blocks or Stumbling Blocks? The Effectiveness of New Approaches to Aid Delivery at the Sector Level
Williamson T et al., Research project of the Advisory Board for Irish Aid, 2008
http://www.odi.org.uk/resources/download/1526.pdf

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

Programme-based approaches have been developed with these principles in mind. While such approaches accommodate all modalities, direct budget support and debt relief provided to recipient governments are those best suited to the use of government systems. Yet, donors are hesitating to move decisively towards these modalities, even in contexts where programme-based approaches have been well established by the adoption of sector-wide approaches (SWAps) and national poverty reduction strategies (PRSs). Instead, they continue to use either project arrangements or intermediate modalities, such as common, pooled or basket funds. The justification usually offered is that recipient country systems are too weak for a shift to sector or general budget support (GBS). Common funds (CFs) are presented as 'transitional' aid modalities by means of which donors can help strengthen country policies and systems while ensuring that aid funds are well spent.

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

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

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

- A balance of sector-based aid and general budget support
- Delivering better aid and better dialogue at the sector level

- Avoiding using projects and common funds in support of service delivery wherever possible.
- Addressing the incentives within donor agencies and recipients.

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

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

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

Do Health Sector-Wide Approaches Achieve Results? Emerging Evidence and Lessons from Six Countries
Vaillancourt D, Independent Evaluation Group, World Bank, 2009
http://siteresources.worldbank.org/EXTWBASSHEANUTPOP/Resources/wp4.pdf

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

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

Findings on benefits and achieving objectives:

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

How did the approach facilitate the achievement of health objectives?

- PoWs that set specific, prioritised, phased, and ambitious-but-feasible targets and that assessed the political economy of reforms were more likely to achieve their objectives.
- The strength of local capacities and systems used for common implementation arrangements determined the pace and efficiency of PoW implementation.
- Country experience has revealed three dimensions of partnerships formed under SWAps that can enable – or undermine – the achievement of results: who is in the

partnership; the main functions of the partnership and how effectively they are carried out; and how the partners interact.
- The predictability, flow, and use of health sector resources – both domestic and external – have affected the efficacy and efficiency of PoW implementation.

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

SWAps in the 21st Century
Grant K., HLSP, 2009
Attached. Not available online.

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

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

The adoption of the Paris Principles in 2005 gave recognition both to the issues to be addressed and the principles in resolving them. However new global initiatives still continue to be approved and donor behaviour continues to be schizophrenic – providing financial support to Global Health Partnerships (GHPs) while supporting governments at country level to cope with the fragmentation that results.

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

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

Effective involvement of the non-state sector needs to be a key task of the new generation of SWAps. While there is now general recognition of the major role the private sector (both not for and for profit) plays in delivering health care to the poor, SWAps to date have not involved

private providers in a way that will improve quality and value for money. Indeed one challenge is that governments are less willing to commission services from NGOs than development partners used to be when using a project approach.

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

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

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

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

- Moving beyond the aid effectiveness agenda in SWAps and adopting a sector development perspective as the basic point of departure, recognising that sectors and SWAps do not start from scratch.
- Adopting an explicit political economy perspective on the sector; developing greater understanding of the stakeholders (including donors) and the wider context in which the sector operates; recognising the fundamental political nature of sector development processes; and understanding the drivers and constraints to change.
- Adding a consistent actor/stakeholder perspective on SWAps and sector programmes, asking not only what is in it, but also who are involved and who does what.
- Strengthening managerial inputs in the process – stronger "management from the top" from domestic authorities, coupled with better "management from below" from donors.
- Focusing on results in a basic, common sense, practical way in processes and arrangements related to SWAps and sector development.

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

Improving the Results Focus in Health Sector Wide Programming
Pearson M, HLSP, 2010
Attached. Not available online.

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

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

B3. Sector budget support in practice, ODI and Mokoro

Sector Budget Support in Practice, Case Study, Health Sector in Mozambique
Visser-Valfrey M & Umarji MB, ODI, 2010
http://mokoro.co.uk/sites/default/files/documents/SBSIP%20Mozambique%20Health%20Case%20Study_31_07_10.pdf

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

Points on the nature of sector budget support:

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

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

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

Progress has been made in a number of areas:

- Other plans co-exist with the PESS, fragmenting the policy environment.

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

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

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

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

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

- The success of SBS will depend to a significant extent on getting the financing channels for service delivery right so that resources may be used in the most effective and efficient way. Addressing the aforementioned challenges and ensuring funds will be channelled to and accessed by decentralised levels to improve service delivery is crucial.
- SBS would be more effective in supporting financing delivery if SBS inscribed as internal funding was allocated to the recurrent budget, and specifically to existing budget lines on service delivery. In this way, the SBS would no longer be traceable. Furthermore, given the fact that the recurrent budget is increasingly reliable, those donors that can provide non-traceable SBS should elect for the funding to be inscribed as internal funds.
- Success of SBS will also depend on further progress by DPs in bringing aid to the sector into PROSAUDE II. This involves letting go of vertical projects and initiatives (a number of partners are moving in this direction) and increasing funding to PROSAUDE as confidence grows. It will also involve developing further confidence in

monitoring systems which will allow partners to have some of the information/security which they are still getting through their project portfolio. For DPs there continues to be tension between the official commitment to more aligned means of funding and the reality of being held accountable for results.

- The increase in vertical funding is an important concern and should be a point of action moving forward – at country level and globally at the headquarters of agencies which are as of yet unable to join PROSAUDE II. As PFM, monitoring systems, and confidence all increase, conditions should allow for these partners to join. Alternatively, reluctant vertical funders may be more willing to join if they can play a key role in strengthening the systems that are currently preventing them from participating in PROSAUDE II.
- Donors are focusing strongly on the success in addressing public financial management issues as this is what they are ultimately held accountable for. A less than favourable audit in 2010 would represent a significant setback to progress whereas a lack of progress on key outcome indicators is perceived as potentially less damaging. The 'incentives' for DPs need to be reviewed so that SBS does not become skewed as a result of an excessive focus on mechanisms.

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

- The focus of the overall dialogue and review processes need to be reoriented towards addressing the key challenges to effective and efficient health service delivery. Sector institutions, and systems for service delivery, must be more prominently on the agenda.
- Capacity constraints emerge throughout this study as a key concern. Efforts will need to be made to ensure that funding is brought on board to pay for the additional expenses.
- Attention to the provision of technical assistance and capacity building alongside SBS funding to strengthen downstream delivery, and central management and monitoring of service delivery.
- The development of stronger systems for accountability for service delivery at lower levels, and not just via SWAp arrangements

Sector Budget Support in Practice, Case Study, Health Sector in Zambia
ODI & Mokoro, 2009
http://mokoro.co.uk/sites/default/files/documents/SBSiP%20Zambia%20Health%20Case%20Study%20-%2026%2011%2009-1.pdf

The nature of sector budget support in Zambia:

- The EC and DFID are the only cooperating partners (CPs) who have provided support to the health sector through SBS.
- The EC was previously providing resources to the MoH basket funds, but began SBS in 2006 as a pilot with EUR 10 million allocated to the Health Human Resources Plan (HRP) under the 9th EDF.
- The EC was previously providing resources to the MoH basket funds, but began SBS in 2006 as a pilot with EUR 10 million allocated to the Health Human Resources Plan (HRP) under the 9th EDF.
- The second tranche was only EUR 3.57 million as it was judged by EC headquarters that the required targets had not been met.
- Part of DFID GBS funds were earmarked to health and then non-traceably earmarked to assist in financing the elimination of user-fees. DFID committed to give an additional US$5 million for health to their GBS commitments over five years (2006-2010). Funds were disbursed into the Treasury account in the MoFNP, with a reporting requirement that DFID should be given evidence that the funds had been transferred to the MoH.

- In 2007 the MoH decided to roll DFID funds into the district grant, with instructions that 4% of the grant should be spent on items that user-fees would have paid for, so districts were free to choose how to spend the funds.
- Although there has been very little SBS, this study is timely as levels of SBS are expected to rise in the near future, as more CPs move to SBS in response to the government of Zambia's statement that general and sector budget support are its preferred aid modalities.

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

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

Sector Budget Support in Practice, Good Practice Note
Williamson T & Dom C, ODI, 2010
http://www.odi.org.uk/resources/download/4732-english.pdf

This report include the following sections:

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

Sector Budget Support in Practice, Synthesis Report
Williamson T & Dom C, ODI, 2010
http://www.odi.org.uk/resources/download/4733-english.pdf

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

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

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

Making sector budget support work for service delivery: wider policy implications
Williamson T, Dom C & Booth D, ODI, 2010
http://www.odi.org.uk/resources/download/4737-english.pdf

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

Key points:

- Incentives are the key to what sector budget support (SBS) does well and what it does badly.
- Strengthening service delivery incentives will involve substantial multilevel efforts by SBS donors and partners.
- These efforts must address the underlying causes, rather than the symptoms, of weak incentives.

Sector Budget Support in Practice
http://www.odi.org.uk/work/projects/details.asp?id=1013&title=sector-budget-support#resources

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

B4. Disease specific programmes

The Five Year Evaluation of the Global Fund
Global Fund, 2010
http://www.theglobalfund.org/en/terg/evaluations/5year/

The synthesis report discusses the following findings:

- The Global Fund, together with major partners, has mobilised impressive resources to support the fight against AIDS, tuberculosis and malaria.
- Collective efforts have resulted in increases in service availability, better coverage, and reduction of disease burden.
- Health systems in most developing countries will need to be greatly strengthened if current levels of services are to be significantly expanded.

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

Effects of the Global Fund on Reproductive Health in Ethiopia and Malawi: Baseline Findings
Schott W, Stillman K, and Bennett S, The Partners for Health Reform*plus* Project, 2005
http://pdf.usaid.gov/pdf_docs/PNADF197.pdf

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

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

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

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

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

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

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

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

Second GAVI Evaluation
GAVI Alliance, CEPA LLP,
http://www.gavialliance.org/resources/GAVI_Second_Evaluation_Report_Final_13Sep2010.pdf

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

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

Report findings on national level include:

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

Findings on programmatic value include:

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

Reviving Dead Aid: Making International Development Assistance Work
Negin J, Lowy Institute, 2010
http://www.lowyinstitute.org/Publication.asp?pid=1355

This document reports on a malaria case study from Ethiopia.

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

B5. Papers on different funding modalities for health

Aid for Better Health – What Are We Learning About What Works and What We Still Have To Do? An Interim Report from the Task Team on Health as a Tracer Sector
OECD/DAC, 2009
http://www.oecd.org/dataoecd/25/54/45014642.pdf

The main findings and messages emerging from this report:

- A great deal of activity has been directed towards making aid for health more effective, and much has been achieved.
- While results are ultimately what matter, the most measurable progress is at the level of globally-agreed frameworks for delivering on commitments, new forms of co-operation and dialogue, and world-wide multi-stakeholder initiatives designed to address some of the complexities of the aid architecture.

- Improvements in aid management, both generally and in relation to health, are slower than they should be, and are uneven.
- The underlying challenges to make aid for health more effective involve moving to a more realistic political economy framework that creates pressure to deliver on commitments.
- Creating alliances across and among partner country governments, donors, global programmes and other players requires not just greater political drive, but also a sound and evidence-based technical discussion on what has to be done in terms both of broad strategies and of specific measures.
- The underlying challenges to make aid for health more effective involve moving to a more realistic political economy framework that creates pressure to deliver on commitments.
- Creating alliances across and among partner country governments, donors, global programmes and other players requires not just greater political drive, but also a sound and evidence-based technical discussion on what has to be done in terms both of broad strategies and of specific measures.
- Experience in health shows that aid effectiveness principles overlap and are mutually-reinforcing.
- Prioritising practical aid effectiveness measures is challenging and is at least partly country-specific. But one of the most important lessons from health is that a sound sector strategy, embedded in a broad national strategy and linked to financing through a medium-term expenditure framework and annual budget, reviewed regularly by stakeholders, is needed not just for government's management of development, but as a means for inducing best-practice behaviour change among donors.
- Active effort is needed to find ways of combining the resource mobilisation effort with keeping the number of players manageable, especially in countries with limited state capacities.
- Even where there is progress, the mechanisms are not always in place for accurately monitoring what is being done.

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

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

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

costs or leading to a more comprehensive, coordinated and context-appropriate development strategy.

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

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

Although it is difficult to link the impact of donor assistance to development outcomes, recent health improvements in aid-recipient countries are a positive indication. For example, in developing countries the under-five mortality rate per 1,000 live births decreased from 103 in 1990 to 74 by 2007. Progress is also evident at the country level. Thailand has experienced a 33% decline in HIV prevalence among young adults and 41% among injecting drug users, as well as an increased survival rate from ARVs. China has increased DOTS coverage and subsequently has achieved a 38% decline in tuberculosis prevalence and tuberculosis mortality. Following a large-scale bed-net distribution and ACT (artemisinin combination therapy) roll-out, Rwanda has shown a 64% decline in child malaria cases and a 66% decline in child malaria deaths. Several other African countries demonstrate equally impressive achievements in the reduction of malaria. Donors are also working to assess the impact of their assistance. DfID, for example, reports that in part due to the support it provides to India‘s National Reproductive and Child Health Programme‘s Sick Newborn Care Units, there has been a marked decline in newborn deaths (DfID, 2009). Similarly, it is reported that by the end of 2008 GAVI Alliance support – including immunising approximately 192 million children against hepatitis B, 42 million against haemophilus influenzae type b and 35.6 million against yellow fever – has averted 3.4 million premature deaths. However, increasingly ‘partners are recognising that attribution of health gains to support provided by particular donors is not only unfeasible […] but also counterproductive’ (WHO, UNICEF, World Bank ,2009, State of the world‘s vaccines and immunisation, 3rd ed.).

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

CTL-for-Health/FTT-with-Health: Resource-Needs Estimates and an Assessment of Funding Modalities
Baker BK, Action for Global Health and International Civil Society Support, 2010
http://ec.europa.eu/health/eu_world/docs/ev_20101013_rd05_en.pdf

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

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

Critics of pooled financing directly to governments admit these potential benefits, but focus as well on historical analysis of some governments' poor planning, inefficiency, corruption, and incapacity to even spend as planned or to monitor and account for the actual flow of resources. Critics worry that most governments neglect important health needs and/or vulnerable populations and that some governments persistently refuse to grant resources to NGO/CBO/FBO organisations for community level health-related activities. A related concern about pooled funding mechanisms from a civil society perspective is that of governance – civil society feels that government-controlled pooled financing modalities have often been planned and implemented without the participation and oversight of civil society. In sum, critics fear that donor funds get put inside a black box and then disappear both in terms of tracking and performance outcomes. They have evidence that government-controlled resources do not reach the local level (as little as 20%), where health programming is most needed, and thus that direct funding to CBOs might have a larger payment.

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

The pros and cons of the following are also discussed:

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

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

Benefits of health system focus:

- More consistent with new focus on comprehensive primary health at WHO, in European countries (especially Scandinavian), and US Global Health Initiative.
- More consistent with stated goals of developing country partners to strengthen health systems more broadly to be able to respond to local epidemiological needs and priorities.

- Serves as a platform to emphasize need for increased and better-trained human resources for health.
- Allows simplified support for national health plans through health sector or general budget support (contested).
- Likely to increase country-ownership and stewardship of WHO Joint Health System
- Strengthening Platform (HSS).
- More likely to result in better integration of services and more robust and durable primary health care service delivery.
- Can direct resources to less sexy health systems needs – labs, health information, procurement and supply, health sector planning/management, etc.
- Can increase attention to health facilities needs, transportation infrastructure, etc.

Benefits of priority disease focus:

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

A Joint Evaluation of General Budget Support 1994-2004
OECD DAC Network on Development Evaluation
http://www.oecd.org/document/51/0,3343,en_21571361_34047972_36556979_1_1_1_1,00.html

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

Towards Equitable Financing Strategies for Reproductive Health
Standing H, IDS, 2002
www.ids.ac.uk/download.cfm?file=wp153.pdf

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

The paper explores three issues:

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

include cost recovery measures such as fees, pre-payments and insurances, as well as safety nets.

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

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

B6. Aid effectiveness

Is Harmonisation and Alignment Improving the Effectiveness of Health Sector aid?
Lewis D, Dickinson C, Walford V, HLSP, 2010
Attached. Not available online.

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

- SWAps
- General budget support and sector budget support
- International Health Partnerships (IHP+)
- Harmonisation and Alignment of Multilateral and Bilateral Partners working in AIDS

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

The report discusses effectiveness under the following question headings:

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

Evaluation of the Implementation of the Paris Declaration, Phase 2
OECD, 2011
http://www.oecd.org/dataoecd/5/37/48113803.pdf

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

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

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

Aid and Budget Transparency in Mozambique, Constraints for Civil Society, the Parliament and the Government
The Informal Governance Group and Alliance 2015, 2010
http://www.eurodad.org/uploadedFiles/Whats_New/Reports/Aid_Budget_Transparency_in_Moz.pdf

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

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

Learning from Experience? A Review of Recipient Government Efforts to Manage Donor Relations and Improve the Quality of Aid
Menocal AR & Mulley S, ODI, 2006
http://www.odi.org.uk/resources/download/1372.pdf

Since the late 1990s, a new paradigm of effective aid has emerged, that, at least in principle, is based on the concepts of country ownership, partnership, and mutual accountability. These principles are embraced in the *Paris Declaration on Aid Effectiveness*, which includes a series of commitments from both donor and recipient countries to improve the quality of international development assistance. Donors have come to recognise that recipient country

ownership is essential to the effectiveness of aid and development efforts. It has become increasingly evident that ownership of specific policy measures or programmes, and good governance in general, can only be achieved if recipient governments begin to take a more proactive role in determining how aid is allocated and managed.

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

Five enabling conditions are identified and discussed:

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

Making the Most of the Money? Strengthening Health Systems through AIDS Responses
Druce N & Dickinson C, HLSP, 2008
http://www.hlsp.org/LinkClick.aspx?fileticket=4G_xupkPwy4%3D&tabid=1698&mid=3353

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

Aid Effectiveness for Health, Towards the 4th High-Level Forum, Busan 2011: Making Health Aid Work Better
Action for Global Health, 2011
http://www.actionforglobalhealth.eu/fileadmin/AfGH_Intranet/AFGH/Publications/2011_Policy_Report_-_Aid_Effectiveness_for_Health/AFGH__FINAL___WEB_.pdf

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

remains well below the levels that have been calculated as necessary to reach the health MDGs.

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

- Donor coordination and alignment
- Ownership
- Managing for results.

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

B7. Further information

Author
This query response was prepared by **Laura Bolton** and **Stephen Thompson**

Contributors
Mark Pearson, HLSP
Veronica Walford, HLSP
Catherine Dom, Mokoro
Tessa Mattholie, DFID

About Helpdesk reports: The HEART Helpdesk is funded by the DFID Human Development Group. Helpdesk reports are based on 2 days of desk-based research per query and are designed to provide a brief overview of the key issues, and a summary of some of the best literature available. Experts may be contacted during the course of the research, and those able to provide input within the short time-frame are acknowledged.

For any further request or enquiry, contact info@heart-resources.org

HEART Helpdesk reports are published online at www.heart-resources.org