Improving the effectiveness of aid for health

The ways in which donors deliver their

aid

- and the priorities and conditions that are attached to it - have an important influence over government health policy and delivery of services. This chapter considers the relevance of aid-effectiveness measures to the health sector, and the emergence of new aid mechanisms - namely, global health initiatives. It also explores approaches to development cooperation in fragile states.

Ownership, harmonization, alignment, and results

Harmonization and *simplification* of various donor policies, and *alignment* with country priorities and systems, are the key elements of the aid-effectiveness agenda. The experience of Viet Nam encapsulates the problems that need to be tackled. In 2003, Viet Nam received approximately 400 separate missions from donors, of which just 2% were undertaken jointly. Donors' use of country systems in Viet Nam is extremely low: the share of donor projects using national monitoring and evaluation systems is just 13%; national procurement systems, 18%; and national auditing systems, 9%. In the health sector, coordination among the many donors is reportedly poor, and there are no systems in place to harmonize donor activities. Further, no donors are using national health monitoring systems (1).

The situation in Viet Nam is neither atypical nor new. As early as the 1980s, there was concern that a proliferation of donor projects - combined with differences in donor policies, operational procedures, and reporting mechanisms - was not only hindering the effectiveness of aid, but also creating obstacles to development by overburdening countries' administrative and reporting systems and reducing country ownership.

Recognition of such problems led, in the late 1980s and early 1990s, to new approaches to development cooperation. Budget support - the provision of resources directly to ministries of finance, either unearmarked or earmarked for a specific sector such as health - was seen as a more efficient way of channelling funds, because this approach leaves decision-making on resource allocation completely in the hands of government and minimizes transaction costs. Similarly, sector-wide approaches (see Chapter 3) emerged as a way of coordinating development partners around a common set of policy objectives at the sector level.

By the late 1990s, the Poverty Reduction Strategy Paper (PRSP) had become the most influential development instrument. Its attraction was that it provided a means of coherence and coordination among donors by encompassing both the international financial institutions and bilateral donors; that it provided financial support directly to governments; and that strategies were developed by countries themselves.

The *high-level fora on aid effectiveness,* held in Rome in February 2003 and Paris in March 2005, have added to the momentum for more effective aid. At Rome, the practical implications of the harmonization and alignment agenda were laid out for the first time - while at Paris, development partners began the important process of adding targets and indicators to their efforts to improve aid (see opposite).

One important issue for the future will be how to include new donors in the aid-effectiveness debate. Over the next decade, the accession countries of the European Union, as well as Brazil, China, the Republic of Korea, and Russia, will likely become important donors. Persuading these countries to follow good practice in development cooperation from the outset is critical.

The Rome Declaration on Harmonization (2) commits donors to:

- ensuring that development assistance is delivered in accordance with partner country priorities, including poverty reduction strategies;
- reducing donor missions, reviews and reports, streamlining conditionalities, and simplifying and harmonizing documentation;
- intensifying donor efforts to work through delegated cooperation at country level and increasing the flexibility of country-based staff to manage country programmes and projects more effectively;
- providing support for country analytical work in ways that will strengthen governments' ability to assume a greater leadership role and take ownership of development results;
- providing budget support, sector support, or balance of payments support where it is consistent with the mandate of the donor and where appropriate policy and fiduciary arrangements are in place. Good practice principles and standards - including aligning with national budget cycles and national poverty reduction strategy reviews - should be used in delivering such assistance[i].

At the Paris Meeting on Aid Effectiveness (3), donors set themselves provisional targets for 2010, including that:

- 75% of aid be disbursed according to agreed schedules;
- 85% of aid be reported on budgets;
- at least 25% of aid be provided in the form of programme-based approaches.

For their part, developing countries agreed to:
- articulate national development strategies that have clear strategic priorities and are linked to medium-term expenditure frameworks and reflected in annual budgets;
- develop results-oriented monitoring frameworks (75% of partner countries to have these in place by 2010).

Targets relating to seven other indicators will be developed by September 2005, in time for the United Nations Summit to review progress towards the Millennium Development Goals. These indicators cover issues such as the percentage of untied aid, use of country systems, the number of joint donor field missions, and reductions in the use of parallel implementation structures such as project implementation units.

i - These points are summarized from the *Rome Declaration on Harmonization.*

The case of health: an increasingly complex sector

Efforts to improve the effectiveness of development cooperation are particularly pertinent to the health sector, which is characterized by a high number of actors, both national and external, and - particularly in the poorest countries - a heavy dependence on aid.

The increase in volume of development assistance for health noted in Chapter 5, has been associated with new health initiatives and partners - many with their own mandate, priorities, and administrative processes. At least three main groups of Global Health Initiatives (GHIs) can be identified:

- those concerned with **research and development** of new technologies (vaccines, drugs, tests, etc.) to tackle diseases neglected by the commercial sector;

- **global funds**, such as the Vaccine Fund and the Global Fund to Fight AIDS, Tuberculosis and Malaria, which provide new resources but also bring new administrative and reporting burdens; and

- **global partnerships**, such as Roll Back Malaria and Stop TB, which aim to coordinate the efforts of various partners working on specific diseases.

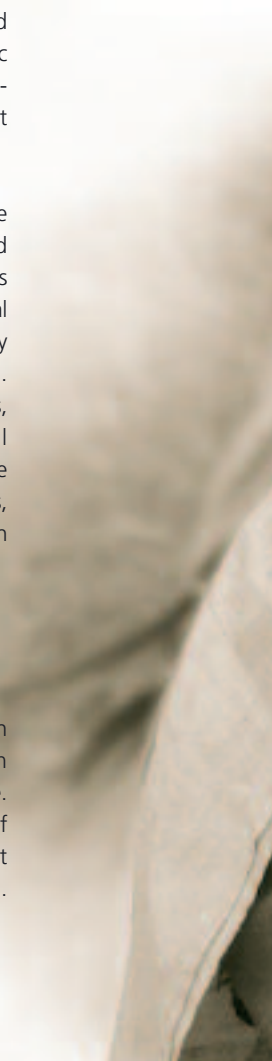
GHIs can help to raise awareness, as well as much-needed resources for health. In just three years, the Global Fund to Fight AIDS, TB and Malaria has approved grants totalling US$ 3.1 billion, covering 127 countries (as of March 2005, US$ 1 billion had been disbursed) (4). In addition, GHIs are often well placed to build links with civil society groups, which is particularly important in the context of tackling HIV/AIDS.

The emergence of GHIs has also raised concerns and challenges. First, there is evidence that large commitments from GHIs are distorting priorities in some countries - by, for example, committing an unsustainable share of resources to HIV/AIDS medicines. Second, GHIs may weaken health systems by diverting staff and resources into vertical programmes - the costs of which are not domestically sustainable in the long term - therefore undermining national institutions and other equally vital health programmes. Third, GHIs may establish separate coordination, implementation, and monitoring arrangements specific to the funds that they provide - increasing the burden on government of managing aid flows.

Many GHIs themselves recognize these problems and are focusing increased attention on ensuring that their activities are in line with a country's national health strategy and policy, and that they help to strengthen the health system. WHO is actively involved in many GHIs, and houses a number of global partnerships. WHO works to increase the involvement of countries in GHIs, and to facilitate access to resources in line with countries needs and priorities.

Development cooperation in fragile states

The orthodoxy that 'aid works best in well-governed countries' is both intuitive and confirmed by experience. The difficulty is that the category of 'well-governed countries' does not include those in greatest need of aid.



Fragile states - those with weak governance and institutions - account for one sixth of the people living in the developing world and one third of those living on less than US$ 1 per day. These countries are least likely to achieve the MDGs: a third of maternal deaths and nearly half of under-five deaths in developing countries occur in fragile states.

There is a growing consensus that investing aid in fragile states is not only necessary, but cost-effective compared to the costs of not engaging. It is better to prevent states from falling into conflict or collapse than to respond after they have failed. A recent study (5) estimated that on average each US$ 1 spent on conflict prevention generates over US$ 4 in savings to the international community. In addition, aid can be a powerful tool in stabilizing countries which are emerging from crisis, and in accelerating their return to the development process.

However, it is not easy for development agencies to engage with fragile states, and consequently aid to such states is approximately 40% less per capita than aid to other (non-fragile) low-income countries. Aid to fragile states also tends to be more volatile. When donors do engage, they often establish parallel systems because

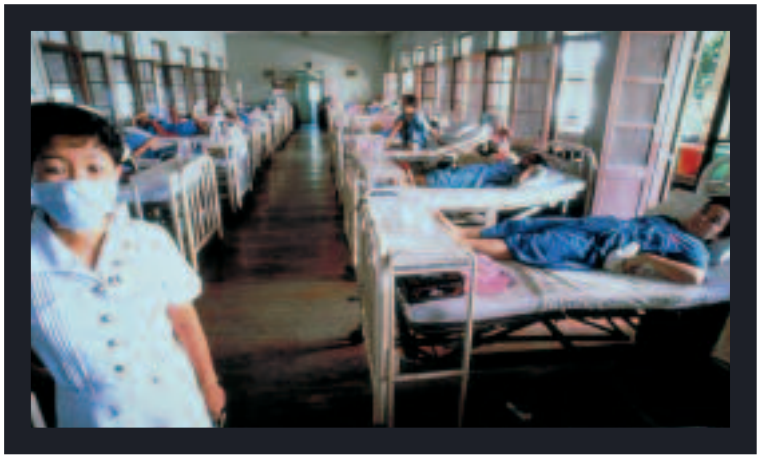
government systems are weak. This approach can further undermine fragile states, and can make future capacity-building difficult. 'Shadow alignment' with government systems and priorities (for example, basing donors' systems on local administrative boundaries or using local planning and budget cycles) is one possible way forward.

Within health, fragile states present particular problems - but also opportunities - for donors. Working in health is likely to be more expensive in fragile states than in other low-income countries due to poor infrastructure, insecurity, and the need to implement small-scale operations. Delivery of health services is nevertheless one of the most viable ways to engage with the people living in fragile states, providing much-needed assistance and helping to restore confidence in the government.

Other issues include:

- how to make best use of non-state providers while enhancing ministry of health leadership and regulatory capacity;
- how to train, equip, and pay health workers when the pool of qualified staff is depleted;
- how to avoid a gap in support during the transition from conflict to post-conflict financing of the health sector.

Donors need to find and institutionalize more effective ways of working with fragile states. There is no golden recipe for success. However, well targeted and sequenced aid - especially to support service delivery and build national capacity (government and non-government) - can support peace-building initiatives, prevent crises, and diminish fragility.



Conclusion

As aid flows increase, development partners should devote special

attention

to the increasingly complex operational field in the health sector, and ensure that strengthening of government institutions and management structures is prioritized. Policy coherence, as well as country ownership and leadership, are equally important. To this end, and as noted in the Paris Declaration, an increasing amount of aid should be provided as budget support to allow governments to make necessary sector-wide improvements - including strengthening core health systems functions - that are necessary to achieve the MDGs.

GHIs can facilitate a dramatic and quick scaling-up of resources for health, and can help give civil-society actors a stronger voice in the health sector. GHIs also present particular challenges in the context of efforts to harmonize aid for health, reduce the administrative and reporting burdens on recipient countries, respect country priorities, and strengthen health systems.

Development partners need to increase their commitment to fragile states, and accept the fact that this engagement will be difficult and will carry a certain level of risk. Further work is also needed to reduce the costs and uncertainty of working in fragile states. This includes finding better tools for harmonization and alignment; building a better evidence base for models of health service delivery and on how to rebuild the workforce in fragile states; and gathering additional evidence on how to make best use of government and donor resources in the financing of the health sector.

1 - *OECD/DAC Survey on harmonization and alignment. Measuring aid harmonization and alignment in 14 partner countries. Preliminary edition*. Paris, Organisation for Economic Co-operation and Development, 2005 (www.oecd.org/dac/effectiveness/harmonisation/survey, accessed 27 April 2005).
2 - *Rome Declaration on harmonization*, Rome, 24-25 February 2003 (http://www.aidharmonisation.org, accessed 27 April 2005).
3 - High-Level Forum on Aid Effectiveness, Paris, 28 February-2 March 2005 (http://www.aidharmonisation.org, accessed 27 April 2005).
4 - *Progress report - 14 March 2005*. Geneva, The Global Fund to Fight AIDS, Tuberculosis and Malaria (http://www.theglobalfund.org/en/files/factsheets/progressreport.pdf, accessed 27 April 2005).
5 - *Why we need to work more effectively in fragile states*. London, Department for International Development, January 2005 (http://www.dfid.gov.uk/pubs/files/fragilestates-paper.pdf, accessed 27 April 2005).