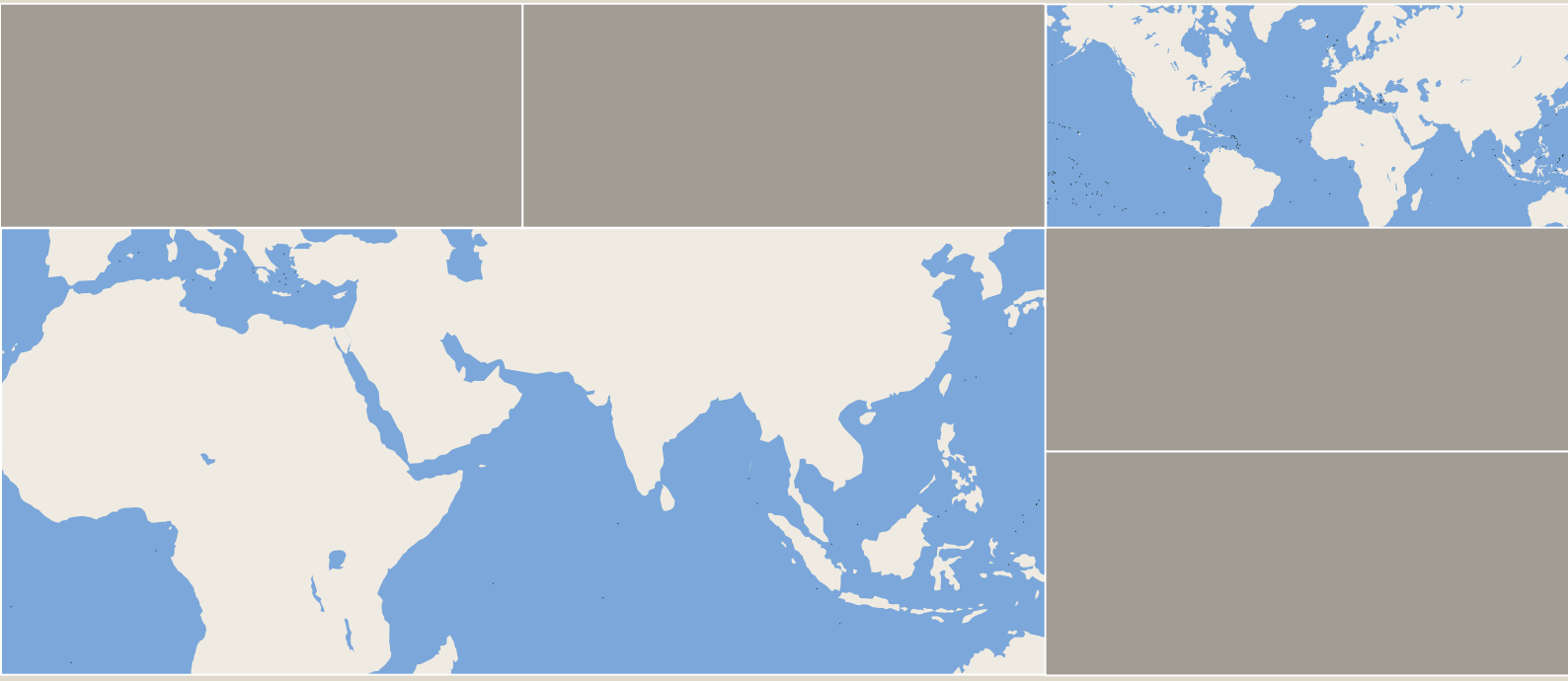
Evaluation Department

Norad

Global Aid Architecture and the Health Millennium Development Goals

Study Report 1/2009



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Global Aid Architecture and the Health Millennium Development Goals

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Contents

Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ADIP	Accelerated Development and Introduction Plans (GAVI)
AMC	Advanced Market Commitments
AMDD	Averting Maternal Death and Disability
ART	Anti retroviral therapy
BMGF	Bill and Melinda Gates Foundation
CBOs	Community-Based Organisations
CH	Child Health
CRS	Creditor Reporting System
DAC CRS	Development Assistance Committee's Creditor Reporting System (part of the OECD)
DFID	Department for International Development (UK)
DOTS	The basic package of TB treatment (originally an abbreviation for Directly Observed Treatment, Short-course)
DPs	Development Partners
DTP	Diphtheria, pertussis and polio (immunisation)
EC	European Commission
FMOH	Federal Ministry of Health
GAVI	The GAVI Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
GF/GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GNI	Gross National Income
GNP	Gross National Product
HepB	Hepatitis B
HI/Hib	Hib Initiative (haemophilus influenzae type B vaccine)
HIV	Human Immunodeficiency Virus
HR	Human resources
HRP	Special Programme of Research, Development and Research Training in Human Reproduction
ICPD	International Conference on Population and Development (Cairo 1994)
IE&C	Information, education and communication
IFFIm	International Finance Facility for Immunisation
IHP+	International Health Partnership +
IMCI	Integrated Management of Childhood Illness
INGO	International non-governmental organisation
IPPF	International Planned Parenthood Federation
ITN	Insecticide-treated net
LIC	Low Income Country
MCH	Maternal and Child Health
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio

MNCH	Maternal, Neonatal and Child Health
MOF	Ministry of Finance
MoH	Ministry of Health
NGO	Non-Governmental Organisation
Norad	Norwegian Agency for Development Cooperation
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
PEPFAR	(US) President's Emergency Programme for AIDS
PETS	Public Expenditure Tracking Survey
PMNCH	Partnership for Maternal, Neonatal and Child Health
PMTCT	Prevention of Mother to Child Transmission (HIV/AIDS)
PRSP	Poverty Reduction Strategy Paper
RBM	Roll Back Malaria
Sida	Swedish International Development Co-operation Agency
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
TA	Technical Assistance
TB	Tuberculosis
TC	Technical Cooperation
TIIFHS	Taskforce on Innovative International Finance for Health Systems
TOR	Terms of Reference
U5MR	Under-five Mortality Rate
UN	United Nations
UNAIDS	The United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing (VCT)
WB	World Bank
WG	Working Group
WHO	World Health Organisation
WSS	Water Supply and Sanitation

A note on terminology
The word "donor" is frequently used. We know that "development partner" is technically more correct - but donor is a simple and easily understood word.

Executive Summary

Executive Summary – Findings and Recommendations

The **aim** of this report was to "come up with recommendations on how further efficiency gains can be made within the overall health architecture".

This was a largely desk-based piece of work which used four main **methodologies**: a study of the financing of the global health aid architecture; analysis of 29 recent evaluations of aspects of health aid architecture; five brief country reviews (Ethiopia, India, Nigeria, Pakistan and Tanzania); and peer assessment by presenting the arguments to "think-tank" audiences.

Funding flows for health – "following the money"
Chapter 2 analyses data on financial flows from the Development Assistance Committee's Creditor Reporting System database (DAC CRS)). This is the most comprehensive database available, but it has serious weaknesses.

Funding flows representing huge sums of money are not included in DAC CRS - for example the Bill and Melinda Gates Foundation spends over $1 billion per year on global health.

There is little systematic data on the extent to which resources provided actually reach service delivery units. Public Expenditure Tracking Surveys (PETS) are a source of useful information, yet are rarely conducted in the health sector.

Commitments for health and population have increased sharply in real terms (in 2007 prices) over the last decade from around $4 billion in 1995, to around $6 billion in 2001 and $15.45 billion in 2007. Including sources not captured by the DAC database, the total may actually be as high as $21 billion.

Donor disbursements for health and population represented around 74% of commitments in 2007. This is up from around 64% in 2002 and suggests a modest increase in **predictability**.

All of the recorded increase in **multilateral spending** over the last 5 years can be attributed to the Global Fund. The World Bank's commitments in health and population declined by more than half between 2003 and 2008.

Funding flows are complex. Resources often pass through a series of intermediaries before reaching the end users. Financial support for multilaterals and NGOs is often extremely fragmented, with institutions relying on a complex mix of flexible

core funding and earmarked extra-budgetary funds.

Resources are heavily concentrated on MDG 6 targets, particularly **HIV/AIDS**. Non-HIV spending has increased dramatically in *absolute* terms. But this increase has been far slower in some areas than others - including fields such as family planning, where highly cost-effective investments can be made.

It is difficult to make much sense of the information on spending on **technical co-operation** (TC). A "re-classification" caused TC spending to apparently drop from 36% in 2006 to less than 10% of total spending in 2007. Multilateral organisations which we know are very active in TC do not record any spending at all on TC.

It is extremely unlikely that there will be enough **funds to meet all the health MDGs** by 2015.

The large increases in donor funding have major long term recurrent cost implications - **sustainability** is a significant challenge.

Chapter 2 ended with three recommendations:

Recommendation 1: *Ensure that unrealistic funding predictions and funding gaps do not dominate global and national analytical work and debate. More attention needs to be paid to realistic financial predictions, prioritisation and sustainability.*

Recommendation 2: *Continue with efforts to link core funding to performance in WHO and other organisations and to reduce the number of extra-budgetary grants.*

Recommendation 3: *Options for improving the current system for tracking international and in-country expenditure on health and population need to be explored.*

Evaluations of components of the aid architecture for health

Chapter 3 analysed 29 evaluations related to global health aid architecture. These evaluations do not form a coherent whole – they simply reflect the major evaluations which have been done.

The overall picture emerging from the evaluations is of an aid architecture populated by:

- Well-funded **global health partnerships** which finance the scaling up of particular technical programmes. (Global Fund, GAVI) They produce results, but are limited by the coverage and quality of health systems. Their achievements will be expensive to sustain. The Global Fund in particular has created many parallel systems, which have created inefficiencies in implementation.
- Interventions which have **not been scaled-up**, because they have not attracted significant funding and/or have not yet made the case that the interventions are sufficiently streamlined and cost-effective. (Integrated Management of Childhood Illness, Averting Maternal Death and Disability)
- Four **UN agencies** (UNAIDS, UNFPA, UNICEF and the World Health Organisa-

tion) which find it difficult to effectively co-ordinate their activities and at times compete or duplicate. WHO has the broadest remit in the health sector and has strength in providing technical guidance. UNFPA and UNICEF fulfil important commodity supply functions.

- The **World Bank**, which provides both technical support and loans/grants. Its strength lies in sector-wide analysis, systems and prioritisation – the division of labour between the Bank and WHO is not clear.
- **Bilaterals**, which have multiple roles because they fund multilaterals, partnerships and NGOs. Bilaterals also have their own programmes, which include a huge variety of types of support. Bilaterals can participate in SWAps and/or fund tailor-made projects to suit particular local needs; some have long-term programmes in particular countries, which allows a longer-term perspective.
- **NGOs** also fund a huge range of activities, including significant amounts of service delivery.
- **Co-ordination partnerships** which find it difficult to be effective because better-funded organisations are not accountable to them. (Roll Back Malaria, Partnership for Maternal, Neo-natal and Child Health)

The evaluations described significant innovations related to the availability and price of **commodities** in recent years.

Gender is not widely discussed in the evaluations - gender has *not* been mainstreamed as a concern in global health.

Two groupings were able to demonstrate **resource penetration to the district level and below**. SWAps tended to encourage increases in unearmarked funds sent to districts. Some NGOs, GAVI and the Global Fund directly funded aspects of service delivery, as did the Stop TB Partnership.

Several evaluations noted UN agencies' attempts at **within-UN collaboration**. Progress was generally limited because each agency had to satisfy its own management systems in terms of planning, budgeting, spending and monitoring.

Examples of **good practice in technical co-operation** were identified – from Stop TB, Averting Maternal Death and Disability and the HIV/AIDS Alliance. All involved well-targeted technical support that was an integral part of a broader plan.

There is often confusion about the divisions of labour for both the funding and supply of **technical support**. This confusion generally occurs when there is an organisation which is regarded as a "big player" in an area, but which does not directly fund significant amounts of technical assistance. The "big player" can be a funder (e.g. the Global Fund) or an "umbrella partnership" such as Roll Back Malaria or Stop TB.

The fragmented aid architecture means that some profound questions are *not* addressed in evaluations – notably **prioritisation** and **service delivery strategies**. With some exceptions, there is an overwhelming public sector focus – the **for-profit private sector** in particular is often not considered.

A number of recommendations emerged from Chapter 3:

Recommendation 4: *The Global Fund should broaden its scope to include "any reasonable interventions that further the MDGs". At the same time, the Fund should address major criticisms of its way of working, notably the creation of many parallel structures.*

Recommendation 5: *It is appropriate to think about what the maximum budgets for the Global Fund and GAVI should reasonably be in the next five or so years and how they should prioritise what they fund. The Government of Norway should ensure that analytical work addresses this question and that it is discussed in various policy forums.*

Recommendation 6: *It is essential that WHO and the World Bank work out how they are going to collaborate to support countries as they address issues of prioritisation, health systems strengthening and sustainability. The Bank and WHO should be challenged to specify how their overlapping remits will be co-ordinated at the country level.*

Recommendation 7: *In collaboration with other partners, the Government of Norway should consider establishing a Global Health Technology Assessment Programme to provide timely information on commodities (and other interventions) that are "good buys" for low-income countries.*

Recommendation 8: *HRP (the Special Programme of Research, Development and Research Training in Human Reproduction) appears to be a successful and unusual arrangement. It is worth exploring whether this model can be expanded or replicated for other technical areas – particularly related to maternal, neo-natal and child health.*

Recommendation 9: *The Government of Norway needs to continue with its efforts to raise the profile of gender. These efforts should be strategic in terms of identifying what needs to be done in organisations to really make a difference, and in terms of which organisations to concentrate on.*

Recommendation 10: *The Paris Principles (for harmonisation and alignment) have to be applied pragmatically on a country by country basis - some countries have plans and systems which should be supported; in other countries, a reliance on government plans and systems is an unacceptably risky use of aid money.*

Recommendation 11: *Reflecting the multiple roles of a bilateral,* the Government of Norway should:

- *Strengthen its voice by being as consistent as possible in all its actions and funding decisions. Take positive action by conducting internal assessments of consistency between bilateral support funded directly at the country level and that financed through global health partnerships.*
- *Develop a shared understanding with other bilaterals of likely funding flows and the implications for prioritisation, sustainability and the budgets of the Global*

Fund, GAVI etc. Share findings of the "internal consistency assessments" (see previous bullet) and encourage other bilaterals to do similar reviews.

- *Work with like-minded donors to have an effective in-country presence in as many aid-dependent and other high-need countries as possible. To be effective, this should be a health specialist with a remit to cover the sector as a whole. The Government of Norway can show the way in terms of innovative arrangements, such as "silent partners".*
- *Support SWAps in appropriate countries. In other countries, work alone or with other bilaterals on tailor-made grants to suit individual country circumstances and to fill gaps.*

The country level: Ethiopia, India, Nigeria, Pakistan and Tanzania

Aid architecture was explored in five countries - Ethiopia, India, Nigeria, Pakistan and Tanzania.

Country information on aid for health is difficult to compile and often incomplete.

The funding flow picture at country level mirrors the global situation described above - countries have generally experienced "more donors plus the rise of the Global Fund" in recent years.

Countries differ significantly in their economics, epidemiology and government leadership and capacity. Key differences include HIV prevalence, levels of government spending on health, degree of aid dependency and the relative size of the private sector. This has **implications for aid** – for example where aid dependency is high, aid funds a significant part of scaling up activities. When it is low, aid must be highly selective and concentrate on pilots/ demonstrations or tackling strategic bottlenecks.

For a number of reasons – but mostly because of its sheer size – **India** is a special case. Global mechanisms need to be locally negotiated and adapted if they are to be effective in India.

Nigeria's level of commitment to primary health care is extremely low and it has a poor track record of public sector management and public health achievement. By default, projects seem the best aid instrument. The challenge is to maximise the wider impact of a project, without being unrealistic about its likely impact. Nigeria is by no means alone in terms of its difficult working environment.

Countries think in terms of **service delivery levels**. This offers an alternative to the current global focus on systems "versus" disease programmes. This focus has shifted attention away from a crucial question: what are the minimum "essential tasks" we expect to be done at each level of the health system – community, clinic, hospital and above?

The role of the Ministry of Health differs from country to country. Channels which start with the central Ministry of Health have to adapt their way of working to meet different situations, including **federalism**. The transaction costs of working in

federal states are inevitably higher, as there are multiple states/provinces with responsibility for health.

Several recommendations from previous chapters are re-inforced by the country perspectives – the need to focus on prioritisation and sustainability; the importance of improving information on donor financing and the flow of funds to districts; and the pragmatic country-by-country application of the Paris Principles.

The Chapter introduced one new recommendation. *The Government of Norway should ensure that sufficient resources are available to allow effective work in federal states. This applies to work which Norway funds both directly and indirectly (through the Global Fund, multilaterals etc).* **(Recommendation 12)**

Overall findings and recommendations

Chapter 5 discusses the findings as a whole and how they link to the recommendations. The chapter includes discussions on a number of key areas: the fragmentation of the sector; the slower progress with MDGs 4 and 5 compared with MDG 6; collaboration between the World Bank, Global Fund, GAVI and WHO; the Paris Principles on harmonisation and alignment; technical co-operation; commodities and the for-profit private sector.

The chapter introduces recommendations in four areas:

- **Fragmentation**. The global architecture for health is currently very fragmented. There are 3 health MDGs, with 6 targets and 19 indicators. The sector is commonly divided up into numerous technical programmes and systems.

  It is worthwhile to briefly compare health with education. *Schools* are the focus of attention – not parts of schools, such as "good maths teaching". The education MDG is directly concerned with schools; education's Fast Track Initiative is about getting children to complete their schooling.

  Similar thinking can be applied in health – education has primary and secondary schools, health has community health workers, clinics and hospitals. The crucial question is: what are the minimum "essential tasks" we expect to be done at each level of the health system – community, clinic and hospital? Or, in the language of performance, what are the minimum *achievements* we should expect from community health care, clinics and hospitals?

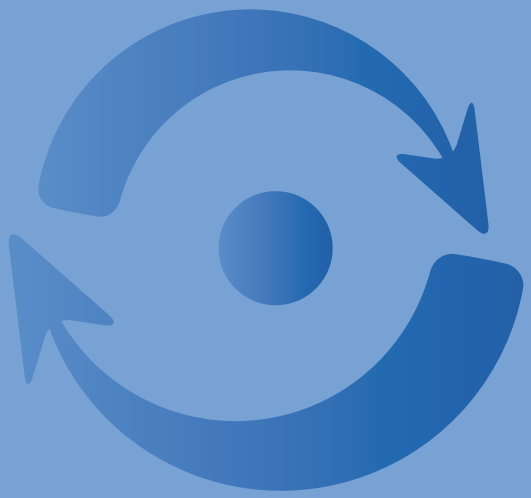
  This focus on levels makes sense to Ministries of Health – this is how well-functioning Ministries tend to plan, deliver and monitor services. It also offers a more attractive basis for resource mobilisation than the abstract notion of "health systems". **Recommendation 13** - *The current fragmented thinking about health should be re-structured around levels - what are the minimum "essential tasks" we expect to be done at each level of the health system – community, clinic, hospital and above? What are the minimum achievements we should expect from each level?*

- **Family planning.** One aspect of maternal and child health ranks alongside immunisation as a "best buy" – family planning. Indeed with its links to women's empowerment, per capita economic growth and environmental sustainability, it is arguably the most important service the health sector provides. Yet we know that funding for family planning has not increased in proportion to the overall increase in aid funding. **Recommendation 14:** *The Government of Norway should ensure that the importance of family planning is fully reflected through its advocacy work and funding.*

- ***World Bank, WHO, GAVI and Global Fund collaboration on health systems.*** A significant recent development in relation to health systems is the undertaking from the World Bank, the Global Fund and GAVI to "streamline their approach to investing in health systems". For GAVI and the Global Fund, this includes an offer to "jointly programme" their health systems support. WHO will act as facilitator. **Recommendation 15:** *The work by the World Bank, Global Fund, GAVI and WHO on streamlining health systems investments is important and should be monitored carefully. The Government of Norway should have clear expectations in terms of an overall vision, shared administrative systems and the fact that this should not become a platform for inappropriate resource mobilisation before the best way of supporting HSS has been established.*

- **Technical co-operation and technical assistance (TA).** The findings of this report about technical support (see above) are similar to the findings of the 2009 evaluation of the Global Fund – that there is "a broad set of problems, inconsistencies, and confusions regarding technical assistance, at both the global and country levels." **Recommendation 16** is thus: *The Government of Norway should ensure that the recommendations related to TA in the 2009 Global Fund evaluation are followed up. This work is important in its own right and provides an excellent opportunity to start addressing the problems with technical support in the health sector as a whole.*

Main Report



1. Introduction: Terms of Reference, Methodology & Context

Key points: Introduction – Terms of Reference, Methodology and Context

- *The* **aim** *of this report is to "come up with recommendations on how further efficiency gains can be made within the overall health architecture".*
- *This is a desk-based piece of work which used four main* **methodologies***: a study of the financing of the global health aid architecture; analysis of 29 recent evaluations of aspects of health aid architecture; five brief country reviews (Ethiopia, India, Nigeria, Pakistan and Tanzania) and peer assessment by presenting the arguments to "think-tank" audiences.*
- *The report covers* **five main groups** *which are involved in health sector aid – multilaterals, bilaterals, global health partnerships, international non-governmental organisations and foundations.*
- In 2007, the predecessor to this report described the now familiar "explosion of global health partnerships and special initiatives", coupled with struggling health systems.
- **Since 2007***, there has been:*
  - *a significant downturn in the world economy*
  - *continued high-level political involvement and efforts to improve co-ordination*
  - *a sharpened understanding of what generously funded disease-specific initiatives can and cannot achieve*
  - *related to the above, an intensified focus on health systems*
  - *ongoing searches for "new" and effective health interventions and delivery strategies.*
- The health MDGs are **fragmented**, with 3 goals, 6 targets and 19 indicators.
- There is a reasonable degree of consensus about what constitutes **"gold standard" interventions for the three MDGs**. Much less attention is paid to how this can be adapted to meet less than ideal conditions – in terms of insufficient resources and/or poor systems.
- There is **uneven progress** towards the three health MDGs.

1.1 Outline

The report starts by setting the scene – why is this report being written and what do we know already? Global financing trends related to health and the MDGs are then analysed (Chapter 2). Chapter 3 reviews a number of recent evaluations of parts of the global health aid architecture – what does this body of literature tell us about what is and is not working well? In Chapter 4, these global-level perspectives are

complemented by country-level viewpoints. Chapters 2-4 all end with recommendations. Finally, the report discusses the overall findings and recommendations.

Before describing the technical context for this work, this chapter summarises the terms of reference and describes the methodologies used.

At the start of each chapter a "Key Points" box summarises the main messages and recommendations from that chapter. Readers wanting to scan the report are advised to concentrate on these boxes.

1.2 The Terms of Reference

While Norway gives broad support to all eight Millennium Development Goals (MDGs), special priority is given to goals 3, 4, 5 and 6.[1] The Prime Minister of Norway has, together with other world leaders, called for an urgent and intensified effort to improve maternal, newborn and child health (MDGs 4 and 5).

A plethora of MDG-relevant global initiatives contributes to an increasingly complex structure, which makes it difficult to get a general overview of the different roles and contributions. It is therefore seen as necessary *to better establish how the various channels and organisations contribute towards the health MDGs in order to make more informed decisions about how to work as efficiently as possible.*

The Terms of Reference describe the purpose of this work as follows:

> *"There is a need to do a "mapping" of different forms of development aid through various channels and organisations aimed at achieving the Millennium Development Goals within the health sector. The intention is to collect data that may inform decision makers about strengths and weaknesses in various forms of development aid, as well as comparative advantages and disadvantages of channels and organisations involved in health efforts in developing countries. The focus will be on improving public health at country level. The study shall include a gender perspective. Based on the analysis and findings, the consultants shall come up with recommendations on how further efficiency gains can be made within the overall health architecture."*

The full Terms of Reference are given in Annex 1.

This report addresses two sets of practical questions:

- What are the strengths, weaknesses and comparative advantages of the various channels through which the Government of Norway can channel funds for the health MDGs? Choices include: multilateral, bilateral or Global Health Partnership? Through a SWAp or not? For commodities, technical assistance or cash transfers?
- How might health aid architecture be made more efficient? What are key points for the global policy dialogue? (This "policy dialogue" takes place in a number of different fora including the Global Campaign for the Health MDGs, the International Health Partnership, the Taskforce on Innovative International Finance for

1 These first paragraphs are taken directly from the Terms of Reference.

Health Systems, UN Reform platforms, the Global Leaders' Forum and the Boards of the Global Fund and GAVI.)

The report concludes with a number of recommendations. Obviously this primarily desk-based report cannot include comprehensive evidence to fully support each recommendation. The recommendations are made in the spirit of using available evidence to make a convincing case in response to questions which need to be answered.

1.3 Methodology

This is a desk-based piece of work which used four main methodologies:

- Analysis of global health aid architecture financing, based on the OECD-DAC[2] database, plus supplementary information collected specifically for this report. (Chapter 2)
- Analysis of 29 recent evaluations of aspects of health aid architecture. (Chapter 3)
- Short desk-based reviews of financing, aid architecture and the MDGs in five countries – Ethiopia, India, Nigeria, Pakistan and Tanzania. Three of these were written fully in-country; one was written at the time of a visit and based on many previous visits; one was written in the UK by an author with extensive in-country experience. (Chapter 4)
- Peer assessment in terms of presenting the arguments to "think-tank" type audiences. Four presentations were made to groups of experts to test out the robustness of the arguments presented here – each session included extensive discussion time. The four presentations were to four types of audience – bilateral, university, NGO and consultants.

The methodologies for the financial analysis and the review of evaluations are described in more detail at the start of Chapters 2 and 3 respectively.

Peer assessment was one part of the methodology – this involved presenting the work-in-progress to "think-tank" type audiences. Four presentations were made to groups of experts to test out the robustness of the arguments presented here – each session included extensive discussion time. The four presentations were to four types of audience:

- A small group of bilateral donor staff at the UK Department for International Development.
- Academics from the University of Oxford at its Global Economic Governance Programme, which is an inter-disciplinary university-wide umbrella that brings together members of the Departments of Economics, Law and Development Studies.
- NGO staff working on health and development
- Consultants working on health and development issues.

The last two events were held at HLSP offices in London.

2 OECD-DAC is the Development Co-operation Directorate of the Organisation for Economic Co-operation and Development.

A number of points came out of these discussions – these included both factual corrections/additions and discussion of the relative emphasis to be put on certain issues. Specific examples are:

- A warning about the importance of explaining what the evaluations did and did not cover. Many of the evaluations were of part of an organisation's work – it was important not to imply that the findings were about the organisation as a whole.
- It became clear from early presentations that the model about the recurrent costs to countries of the global partnerships was too complicated and had to be made clearer.
- A strong reminder that some of the most cost-effective interventions are not related to immunisation, HIV/AIDS, TB or malaria. The emphasis on family planning originated from the session with consultants.
- The report highlights the fact that "all of the recorded increase in multilateral spending over the last 5 years can be attributed to the Global Fund". This statement always aroused interest, as it serves as a reminder of how relatively "young" and significant the Global Fund is. This provoked discussion about the future role of the Fund in terms of the technical areas covered and how it should deal with sustainability.

The methodologies do not together form a systematic and comprehensive analysis of the issues – that would be an enormous job and impossible to achieve with the available resources. Nevertheless, the findings from these disparate methods combine to offer valuable insights into topical questions.

This report covers five main groups which are involved in health sector aid:

- Multilaterals. Organisations formed among three or more nations – for example the World Bank and United Nations agencies such as UNICEF and the World Health Organisation.
- Bilaterals. National organisations which act as donors in other countries – for example Norad and the UK's Department for International Development.
- Global Health Partnerships. Collaborations among multiple organisations (public and private) which share risks and benefits in pursuit of a shared health goal. Examples are the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance, which focuses on immunisation.
- International Non-Governmental Organisations. NGOs are not public organisations, though they may receive government funding and collaborate closely with governments. An INGO is in effect any international organisation which has not been founded by an international treaty. Examples relevant to the health sector are the International HIV/AIDS Alliance and IPPF, the International Planned Parenthood Federation.

1.4 The story so far – the 2007 report on aid architecture and events since then

In 2006, Norad commissioned work "to present ideas for improvements in the effectiveness of the aid architecture {related to MDG 4 on child health}". The report *Mapping and analysis of the aid architecture for achieving MDG4* was completed in early 2007. In practice it dealt with issues surrounding MDGs 4 and 5, having

argued that improvements in child health require maternal and neonatal health to be addressed at the same time – hence the term "maternal, neo-natal and child health" (MNCH), (HLSP 2007).

Despite fast-moving events, many of the conclusions of the 2007 report remain valid and can act as a starting point for this report:

- A key feature of the child health aid architecture is similar to the overall health architecture - an **explosion of global health partnerships and special initiatives** in recent years. Most support for child health is off-budget and in the form of projects. This projectisation has advantages in terms of advocacy, research, fundraising, manageability and quicker and clearer results. But it also distracts from the "big questions" of prioritisation and equity.
- Development partner co-operation is good in some countries – the considerable variation amongst countries seems to be driven by country office staff attitudes and local policy, rather than by the agencies' overall policies. However a major driver of development partner behaviour is the **need to obtain, disburse and monitor funds** under one's own organisational label.
- In most countries, both procurement and supply chains for different commodities are managed through **separate systems**. Most attention is paid to the supply chains associated with immunisation, HIV/AIDS, TB and malaria, often ignoring other equally important products.
- Donor support tends to focus on the marginal costs specific to that technical area, rather than on the **systems "building blocks",** such as levels of care, human resources and infrastructure. These building blocks need to be developed and realistic assessments made of the current and potential capacity of government systems.
- Different organisations have different **comparative advantages**:
  - WHO: overall lead agency for MNCH (the only UN agency covering all of MNCH); technical guidelines and advice
  - UNICEF: supplies, links beyond health (e.g. nutrition)
  - UNFPA: reproductive health issues
  - World Bank: economics, budgeting, financial management, links with Ministry of Finance
  - Partnership for MNCH: advocacy for funding, availability of evidence-based information, directing appropriate support to countries. (This was about a potential role for the Partnership and pre-dated its 2008 evaluation.)

Unlike this report, the 2007 document did not cover MDG 6. However the broad conclusions remain valid when we add in MDG 6 – if anything they are *more* pertinent, given the huge number of initiatives and funding channels related to HIV/AIDS, TB and malaria.

Since the 2007 report, a number of relevant developments have occurred. A broad-brush summary of these developments is:

- The downturn in the world **economy** – which will surely lead to reductions in health expenditures by domestic government, households and donors.
- **High-level political initiatives** to maintain momentum and funding for the health MDGs, as well as ongoing efforts to improve co-ordination.

- An increasing understanding of what generously funded **disease-specific initiatives** can and cannot achieve – in effect, they are constrained by the coverage and quality of the health systems through which they work.
- Linked to the renewed interest in **health systems**, the major **stakeholders** positioning themselves to meet the challenge.
- An ongoing search for **"new" and effective health interventions and delivery strategies**, given the shortfalls in progress towards MDG targets.
- These developments are described in more detail in Box 1 on the next page.

1.5 The health MDGs – key points

There is substantial documentation of progress towards the MDGs – this is not reviewed comprehensively here. (See for example the websites of MDG Monitor, and Countdown to 2015.) This section concentrates on three key points:

- The health MDGs are fragmented, with 3 goals, 6 targets and 19 indicators.
- There is a reasonable degree of consensus about what constitutes "gold standard" interventions for the three MDGs. Much less attention is paid to how
- this can be adapted to meet less than ideal conditions – in terms of insufficient resources and/or poor systems.
- There is uneven progress towards the three health MDGs.

Box 1 Developments related to health and aid architecture since 2007

Economic

A **global financial crisis.** The full effects of the current financial crisis are unclear. At the very least, the crisis signals a drastic change from recent years, when aid more than doubled and several countries, notably in Africa, used economic growth to increase levels of domestic spending on health. OECD and European Union countries have made pledges not to cut aid – but at the same time, despite public statements to the contrary, some donors have indicated that reductions in aid spending are likely. (WHO 2009)

High level political initiatives

The launch in 2007 of both the **Global Campaign for the Health Millennium Development Goals** and the **International Health Partnership**. The Global Campaign encompasses several related initiatives, all of which address some aspect of persistently high mortality rates in developing countries. The IHP focuses on how effective health services can be scaled up, with a major focus on co-ordination.

Establishment in 2008 of the **Taskforce on Innovative International Finance for Health Systems.** Its objective is "to contribute to filling national financing gaps to reach the health MDGs through mobilizing additional resources; increasing the financial efficiency of health financing; and enhancing the effective use of funds."

It is not yet clear how these initiatives will be viewed by the **new administration in the USA**. The US is a highly significant donor in relation to the health MDGs, including through USAID, PEPFAR and the President's Malaria Initiative.

Disease-specific initiatives, health systems and health systems stakeholders

Publication of some significant **evaluations** – including of the Global Fund (2009), GAVI (2008) and the Partnership for Maternal, Neo-natal and Child Health (2008).

Launch of the 2007 **World Bank Health, Nutrition and Population Strategy** and subsequent appointments to strengthen the Bank's capacity in health systems issues.

Work convened by WHO on "**positive synergies**" – i.e. generating "mutual added value for both health systems and disease specific investments by maximizing the synergies between the two".

An announcement in 2009 by the **Global Fund and GAVI** that they would **"jointly programme**" their health systems strengthening resources. This is part of a wider process for the Global Fund, GAVI and the World Bank to streamline their approach to investing in health systems, which will be facilitated by WHO. (TIIFHS)

Searches for "new", effective health interventions and delivery strategies

A focus on **results-based financing**, notably the establishment of a Health Results Innovation Trust Fund at the World Bank.

Pilots in "**Affordable Medicines**", making subsidised medicines available through a variety of public and private outlets.

Fragmented thinking

Health has many more MDGs, targets and indicators than other sectors. (See Table 1) There are 3 goals and 19 indicators, compared with 1 and 3 respectively in education, despite education being a higher-spend sector. This relative "micro-managing" of the health goals is reflected in highly fragmented aid architecture and delivery systems. (It is a moot point which came first, the fragmentation at national or global level.)

Table 1: The MDGs, with numbers of targets and indicators

Goal	Targets	Indicators
1. Eradicate extreme poverty and hunger	3	9
2. Universal primary education	1	3
3. Promote gender equality and empower women	1	3
4. Reduce child mortality	1	3
5. Improve maternal health	2	6
6. Combat HIV/AIDS, malaria and other diseases	3	10
7. Ensure environmental sustainability	4	10
8. Develop a Global Partnership for Development	6	16
Total	**21**	**60**
Of which "health" (MDGs 4,5,6)	6	19
3% of government expenditure (1997–2006) allocated to health in developing countries (UNICEF, 2009)		

Gold standard interventions

There is a reasonable degree of consensus about what constitutes "gold standard" interventions for the three MDGs – of course there will be never be complete agreement. To promote the health MDGs within the health sector, the "ideal" is a network of community and primary level services providing basic interventions and promoting healthy behaviour, supported by a secondary level which is able to provide a limited package of more complex services. All this needs to be complemented by other specific activities such as legislation, public health campaigns and social marketing. Table 2 gives some *examples* of core services by level – this is not a comprehensive list of all the interventions required to meet the health MDGs.

The common "currency" amongst the three MDGs is ***levels of service delivery*** – community, primary (clinics) and secondary (hospitals). These levels provide the building blocks for national planning and budgeting. In contrast, the language of global debate is *systems+diseases*.

There is relatively little discussion about:

- How to prioritise *within* the gold standard – i.e. what to do when either the resources or management capacity are insufficient to provide all the elements of the gold standard? (This is despite the availability of good global information on cost-effectiveness.[3])
- How to relate the "gold standard" to the non-state sector. In particular, what can the vast for-profit sector contribute to the MDGs?

3 E.g. the work of CHOICE in WHO. (CHOosing Interventions that are Cost Effective)

Table 2: Examples of core functions by level (i.e. not a complete list)

Level	Examples of activities related to MDGs 4-6
Community-based ("whole" communities, families and particular sub-groups, e.g. youth)	• Prevention of HIV & sexually transmitted infections (STIs) • Family planning • ITN distribution (i.e. insecticide-treated nets for malaria) • Case management of diarrhoea, pneumonia, malaria • Childbirth support (specifics depend on whether or not access to skilled care) • Oversight of DOTS (the basic package of TB treatment)
Clinic (out-patient and outreach)	• Family planning • Prevention & management of HIV & STIs, including VCT (voluntary counselling & testing) & anti-retrovirals (ART) • Four-visit focussed ante-natal care • Prevention of mother-to-child transmission (PMTCT), HIV • ITN distribution • Immunisation • Integrated Management of Childhood Illness (IMCI) • DOTS for TB
Hospital	• Skilled care at birth and for neonates • Emergency obstetrics and neonatal care • PMTCT of HIV • Elective abortion where legal and post-abortion care
Other	• Social marketing of contraceptives • Legislation about infant feeding products

Source: highly abridged and amended from Kerber et al.

Uneven progress towards the three health MDGs

In terms of the health MDGs, progress is "best" (though still challenging) for MDG 6 and worst for MDG 5 – see Table 3. Progress is mirrored by the funding situation - in 2002-6, more than 50% of all health aid provided directly to countries was absorbed by commitments relating to MDG 6, leaving only $2.25 per capita per year for MDGs 4 and 5 and broader health system support. (TIIFHS WG1)

Table 3: Progress with the health MDGs

The health-related MDGs	% of goal achieved by half way point
MDG 4 (Reduce under-5 mortality rate by 66%)	34
MDG 5 (Reduce maternal mortality rate by 75%)	10
MDG 6 (HIV prevalence)	Estimated HIV prevalence in 15-24 year olds fell 0.1% during 2000-2007 (developing countries)

2. Funding Flows for Health – "Following the Money"

Key points - Funding flows for health – "following the money"

Sources of information

- This chapter analyses data on financial flows from the DAC CRS database (Development Assistance Committee Creditor Reporting System). This is the most comprehensive database available, but it has serious weaknesses.

- Funding flows representing huge sums of money are not included in DAC CRS - for example the Bill and Melinda Gates Foundation spends over $1 billion per year on global health.

- There is little systematic data on the extent to which resources provided actually reach service delivery units. Public Expenditure Tracking Surveys (PETS) are a source of useful information, yet are rarely conducted *in the health sector.*

Donor spending on health and population

- Commitments for health and population have increased sharply in real terms (in 2007 prices) over the last decade from around $4 billion in 1995, to around $6 billion in 2001 and reaching an estimated $15.45 billion in 2007. An alternative source suggests that the total may actually be as high as $21 billion, including sources not captured by the DAC database.

- Donor disbursements for health and population represented around 74% of commitments in 2007. This is up from around 64% in 2002 and suggests a modest increase in predictability.

- All of the recorded increase in multilateral spending over the last 5 years can be attributed to the Global Fund. The World Bank's commitments in health and population declined by more than half between 2003 and 2008.

- Funding flows are complex. Resources often pass through a series of intermediaries before reaching the end users. Financial support for multilaterals and NGOs is often extremely fragmented, with institutions relying on a complex mix of flexible core funding and earmarked extra-budgetary funds.

- At most, 7.7% of health aid between 2002 and 2006 was in the form of sector programmes. The World Bank is the main source of sector budget support. Projects remain a popular aid modality, with an average disbursement of around $550,000 in 2007.

- Resources are heavily concentrated on MDG 6 targets, particularly HIV/AIDS. The discrepancy between the share of donor support for HIV/AIDS and the burden of disease attributable to HIV/AIDS is large and growing in a number of countries.

- Non-HIV spending has increased dramatically in absolute terms. But this increase has been far slower in some areas than others - including fields such as family planning, where highly cost-effective investments can be made.

- It is difficult to make much sense of the information on spending on technical co-operation. A "re-classification" caused TC spending to drop from 36% in 2006 to less *than 10% of total spending in 2007. Moreover, multilateral organisations which we know are very active in TC do not record any spending at all on TC – for example WHO.*

Issues raised by funding flow analysis

- This is a time of change after a period of huge increases in global financial flows for health. It is extremely unlikely that there will be enough funds to meet all the health MDGs by 2015.

- Some areas are already relatively under-funded – e.g. health systems and family planning.

- The large increases in donor funding have major long term recurrent cost implications. Sustainability needs to be seen in the context of all of the recurrent obligations taken on by governments.

Recommendations

Recommendation 1: *Ensure that unrealistic funding predictions and funding gaps do not dominate global and national analytical work and debate. More attention needs to be paid to realistic financial predictions, prioritisation and sustainability.*

Recommendation 2: *Continue with efforts to link core funding to performance in WHO and other organisations and to reduce the number of extra-budgetary grants.*

Recommendation 3: *Options for improving the current system for tracking international and in-country expenditure on health and population need to be explored.*

The Government of Norway can pursue all of these recommendations both in terms of direct funding and through the various policy forums in which it is active.

2.1 Chapter outline – funding flows for health

This chapter starts by describing the sources of information on international funding flows in health.

Section 2.3 then gives quantitative information on key aspects of the funding situation. Section 2.4 continues with a more nuanced description of financial flows – money often passes through several intermediaries between the primary funder and the final beneficiary. The sources of funding and areas of work of a number of key institutions are presented in some detail. Finally, the section describes which types of organisation support different types of aid – technical co-operation, advocacy and various types of financial grant.

Sections 2.5 and 2.6 discuss particular areas of interest identified in the terms of reference for this work – technical co-operation, predictability, sustainability and the extent to which resources reach the service delivery level.

Finally Section 2.7 discusses a number of issues raised by this analysis.

2.2 Sources of information

There is currently no comprehensive system for tracking international expenditure on health and population. The analysis carried out here draws heavily on the OECD's Development Assistance Committee Creditor Reporting System (DAC CRS) which, although it has its weaknesses, is the most comprehensive system available. It includes spending from bilateral and multilateral donors, but not foundations and NGOs[4]. It also omits non-traditional donors such as China.

The coverage of the database has improved over time. In the 1990s some 75-80% of donor spend was captured, but coverage is now complete following the inclusion of multilateral spending and the incorporation of spending on technical co-operation by France and Germany (in 1999) and Japan (in 2003). However, the changing levels of coverage mean that analysing trends over time is problematic.

The DAC definition of health and population excludes spending on other sectors which have a direct or indirect effect on health outcomes, such as water and sanitation or general budget support. The sector is divided into health and population and then further divided into 17 sub-sectors. The classification means it is not possible to assign spending to specific MDGs - although some inferences can be made. As an additional complication, some types of expenditure have recently been re-classified – see Section 2.5 about technical co-operation.

Another layer of complexity is added by the fact that there are multiple intermediaries between the original source of funding and the final recipient – for example a bilateral might provide support to the Global Fund, which transfers resources to an NGO which ultimately spends the money and delivers services. Some institutions appear to have relatively low expenditure according to DAC, but in fact are responsible for channelling large amounts of money. WHO is an example – only some of its core funding is recorded as WHO expenditure, with its considerable extra-budgetary support classified according to the original bilateral funder.

GAVI spending is not currently reflected separately in the database - it was only classified as a multilateral agency by the database in June 2008. (The Global Fund spending *is* fully reflected.)

Efforts are now being made to classify data according to the delivery channel (public, NGO, private) and by type of aid instrument (sector support, technical co-operation etc.) but coverage so far is patchy. It is still not possible to routinely know, for example, how much donor support actually goes through government budgets.

Much of the data for funders not covered in the DAC database - such as the Bill and Melinda Gates Foundation (BMGF) - has to be laboriously mined from various sources, including on-line websites and annual reports. Lack of transparency makes this a problem. An ongoing research project led by Professor Chris Murray is attempting to pull together the available data from all sources.

4 Other than core contributions by DAC donors to NGOs, which are reflected in the bilateral aid figures.

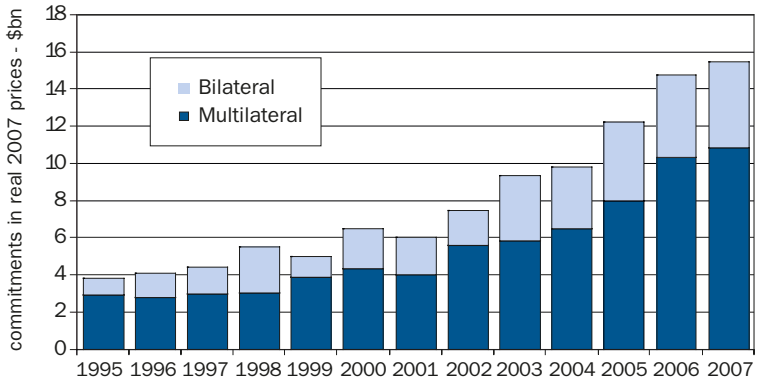
2.3 Key aspects of donor spending – a quantitative analysis

This section looks at recent trends in health and aid financing. The sub-sections are structured to address the issues identified in the Terms of Reference.

2.3.1 Overall Spending Trends

Commitments for health and population have increased sharply in real terms (in 2007 prices) over the last decade from around $4 billion in 1995, to around $6 billion in 2001 and reaching an estimated $15.45 billion in 2007. (However Murray suggests the overall total from all sources including those not captured by the DAC CRS is about $21 billion, with US foundations and NGOs accounting for most of this discrepancy.) As Chart 1 shows, bilateral spending accounts for the majority of commitments – its share remaining broadly constant at around 70% of total commitments over the period. (As we have seen, in practice some of this bilateral spend goes to multilaterals in the form of extra-budgetary support).

Chart 1 Overall Support for Health and Population

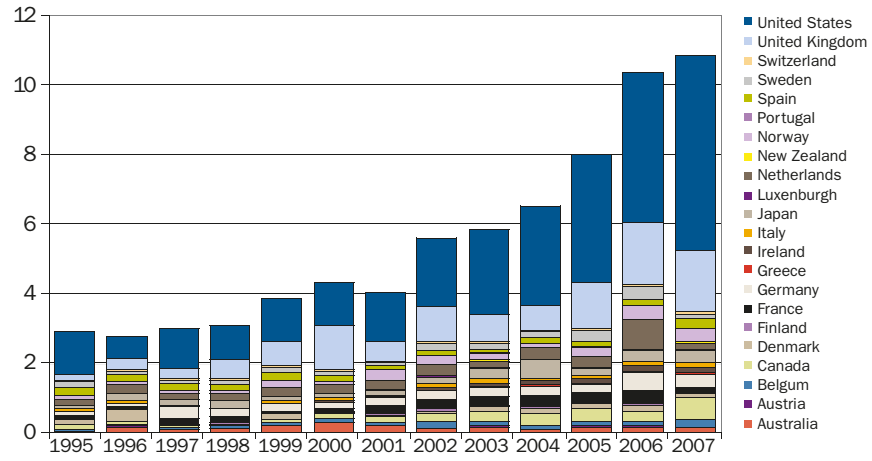


Source: DAC CRS database – author's analysis

Chart 2 shows the increase in **bilateral** spending commitments on health and population[5], illustrating the more than three-fold increase from $3 billion in 1997 to almost $11 billion in 2007 (in real 2007 prices). Bilateral donors committed $71 billion for health and population between 1997 and 2007, with the US accounting for 40% of this and the UK a further 15%. Norway committed a total of $2.5 billion, or 3.5% of the total over the period.

5 Noting, as explained above, that some of this funding is channelled through multilaterals.

Chart 2 Bilateral Support for Health and Population



Source: DAC CRS database – author's analysis

Chart 3 shows the trend in **multilateral** spending. There has been a major increase from around $1 billion in 1995 to over $4.5 billion in 2007 - **all of this increase over the last 5 years can be attributed to the Global Fund.** Between 1995 and 2007 total multilateral commitments amounted to some $33 billion, with the World Bank accounting for around 35%, the Global Fund 24% (despite its establishment late in the period) and the EC just over 18%. Although the World Bank remains a significant player in the sector its commitments declined by more than half between 2003 and 2008.

Note that the inclusion of GAVI data in 2009 will increase the multilateral spending figures.

2.3.2 Future Prospects for Donor Funding

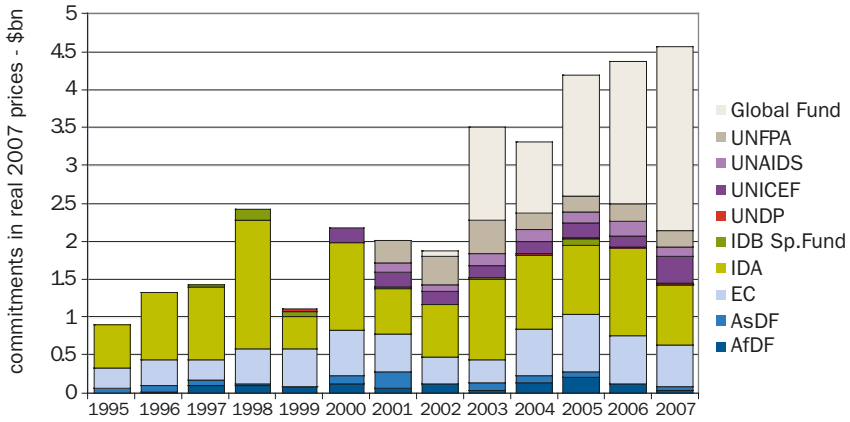
The ongoing financial crisis is likely to have major effects on aid flows for health and population. Even if donors are to meet existing commitments – for example to spend 0.7% of GDP on aid – the fact that GDP is lower than it would have been reduces aid flows in absolute terms. In broad terms a 1% reduction in donor countries' GDP might result in health and population commitments being roughly $150 million lower than would have been the case otherwise. (This is a 1% decrease in overall commitments based on the figures presented in Chart 1.) The overall impact of the current recession is not known, but drops in GDP of the order of 5-10% seem realistic. Moreover, two major donors for health – the US and UK – appear likely to be particularly badly affected.

Developing countries will also suffer – particularly those heavily reliant on export markets - this will potentially have major effects on domestic funding for health.

We need to be realistic about the huge financing challenges. Even if donors fulfil their 2005 Gleneagles G8 commitments *and* countries are able to boost domestic spending, this is unlikely to be enough to ensure access to the services needed for

the health MDGs. In short, it is extremely likely that there will not be enough money to achieve all the health MDGs by 2015.

Chart 3 Multilateral Spending on Health and Population

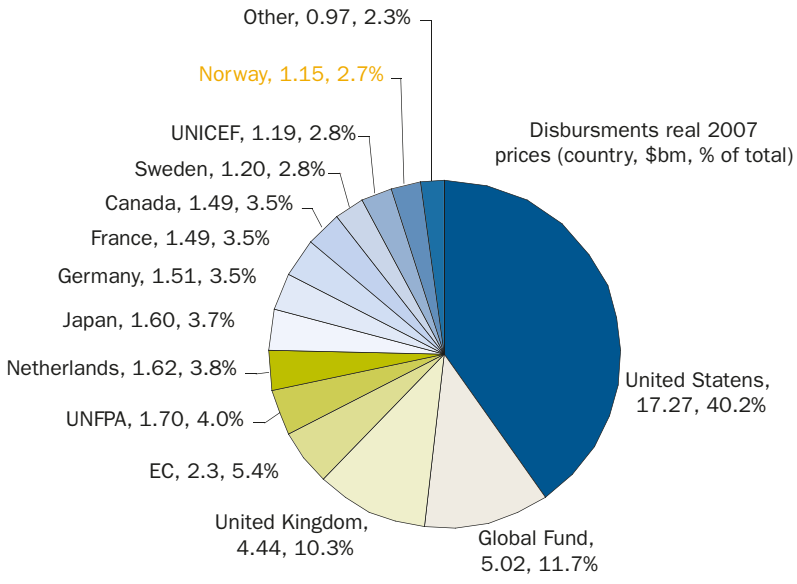


Source: DAC CRS database – author's analysis

2.3.3 Sources of Funding And Aid Instruments Used

Chart 4 shows the main sources of disbursements for health and population between 2002 and 2007. The chart shows source by donor, total disbursements in real 2007 prices and the share of total health and population disbursements over the period. For example, Norway is reported to have spent $1.15 billion or 2.7% of total health and population disbursements over the period. Support is heavily dependent on a relatively small number of donors with the US, Global Fund and UK accounting for over 60% of the total. (The US alone accounts for 40%.)

Chart 4 Sources of Donor Support for Health and Population since 2002



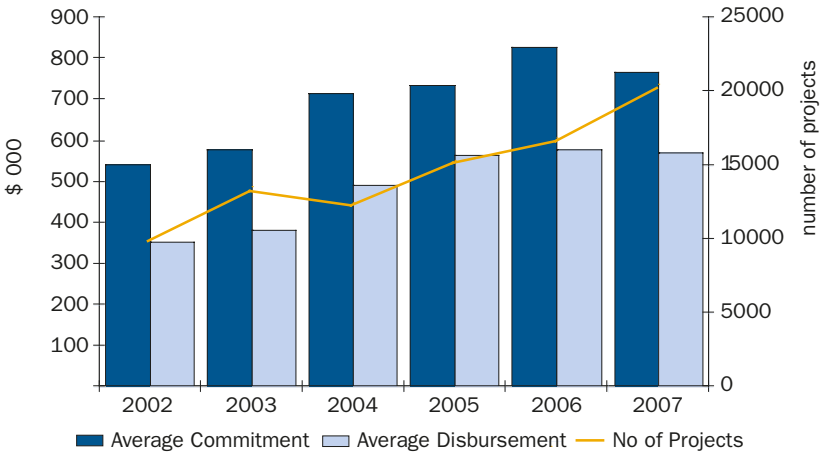
Source: DAC CRS database – author's analysis

Despite major interest in **general budget support** as a means of taking forward the Paris Principles, this form of support accounted for only 6.4% of Official Development Assistance (ODA) commitments between 2002 and 2006. Furthermore, only a small fraction of this would have been allocated to health - low income countries generally allocate 8-10% of their government budgets to health.

CRS data suggests that around 7.7% of health ODA between 2002 and 2006 was in the form of **sector programmes** – though this is likely to be an over-estimate, as detailed analysis of programmes classified this way suggests that some should not really have been counted as sector programmes.

Projects remain a popular aid modality. The number of projects (see the line and right hand axis on Chart 5) increased from less than 10,000 in 2002 to over 20,000 in 2007. The Chart also shows increases in average commitment and disbursement per project (left axis and the block columns) – average disbursement per project increased from around $350,000 in 2002 to around $550,000 in real terms in 2007. The average size of "projects" thus remains extremely small. For some donors – notably the Global Fund and the UK – average commitment per project is higher than average.

Chart 5 Average Size of Donor Health and Population Project



Source: DAC CRS database – author's analysis

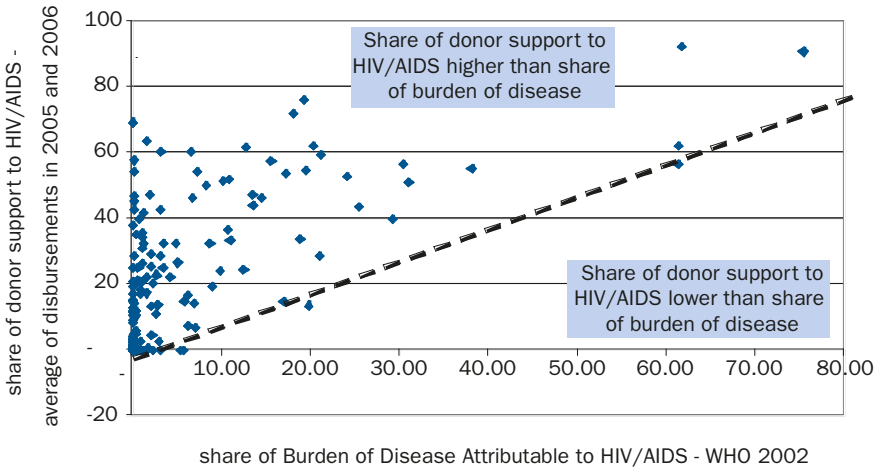
2.3.4 Allocation of Donor Funding and Alignment with Health Needs

There is a growing misalignment between what countries need (in terms of country priorities, burden of disease and cost effectiveness) and what donors provide. Resources are heavily concentrated on MDG 6 targets and are particularly heavily focussed on HIV/AIDS. There has been a significant and relatively sudden rise in spending on HIV/AIDS, TB and malaria - according to DAC data, commitments for HIV/AIDS rose four-fold between 2000 and 2006 to some $4.7 billion. Donor support for HIV/AIDS far outweighs support for other health and population activities in many countries. These increases are largely accounted for by PEPFAR and the

Global Fund, as well as by UNITAID[6] and increases from bilaterals (notably the UK).

The discrepancy between the share of donor support for HIV/AIDS and the burden of disease attributable to HIV/AIDS is large and growing in a number of countries. (HLSP, forthcoming). Chart 6 suggests that the share of donor support going to HIV/AIDS far outweighs the burden of disease attributable to HIV/AIDS[7].

Chart 6 Association between Burden of Disease and Allocation of Donor Support for HIV/AIDS



Source: DAC CRS database – author's analysis.
WHO Burden of Disease data http://www.who.int/healthinfo/statistics/bodgbddeathdalyestimates.xls

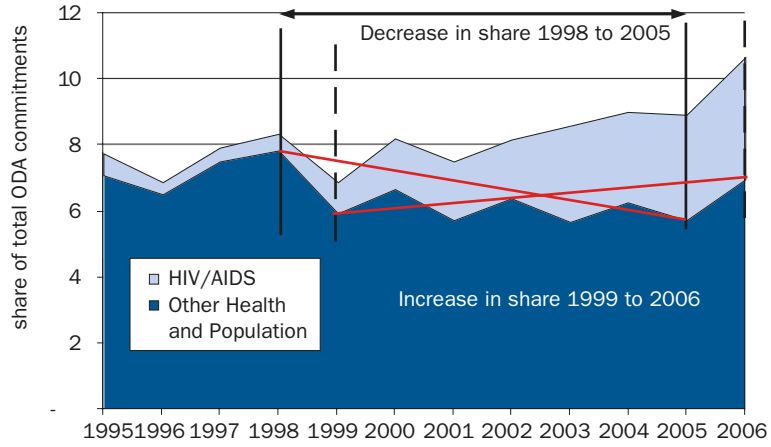
Is this support for HIV/AIDS additional or has it undermined support for other aspects of health and population? DAC data suggest that the share of donor support for health and population excluding HIV/AIDS has remained broadly constant since the late 1990s (Chart 7). This suggests that the increase in donor support for the HIV/AIDS response has been additional to other health and population support. However, by looking at different timeframes one could argue quite plausibly that its share has either gone up or down. What *is* clear, is that non-HIV spending has increased dramatically in *absolute* terms (if not in *relative* terms). But this increase has been far slower in some areas than others - including areas such as family planning, where highly cost-effective investments can be made.

The fact that such support might be additional in overall terms does not mean that this is true of all countries – for example there have been substantial increases in donor support for HIV/AIDS in Mozambique in recent years, even though total development assistance to Mozambique has declined.

6 UNITAID raises money primarily through a levy on airline tickets which accounts for around 82% of its revenue. The tax is currently implemented in a number of developed and developing countries with others in the process of joining. Estimated funding for 2008 was around $370 million. The UNITAID Board has approved the introduction of a Voluntary Solidarity Contribution Scheme which, it is estimated, could contribute up to $2 billion per annum. This will be piloted in 2009 and should be fully operational in 2010.

7 This chart should be treated with some caution. The Burden of Disease data relates to 2002 and the spending figures for 2005 and 2006. Additionally, it makes no reference to domestic funding of HIV/AIDS.

Chart 7 Share of ODA to Health and Population



Source: DAC CRS database – author's analysis

Allocations often do not match with countries' stated priorities - as shown in Box 2 for Cambodia.

Box 2 Aid allocations and country priorities in Cambodia

- A study by Michaud (2005) found "the most striking imbalance between disease burden and financial resources pertains to HIV/AIDS, relative to maternal and child health."
- The Sector-Wide Management Review (2007) suggested that "despite constructive political and technical relationships at central level, activities remain largely uncoordinated and driven by donor priorities, policies and procedures".
- The National Strategic Development Plan (the Cambodian equivalent of a PRSP) sets out the intention of spending the majority of resources on primary health care – including the expansion of the Minimum Package of Activities and Complementary Package of Activities – over the period 2003-5. In practice, however, around 60% of donor funding went into HIV/AIDS and other infectious diseases (Lane, 2007). HIV prevalence in Cambodia is 0.6%.

This misalignment is encouraged by the fact that global estimates of funding requirements have tended to be wildly ambitious. (In practice, many low income countries are currently not spending the $12 per head set out in the 1993 World Development Report, let alone the $35 spelt out in the Commission for Macro-economics and Health Report in 2001.) The picture is further complicated by numerous disease-specific funding needs assessments. This focus on needs, funding gaps and sums of money far in excess of what is available distracts countries from the need to prioritise, even within the health MDGs.

2.4 Multiple stages of funding – the financing of key institutions

This section provides a more nuanced description of financial flows than the previous section, which relied on financial data from DAC CRS. Section 2.4.1 describes how money often passes through several intermediaries between the primary funder and the final beneficiary. Section 2.4.2 then presents the sources of funding and areas of work of a number of key institutions. Finally, Section 2.4.3

describes how different organisations support different types of aid – technical co-operation, advocacy and various types of financial grant.

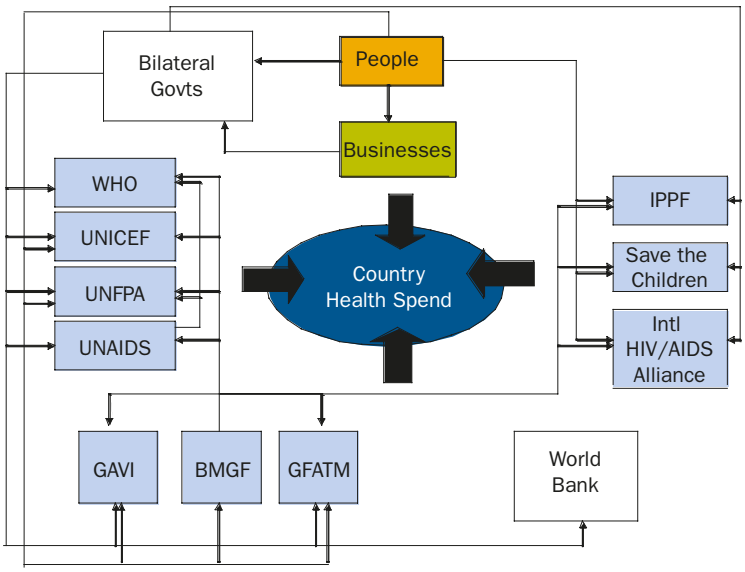
2.4.1 The Complexity of Funding Flows

Chart 8 maps out the flow of funds between key actors. The picture is extremely complex. The diagram distinguishes between *primary funding sources* (people and businesses which fund bilateral aid programmes through tax payments or through voluntary contributions to other organisations) and *financing intermediaries* (which subsequently channel resources to end users). The chart illustrates the range of financing intermediaries – bilateral donors, the UN, global health initiatives and international NGOs[8]. It then shows which financing intermediaries fund others before funds are actually spent at the country level[9]. **Resources often pass through a series of intermediaries before reaching the end users.** Funds from primary sources and bilaterals go through a variety of routes to reach their destination.

As examples:

- The Bill and Melinda Gates Foundation (BMGF) has provided a large amount of support for GAVI, international NGOs and the UN (either directly, or indirectly to organisations which advocate on its behalf in the US).
- UNAIDS channels a large share of its income through co-sponsors, particularly WHO and UNICEF.
- Bilateral donors and the Global Fund provide substantial support to international NGOs.

Chart 8 Fund flows between organisations



8 In practice the Bill and Melinda Gates Foundation could be classed as a "business" or as an International NGO.

9 To avoid complicating the picture even more, direct support by private businesses is excluded - other than in terms of the tax payments which support aid programmes. In practice, many of the institutions identified here receive cash or in-kind support from private corporations.

2.4.2 Key Institutions- How They Raise and Spend Money

This section explores the flows illustrated in Chart 8 in more detail, focussing on the institutions identified in the Terms of Reference as being of major interest.

Table 4 describes key financing characteristics of institutions – sources of finance, levels of expenditure and the areas financed.

Key points from Table 4 are:

- Funding flows representing huge sums of money are not included in DAC CRS - for example the Bill and Melinda Gates Foundation spends over $1 billion per year on global health and the International Save the Children Alliance spends about one-fifth of its almost $1 billion annual budget on health and HIV/AIDS.
- Money from donor governments flows through global health partnerships, multilaterals and international NGOs. Strikingly, 96% of the funding for the Global Fund comes from donor governments.
- Funding channels are extremely complex, with many institutions channelling significant resources through many others.
- Financial support for multilaterals and NGOs is often extremely fragmented, with institutions relying on a mix of flexible funding and earmarked extra-budgetary funds. For example, only 27% of WHO's income comes from regular sources – the rest consists of earmarked, extra-budgetary funds.

Table 4 Key Institutions: Sources and Uses of Funds

		Degree of Focus on Health, Population and HIV/AIDS	Sources of Funding	Level and Type of Expenditure	Areas of spending	Comments
Global Partnerships and Foundations	**Bill & Melinda Gates Foundation (BMGF)**	59% of total disbursements to global health ($11.66bn to date)	Internal: Endowment valued at $44bn (end 2007). Supplemented by Buffet	High. >$1bn annually for global health. Earmarked – much to global (e.g. GAVI) or US institutions.	28% for HIV/AIDS, 22% for advocacy and public policy, 12% to malaria and 9% to neglected diseases. 33% for Africa; 44% global in nature.	Database does not allow ready analysis of spend.
	GAVI	Exclusively on health and population	BMGF provided seed funding. $1.2bn donors, $1bn private, $0.95bn IFFIm	Medium/high – large increase to ~$889m in 2007	Restricted to countries under a per capita income threshold. Spending 2000-7: new/under-used vaccines $889m; HSS $118m; injection safety $117m, immunisation services $289m	
	Global Fund	Exclusively on health and population. $7.6bn+ disbursed to date	Primarily bilateral donors – 95.6% of total (99% excluding BMGF)	High. $2.6bn disbursed in 2007; operating costs $117m	*68% to low income countries, 57% to sub Saharan Africa, 61% to HIV/AIDS*	
UN	**WHO**	Exclusively on health and population	Mix of core funding (assessed "compulsory" funding from countries) and earmarked extra budgetary funds (voluntary)	High. $3.3bn in 2006-7. $915m from regular sources (assessed contributions + other income); $2.4bn voluntary contributions	Essential health interventions (55%), health systems policies and products (13%) determinants of health (11%) support for Member States (21%)	
	UNFPA	Exclusively on health and population	All voluntary. Mainly public sector	Medium ~ $752m income in 2007.Regular income $457m; other income (earmarked for particular uses) $295m. Total expenditure on programmes $517m	Spending from regular resource: $273.1m in 2007. 46% of programme expenditure in Africa, 28% in Asia. $146.6 million for reproductive health; $52.2m for population and development; $20.8 million for gender equality and women's empowerment; $54 million for programme co-ordination and assistance. Of total spending: $370m on country projects; $26m regional projects; $81m inter-regional, HQ and procurement services; $39m for professional officers and other programmes.	

UN	**UNICEF**	Majority not on health. 6.4% on HIV/AIDS.	All voluntary. Public sector accounted for $1.96bn in 2007 (~2/3 of the total)	High - ~$2.5bn programme expenditure in 2007	52.4% on young child survival and development, 20.3% on basic education and gender equality. 52.4% in sub Saharan Africa; 30.2% in Asia.	
	UNAIDS	Exclusively on health and population	Income Jan 2006-April 2007 - $250m – 93% from donors	Low ~ $250m per annum	~1/3 transferred to co-sponsors for implementation of HIV/AIDS activities (21% to WHO, 16% to UNICEF)	
Inter-national NGOs	**Save the Children Alliance**	Range of child-centred activities – 21% to health and HIV/AIDS	$1bn income in 2007 – of which 40% from development partner donors.	High – just under $1bn per annum - ~ $200m per annum for health and HIV/AIDS	14% was spent on health and a further 7% on HIV/AIDS. 35% was spent on protecting children in emergencies and on promoting children's rights. 42% was spent in Africa 36% in Asia. Operating in "over 120 countries"	
	International HIV/AIDS Alliance	Exclusively on health and population	$60m income. Half earmarked (of which ~half from donors) – the rest unrestricted	Low ~ $60m per annum	40 countries. Key areas of emphasis include integrated responses combining HIV prevention, access to treatment, care and support, and lessening the impact of AIDS. Heavily involved in Eastern Europe.	
	International Planned Parenthood Federation	Exclusively on health and population	Income $120m. 2/3 unrestricted support from Governments.	Low. ~$300m per annum including member associations which raise 2/3 of their income locally	Member organisations working in 176 countries - providing and campaigning for sexual and reproductive health care and rights.	
World Bank		~ 6% to health and population and declining	Capital markets based on periodic replenishments from donor Governments	High, declining. Ca $1.6bn committed for health in 2008; $3.4bn in 2003. (Overall Bank commitments rose from $18.5bn to $24.7bn)		*Not in grant form.*

2.4.3 Different Organisations Support Different Types of Aid

Financing intermediaries provide support using a range of modalities. These are outlined in Table 5. In broad terms:

- The UN, World Bank and Gates Foundation (BMGF) play important roles in the provision of technical co-operation – but recall that most of this is not captured on the DAC database. GAVI and the Global Fund, by contrast, act primarily as financing instruments.
- Most support is in the form of projects – almost exclusively so for the international NGOs, BMGF and UN. However UNFPA, Global Fund and GAVI are increasingly interested in engaging in SWAps.
- Very little support is provided through government budgets as sector or budget support, with the exception of funding from the World Bank.
- All of the organisations to some degree see advocacy and policy dialogue as part of their mandate.

Table 5 Use of Aid Instruments by Organisation

		UN	World Bank	Global Fund, GAVI	B&M Gates Foundation	International NGOs
Technical Co-operation	Long Term	■	■		■	
	Short Term	■	■		■	
	Institutional Cooperation	■	■		■	
	Research	■	■		■	
$	In Kind	■	■	■		
	Project	■	■	■	■	■
	Sector Support		■	■		
	Budget Support		■			
Advocacy/Dialogue		■	■	■	■	■

2.5 Donor funding of technical co-operation

This chapter now moves on to discuss particular areas of interest identified in the terms of reference – technical co-operation, predictability, sustainability and the extent to which resources reach the service delivery level.

The TORs asked us to look in particular at funding for technical co-operation (TC). Why does it appear to account for such a large percentage of donor funding?

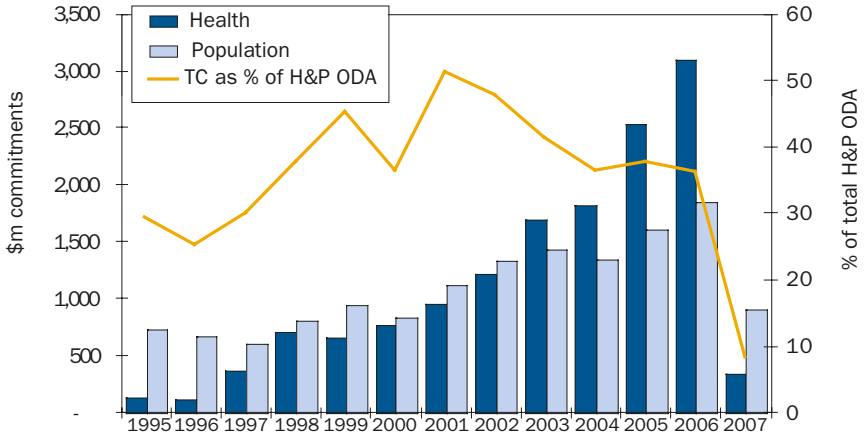
DAC defines technical co-operation as "activities whose primary purpose is to augment the level of knowledge, skills, technical know-how or productive aptitudes of the population of developing countries - i.e. increasing their stock of human intellectual capital, or their capacity for more effective use of their existing factor endowment." According to DAC CRS, TC has accounted for a significant share of donor support – around 36% of total health and population assistance in 2006.

However, this figure suddenly dropped to less than 10% of total spend in 2007. This seemingly dramatic reduction appears to be due largely to a re-classification of US spending, rather than any real change[10].

Total funding for technical co-operation for health and population between 2002 and 2006 is estimated at some $18 billion, with most funded by the US. The share of donor health and population programmes allocated to TC varies widely - from the US where it has been around 90% (before the recent re-classification), to the UK and Germany where it is around 40%.

Trends are illustrated in Chart 9, which shows the levels of TC funding in health and population (the blocks and the left hand axis) and spending on technical co-operation as a share of total sector spending (the yellow line and the right hand axis). In practice all these numbers are under-estimates, *as none of the multilaterals report any TC spending*. Whilst this might be broadly true for the global initiatives which operate primarily as financiers (such as the Global Fund), it is certainly not the case for many multilaterals, such as WHO. We saw in Table 4 that 21% of WHO's pending was on support for member states – and we will see in Chapter 5 that WHO and UNICEF hire hundreds of "TC" staff in Ethiopia. (Table 11)

Chart 9 Technical Cooperation for health and Population

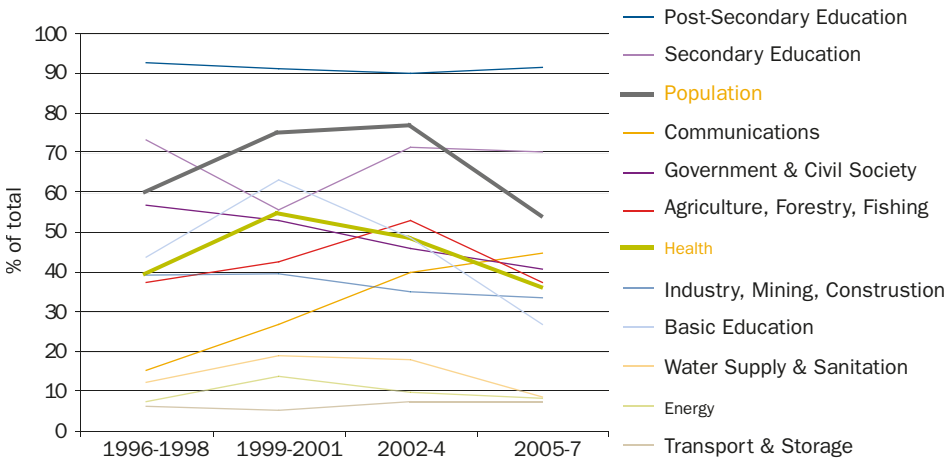


Source: DAC CRS database – author's analysis

Chart 10 suggests that the share of aid going to technical co-operation in the health and population sectors is not out of line with other sectors. Although higher in population (>50% from 2005 to 2007) than health (<35%), it remains well below post- secondary education (~90%) and secondary education (~70%). However it is well above water supply and sanitation, energy, and transport/storage, where TC accounts for less than 10% of donor assistance.

10 USAID states: "TC is more narrowly defined now as the specific conveyance of expertise, training, and other knowledge directly to the aid recipient country as opposed to the inputs of technical services for the delivery of assistance." Personal correspondence, USAID to Catriona Waddington, May 2009.

Chart 10 Share of Developement Assistance to TC by Sector



Source: DAC CRS database – author's analysis

In summary, it is difficult to make much sense of the information on spending on TC. A "re-classification" caused TC spending to drop from 36% in 2006 to less than 10% of total spending in 2007. Moreover, multilateral organisations which we know are very active in TC do not record any spending at all on TC – for example WHO.

2.6 Features of aid funding – predictability, sustainability and penetration to the service delivery level

The TORs for this work expressed an interest in predictability, sustainability and penetration to the service delivery level. As we saw in Chapter 1, this "penetration" of resources is seen as one useful indicator of the efficiency of aid organisations.

2.6.1 Predictability

Donor disbursements for health and population were estimated at some $11.51 billion in 2007 - around 74% of commitments. This is up from around 64% in 2002 and suggests a modest increase in predictability.

There are different ways of looking at predictability. With GAVI support for Health Systems Strengthening, for example, countries know exactly how much funding they are entitled to, as this is determined by a global formula. The Global Fund, by contrast, relies on proposals from countries, with no specific guidance on size. This poses countries with a dilemma – should they play safe and go for a small amount or be more ambitious but increase the risk of proposal rejection? The period before a Global Fund grant is awarded is a time of considerable uncertainty. (Following approval, GAVI and the Global Fund operate in similar ways.)

2.6.2 Sustainability

The large increases in donor funding have major long term recurrent cost implications. In countries where disease specific programmes such as the Global Fund and PEPFAR account for a large share of support, health sectors are extremely vulner-

able to any changes in donor funding practices.[11] Annex 2 models the effects of phasing out support from global health initiatives in a hypothetical poor, aid-dependant country. It concludes that **a large share of any future increase in health spending may have to be devoted to sustaining the work originally funded by the global health initiatives.** Donors providing budget support may simply find that their support will be used to service these and not, as they had intended, to support overall country priorities.

Sustainability needs to be seen in the context of *all* of the recurrent obligations taken on by governments. Ideally, this should be done through a medium term financial planning process such as an MTEF (Medium Term Expenditure Framework).

2.6.3 Do Resources Reach Service Delivery Units?

There is little systematic data on the extent to which resources provided actually reach service delivery units. Public Expenditure Reviews and Public Expenditure Tracking Surveys (PETS) are the best means for assessing this – especially the latter. The former gives an idea of how resources are allocated, indicating the share of resources which *should* reach providers. More intensive tracking studies are required to assess the extent to which resources *actually* reach providers – see Box 3 for an example.

PETS can provide valuable information, particularly where there are major concerns about absorptive capacity or mismanagement – yet relatively few PETS have been carried out in the health sector.

Box 3 Do resources get to the right places? The experience of Cambodia

The Cambodia health PETS found that "only a small share of government budget expenditures was spent on direct delivery of health services. In 2003 and 2004, only 36% and 32% of the government health budget was spent for providing services in government health centres and referral hospitals". It also found significant disbursement delays – this significantly hampered operational efficiency, with officials often resorting to borrowing funds from money-lenders or getting supplies such as fuel on credit.

2.7 Discussion – funding flows and aid architecture efficiency

The aim of this report is to "come up with recommendations on how further efficiency gains can be made within the overall health architecture". What does this analysis of finding flows contribute to the aim?

Four issues of relevance to aid architecture efficiency emerge from this chapter:

- Following several years of enormous growth in donor funding, there is a need to balance the many analyses of funding gaps with a focus **on realistic budget predictions and prioritisation.**
- The need for realistic assessments of **sustainability**.
- The importance of focussing on **core tasks and core funding for key organisations.**

11 For example, Mozambique is currently facing major problems in this respect - see http://blogs.dfid.gov.uk/2009/05/mozambique-prepares-its-global-fund-application/

- The need for **better global financial databases and country surveys of public expenditure.**

Focus on realistic assessments of budgets and on prioritisation

Recent years have seen a huge increase in donor funding for health. Huge efforts to mobilise resources at the global level have been informed by analyses of funding needs and gaps. This global attention to the health sector is of course most welcome and should be sustained.

It is not enough to say that if money is filling an MDG-related gap, this is by definition a good thing. There can be real problems with "skewed spending". (Skewed spending is when the mix of expenditure on various technical programmes is not the mix that countries want, or it is not the best mix in public health terms.)

Concentrating too much on funding needs and gaps has risks. Realistically, there will not be enough money available to achieve all the health MDGs. Countries therefore need to be explicit about their priorities.

What does this mean in practical terms? At global level, more work needs to be done on realistic assessments of available funds and priorities for their use. This involves questions such as: what vaccines should be available in all low income countries and for how long will the donor community need to pay for them? Is the balance of expenditure between family planning and AIDS/TB/malaria correct? If not, how do we address this? (WHO's CHOICE programme is relevant here, as it gives guidance on what investments provide value for money in different country settings.)

This work is different in emphasis from that of Working Group 1 of the Innovative Financing Taskforce. We fully appreciate that Working Group 1 is working in the context of efforts to mobilise more resources. The point here is that there also needs to be work at the global level that reflects the current funding situation and how the available funds can best be spent.

The same thinking applies at country level. National sector and sub-sector plans need to be based on realistic budgets – unrealistic budget forecasts are the opposite of trying to improve predictability. Scenarios are a useful way of showing what is planned for different levels of budget – see, for example, Ethiopia's five-year Health Sector Development Programme. Uncosted plans and stand-alone assessments of funding needs should be discouraged.

Realistic assessments of sustainability

Current spending on immunisation, HIV/AIDS, TB and malaria implies high recurrent costs if these programmes are to be maintained. Curtailing activities in these areas would be damaging in both public health and political terms.

More work needs to be done about this issue at both the global and national levels. What will it cost to maintain current levels of immunisation, anti-retrovirals, malaria and TB treatment etc? Realistically, who will pay for this? How much of the available global and national finances will these activities use up in the next 5-10 years?

GAVI's work on financial sustainability is an example of good practice here – see *Financial sustainability for immunisation in the poorest countries: lessons from GAVI 2000-2006.*

These concerns about future funding, prioritisation and sustainability are reflected in Recommendation 1. This is a time of change after a period of huge increases in global financial flows for health. The focus and time of global and national technical debates need to move away from a mentality of growth and consider the implications of realistic funding projections. There are not enough funds to meet all the health MDGs and some areas are already relatively under-funded – e.g. health systems and family planning. The recurrent cost implications of current spending on HIV/AIDS, TB, malaria and immunisations are huge.

Recommendation 1: *Ensure that unrealistic funding predictions and funding gaps do not dominate global and national analytical work and debate. More attention needs to be paid to realistic financial predictions, prioritisation and sustainability.*

The Government of Norway can act on this recommendation in terms of both policy dialogue and funding. It should *discourage* excessive analytical work on funding gaps that are unlikely to be filled and plans that are unlikely to be financed. It should *encourage* realistic budgeting, prioritisation and sustainability.

This recommendation in no way undermines efforts to mobilise more global resources – efforts which we very much respect. Funding needs assessments have a clear use – but there is also a need to tackle difficult questions of prioritisation.

Core tasks and core funding for key organisations

This chapter has described the complexities of international funding flows. Table 4 shows, for example, that only 27% of WHO's income comes from regular sources – the rest consists of earmarked, extra-budgetary funds. This picture – limited core funding and substantial time-limited earmarked funding - is broadly typical of many multilaterals and NGOs.

Ways need to be found to reduce the number of ad hoc grants to organisations, whilst maintaining a link to performance. (There are similarities to the function of SWAps in countries.) This is not a new challenge for organisations such as WHO – but it is an area of profound importance.

Recommendation 2 is to *continue with efforts to link core funding to performance in WHO and other organisations and to reduce the number of extra-budgetary grants.* Extra-budgetary grants should be avoided – and if they are awarded, should be pooled with funds from other donors wherever possible.

This recommendation reflects a familiar dilemma – earmarked grants are popular because the funder can specify what will be done with the money. But this practice cumulatively undermines an organisation's ability to prioritise effectively.

The need for better global databases and country surveys

There is currently no comprehensive system for tracking international expenditure on health and population. The DAC CRS database is the most comprehensive system available, but it has significant shortcomings and omissions. The data for funders not covered in the DAC database has to be laboriously mined from various sources. Such weaknesses sit uncomfortably against the reporting requirements placed on recipient countries and the objective of promoting mutual accountability.

Options for improving the current system for tracking international and in-country expenditure on health and population need to be explored. (**Recommendation 3**) Globally, the options include maintaining the DAC database in its current form; retaining it with significant modifications (in relation to classifications, coverage and quality assurance); and/or funding periodic studies that estimate funding flows (such as the work currently being done by Murray et al.). For the database, a key question is how to "police" data to ensure that the results are credible.

In-country, Public Expenditure Reviews and Public Expenditure Tracking Surveys (PETS) can provide valuable information on resource allocation in countries. PETS in particular are a good method for assessing what resources actually reach service delivery points. These reviews and surveys potentially pay-for-themselves in terms of the inefficiencies they expose – but they are currently carried out in a rather ad hoc, intermittent manner. Donors should consider more systematic ways of organising Public Expenditure Reviews and Public Expenditure Tracking Surveys.

3. Evaluations of Components of the Aid Architecture for Health

Key points - Evaluations of components of the aid architecture for health

- This chapter analysed **29 evaluations** related to global health aid architecture. These evaluations do not form a coherent whole – they simply reflect the major evaluations which have been done. Despite this, the evaluations offer important insights into what a bilateral donor might expect if it channelled money through the different organisations described here.

- *The overall (and clearly much simplified) picture emerging from the evaluations is of an aid architecture populated by:*
  - Well-funded **global health partnerships** which finance the scaling up of particular technical programmes. (Global Fund, GAVI) They produce results, but are limited by the coverage and quality of health systems. Their achievements will be expensive to sustain. The Global Fund in particular has created many parallel systems, which have created inefficiencies in implementation.
  - Interventions which have **not been scaled-up**, because they have not attracted significant funding and/or have not yet made the case that the interventions are sufficiently streamlined and cost-effective. (IMCI, Averting Maternal Death and Disability)
  - Four **UN agencies** which find it difficult to effectively co-ordinate their activities and at times compete or duplicate. WHO has the broadest remit in the health sector and has strength in providing technical guidance. UNFPA and UNICEF fulfil important commodity supply functions.
  - The **World Bank**, which provides both technical support and loans/grants. Its strength lies in sector-wide analysis, systems and prioritisation – the division of labour between the Bank and WHO is not clear.
  - **Bilaterals**, which have multiple roles because they fund multilaterals, partnerships and NGOs. Bilaterals also have their own programmes, which include a huge variety of types of support. Bilaterals can fund tailor-made projects to suit particular local needs; some have long-term programmes in particular countries, which allows a longer-term perspective.
  - **NGOs** also fund a huge range of activities, including significant amounts of service delivery.
  - **Co-ordination partnerships** which find it difficult to be effective because better-funded organisations are not accountable to them. (Roll Back Malaria, Partnership for MNCH)
  - Some organisations have found a particular **niche** in which to work. The HRP is of particular interest. It has taken its particular area - research, development and research training in human reproduction – and developed this into a programme of work which has had a significant influence on service delivery.

- Two groupings were able to demonstrate **resource penetration to the district level and below**. SWAps tended to encourage increases in unearmarked funds sent to districts. Some NGOs, GAVI and the Global Fund directly funded aspects of service delivery, as did the Stop TB Partnership.

- Several evaluations noted UN agencies' attempts at **within-UN collaboration**. Progress was generally limited because each agency had to satisfy its own management systems in terms of planning, budgeting, spending and monitoring.

- Examples of **good practice in technical co-operation** were identified – from Stop TB, Averting Maternal Death and Disability and the HIV/AIDS Alliance. All involved well-targeted support that was an integral part of a broader plan.
- There is often confusion about the divisions of labour for both the funding and supply of **technical support**. This confusion generally occurs when there is an organisation which is regarded as a "big player" in an area, but which does not directly fund significant amounts of TA. The "big player" can be a funder (e.g. the Global Fund) or an "umbrella partnership" such as Roll Back Malaria or Stop TB.

- The fragmented aid architecture means that some profound questions are *not* addressed in evaluations – notably **prioritisation** and **service delivery strategies**. With some exceptions, there is an overwhelming public sector focus – the **for-profit private sector** in particular is often not considered.

Recommendations

The review of evaluations reinforced the recommendations made in the previous chapter – about the need for better information and more of a focus on prioritisation and sustainability; and about the importance of core funding (and fewer extra-budgetary grants) for strategic organisations such as WHO.

- **Recommendation 4:** *The Global Fund should broaden its scope to include "any reasonable interventions that further the MDGs".* It makes no sense to limit this valuable source of money to three diseases when a country may want to pursue a cost-effective strategy related to other health issues, especially maternal, neo-natal or child health. Immunisations should not be funded by the Global Fund – this role should remain with GAVI. At the same time, the Fund should address major criticisms of its way of working, notably the creation of many parallel structures.

- **Recommendation 5:** *It is appropriate to think about what the maximum budgets for the Global Fund and GAVI should reasonably be in the next five or so years and how they should prioritise what they fund. The Government of Norway should ensure that analytical work addresses this question and that it is discussed in various policy forums.* There are not enough resources available to meet all the health MDGs – there is a risk that the budgets of the Global Fund and GAVI become out of balance with spending in other areas, notably health systems.

- **Recommendation 6:** *It is essential that WHO and the World Bank work out how they are going to collaborate to support countries as they address issues of prioritisation, health systems strengthening and sustainability. The Bank and WHO should be challenged to specify how their overlapping remits will be co-ordinated at the country level.*

- **Recommendation 7:** *In collaboration with other partners, the Government of Norway should consider establishing a Global Health Technology Assessment Programme to provide timely information on commodities (and other interventions) that are "good buys" for low-income countries.*

- **Recommendation 8:** *HRP (the Special Programme of Research, Development and Research Training in Human Reproduction) appears to be a successful and unusual arrangement. It is worth exploring whether this model can be expanded or replicated for other technical areas – particularly related to maternal, neo-natal and child health.* (HRP is the main instrument within the United Nations system for research in human reproduction.)

- Gender is not widely discussed in the evaluations - gender has *not* been mainstreamed as a concern in global health. Hence **Recommendation 9:** *The Government of Norway needs to continue with its efforts to raise the profile of gender. These efforts should be strategic in terms of identifying what needs to be done in organisations to really make a difference, and in terms of which organisations to concentrate on.*

- **Recommendation 10:** *The Paris Principles* (for harmonisation and alignment) *have to be applied pragmatically on a country by country basis - some countries have plans and systems which should be supported; in other countries, a reliance on government plans and systems is an unacceptably risky use of aid money.*

- **Recommendation 11:** Reflects the multiple roles performed by bilaterals. *The Government of Norway should:*
  - *Strengthen its voice by being as consistent as possible in all its actions and funding decisions. Take positive action by conducting internal assessments of consistency between bilateral support funded directly at the country level and that financed through global health partnerships.*
  - *Develop a shared understanding with other bilaterals of likely funding flows and the implications for prioritisation, sustainability and the budgets of the Global Fund, GAVI etc. Share findings of the "internal consistency assessments" (see previous bullet) and encourage other bilaterals to do similar reviews.*
  - *Work with like-minded donors to have an effective in-country presence in as many aid-dependent and other high-need countries as possible. To be effective, this should be a health specialist with a remit to cover the sector as a whole. The Government of Norway can show the way in terms of innovative arrangements, such as "silent partners".*
  - *Support SWAps in appropriate countries. In other countries, work alone or with other bilaterals on tailor-made grants to suit individual country circumstances and to fill gaps.*

3.1 Outline of chapter

This chapter analyses 29 "evaluations" of significant aspects of global health aid architecture. The subject matter of the evaluations includes multilaterals and some of their initiatives; several global health partnerships; two in-country bilateral programmes; three international NGOs; SWAps and commodity-focussed initiatives.

The next section describes the methodology for the analysis. Key points from the evaluations are then summarised in Tables 6 and 7 (see annex 3). Section 3.3 outlines and discusses these points, focussing on issues such as effectiveness, gender, harmonisation, technical co-operation and sustainability. Section 3.4 briefly discusses what the evaluations do *not* cover, before Sections 3.5 and 3.6 summarise and discuss the findings. Section 3.6 includes recommendations.

3.2 Methodology

29 evaluations of significant aspects of the global health aid architecture have been reviewed. The 29 documents are listed in Part B of the References. Each evaluation has a number, for ease of reference. Many of the evaluations were suggested by Norad; others were added where there were significant gaps. Publication dates range from 2002-2009. The review includes the massive evaluation of the Global Fund, which was published towards the end of the study period for this report.

Technically, "evaluation" is a rather inappropriate term for some of the 29 documents because they occurred very early on in the lifetime of the subject matter, or because they did not systematically look at results in terms of outputs, outcomes or impact. "Reviews" is a more appropriate term for some of the documents. For convenience, however, the term "evaluation" is used to collectively describe these documents. In the same spirit, the word "organisation" is used as a collective word for "anything that has been evaluated". This is for ease of expression – strictly speaking, not all of the arrangements being evaluated are "organisations" (e.g. SWAps).

It is important to recognise that these evaluations do not form a coherent whole – they are, quite simply, some of the major evaluations which have been done. Some are internal evaluations, some external. They range hugely in their size, scope and definition of results. Some are several years old and some of the problems they identify have already been dealt with. Some concentrate on processes, others on outputs; some have a very narrow range of outputs; others are more broadly focussed.

For some organisations, only a relatively small portion of their work is reflected in the evaluations included here. In particular, WHO and the World Bank are not covered extensively. WHO is represented through the 3-by-5 Initiative and as a member of a number of partnerships. Two World Bank documents cover aspects of the Bank's work – the health strategy review and the evaluation of the health impacts of the Bank's water and sanitation programme – but neither directly evaluates the Bank's health projects.

Tables 6 and 7 in Annex 3 summarise the 29 evaluations along 8 main dimensions – level of effect assessed, effects, efficiency, gender, harmonisation/alignment, technical co-operation, sustainability and relationship to health systems. The key terms "effect" and "efficiency" are explained below.

Effect

The results achieved by a health organisation can be assessed at a number of different levels – inputs, processes, outputs, outcomes and impact. At the lowest end of the hierarchy "inputs" refers to the resources available for the organisation to use. At the other extreme, "impact" refers to an effect on overall health status. Interim measures refer to stages that might be expected to lead to a positive impact – for example, increased coverage of a health intervention is classified as an outcome. To identify impact, there would have to be proof that the coverage was

effective in terms of actually improving health. The question of relevance here is – what level of effect did the various evaluations describe?

Efficiency

The technical definition of efficiency is "return on spending" or "value for money". In practice, most evaluations did not assess efficiency in this sense – they concentrated more on whether an organisation was "doing its job in a reasonable way" and often did not refer to the overall budget of the organisation. A pragmatic definition of "efficiency" was thus adopted – anything that gave an indication of value-for-money or of the extent to which resources reached the district level or below in countries.

Tables 6 and 7 in Annex 3, summarise huge amounts of information as succinctly as possible – they are an integral part of this report and have been placed in an annex simply for convenience. Readers can choose to read the tables horizontally (to find out what the evaluation of a particular organisation says) or vertically (to find a range of comments about, for example, gender or sustainability).

For all the methodological reasons listed above, Tables 6 and 7 in Annex 3, should not be seen as an exhaustive list of possible funding channels, nor as a scientific comparison of the effectiveness of different organisations. Despite all these caveats, the evaluations as a whole produce a sense of the different kinds of benefits being produced by different organisations and offer important insights into what a bilateral donor might expect if it channelled money through the different organisations described here.

3.3 Twenty-nine evaluations – an issue-by-issue analysis

This section summarises and discusses Tables 6 and 7 in Annex 3, column by column. Note that "-"in the tables means that the evaluation does not substantively deal with this issue.

3.3.1 Level of Effect Assessed

Column 2, table 6 in Annex 3, shows the highest level of achievement which the evaluation assessed, using the hierarchy inputs ~~p~~process ~~o~~utput ~~o~~utcome ~~i~~mpact. (See Section 3.2 for an explanation.) Different evaluations assessed different levels of result – the point of this column is to identify which evaluations did or did not come close to assessing the ultimate impact in terms of health status.

Table 8 shows that about half the evaluations (15/29) assessed outcome or impact.[12] The others relied on an *assumption* that better outputs (in 7 cases) or better processes and inputs (another 7) would lead to better health.

12 When two levels are indicated – e.g. "process/output" – the higher level is counted here.

Table 8 Level of effectiveness assessed in the evaluations

Level of achievement assessed	Number of evaluations (n=29)
Impact	7
Outcome	8
Output	7
Process	6
Input	1

Behind these statistics lies a recurrent theme – a **pervasive lack of information for effective monitoring and evaluation**. Most evaluations did not have the resources for primary data collection about health outputs, outcomes or impact - they relied on existing information. And most evaluations were limited in their conclusions by shortcomings in terms of the availability and/or quality of information.

3.3.2 Main Effects

Column 3, table 6 in Annex 3, describes what has been achieved. In many evaluations, this was predominantly a qualitative judgement rather than a statistical analysis. The column reveals the co-existence of high-spend, disease-focussed, target-driven organisations with organisations that concentrate on health challenges more "in the round". At the same time, a number of "loose partnerships" try to improve co-ordination, but find it difficult to work with organisations which have significantly more money at their disposal. The evaluations record innovative developments related to commodities – in contrast there are recurring problems, such as a failure to scale up aspects of maternal and child health.

Table 9 offers a crude grouping of organisations into 8 types, according to the type of result it produces. Some organisations feature in more than one row – for example UNFPA both supplies commodities and is directly concerned with aspects of service delivery. The 8 types of result produced are:

- Service delivery on a large scale
- Service delivery – but not scaled up
- Commodity availability, procurement and /or supply
- Technical guidance
- Co-ordination, planning, advocacy
- Hybrid (a mix of the above)
- Niche (a particular, relatively narrow, aspect of parts of the above)
- Channelling money to national or sub-national NGOs.

Table 9 Organisations/evaluations by type of result produced

Type of result produced	Organisation/programme (with evaluation number)	Commentary
Service delivery on a large scale	3-by-5 (9); GAVI (13,15); Global Fund (16) {less directly, HRP (10)}	Significant increases in access – immunisation, HIV, TB, malaria
Service delivery – but not scaled up	UNFPA (3, 4); World Bank Water and Sanitation (8); Nigeria bilateral project (11); AMDD (18); Family Care International (19); IPPF (3, 21); IMCI (22)	There are essentially three reasons for not scaling up: Wanted to scale up but could not, because of technical complexity (22) or missed opportunities (3,4,8) Designed as a demonstration (18) NGO or geographically limited activity (3,11,19,21)
Commodity availability, procurement and/or supply	UNFPA (4); UNICEF (6); GAVI (13); Stop TB (25); Affordable Medicines for Malaria (29)	UNFPA, UNICEF and the Global Drug Facility (Stop TB) procure and supply commodities to countries; GAVI and AMM fund/ partially fund commodities; GAVI's ADIPs accelerated the introduction of vaccines in target countries. Commodity availability is normally a key part of scaling up.
Technical guidance	World Bank (7); WHO (9); HRP (10); SIDA (12); International HIV/AIDS Alliance (20)	Scaling up needs good technical guidance. The World Bank, WHO and HRP have at times fulfilled this role. INGOs can offer technical guidance to their affiliates (20).
Co-ordination, planning, advocacy	IHP+ (1); UNAIDS (2); 3-by-5 (9); SIDA (12); Family Care International (19); Partnership for MNCH (23); Roll Back Malaria (24); Stop TB (25)	"Upstream" activities are difficult to link to outcomes or impact. Several loosely knit partnerships attempt to co-ordinate systems and disease-specific activities, but cannot hold better-resourced organisations to account. (2, 9, 23, 24, potentially 1) Some organisations focus on developing sound plans – but their timeframes rarely fit in with the faster-moving scale-uppers and are somewhat detached from implementation. (2, 24)
Hybrid	SWAps (26, 27, 28)	SWAps are a hybrid of upstream and service delivery work – they work "in the round" in a country.

Type of result produced	Organisation/programme (with evaluation number)	Commentary
Niche	HRP (10); AMDD (18); IPPF (21)	Some organisations work in a carefully defined niche where they can be highly effective.
Channelling money to country/sub-national NGOs	Global Fund (17); International HIV/AIDS Alliance (20)	

3.3.3 Efficiency

As noted in Section 3.2, it was not possible to consistently assess the findings of the 29 evaluations in relation to "efficiency" (**Column 4**, table 6 in Annex 3). Most evaluations did not directly address the question of efficiency and there was certainly no consistent use of the term. Despite these practical problems, a number of issues related to efficiency can be extracted from the collection of evaluations.

Value for money was discussed in two contexts:

- Commodities offer good opportunities for improving efficiency – for example UNICEF is able to buy many commodities at a highly competitive price because of its bulk procurement.
- GAVI stands out as the organisation which most uses cost-effectiveness information. This is unsurprising, as immunisations are acknowledged to be one of the most cost-effective of interventions. However if information on cost-effectiveness is to be meaningful for countries, it needs to be related to comparable data on other interventions and to affordability in the context of overall national health budgets.

Two groupings were able to demonstrate *resource penetration to the district level and below*. SWAps tended to enable increases in unearmarked funds sent to districts – as documented for Zambia and Tanzania. Some NGOs, GAVI and the Global Fund directly funded aspects of service delivery, as did the Stop TB Partnership.

Several examples of *inefficient* practices were noted:

- Several organisations are too unfocussed, with many objectives in many countries. For example, UNFPA's work on both HIV/AIDS and youth sexual/reproductive health was judged to be "spread too thin".
- There are many missed opportunities because thinking is compartmentalised by project, programme or sector. The Global Fund has funded parallel systems for single diseases; the World Bank's water projects do little to maximise their health effects.
- Several instances were documented of serious problems related to weak governance and/or management structures. (e.g. PMNCH, Roll Back Malaria)

3.3.4 Gender

Column 5, table 6 in Annex 3, documents whether the evaluation assessed gender considerations. This column reflects what is covered in the evaluations, rather than whether or not gender is an important issue for the organisations themselves. The conclusion is that gender has *not* been mainstreamed as a concern in global health.

13 of the 29 evaluations made no mention of gender issues, and in a few more there was only a superficial mention. Three evaluations documented organisations that were *not* actively considering gender issues (Global Fund, Tanzanian SWAp, 3-by-5). Organisations with women as the primary beneficiaries were not necessarily "gender-strong" - for example the Family Planning Associations affiliated to IPPF largely neglected the needs of adolescent men. There were two references to inadequate representation of women on Boards (IPPF and Stop TB).

Some positive experiences were documented:

- UNAIDS had supported two campaigns (related to youth and the role of men) which were said to "challenge conventional thinking on gender" related to HIV/AIDS.
- The Human Reproduction Research Programme "works to ensure that gender issues, especially the perspectives of women, are reflected in both its research and research capability strengthening activities".
- Family Care International was involved in "ground-breaking work" in Bolivia with Amazonian indigenous peoples to introduce sensitive issues such as sexual and reproductive health and gender-based violence in a culturally appropriate way.
- UNFPA seemed more gender-aware than many organisations, but often could not translate this into effective activities. (Recall that Table 4 in Chapter 2 showed that UNFPA spent $20.8 million on "gender equality and women's empowerment" in 2007.)

GAVI funding was correlated with reduced gender disparities in immunisation coverage, though this was probably an effect of significant overall increases in coverage rather than gender-targeted activities.

SWAps were said to offer an opportunity for partners to bring gender issues "to the table. (Walford) However the review of Tanzania in the period 1999-2006 concluded "there has been no apparent systematic attention to issues of gender equity."

Column 6, table 6 in Annex 3, is a summary column which describes what the organisation/programme achieves – i.e. what do you get if you put your money here?

Table 7 in Annex 3 deals with the same 29 evaluations as Table 6. It covers some issues in more detail – harmonisation and alignment; technical co-operation; sustainability; and links to health systems.

3.3.5 Harmonisation and Alignment

Column 2, table 7 in Annex 3, looks at harmonisation and alignment – i.e. adherence to the Paris Principles for aid effectiveness. Two main groupings emerged – the fast "vertical" scale-uppers and those with a more horizontal, system-wide focus.

Various forms of partnership sought to promote harmonisation – for example SWAps, IHP+, Roll Back Malaria and the Partnership for MNCH:

- In some ways the job was easiest for SWAps, as it is simpler to harmonise around "your own" money rather than someone else's. SWAps (and in time perhaps IHP?) developed some new formal country structures for government/

donor dialogue, though these were often initially cumbersome and expensive in terms of transaction costs.

- The "loose partnership" basis of initiatives such as Roll Back Malaria and the Partnership for MNCH was often ineffective in securing practical improvements to co-ordination at country level.

Several evaluations noted UN agencies' attempts at within-UN collaboration. Progress was generally limited because each agency had to satisfy its own management systems in terms of planning, budgeting, spending and monitoring.

The 2009 evaluation of the Global Fund described a situation which was broadly typical of disease-specific scaling up: "the Global Fund's model has often inadvertently created parallel systems, due to lack of alignment and harmonisation at the country and global levels, which have created inefficiencies in implementation". (Final Synthesis Report, page 48)

Two interesting standpoints were described in the evaluations. Document 7 related how the World Bank's position in the global architecture had changed over the last decade. It was once the dominant funder in health and had a status as the intellectual foundation for systems work. However, the review judged that this position had been compromised by a move towards easier-to-finance disease-focussed work.

The evaluation of SIDA work in Vietnam exposes some different interpretations of how aid effectiveness is perceived on the ground. The Government of Vietnam did not champion harmonisation and alignment, despite opportunities to do so. It seemed to prefer a "divide and rule" approach.

Evaluations generally did not comment on the pros and cons of harmonisation and alignment. The Phase 1 evaluation of GAVI (13) did, however, question whether "harmonised" was always "better". One OECD indicator of aid effectiveness relates to the use of country procurement systems (Indicator 5b). UNICEF was GAVI's procurement agent for vaccines and injection supplies. Countries could choose to procure their own supplies, but vaccines procured through UNICEF were obtained at competitive prices, quality-assured and predictable. A country with doubts about the reliability of its own supply systems could thus rationally choose to use UNICEF as a procurement agent. Yet this was classified as "unharmonised".

3.3.6 Technical Co-operation/Assistance

Column 3, table 7 in Annex 3, ooks at issues related to technical co-operation/assistance. Again, inconsistent definitions made it difficult to fill in this column. The terms "technical co-operation" (TC) and "technical assistance" (TA) are not used consistently and are sometimes used inter-changeably. Moreover TC includes a range of activities, each of which can be described with a variety of terms - activities include institutional development, short-term focussed advice, long-term gap-filling and project management on behalf of the funder.

The SWAp review by Walford (evaluation 26) identifies a number of issues which are of wider relevance. Walford found that even in well-functioning SWAps, there was

generally relatively poor "progress in co-ordination of technical co-operation for capacity building, especially technical assistance." The review identified a number of possible reasons for this:

- For *governments*, TA is expensive and administratively burdensome. The large difference between national and international rates of pay is particularly striking and can be very hard to justify when there are funding gaps in other areas. Administratively, identifying, selecting and contracting TA requires particular skills and can be time-consuming, especially for short-term inputs.
- For *development partners* there are various intangible but important benefits in using "their" consultants – they are more likely to address the issues of particular concern to that partner and may give more honest feedback to the agency that is funding them. Partners can also feel that having "their" TA on the ground improves access to key government players.
- Development partners and governments often view the need for TA very differently. Ministries often see less need for TA and may even regard consultants as 'spies'. Ministries are thus unlikely to propose as much TA as development partners are prepared to fund, given their perceptions of fiduciary risks and capacity needs.

Another issue emerged from the evaluations – there is often confusion about the divisions of labour for both the funding and supply of technical support. This confusion generally occurs when there is an organisation which is regarded as a "big player" in an area, but which does not directly fund significant amounts of TA. The "big player" can be a funder (notably the Global Fund) or an "umbrella partnership" such as Roll Back Malaria, Stop TB or (in some circumstances) UNAIDS.

The Global Fund, GAVI, Stop TB Partnership and Roll Back Malaria have all found that donors think they have "already funded" TA in their respective specialist areas because of the funding provided to these organisations. And, as providers of technical support, WHO, UNICEF and the World Bank have all found that the disease-focussed organisations catalyse an increased demand for their technical support in countries. From the perspective of the multilaterals, this new work can seem unfunded (or at least under-funded) and additional to their "core work".

Examples of good practice were also identified in the evaluations. Stop TB's *Global Drug Facility* was praised for its "unique bundled model comprising grant-making, procurement and partner mobilisation for technical assistance". Technical assistance was clearly positioned as a necessary, but not in itself sufficient, part of a package of work – and that package was bundled to be managed as a whole.

Averting Maternal Death and Disability (AMDD) provided "extensive and effective" technical assistance to develop capacity to provide effective emergency obstetrical care. TA was very focussed and consistently used a technical gold-standard of sequenced interventions. Using this gold standard as a starting point, local variations could then be developed. The programme was led by a highly-regarded academic institution (Columbia University) and built on its already-existing collaborative relationships in a number of countries. The evaluation noted that the technical support worked least well in the weakest countries.

The *International HIV/AIDS Alliance* Secretariat provided well-targeted, effective support which was instrumental in establishing the reputation and status of the country "Linking Organisations" and in strengthening their ability to attract donor funds directly. The Alliance's work included TA on systems and procedures for financial management, administration, onward granting and accountability.

Long-term capacity-building support can bring dividends (though it is a risky process which sometimes yields little). In Vietnam, long-term *bilateral support from Sweden* was instrumental in the creation of both the Policy and Project Co-ordination Units of the Ministry. For 30 years, the *Special Programme of Research, Development and Research Training in Human Reproduction* (HRP) has helped to establish and strengthen a network of research institutes. It has built the capacity of researchers in China and had a productive long-term collaborative arrangement with the National Population and Family Planning Commission of China.

3.3.7 Sustainability

Column 4, table 7 in Annex 3, summarises what the evaluations say about sustainability – again, evaluations differ in the extent to which they consider this issue.

Earlier in this section we saw that different organisations are connected with different kinds of results – some fund service delivery on a large scale; some concentrate on upstream considerations such as planning and co-ordination; others provide a hybrid of upstream and service delivery level support. The challenges in terms of sustainability differ according to the type of organisation.

The sustainability challenges related to **scaled-up disease programmes** are well documented in the evaluations of the Global Fund and GAVI. A good way of understanding the issue is to first focus on one fairly straightforward example – GAVI's support for injection safety (Document 15). 46 countries received in-kind support for injection safety in the form of auto-destruct syringes and safety boxes. Of these, 44 sustained the use of these items after the end of GAVI support. 54% fully financed the commodities with government support, 15% used a combination of government and donor funding; 26% were donor dependent. So in about half of the countries which received injection safety commodities, government was able to pick up all the recurrent costs of buying the commodities. This is for a relatively low-cost (but high-volume) commodity.

The Phase 1 GAVI evaluation (Document 13) builds on this analysis for other forms of support. For countries that introduced the pricey pentavalent vaccine[13], immunisation programme costs are projected to average 9.2% of government health expenditures in 2005-2010. This will obviously increase as and when new vaccines are added. As the evaluation notes, potential GAVI spending "involves such huge amounts that sustainability has to be a *long-term* consideration". The desire to provide more vaccines needs to be tempered by realistic projections of domestic and international funding.

13 Diphtheria, tetanus, pertussis, hepatitis B, Hib (haemophilus influenzae type B)

If we now add on work in the high-spend areas of HIV, TB and malaria, the sustainability challenge becomes very apparent. Between them, the scale-ups have massive recurrent cost implications. The 2009 evaluation of the Global Fund recognises the challenge: "the current reliance of countries on external support raises significant concerns with respect to the long-term sustainability of programs. The international development community needs to systematically address the requirements of sustainability in the global response to the three pandemics." (Final Synthesis Report, page 14)

In contrast, the *institutional* sustainability issues are rather different for GAVI and the Global Fund – the Global Fund has been much more prone to using parallel systems than GAVI. The Global Fund evaluation synthesis gave the following examples of challenges in terms of institutional sustainability:

> *"Country stakeholders also expressed sustainability concerns with respect to capacity building. Longer-term capacity investments were seen as critical to the sustainability of program achievements and were often called into question by respondents because of a perceived lack of alignment of Global Fund systems with country systems. Particular concern was expressed with regard to discordant salary scales that contributed to an internal "brain drain" from public to non-public sectors." (Final Synthesis Report page 16)*

SWAps are fundamentally concerned with institutional sustainability – they are an attempt to institutionalise prioritisation and management, and to foster local ownership. Paradoxically, SWAps can themselves be difficult to sustain, particularly in the early years and/or when there is a change of government. Before structures are institutionalised, SWAps depend to some extent on good personal relationships and are vulnerable to changes in government and development partners' personnel.

NGOs. Amidst all these challenges of sustainability, the Family Planning Associations should not be forgotten. Many owe their long-term survival to their ability to provide quality services whilst balancing access with the need to cover some costs through fees.

3.3.8 Health Systems

Column 5, table 7 in Annex 3, looks at the role of health systems in relation to the work being evaluated. Many disease-focussed evaluations fully acknowledged the crucial role of health systems, especially human resources – for example:

- The 2009 Global Fund evaluation stated the issue very clearly:
  - "Within the limitations described, the Five-Year Evaluation found that health systems capacity is an important statistical predictor of grant performance." (page 21)
  - "Going forward, the weaknesses of existing health systems critically limit the performance potential of the Global Fund." (page 21)
  - The evaluation found evidence of "a relationship between investment in human resources and improvement in grant performance". (page 22)
- The IMCI and AMDD evaluations (about child and maternal health respectively) were both eloquent in recognising their dependence on health systems. The IMCI evaluation described how thinking changed over time: "The full weight of

health system limitations on IMCI implementation was not appreciated at the outset, and only now is it clear that solutions to problems in political commitment, human resources, financing, integrated or at least co-ordinated programme management and effective decentralisation are essential underpinnings of efforts to reduce child mortality."

Column 6, table 7 in Annex 3, is for miscellaneous points which did not fit elsewhere. The column serves as a reminder that there are some interesting new developments happening which are too new to have been fully evaluated – the two included here are IHP+ and Affordable Medicines for Malaria.

3.4 Areas not covered by the evaluations as a whole

Section 3.5 summarises the findings of this chapter – before that, this section reflects on areas which the evaluations as a whole did *not* cover in any detail.

Reading the evaluations as a whole, the overwhelming impression is of fragmentation and the difficulties of overcoming it. Money talks louder than a poorly-resourced partnership extolling the virtues of co-ordination. This fragmentation means that some profound questions are not addressed by the evaluations, which each deal with a separate part of the aid architecture. Two vital issues which are bypassed are **prioritisation** and **service delivery strategies.**

As we saw in Chapter 2, gap analysis has become a dominant way of thinking – "this is how much money is needed to reach the MDGs". Obviously this positive thinking has a place – but it distracts from serious questions of national prioritisation related to what resources really are available. Is all money equally well spent as long as it is relevant to the health MDGs? If a country has a limited short-term supply of nurses, how should they be spending their time? What are the relative priorities of their time in terms of HIV/AIDS, malaria, immunisation etc? These questions take second place when massive sums of money are made available with labels such as HIV/AIDS, TB etc., although some initiatives are trying to address this issue (e.g. SWAps, IHP+).

The evaluations include very little about overall "service delivery strategies". This term covers questions such as: Should there be a cadre of multi-purpose community health worker? What could they reasonably be expected to do? What should be the minimum package of services that a country aims to provide at every primary care facility? How can interventions best be bundled – for example what else can a professional do during an immunisation outreach session? Sell mosquito nets? Provide Vitamin A? Distribute condoms? These cross-programme debates tend to be pre-empted by short-term disease-specific decisions.[14]

Finally, the high utilisation and costs to households of **for-profit private providers** is not reflected in the work of many of the organisations and initiatives – though there are exceptions such as Roll Back Malaria, Stop TB and the work on Affordable

14 See, however, WHO's recent "Making Health Systems Work" series of technical briefs on health systems challenges which covers scaling up, integrated services, essential packages, the private sector and community health workers.

Medicines. As we will see in the next chapter, for-profit service provision is highly significant in many countries – yet it receives relatively little attention from the players in the global aid architecture for health.

3.5 Summary of findings

Table 10 summarises the 29 evaluations in terms of "what did you get if you put your money here?" It is important to remember the methodological limitation described in Section 3.2 – the evaluations do not systematically cover all the parts of the health aid architecture. For this reason we do not use the term "comparative advantage" in Table 10, as this would suggest a more holistic piece of work than has been done here.

The overall (and clearly much simplified) picture emerging from Table 10 is of an aid architecture populated by:

- Well funded **global health partnerships** which finance the scaling up of particular technical programmes. They are effective, but limited by the coverage and quality of health systems. Their achievements will be expensive to sustain. (Global Fund, GAVI)
- **Areas that would like to scale-up,** but which have not attracted significant funding and/or have not yet made the case that the interventions are sufficiently streamlined and cost-effective. (IMCI, Averting Maternal Death and Disability)
- Four **UN agencies** (UNAIDS, UNFPA, UNICEF and the World Health Organisation) which find it difficult to effectively co-ordinate their activities and at times compete or duplicate. WHO has the broadest remit and has strength in providing technical guidance. UNFPA and UNICEF fulfil important commodity supply functions.
- The **World Bank**, which provides both technical support and loans/grants. Its strength lies in sector-wide analysis, systems and prioritisation – the division of labour between the Bank and WHO is not clear.
- **Bilaterals**, which have multiple roles because they fund multilaterals, partnerships and NGOs. Bilaterals also have their own programmes, which include a huge variety of types of project/programme. They can fund tailor-made projects to suit particular local needs; some bilaterals have long-term bilateral programmes in particular countries, which allows a longer-term perspective.
- **NGOs** also fund a huge range of activities, including significant amounts of service delivery.
- **Co-ordination partnerships** which find it difficult to be effective because better-funded organisations are not accountable to them. (Roll Back Malaria, Partnership for MNCH)
- Some organisations have found a **niche** in which to work. The HRP is of particular interest. It has taken its area - research, development and research training in human reproduction – and developed this into a programme of work which has had a significant influence on service delivery.

Table 10 Results produced by various organisations and programmes –findings from 29 evaluations

Organisation/ programme	Results - what did you get if you put your money through this channel?	Comments/Issues
1. **IHP+** (2008)	Aim is national compacts which facilitate a national plan to be implemented and monitored in a less fragmented way.	New – effectiveness not proven. Key issue is what *leverage* IHP has to get partners to change behaviour and to deal with violations of compacts?
2. **UNAIDS** (2002)	Global level: advocacy, resource mobilisation, sharing best practice. Supports national AIDS planning. Some UN co-ordination.	Compromised because a co-ordination-agency-without-teeth.
3. and 4. **UNFPA** work on **youth** and **HIV/AIDS prevention** (2004, 2002)	At best, an effective country advocate for sexual and reproductive rights/health. Significant role in condom supply. But see next column.	Very variable between countries; many missed opportunities for effective work. Tendency for involvement in ad hoc and poorly monitored activities.
4. **IPPF youth work** (2004)	Service delivery and standard setting, but not targeted at young people.	Clear comfort zones of traditional service delivery and promoting quality.
5. **UNFPA evaluations** (2005)	Limited evaluation capacity and lesson-learning.	Interested in improving evaluation capacity?
6. **UNICEF supplies** (2007)	An effective supplier that could be more efficient. Little development of country capacity. Does not systematically monitor who uses its products and how they are used.	Supplies more effective when integrated into a wider programme; when locally applicable because of innovation and customisation; and when delivered alongside IE&C (information, education and communication).
7. **World Bank HNP Evolution** (2008)	Multi-sectoral, economic viewpoint. In health: intends to focus on health systems and financial protection. Regards M&E as central.	Understands need for systems/ disease balance but also needs to "follow the money". Could provide multi-sector context for family planning/population?
8. **World Bank: Health Benefits of Water and Sanitation Projects** (2008)	Little information and missed opportunities in terms of health from spending on water and sanitation.	World Bank's claim to work cross-sectorally challenged by this finding of poor links between health and water/ sanitation.
9. **WHO 3-by-5 Initiative** (2006)	Significantly increased coverage (but shared attribution). Little systematic monitoring or co-ordination. WHO has comparative advantage in technical guidance; quality varied between countries.	Lines of accountability not always clear – co-ordination function, but with what powers? Technical guidance/support was under-funded.

Organisation/ programme	Results - what did you get if you put your money through this channel?	Comments/Issues
10. *Multi-multilateral (UNDP, UNFPA, WB, WHO)* **Special Programme of Research, Development and Research Training in Human Reproduction (HRP)** *(2008)*	Cost-effective production and dissemination of reproductive health research (i.e. global public goods); ability to follow up through initial implementation stage. Track record of influencing change in China.	Some unfinished business, e.g. gap between evidence and public per-ception of IUDs (intra-uterine devices. An effective and unusual arrangement.
11. **Nigeria Routine Immunisation and MNCH DFID/Norad** (2009)	Possibility of improvements in basic health care in a chronically under-performing system.	From the start, identified as a high risk project, with limited chances of significant scale-up.
12. **Vietnam-Sweden Health Co-operation 1994-2000. SIDA** (2003)	Local capacity strengthened in key areas - policy, teaching hospitals. Access to Disadvantaged Areas.	Long term institutional development vulnerable to resource availability and political will. Less effective links at provincial level.
13. **GAVI** *Phase 1 (2008)*	More people vaccinated. Global advocacy and fund-raising. Incorporated innovative ideas. Some improvements in vaccine supply and price.	Sustainability needs to be a long-term aim.
14. **GAVI Accelerated Development & Introduction Plans and Hib Initiative** *(2007)*	Vaccines available in developing countries more quickly. Creates good platform for fund-raising for vaccines.	Idea can be adapted and extended to other technologies? Could scan pipeline for “ADIP”-ready technologies and develop country work on “technology-readiness”? Would work better for a range of technologies, not just vaccines.
15. **GAVI Injection Safety** *Support (2009)*	A commodity distributed for a pre-set time-span and then taken over by government planning systems.	Example of catalytic spending. For this cheap, high volume item, 41% of countries needed donor funding after GAVI support ended.
16. **Global Fund** *Five-year Evaluation (2009)*	Increased service delivery especially for HIV/AIDS and malaria.	Limited by strength of the health system. Key challenges are sustainability and reducing the use of parallel systems.
17. **GFATM Community perspective** *from South Africa (2006)*	Money reaches community groups for HIV/AIDS.	Multiple groups with short-term perspectives – difficult to develop institutional capacity when reliant on short-term project funding.

Organisation/ programme	Results - what did you get if you put your money through this channel?	Comments/Issues
18. **Averting Maternal Death & Disability** *(2004)*	Effective focus on emergency obstetric services at (selected) national, district and sub-district levels.	Important demonstration effect – that targeted investment can make a difference in reducing maternal mort-ality in the right setting and under certain conditions. But the critical hospital-based services imply relative-ly high costs. Limited community focus.
19. **Family Care International** *(2007)*	Good advocacy record. Country programmes of mixed effectiveness.	
20. **International HIV/AIDS Alliance** *(2006)*	Strong global advocacy and resource mobilisation. Provides funds and technical support to country "Linking Organisations". LOs in turn perform same services to local NGOs.	Many Linking Organisations have good reputation and sound financial accountability systems. Alliance support weaker at implementation stages.
21. **IPPF, reaching poor people** *(2006)*	Provision of good quality family planning, sexual & reproductive health services.	Often rely on fee-for-service. Weak advocacy.
22. **Integrated Management of Childhood Illness** *(IMCI) (2005)*	Effective, quality care for child-ren in some parts of a country with high child mortality. Increased utilisation (some-times). But see next column.	Limited effects without a major push on health systems issues, plus work with private sector and at community level.
23. **Partnership for MNCH** *(2008)*	Some advocacy work and role in convening experts.	Evaluation identified little added value of the Partnership.
24. **Roll Back Malaria** *(2002)*	A raised profile for malaria. Better technical support and co-ordination in relatively few countries.	Loose partnership - not effective at in-country co-ordination. Quickly identified need to work with private sector.
25. **Stop TB** *(2003)*	*Effective support for national TB plans and practical technical components of implementation. Effective operator at global level to progress with various TB inputs.*	*2003 evaluation stated that Stop TB had "a formidable record", although some governance/ management concerns. Why was Stop TB more effective than other "umbrellas"?*
26. **Review of health SWAps in Africa** *(2007)*	*In "SWAp-suitable" countries, improvements in planning, policies, resource allocation and co-ordination.*	*Long-term process - not quick service delivery/public health gains. Ca 3 years to get a SWAp up and running.*
27. **Zambia SWAp and resource allocation and use** *(2008)*	*Some progress with channelling regular funding to district health administrations; persistently high transaction costs.*	

Organisation/ programme	Results - what did you get if you put your money through this channel?	Comments/Issues
28. **Tanzania Health Sector**, *1999-2006 (2007)*	*Sector plans; coherent support to district health services that led to improvements in service quality and some identifiable health impacts.*	*SWAp complemented by disease-specific support, especially for malaria and HIV/AIDS.*
29. **Affordable Medicines – Malaria** *(2008)*	*Increased use of effective treatment for malaria.*	*Very early stage – this is a review of pilots.*

3.6 Discussion – what do the evaluations tell us about aid efficiency?

The limitations of this methodology of reviewing evaluations were clearly described in Section 3.2. The evaluations provide a patchwork of insights into the overall aid architecture – they do not provide a complete picture. Nevertheless, the evaluations can inform the debate about aid efficiency.

The Global Fund and GAVI

There is clearly a place for organisations such as the Global Fund and GAVI. They produce results and can generate a virtuous circle - because they have money, they can demonstrate effects, which helps with advocacy and further resource mobilisation.

The Global Fund and GAVI's comparative advantage is in financing particular technical programmes. Their effectiveness in supporting health systems is unproven. Moreover it may not be suitable to fund some health systems work through these types of global partnership - for example some aspects of human resource development, which require work across several government ministries and a long time horizon.

If the Global Fund can bring successes in HIV/AIDS, TB and malaria, it can also potentially bring successes in other areas, such as family planning. It makes sense, therefore, for the Global Fund to expand its remit – this would allow it to fund other MDG-relevant, cost-effective interventions and would mean it could be more truly aligned with country priorities.

The Global Fund should broaden its scope to include "any reasonable interventions that further the MDGs". **(Recommendation 4)** It makes no sense to limit this valuable source of money to three diseases when a country may want to pursue a cost-effective strategy related to MDG 4 or 5 (maternal, neo-natal or child health). Immunisations should not be funded by the Global Fund – this role should remain with GAVI. At the same time, the Fund should address major criticisms of its way of working, notably the creation of many parallel structures (for budgeting, reporting etc.).

There are not enough resources available to meet all the health MDGs – there is a risk that the budgets of the Global Fund and GAVI become out of balance with spending in other areas, notably health systems. *It is appropriate to think about*

what the maximum *budgets for the Global Fund and GAVI should reasonably be in the next five or so years and how they should prioritise what they fund. The Government of Norway should ensure that analytical work addresses this question and that it is discussed in various policy forums.* **(Recommendation 5)**

WHO and the World Bank

Aid architecture at country level has changed dramatically in recent years. Improvements in technical programmes will be difficult to sustain, given the current economic crisis and the weaknesses in many countries' health systems. The World Bank is *technically* best placed to support countries as they address issues of prioritisation, health systems strengthening and sustainability. On the other hand, WHO is best placed in many countries in terms of *relationships* – WHO often has strong, positive links with ministries of health. *It is essential that WHO and the World Bank work out how they are going to collaborate to support countries as they address issues of prioritisation, health systems strengthening and sustainability. The Bank and WHO should be challenged to specify how their overlapping remits will be co-ordinated at the country level.* **(Recommendation 6)**

Commodities

There have been many effective measures recently to increase the flow of *commodities* – this is an area which has attracted considerable innovation (GAVI, Affordable Medicines for Malaria, HRP). At the same time, "older" suppliers continue to perform valuable roles (UNICEF, UNFPA).

It can be an efficient use of global aid money to develop commodities for use in low-income countries and to lower their prices. However countries should not be encouraged to introduce too many new interventions at once, or interventions which are not cost-effective.

Health Technology Assessments are independent pieces of research on the effectiveness, costs and broader impact of health treatments and tests. Many countries use them to inform decisions about whether a particular intervention should receive public (or social insurance) funding.[15] Given that many commodities are effectively global public goods, there is a case for global Health Technology Assessments to provide information that is useful to low-income countries and donors. The Assessments could be on the alert for new technologies and could provide information on the suitability of an intervention for scaled-up use in low-income countries. This is a better system than relying on organisations such as GAVI to make the case for "their own" commodities – information on costs and benefits needs to be compared with the same information for other available technologies to make an informed decision. *In collaboration with other partners, the Government of Norway should consider establishing a Global Health Technology Assessment Programme to provide timely information on commodities (and other interventions) that are "good buys" for low-income countries.* **(Recommendation 7)** The work of HRP and GAVI's ADIPs (Accelerated Development and Introduction Plans) can provide useful lessons to inform this idea.

15 See for example the UK's Health Technology Assessment Programme on http://www.hta.ac.uk/about/index.shtml.

HRP- Research, Development and Research Training in Human Reproduction
HRP is the main instrument within the United Nations system for research in human reproduction, bringing together policy-makers, scientists, health care providers, clinicians, consumers and community representatives to identify and address priorities for research to improve sexual and reproductive health. It involves UNDP, UNFPA, the World Bank and WHO.

HRP (the Special Programme of Research, Development and Research Training in Human Reproduction) appears to be a successful and unusual arrangement. It is worth exploring whether this model can be expanded or replicated for other technical areas – particularly related to maternal, neo-natal and child health (MDGs 4 and 5). **(Recommendation 8)**

Gender
The analysis of how evaluations deal with gender showed that the issue is far from being a mainstream consideration in the global aid architecture. *The Government of Norway therefore needs to continue with its efforts to raise the profile of gender. These efforts should be strategic in terms of identifying what needs to be done in organisations to really make a difference, and in terms of which organisations to concentrate on.* **(Recommendation 9)**

Harmonisation and alignment: the Paris Principles
Section 3.3.5 discussed the Paris Principles of harmonisation and alignment. These principles reflect the idea that aid will be more efficient if it is combined with government resources into one plan, one budget and one reporting/monitoring system. In contrast, we have seen the big increases in coverage achieved by "vertical" technical programmes – by using earmarked funding, often through parallel channels.

Using government systems in countries where these systems are weak is risky and means that benefits will be realised more slowly – because the systems have to be made to work first. Given the number of countries with extremely weak systems and/or disinterested government leadership, what is wrong with using efficient non-government systems (for example UNICEF's supply system in a country with very limited capacity in procurement and logistics)? But if there *are* parallel systems, the issue is to make these efficient. How many supply chains or financial management systems are operating in a country? Can this be rationalised? An over-emphasis on one system is not appropriate – the challenge is to spread the risk where appropriate, but to avoid a proliferation of channels.

It can make sense to have more than one channel for implementation activities such as financial management and logistics. The situation for overall planning and resource allocation is somewhat different. There needs to be an overall picture of what activities will be done and at what costs, so that sensible decisions about priorities can be made.

Alignment implies respecting a country's priorities. Countries can use scenarios to show what services they would provide given various levels of funding. Aligned aid

should follow these plans. But many donors (including the Global Fund) state that their support should be *additional* – i.e. more than what would otherwise have been spent. For some countries, the criterion of additionality means that they cannot fulfil their own prioritisation decisions.

This discussion suggests that not all "violations" of the Paris Principles are a bad thing. The spirit of the principles is more important than the individual indicators - i.e. that all aid spending contributes to a coherent whole, without unnecessary duplication or priority areas which are unfunded. It can make sense to follow global priorities and use parallel systems when government leadership and systems are weak - but then donors should harmonise amongst themselves to ensure that the parallel channels are efficient and do not proliferate. Countries with good quality planning and prioritisation, on the other hand, can see that work undermined by large sums of money that are effectively earmarked and have to be shown to be additional.

The Paris Principles have to be applied pragmatically on a country by country basis - some countries have plans and systems which should be supported; in other countries, a reliance on government plans and systems is an unacceptably risky use of aid money. **(Recommendation 10)**

Bilaterals

Bilaterals play many roles – they fund multilaterals, Global Health Partnerships (GHPs) and NGOs; they directly finance programmes in some countries; their governments are central players in the high-level global policy dialogue. Some of their actions can seem contradictory – providing funds to multiple players and then more funds to co-ordinate these players; supporting the Paris Principles in-country but then funding the Global Fund to provide huge sums of disease-earmarked funding through parallel systems; reducing the numbers of health advisers in countries and not encouraging them in constructive criticism of the work of the GHPs.

Bilaterals also fund country programmes directly and have an in-country presence. In recent years there has been a tendency to downplay the importance of this role – because of concerns about the proliferation of in-country donors and because of a desire to reduce bilaterals' "administration costs". However a strong bilateral presence in-country brings important advantages ("strong" in this context means knowledgeable about the health sector and able to identify the impact of aid flows on the sector as a whole):

- Bilaterals can tailor their programmes to local needs and identify areas which other partners are not funding. For example, some bilaterals are able to focus on long-term support and capacity/institutional development issues which other organisations find difficult. (e.g. SIDA, DFID/Norad Nigeria Routine Immunisation and MNCH)
- Strong bilateral participation in country health sectors – with appropriate sectoral expertise – can serve an informal "checks and balances" role to question whether the work of the multilaterals and global funds combines into a coherent whole.

Given these multiple roles performed by bilaterals, it is not surprising that there are several aspects to **Recommendation 11:** *The Government of Norway should:*

- *Strengthen its voice by being as consistent as possible in all its actions and funding decisions. Take positive action by conducting internal assessments of consistency between bilateral support funded directly at the country level and that financed through global health partnerships.*
- *Develop a shared understanding with other bilaterals of likely funding flows and the implications for prioritisation, sustainability and the budgets of the Global Fund, GAVI etc. Share findings of the "internal consistency assessments" (see previous bullet) and encourage other bilaterals to do similar reviews.*
- *Work with like-minded donors to have an effective in-country presence in as many aid-dependent and other high-need countries as possible. To be effective, this should be a health specialist with a remit to cover the sector as a whole. The Government of Norway can show the way in terms of innovative arrangements, such as "silent partners".*
- *Support SWAps in appropriate countries. In other countries, work alone or with other bilaterals on tailor-made grants to suit individual country circumstances and to fill gaps.* If there is already relatively high spending on HIV/AIDS, for example (i.e. relative to other priorities), then it does not make sense for a bilateral programme to directly fund yet more HIV/AIDS work.

Information

The review of evaluations reinforced Recommendation 3 from Chapter 2 about the importance of improving information. Inadequate information limited the conclusions which many of the evaluations could make.

Note: The issue of technical co-ordination is followed up and discussed in Chapter 5.

4. The Country Level - Ethiopia, India, Nigeria, Pakistan and Tanzania

Key points - The country level: Ethiopia, India, Nigeria, Pakistan and Tanzania

- Aid architecture was explored in five countries - Ethiopia, India, Nigeria, Pakistan and Tanzania.
- Country information on aid for health is difficult to compile and often incomplete.
- The funding flow picture at country level mirrors the global situation described in Chapter 2 - countries have generally experienced "more donors plus the rise of the Global Fund" in recent years.
- Countries differ significantly in their economics, epidemiology and government leadership and capacity. Key differences include HIV prevalence, levels of government spending on health, degree of aid dependency and the relative size of the private sector. This has implications for aid – for example where aid dependency is high, aid funds a significant part of scaling up activities. When it is low, aid must be highly selective and concentrate on pilots/ demonstrations or tackling strategic bottlenecks.
- For a number of reasons – but mostly because of its sheer size – India is a special case. Global mechanisms need to be locally negotiated and adapted if they are to be effective in India.
- Nigeria's level of commitment to primary health care is extremely low and it has a poor track record of public sector management and public health achievement. By default, projects seem the best aid instrument. The challenge is to maximise the wider impact of a project, without being unrealistic about its likely impact. Nigeria is by no means alone in terms of its difficult working environment.
- Countries think in terms of service delivery levels. This offers an alternative to the current global focus on systems "versus" disease programmes. This focus has shifted attention away from a crucial question: what are the minimum "essential tasks" we expect to be done at each level of the health system – community, clinic, hospital and above?
- The role of the Ministry of Health differs from country to country. Channels which start with the central Ministry of Health have to adapt their way of working to meet different situations, including federalism. The transaction costs of working in federal states are inevitably higher, as there are multiple states/provinces with responsibility for health. *The Government of Norway should ensure that sufficient resources are available to allow effective work in federal states. This applies to work which Norway funds both directly and indirectly (through the Global Fund, multilaterals etc).* **(Recommendation 12)**

- Several of the recommendations from previous chapters are re-inforced by the country perspectives – including the recommendations on the need to focus on prioritisation and sustainability; the importance of improving information on donor financing and the flow of funds to districts; and the pragmatic country-by-country application of the Paris Principles.

4.1 Chapter outline

Chapters 2 and 3 on funding flows and evaluations took a global perspective – what do country viewpoints add to this? This chapter looks at a number of issues from the country perspective, based on inputs from Ethiopia, India, Nigeria, Pakistan and Tanzania. These are generally large countries with significant challenges to meet the health MDGs. The absolute numbers of child and maternal deaths in India and Nigeria dominate the statistics for MDGs 4 and 5?[16]

The following points emerge from the country analyses:

- Country information on aid for health is difficult to compile and often incomplete.
- Countries differ significantly in their basic economics, epidemiology and government - so the same type of aid can look very different in different countries.
- Countries have generally experienced an increase in the number of donors, plus the rise of the Global Fund in recent years.
- Countries think in terms of service delivery units – donors don't.
- The role of the Ministry of Health differs from country to country.

4.2 Country information on aid for health is difficult to compile and often incomplete

Chapter 2 described the importance and shortcomings of the DAC CRS financial database and the need to "run around" after information not included in DAC. These problems are magnified at country level – and the resulting information tends to look very different from the DAC data.

There are a number of reasons for differences between financial data collected at the global and country levels, including:

- commodities and TC are often not given a financial value in country
- different donors are included – for example it is relatively easy to find out the level of GAVI spending in a country, but difficult to ascertain PEPFAR's budget
- the extent to which HIV/AIDS expenditure is included. Some countries compile separate information for spending on health and HIV/AIDS – in other countries they are combined. Comparisons need to be made with care.

Whatever the cause, the confused picture does not encourage informed debate at the country level.

A recent donor mapping exercise in Ethiopia made it relatively easy to compare data collected by DAC and in-country – see Table 11. In-country figures on aid are much higher than the DAC figures – in 2007 the in-country figure was two-and-a-half times larger.

16 Nigeria and India also have the second and third highest absolute numbers of HIV positive 15-24 year olds. However much the largest absolute number is in South Africa.

Table 11 Health aid by category of donor and two sources of data, Ethiopia

Year	Data from DAC CRS				Data from in-country resource mapping, 2008			
	Bilat-eral	Multi-lateral	Global Fund	Total	Bilateral	Multi-lateral	Global Health Initiatives	Total
2005	50	9	25	84	70.5	34.6	28.8	183
2006	77	8	74	160	50.6	76.7	108.9	320
2007	66	38	21	125	108.9	113.3	77	311

Note: exchange rate used is 8.7, 8.8 and 9.03 birr per dollar for 2005-7 respectively to convert the resourcing mapping figures into dollars. "Global Health Initiatives" includes GAVI and the Global Fund.

A particularly striking aspect of the comprehensive resource mapping exercise was the difficulty in finding out about PEPFAR's enormous spending (ca $354 million in Ethiopia in 2008). Most PEPFAR spending is channelled off-budget through NGOs and US-based contracting agencies – for Ethiopia, there were about 50 prime partners (some in the public sector) funded directly from the US in 2007.

Overall expenditure on technical co-operation is generally not known at the country level. It is easier to collect information about *numbers of people*, rather than money spent – see Table 12, which reveals the significant role of UNICEF and WHO. Much of this TC is in response to requests from government, using UN systems because of the better pay packages that can be offered. Note how different the picture revealed here is from the analysis in Chapter 2, section 2.5. The DAC CRS data-base does not record *any* TC spending for multilaterals.

Table 12 Donor funding and Technical Co-operation, Ethiopia

Development partner	Type , magnitude and nature of support			Technical Co-operation (short and long term assignments)
	Nature of support (earmarked or not)	Earmarked support (Ethiopian Birr)	Un-earmarked support (Ethiopian Birr)	Number of people hired (where information has been made available)
African Development Bank	Earmarked	147,000,000		
Austrian Development Co-operation	Earmarked	73,840,000		
DFID, UK	Earmarked	120,160,168		1
Irish Aid	Both	37,204,000	24,850,000	0
Packard Foundation	Earmarked			3

Development partner	Type , magnitude and nature of support			Technical Co-operation (short and long term assignments)
	Nature of support (earmarked or not)	Earmarked support (Ethiopian Birr)	Un-earmarked support (Ethiopian Birr)	Number of people hired (where information has been made available)
Royal Netherlands Embassy	Earmarked	67,600,000		0
UNICEF	Earmarked			100
USAID	Earmarked	674,952,255		
World Bank	Both	446,640,000	309,120,000	1
WHO	Earmarked	229,796,676		224
Total		1,797,193,099	333,970,000	329
Percentage		84%	16%	

Source: Ethiopian Federal Ministry of Health, 2008, MDG Appraisal Team, Programming Report - Baseline Survey for MDG Performance Fund

The case of Tanzania illustrates how SWAps can simplify the aid architecture and make information easier to compile. Table 13 shows that the SWAp combined information on funding from 10 separate donors. When this kind of information is easily available, it makes it more likely that "big picture" questions will be addressed – for example, how much money is available overall and how should it be allocated?

Table 13 SWAp and non-SWAp health aid, Tanzania

Type	Number of donors	Value	Reviews/evaluation	Comments
Non-SWAp, off-budget	4	$350 million	Each donor has own reporting mechanism	Some earmarked funding; some commodity support
SWAp	10	$82	Annual joint donor reviews	Unearmarked

4.3 Countries differ significantly in their basic economics, epidemiology and government - so the same type of aid can look very different in different countries

Countries are clearly so different that the same aid instrument works differently according to country. The key differences can be summarised as "epidemiology + economics + government leadership and capacity".

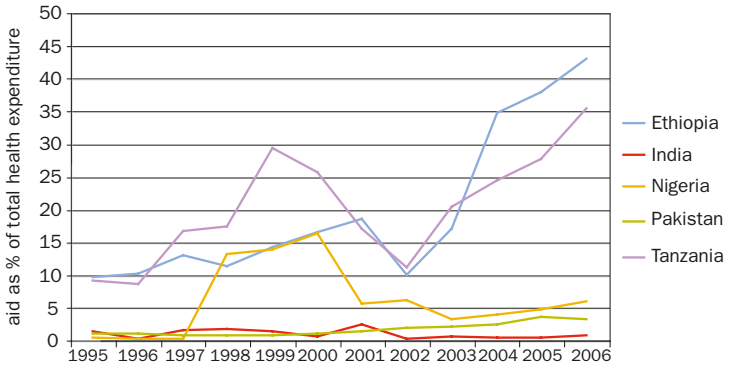
Epidemiology and economics can be captured in numbers. For **epidemiology**, one of the most striking differences in terms of aid architecture relates to HIV. For exam-

ple the estimated adult (15-49 years) prevalence rate in 2007 ranged from less than 1% in Pakistan and India, through 2.1% in Ethiopia, 3.1% in Nigeria and 6.2% in Tanzania to the extremely high Southern African rates of 18.1% in South Africa and 26.1% in Swaziland. Clearly the relative health spend on HIV/AIDS should be very different in these countries – and aid as a whole should also send different "signals" about how much money is available for different purposes.

The following set of graphs illustrates differences among the countries from a health financing/**economics** perspective. The graphs have all been compiled by the authors, using DAC CRS as the main source of information. Differences among countries include:

- **Levels of government spending on health**: ranging from around $10 per capita in Tanzania and Ethiopia down to $2-$4 in Nigeria and Pakistan.
- **Degree of commitment to health**: high in Tanzania and Ethiopia (over 10% of government budget), low in India, Pakistan and Nigeria (less than 4%). In federal states, we should also take note of the percentage of state/provincial level public expenditure which goes to the health sector. For example in Nigeria, where health is predominantly not a federal responsibility, state spending on health varies from 5-12%.

Chart 11 Degree of Aid Dependency



- **Levels of aid dependency**: high and increasing in Tanzania and Ethiopia (over 30% aid funded), low in India, Pakistan and Nigeria (less than 5% aid funded).
- **Relative size of the private sector**: relatively small in Ethiopia and Tanzania; large in India, Pakistan and Nigeria.
- **Degree of risk protection**: a relatively low percentage of health expenditure is in the form of out of pocket payments by households in Tanzania and Ethiopia (~ 35% of total spending). The percentage is higher in India, Pakistan and Nigeria (around 60%) - households in these countries are highly vulnerable to catastrophic health expenditures and could potentially benefit from the development of insurance markets to pool financial risk.

Chart 12 Share of Government Spending to Health

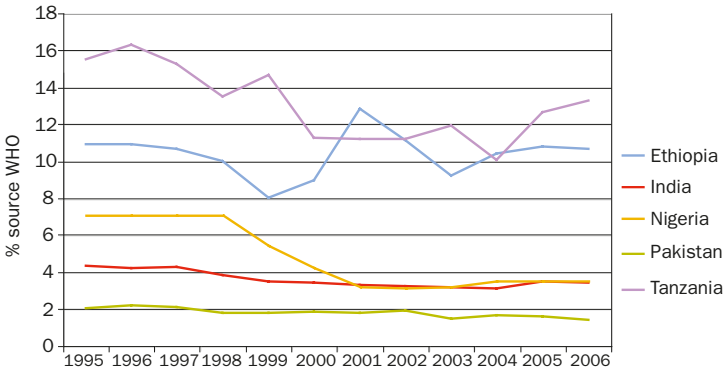


Chart 13 Share of Public Funding

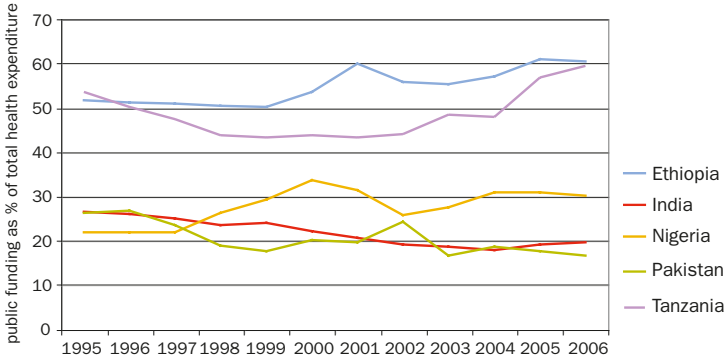


Chart 14 Per Capita Government Expenditure on Health

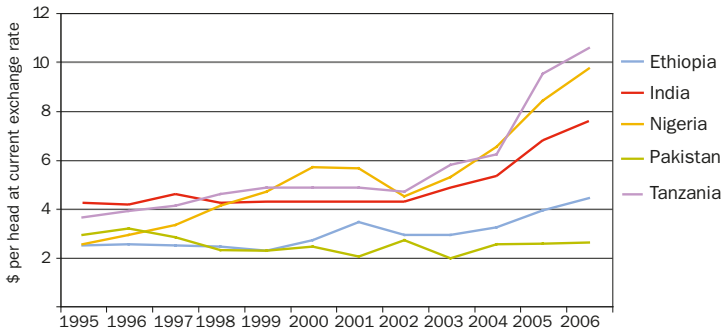
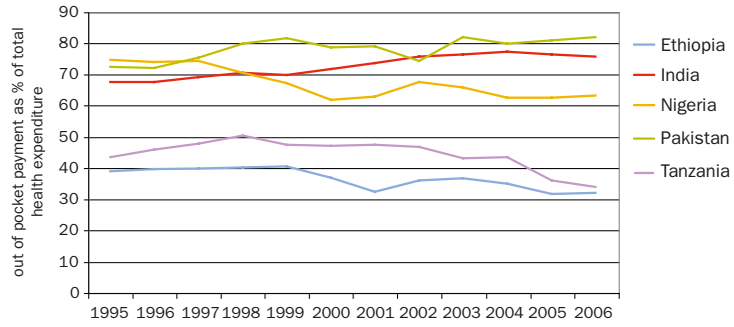


Chart 15 Degree of Protection against Financial Risk



There are clear implications for aid:

- There must be very different expectations of what a $3 per capita per year health system can provide from what a $10 system can provide. The long list of must-haves to meet the health-related MDGs tends to detract from this basic point. (Especially when lower per capita government health spending is not necessarily linked with higher aid.)
- Where aid dependency is high, aid funds a significant part of scaling up activities. When it is low, aid must be highly selective and concentrate on pilots/demonstrations or tackling strategic bottlenecks.
- Over half of all health care transactions in India, Pakistan and Nigeria take place in the private sector. In countries with a large private-for-profit sector and a high percentage of out of pocket expenditure, even marginal improvements in private sector health care can have a sizeable impact.

Classifying countries according to the level of **government leadership and capacity** is of course more difficult. But these attributes are crucial. A country with strong health sector leadership can, to some extent, mould aid to fit its priorities. For example, whilst Global Fund proposals must always demonstrate their links to HIV/AIDS, TB or malaria, there is in practice a good deal of flexibility about what health inputs will be funded. A less confident Ministry of Health, in contrast, will tend to seek funds for a conventional disease programme, no matter how flexible the rules.

"Government capacity" refers to the public sector's ability to deliver health outcomes. Is public sector management – particularly related to human resources – so flawed that little systematic progress can be achieved? Box 4 discusses Nigeria. In countries like Nigeria, well-designed projects may be a rational choice as the main aid instrument – a notion which is out of step with recent developments in aid architecture and concerns about overhead costs in aid.

India – a special case

Even a superficial look at facts and figures about India leads to the conclusion that it must be seen as a special case in development terms. This is a massive, lower-middle income country which accounts for more unmet health needs (in MDG terms) than any other individual country – by a long way. Its government has clear ideas about the role of development partners and has demonstrated its ability to negotiate strongly to receive support on its own terms. It has a massive private sector; a large academic community; and a rather poor record of public sector financial management and responsiveness.

Table 14 summarises the forms of support provided by some significant health development partners in India. The pattern of support is striking – research and institutional co-operation, for example, are much more frequent than commodity and earmarked financial support. This makes sense in a country where donor expenditure is tiny in relative terms – an impact has to be made through influencing institutions and demonstrating good practice, rather than through levels of spending that allow scaling up.

Table 14 Forms of support by development partner, India

Development Partner		UNFPA	UNICEF	World Bank	WHO	EC	NORAD	USAID	DFID
MDG supported		4,5	4,5	4,5,6	4,5,6	4,5,6	4	4,5,6	4,5,6
Technical Co-operation	**Long Term**	√	√		√	√	√	√	√
	Short Term	√	√	√	√	√	√		√
	Institutional co-operation	√	√	√	√	√	√	√	√
	Research	√			√		√	√	√
Financial Support	**Commodity Support**		√					√	√
	Project Support	√	√	√		√		√	√
	Earmarked								
	Sector	√	√	√		√			√
	Budget Support								
Advocacy/ Dialogue		√	√	√	√			√	√

* NIPI, the **Norway**-**India** Partnership Initiative

Box 4 Nigeria – a chronic under-performer

In some ways Nigeria is an extreme case – but one that has to be thought about very seriously. Nigeria represents a significant share of the work to be done to achieve the MDGs. Many of the characteristics of Nigeria which are discussed in this Box are evident in many other countries – yet the global dialogue tends to be dominated by what can be achieved in better-managed countries such as Ethiopia, Mozambique and Tanzania.

Many aspects of the Nigerian public health system are discouraging:

- Extremely low immunisation coverage - DPT3 coverage in 2007 was 54%, compared with a Sub-Saharan Africa average of 73%. (UNICEF 2009)
- Extremely low commitment to spending on health overall or to directing resources according to need (state allocations, primary care). This includes use of recent "DRG" money ("debt-relief gains"), a disproportionate amount of which was spent centrally and on tertiary care.
- A poor track record of financial management and translating budgets into actual expenditures, plus extremely low transparency of government financing for health, from federal level, through states to local government. For example: "In Zamfara State, according to the 2007 Budget Document, allocations to the state health sector represented less than 2% of the state budget in 2006. This has reportedly increased to around 5% for 2009 but it was not possible to verify this. Budgets are heavily skewed towards capital expenditures at the expense of recurrent expenditures. For example, for 2007, roughly two thirds of the health budget was allocated to capital expenditure. There are other monies for health transferred directly from the Governor to LGAs, but figures on this are difficult to obtain……State health allocations often remain unspent; in 2006 little more than 50% of the health budget was actually drawn down by the State Ministry of Health." (DFID/Norad – Evaluation number 11)
- Extremely slow pace of reform - for example, significant delays in passing a new Health Bill which seeks more transparent financing of primary health care.

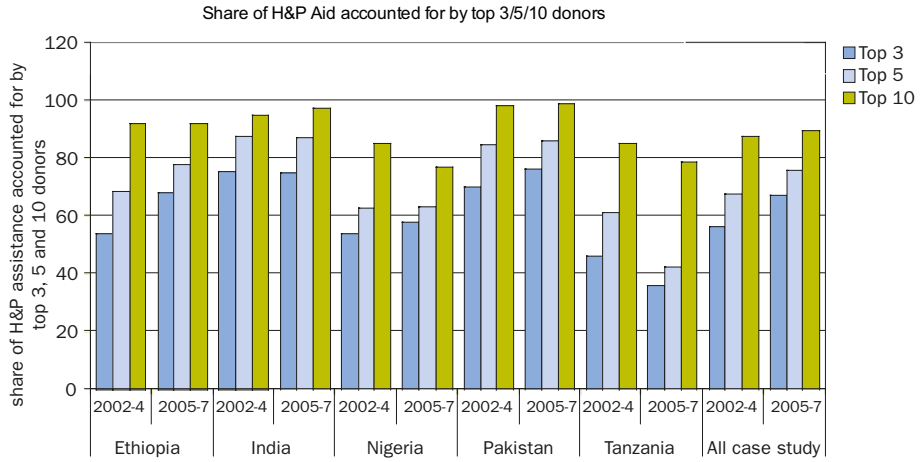
This difficult environment leads to a very different type of aid dialogue than with governments with a more palpable commitment to health improvements. Crudely put, the underlying conditions in which the Paris Principles may be made to work do not apply. Not surprisingly, therefore, donor support is overwhelmingly in the form of off-budget projects (whether narrowly focussed or more programmatic), rather than in the form of budget or pooled support.

If we accept that budget support and SWAps are not appropriate in Nigeria (despite its status as an IHP signatory), then the focus of questions concentrates on the nature of projects. What should they be about? How to avoid duplication and encourage complementarity? How to maximise the wider impact of a project, without being unrealistic about its likely impact? Who should plan and agree funding for these projects?

4.4 Countries have generally experienced an increase in the number of donors, plus the rise of the Global Fund, in recent years

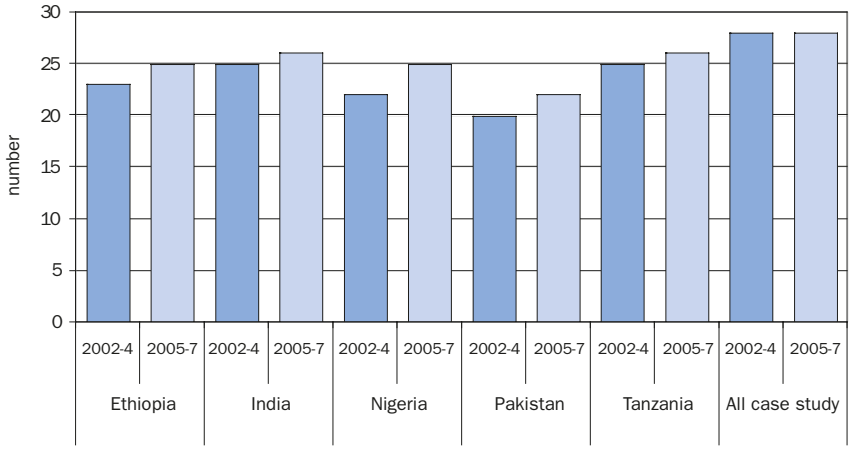
Chapters 2 and 3 described a general picture of "more donors + the rise of the Global Fund" – this pattern is repeated in the case study countries, as shown in Charts 16 and 17. Chart 16 shows that aid for health and population is increasingly concentrated[17] in a few large donors. There is one exception – in Tanzania, the degree of concentration is lower and declining. We believe that this is because some large donors – notably the UK – moved from sector to budget support. At the same time Chart 17 shows that the *number* of donors in country is tending to increase.

Chart 16 Degree of fragmentation



Source: DAC CRS database – author's analysis

Chart 17 Number of active donors in country



Source: DAC CRS database – author's analysi

17 Defined in terms of the share of total country health and population Official Development Assistance which is accounted for by the top 3, 5 or 10 donors.

This rise in donor numbers and increase in disease-related funding looks very different from different country viewpoints – the examples of Ethiopia and Nigeria are contrasted here:

- Ethiopia has an aid-dependent health sector (ca 42% of expenditure) without a SWAp - even though there have been various forms of pooling. The five-year Health Plan clearly outlines three scenarios based on three levels of financing – the most expensive is at the level of achieving the MDGs. Each level includes an increasing number of interventions. In practice, aid money was available to achieve the HIV aspects of scenario 3, but at the same time not some of the maternal and child aspects of the cheaper scenario 2. This is a clear example of aid resource allocation not being able to respond to in-country plans – even though these plans were in line with the MDGs.
- Nigeria is not aid-dependent (ca 6%) – although some programmes in some states are. Whilst a lack of co-ordination may cause inefficiencies, the effects of this are very much less serious than in an aid-dependent country where aid decisions affect the overall macro-allocation of resources in health.

4.5 Countries think in terms of service delivery units – donors don't

Countries think in terms of service delivery levels – facilities are their "units" for planning, reporting and allocating crucial resources such as staff. There is a disconnect between this and the "global health literature", with its focus on interventions, technical programmes and systems.

The *Joint External Evaluation of the Health Sector in Tanzania* is interesting because it combines both ways of thinking, with chapters on (for example) local level services, hospitals, central support, human resources and HIV/AIDS. The long-running SWAp has led to an environment where "big questions" about both performance in disease-specific work *and* at different service delivery levels can be tackled in one document.

4.6 The role of the Ministry of Health differs from country to country

The role of the Ministry of Health differs from country to country. Channels which start with the Ministry of Health have to adapt their way of working to meet different situations:

- In Ethiopia, a conventional SWAp would not work because on-budget funds which are earmarked for a particular sector cannot be channelled to regions. A basic services support programme – in effect "partial budget support" for the three sectors of education, agriculture and health – has created a channel for donor funds to reach districts.
- Nigeria, India and Pakistan are all federal states where the states/provinces have very considerable autonomy in health. In all three countries there are substantial differences in health status between states/provinces. India and Pakistan both have federal programmes which offer a way of channelling resources around the country (or needy parts of the country) for priority health activities – for example India's National Rural Health Mission and Pakistan's Lady Health Worker Programme. Box 5 further describes devolution in Pakistan and its implications for donors.

- In Tanzania, part of the Prime Minister's Office deals with Regional and Local Government (PMO-RALG). This is where crucial decisions are made about channelling funds to regions and districts.

Donors have to be very adaptable to different political set-ups – this can be difficult when the focus is on one relationship (e.g. WHO and Ministries of Health) or when resource allocation decisions based on proposals are made by people who may not know the political structure of individual countries (Global Fund, GAVI).

Box 5 Federalism and devolution in Pakistan

Devolution to districts was introduced in Pakistan in 2001. It was assumed that provinces would take on the role of developing policies and supporting local governments in policy implementation, though this was not explicit in key government documents.

After 2001, donors often found their work hampered by uncertainties about the respective roles and responsibilities of federal, provincial and district authorities within the programme cycle. (Economic Affairs Division)

In the health sector the management of primary and secondary health programmes was transferred to districts, and Executive District Officers (EDOs)-Health were put in charge of health programmes. Many staff were re-located from province to district and most EDO-Health posts were filled.

There have been challenges. Some EDOs-Health have been unable to develop good working relationships with the District *Nazims*, and there are conflicts between some Provincial Health Departments, District Councils and EDOs-Health. Some EDOs feel disempowered to make decisions. Many *Nazims* have been primarily concerned with highly visible and short-term interventions that will ensure re-election. District health plans give low priority to women's health.

Donor support to MNCH in Pakistan cannot ignore these crucial provincial-district and within-district relationships. In particular, people with responsibilities for resource allocation within districts need to be made aware of what improved maternal and child health services could achieve.

4.7 Discussion – the country perspective and aid architecture efficiency

What do these country viewpoints contribute to the question of aid architecture efficiency?

Encouragingly, several of the earlier recommendations are re-inforced by these country perspectives – these include Recommendation 1 about the need to focus on prioritisation and sustainability and Recommendation 3 about the importance of improving information on donor financing and the flow of funds to districts.

These country examples also confirm the validity of Recommendation 10 – that the Paris Principles on harmonisation and alignment have to be applied pragmatically on a country by country basis. In Tanzania, 10 donors felt able to work together with the government in a SWAp and to provide funds to local council health services. In Nigeria, in contrast, development partners felt unable to work so closely

with a system that seemed disinterested in primary health care and un-transparent in its resource allocation. India is yet a different situation – collectively, development partners contribute only a tiny fraction of funding for health, so are in no position to set up parallel systems that would significantly undermine government capacity, even if they wanted to.

Although many of the points reinforce the findings of the previous chapters, two significant new points emerge from the country studies – about the **adaptability of aid modalities** and a focus on **service delivery levels**.

The adaptability of aid modalities

Aid modalities clearly need to adapt to a huge variety of country contexts. An appropriate pattern of investment in one country may be totally inappropriate in another. This is where the development partners with an in-country presence (multilaterals in most countries and bilaterals in some) complement the likes of the Global Fund and GAVI. The more that the Global Fund and GAVI can make decisions based on a deep understanding of country situations, the better – the Global Fund's move towards Joint Assessment of national strategies is a positive step.

Federal states provide particular challenges for development partners – but they are important because they tend to be big countries which are highly significant in terms of the MDGs. Responsibility for health in federal states is generally at the state/provincial level –and sometimes at the level of local councils. It is vital that state/provincial stakeholders are involved in the planning and implementation of health programmes. This inevitably implies higher transaction costs for development partners. As examples: a multilateral in a federal country needs to have enough staff to be familiar with the health plans of each state/province; a project design mission would need to allow time to visit a number of states/provinces. There are many potential pitfalls if the state/provincial level is not involved – there may be little local ownership of a project designed in the federal capital or the federal government may simply spread the available resources very thinly amongst all the states, without regard to need.

Recommendation 12: The transaction costs of working in federal states are inevitably higher, as there are multiple states/provinces with responsibility for health. *The Government of Norway should ensure that sufficient resources are available to allow effective work in federal states. This applies to work which Norway funds both directly and indirectly (through the Global Fund, multilaterals etc.).*

Service delivery levels

We have seen that countries generally think in terms of service delivery levels. This fits in with the discussion in Chapter 1 (section 1.4) of how to break the health MDGs down into tasks which need to be performed at various levels of the health system. Focussing on levels of care has two advantages:

- It reflects how countries think about their health sectors.
- It offers an alternative to the current global focus on systems "versus" disease programmes. This systems/disease dichotomy is an artificial construct which is of limited value. Is a primary care nurse working in maternal and child health a

"system" or a "technical programme"? How can the performance of health systems be assessed if they are regarded as something separate from technical disease-oriented programmes?

The systems/disease distinction has shifted attention away from crucial questions: what are the minimum "essential tasks" we expect to be done at each level of the health system – community, clinic, hospital and above? Or, in the language of performance, what are the minimum *achievements* we should expect from community health care, clinics, hospitals and higher levels?

The benefits of thinking in terms of service delivery levels are further discussed in Chapter 5.

5. Findings and Recommendations

This chapter brings together the many threads from previous chapters and relates them to the central question of the efficiency of the health aid architecture. It describes the wider context of the recommendations which have been made so far and adds some new recommendations. The chapter is divided into four sections – issues, organisations, topical questions and cross-cutting concerns.

Recommendations are numbered according to the first time they appear in this report.

5.1 Issues

Recent years have seen huge increases in spending on health in low-income countries. Much the biggest increase has been in spending on HIV/AIDS, followed by TB, malaria and immunisation. There have been significant improvements in coverage in all these areas. Further expansion of these programmes, however, is difficult in many countries because of weaknesses in the health systems which deliver the technical interventions. Well-funded programmes respond to systems weaknesses by setting up parallel structures.

Earmarking huge sums of money for four technical programmes has inevitably meant that other programmes have received relatively less funding and countries' priorities have at times been compromised.

There is now a global economic recession - it is most unlikely that spending on HIV/AIDS, TB, malaria and immunisation will continue to increase as it has in recent years. It is also most unlikely that there will be sufficient funds to achieve all the health MDGs. There has to be a shift in global debate away from a focus on funding gaps and towards practical questions about prioritisation and sustaining recent improvements in coverage. This is the thinking behind *Recommendation 1:* -Ensure that unrealistic funding predictions and funding gaps do not dominate global and national analytical work and debate. More attention needs to be paid to realistic financial predictions, prioritisation and sustainability.

The global architecture for health is currently very fragmented. There are 3 health MDGs, with 6 targets and 19 indicators. The sector is commonly divided up into numerous technical programmes and systems.

It is worthwhile to briefly compare health with education. *Schools* are the focus of attention – not parts of schools, such as "good maths teaching". The education

MDG is directly concerned with schools; education's Fast Track Initiative is about getting children to complete their schooling.

Similar thinking can be applied in health – education has primary and secondary schools, health has community health workers, clinics and hospitals. The crucial question is: what are the **minimum "essential tasks" we expect to be done at each level of the health system** – **community, clinic and hospital?** Or, in the language of performance, what are the minimum *achievements* we should expect from community health care, clinics and hospitals?

This focus on levels makes sense to Ministries of Health – this is how well-functioning Ministries tend to plan, deliver and monitor services. It also offers a more attractive basis for resource mobilisation than the abstract notion of "health systems".

This is the thinking behind **Recommendation 13:** *-The current fragmented thinking about health should be re-structured around levels - what are the minimum "essential tasks" we expect to be done at each level of the health system – community, clinic, hospital and above? What are the minimum achievements we should expect from each level?*

5.2 Organisations

Chapter 3 made clear that this report cannot make comprehensive recommendations based on the comparative advantages of all the main international players – the methodologies used simply do not justify this. Despite this caveat, the recommendations below do cover highly significant issues.

The Global Fund and GAVI

The previous section described how the Global Fund and GAVI have contributed to huge increases in coverage. But these successes do not mean that it is appropriate to channel more and more money through the Global Fund and GAVI with their existing mandates – in relative terms (though of course never in absolute terms) a large enough share of available resource is already spent on HIV/AIDS, TB, malaria and immunisation.

The Global Fund in particular is an extremely significant player in the current global health architecture - it gives countries the opportunity to apply for significant sums of money. It makes no sense to limit this valuable source of money to three diseases when a country may want to pursue a cost-effective strategy related to other health issues, especially maternal, neo-natal or child health. (Immunisations should not be funded by the Global Fund – this role should remain with GAVI.)

The above thinking led to **Recommendations 4:** *The Global Fund should broaden its scope to include "any reasonable interventions that further the MDGs".* And **Recommendation 5:** *It is appropriate to think about what the maximum budgets for the Global Fund and GAVI should reasonably be in the next five or so years and how they should prioritise what they fund. The Government of Norway should ensure that analytical work addresses this question and that it is discussed in various policy forums.*

The United Nations Agencies and the World Bank

Chapter 2 described how multilateral agencies typically receive funding from many sources. For example, in 2006-7 27% of WHO's income came from regular sources – the rest consisted of earmarked, extra-budgetary funds. This makes it very difficult for multilaterals to work efficiently. Huge efforts are under way to reform the UN to try to make it more efficient. Hence **Recommendation 2:** *Continue with efforts to link core funding to performance in WHO and other organisations and to reduce the number of extra-budgetary grants.*

Countries face difficult challenges in terms of prioritisation, sustainability and health systems strengthening. They need good quality support to help them make well-informed decisions. Whilst the World Bank is *technically* best placed to support countries as they address these issues, WHO is better placed in many countries in terms of its *relationship* with the ministry of health. This is the thinking behind **Recommendation 6:** *It is essential that WHO and the World Bank work out how they are going to collaborate to support countries as they address issues of prioritisation, health systems strengthening and sustainability. The Bank and WHO should be challenged to specify how their overlapping remits will be co-ordinated at the country level.*

Bilaterals

Bilaterals perform many roles – they fund activities directly in some countries, but also fund multilaterals, global health partnerships and NGOs. Strikingly, over 90% of the Global Fund's income comes from donor governments. Individually, and as a like-minded group, bilaterals could achieve more if their activities appeared to be more "joined up". **Recommendation 11** describes how this might be achieved.

The Government of Norway should:

- *Strengthen its voice by being as consistent as possible in all its actions and funding decisions. Take positive action by conducting internal assessments of consistency between bilateral support funded directly at the country level and that financed through global health partnerships.*
- *Develop a shared understanding with other bilaterals of likely funding flows and the implications for prioritisation, sustainability and the budgets of the Global Fund, GAVI etc. Share findings of the "internal consistency assessments" (see previous bullet) and encourage other bilaterals to do similar reviews.*
- *Work with like-minded donors to have an effective in-country presence in as many aid-dependent and other high-need countries as possible. To be effective, this should be a health specialist with a remit to cover the sector as a whole. Norway can show the way in terms of innovative arrangements, such as "silent partners".*
- *Support SWAps in appropriate countries. In other countries, work alone or with other bilaterals on tailor-made grants to suit individual country circumstances and to fill gaps.*

5.3 Topical questions

The TORs and subsequent discussions have identified a number of topical questions – these are addressed in this section. As ever, readers are reminded that the methodologies used in this paper do not always allow comprehensive answers – but they do provide useful insights.

5.3.1 There is Less Progress with MDGs 4 and 5 than with MDG 6 – what can be Done about this?

Chapter 1 demonstrated how progress is best (though still challenging) for MDG 6 (HIV/AIDS etc.) and worst for MDG 5 (maternal health). Progress is mirrored by the funding situation - in 2002-6, more than 50% of all health aid provided directly to countries was absorbed by commitments relating to MDG 6, leaving only $2.25 per capita per year for all other health activities. (Section 1.4)

Recommendation 4 above has already addressed the funding issue to some extent by stating that the Global Fund should broaden its scope to include other interventions that further the MDGs. This expanded mandate for the Global Fund would give countries the opportunity to apply for money to expand maternal, neo-natal and/or child health services.

As well as making more funding available, more work can be done to link the stages of research, piloting and scaling up in MNCH. The HRP has been notably successful with this in the field of sexual and reproductive health. (HRP – the Special Programme of Research, Development and Research Training in Human Reproduction - is the main instrument within the United Nations system for research in reproductive health. UNDP, UNFPA, WHO and the World Bank are all involved.) *Recommendation 8*, therefore states: HRP appears to be a successful and unusual arrangement. It is worth exploring whether this model can be expanded or replicated for other technical areas – particularly related to maternal, neo-natal and child health.

One aspect of maternal and child health ranks alongside immunisation as a "best buy" – **family planning**. Indeed with its links to women's empowerment, per capita economic growth and environmental sustainability, it is arguably the most important service the health sector provides. Yet we know that funding for family planning has not increased in proportion to the overall increase in aid funding. *Recommendation 14:* The Government of Norway should ensure that the importance of family planning is fully reflected through its advocacy work and funding.

5.3.2 What should be the Expectations of Work by the World Bank, WHO, GAVI and the Global Fund to "Streamline Investments in Health Systems"?

Further improvements related to HIV/AIDS, immunisation, TB and malaria are constrained by the capacity of health systems – particularly the distribution of existing health facilities and the health workers to run them. A significant recent development in relation to health systems is the undertaking from the World Bank, the Global Fund and GAVI to "streamline their approach to investing in health systems". For GAVI and the Global Fund, this includes an offer to "jointly programme" their health systems support. WHO will act as facilitator.

What expectations should we have of this work?:

- The work needs to be under-pinned by a vision of the linkages between health systems and the four technical programmes. Countries should not be expected to show piecemeal connections between health systems activities and improved health outcomes. The linkages can be expressed in terms of levels - for example, what does "health systems" mean at the clinic level? What do clinics need in

order to be able to perform their essential tasks?

- WHO should ensure that the work includes a proper analysis of the suitability of the business models of the Bank, Global Fund and GAVI for health systems strengthening. At best, the case for the Global Fund and GAVI to fund health systems strengthening is unproven. (An evaluation of GAVI's health systems support is due out later this year.) It is important that the work does not become a platform for unjustified requests for additional resources.
- For "joint programming" to be meaningful, it needs to mean "the same administrative systems". The Global Fund and GAVI need to be explicit about how they will combine their proposal forms, review panels, monitoring requirements and financial management.

Recommendation 15: *The work by the World Bank, Global Fund, GAVI and WHO on streamlining health systems investments is important and should be monitored carefully. The Government of Norway should have clear expectations in terms of an overall vision, shared administrative systems and the fact that this should not become a platform for inappropriate resource mobilisation before the best way of supporting HSS has been established.*

5.3.3 Does it Always Make sense to Abide by the Paris Principles on Harmonisation and Alignment?

This question was discussed in some detail in Chapter 3 (see Section 3.6). In some countries it makes sense to support government priorities and use government systems – and in some countries it does not. This led to **Recommendation 10:** *The Paris Principles have to be applied pragmatically on a country by country basis - some countries have plans and systems which should be supported; in other countries, a reliance on government plans and systems is an unacceptably risky use of aid money.*

5.3.4 How might Technical Co-operation and Technical Assistance be Improved?

This largely desk-based study uncovered a great deal of confusion about technical co-operation and technical assistance. In particular, the information about global spending on technical co-operation is confused and tells us little. A "re-classification" caused TC spending to apparently drop from 36% in 2006 to less than 10% of total spending in 2007. Moreover, multilateral organisations which we know are very active in TC (for example WHO employs over 200 "TC staff" in Ethiopia) do not record *any* spending at all on TC. (Recommendation 3 addresses problems with information.)

Section 3.3.6 in Chapter 3 described the reasons why ad hoc TA tends to be so common – donors tend to use it to get noticed and to get jobs finished quickly. Fragmented aid leads to a lot of ad hoc TA. More positively, the section also identified examples of good practice in relation to TC. These included:

- The *Global Drug Facility* (TB) - praised for its "unique bundled model comprising grant-making, procurement and partner mobilisation for technical assistance".
- *Averting Maternal Death and Disability* (AMDD) - very focussed TA which consistently referred to a technical gold-standard.

- The *International HIV/AIDS Alliance* Secretariat - technical support with a very clear aim (to develop national organisations that could mobilise and manage donor funds).
- HRP - a productive long-term collaborative arrangement with the National Population and Family Planning Commission of China.

These four examples have something in common – in each case TA is embedded in a wider plan, with clearly specified results.

TA is far from "embedded" in much of the current work on HIV/AIDS, TB, malaria and immunisation. On the contrary, there is often confusion about the division of labour for both the funding and supply of technical support in these areas. This confusion generally occurs when there is an organisation which is regarded as a "big player" in an area, but which does not directly fund significant amounts of TA. The "big player" can be a funder (e.g. the Global Fund) or an "umbrella partnership" such as Roll Back Malaria.

This report is not alone in identifying serious problems with TA. The 2009 evaluation of the Global Fund similarly identified "a broad set of problems, inconsistencies, and confusions regarding technical assistance, at both the global and country levels, some of which are common to development aid in general, and others of which are specific to the Global Fund." [18]The evaluation recommended "as a first priority resolving the issues that impede the provision of essential technical assistance on a reliable and timely basis." (Global Fund Recommendation # 20, page 32) *The Government of Norway should ensure that the recommendations related to TA in the 2009 Global Fund evaluation are followed up. This work is important in its own right and provides an excellent opportunity to start addressing the problems with technical support in the health sector as a whole.* **(Recommendation 16)**

5.3.5 How can New Commodities be Identified which Merit Large-Scale Distribution?

There have been many effective measures recently to increase the flow of **commodities** – this is an area which has attracted considerable innovation, whilst at the same time "older" suppliers continue to perform valuable roles (UNICEF, UNFPA).

It can be an efficient use of global aid money to develop commodities for use in low-income countries and to lower their prices. However countries should not be encouraged to introduce too many new interventions at once, or interventions which are not cost-effective.

How can appropriate new commodities be identified – i.e. commodities which merit large-scale distribution in low-income countries? This question is addressed by **Recommendation 7:** *In collaboration with other partners, the Government of Norway should consider establishing a Global Health Technology Assessment Programme to provide timely information on commodities (and other interventions) that are "good buys" for low-income countries.*

18 Macro International (2009) Global Fund to fight AIDS, TB and Malaria - Five-year Evaluation, Synthesis Report (page 36).

5.3.6 What's so Special About Federal States?

Federal states are different because their states/provinces usually have a constitutionally mandated responsibility for health. In some federal states, therefore, the Federal Ministry of Health is relatively weak, with a comparatively small budget. Federal countries tend to be large – it is therefore important to get things right in these countries, even though this entails higher transaction costs.

The Government of Norway should ensure that sufficient resources are available to allow effective work in federal states. This applies to work which Norway funds both directly and indirectly (through the Global Fund, multilaterals etc.). **(Recommendation 12)**

5.4 Cross-cutting concerns

Three cross-cutting concerns were identified – gender, poor financial information and the relative neglect of the for-profit private sector.

Gender

Despite efforts by some parties, gender is not a mainstreamed concern in the global health architecture. *The Government of Norway therefore needs to continue with its efforts to raise the profile of gender. These efforts should be strategic in terms of identifying what needs to be done in organisations to really make a difference, and in terms of which organisations to concentrate on.* **(Recommendation 9)**

Poor financial information

There were serious problems in identifying levels and flows of funding, both globally and in-country. The lack of accessible information on donor funding co-exists uncomfortably with the reporting requirements placed on recipient countries and with pledges about predictable financing. **Recommendation 3** is thus: *Options for improving the current system for tracking international and in-country expenditure on health and population need to be explored. These options should focus on the DAC-CRS financing database and efficient ways of conducting regular Public Expenditure Reviews and Public Expenditure Tracking Surveys in countries.*

The for-profit private sector

A significant percentage of health care interactions take place in the private sector, especially with for-profit providers. Improvements in quality and/or reductions in costs to households could benefit huge numbers of people. There are a number of ways of working with the private sector, including franchising, contracting and less formal arrangements related, for example, to referrals. Innovative work in malaria, TB and HIV/AIDS provides lessons on what can and cannot be achieved in terms of public health improvements by collaborating with private providers. Nevertheless, there are many missed opportunities for working with for-profit providers who have poor people as their customers.

The Government of Norway should promote more work on collaboration with for-profit private providers, ensuring that the impact on poor people is carefully monitored. **(Recommendation 17)**

Appendixes

ANNEX 1:
Terms of Reference

Millennium Development Goals for Health – A desk study to assess forms of development aid through various channels and organisations regarding their effectiveness and efficiency in improving public health at country level.

1 Background

While Norway gives broad support to all eight Millennium Development Goals, special priority is given to goals three, four, five and six. The Prime Minister of Norway has, together with other world leaders, called for an urgent and intensified effort to improving maternal, newborn and child health (MDGs 4&5). The efforts focus on the need to address health systems barriers, which hamper access to, and provision and utilisation of, quality health services. These may include tackling the health workforce crisis, improving effective delivery of services, as well as eliminating financial obstacles to care and protect women and their children from poverty.

Several other international initiatives for health of mothers and children have evolved over the last few years. The Global Campaign for the Health Millennium Development Goals encompassing several initiatives was launched in 2007 by a group of global leaders from the North and the South. The International Health Partnership, which aims to scale up coverage and use of health services in order to achieve the health-related MDGs by 2015, was also launched in 2007. In parallel, initiatives for innovative financing mechanism have been taken, whereby for instance the Taskforce on Innovative International Finance for Health Systems has been established in order to find new sources of financing to help developing countries achieve the health MDGs.

While all these different global initiatives strive towards the very same goals, they also contribute to an increasingly complex structure, which again makes it difficult to get a general overview of the different roles and contributions. It is therefore seen as necessary to better establish how the various channels and organisations contribute towards the health MDGs in order to make more informed decisions about how to work as efficiently as possible.

2 Purpose

There is a need to do a ”mapping” of different forms of development aid through various channels and organisations aimed at achieving the Millennium Development Goals within the health sector. The intention is to collect data that may inform decision makers about strengths and weaknesses in various forms of development aid, as well as comparative advantages and disadvantages of channels and organisations involved in health efforts in developing countries. The focus will be on improving public health at country level. The study shall include a gender perspective. Based on the analysis and findings, the consultants shall come up with recom-

mendations on how further efficiency gains can be made within the overall health architecture.

3 Scope

The study will cover development goals four, five and six within the context of overall scaling-up for the health MDGs:

Reduce Child Mortality:

- Reduce by two-thirds,
  - between 1990 and 2015, the under-five mortality rate
- Improve Maternal Mortality –
  - Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio;
- Combat HIV/AIDS, malaria and other diseases
  - By 2015, halt and begin to reverse the spread of HIV/AIDS and the incidence of malaria and other major diseases.

The development aid should be categorised as follows and analysed according to the criteria described under four (4) below.

1. Technical cooperation
   - long term experts
   - short term
   - institutional cooperation
   - research
2. Commodity centred assistance
3. Financial contribution
   - Earmarked
   - Sector support
   - Share of support to public sector reflected in Government budgets

The study should cover, but not necessarily be limited to the following channels and organisations:

- UN organisations (WHO, UNICEF, UNFPA, UNAIDS)
- World Bank
- Global funds, private/public, philanthropic (GAVI, Gates Foundation, GFATM)
- International non-governmental organisations (IPPF, Save the Children Alliance, International HIV/AIDS Alliance).

It should be noted that global campaigns, innovative finance mechanisms and international partnerships can neither be defined as channels nor organisations, as the funds raised will have to be channelled through some agencies.

In February 2007, HLSP Ltd conducted a study for Norad entitled “Mapping and analysis of the aid architecture for achieving MDG-4”. The purpose of the study was to identify the key stakeholders, assessing their strengths and challenges, and to present ideas for improvements in the effectiveness of the aid architecture. The

focus of the study was on maternal, neonatal and child health. It is important that the planned mapping exercise build on the findings and conclusions of this report, avoiding any unnecessary overlap.

4 Criteria for the assessment

The team should assess the categories of development aid through various channels and organisations against the following criteria:

- Measurable results reported along the chain: inputs – output – outcome
- Effectiveness and efficiency
- Contribution to co-ordination among partners and reduced fragmentation
- Sustainability (health system strengthening, vertical vs. horizontal services)
- Predictability and flexibility of funding

5 Methods

The mapping exercise will be done as a desk study based on existing documentation, including evaluations, reviews, research findings, and reports from organisations and programmes from the last five years. It is understood that that availability of data in existing documentation may limit the findings related to the specific criteria mentioned above. The first task will be to collect available reports. This should be done through the web, by contacting each of the organisations and with visits to the headquarters of the agencies if required.

The consultants will develop a framework for use in the assessment and further methods to implement the assignment. They will also present a work plan. The consultants may select some countries for a more thorough investigation based on available reports. These could be Tanzania, Ethiopia and Pakistan. The consultants will, to a reasonable extent, assess quality of evaluations/reviews/reports as part of basis for drawing conclusions, in particular issues related to the robustness of findings and contribution versus attribution.

The consultants are expected to adhere to the OECD/DAC evaluation quality standards. The assignment should be done by two or more consultants within a frame of 16 consultants' weeks.

6 Organisation

The project will be organised as a commissioned study by the Evaluation Department of Norad in consultation with the Global Health and AIDS Department, Norad. The Norwegian reference group for HTLF will function as a reference group for the study.

7 The tender process

The procurement procedure shall be carried out as a purchase following an open tender competition. The main selection criteria will be the quality of the consultants, methods chosen, availability of consultant, and price. The consultants shall cover the following competencies:

- higher relevant academic degree
- extensive knowledge of and/or experience from work in international health issues

– analytic competence (research and/or evaluation experience)
– fluency in English
– proven writing skills

8 Timetable

25 November 2008	Terms of Reference finalised/Open international tender
6 January 2009	Tender deadline
9 January 2009	Decision on Contractor
21 January 2009	Signing of contract
2 February 2009	Inception report (Presentation of assessment framework and workplan)
February – April 2009	Documentation study undertaken. Possible visits to HQs
16 March 2009	Progress report meeting
8 May 2009	Draft report (max 30 pages text)
29 May 2009	Final report

ANNEX 2:
How long-lasting are the effects of GHP funding likely to be?

This annex describes a model of the recurrent cost implications of current spending by global health partnerships on HIV/AIDS. The main body of this report has described the high levels of spending on HIV/AIDS (and to a lesser extent malaria, TB and immunisation) and how this spending is not always in line with country priorities. (See Chapter 2, Section 2.3.4)

Current donor support for HIV/AIDS has long term funding implications. People on ARV treatment, for instance, will need continued treatment for the rest of their lives. Hopefully the recurrent costs will come down – as drug prices continue to decline - but they will still be substantial. Current funders will not support these programmes indefinitely - someone else will have to take on the costs at some point. Effectively this means increasing amounts of Government (or other donor) funding will be required to meet any shortfalls. The risk, therefore, is that vertical disease programmes – and not country priorities - will continue to drive the pattern of resource allocation at the country level by commanding a large share of any increases in fiscal space[19]. This raises serious questions as to whether flexible aid instruments such as general budget support remain relevant if they serve only to prop up disease programmes, rather than support country priorities. The fact that budget support may be used to sustain HIV/AIDS programmes may only serve to encourage further investments (by demonstrating their sustainability), driving an even greater wedge between country priorities and the allocation of resources.

Even if donors were to disappear tomorrow, their effects would be felt for some time to come. The longer they keep channelling significant amounts of funding towards HIV/AIDS, the larger and longer-lasting the effects will be. A key question is how much this will restrict Governments' future room for manoeuvre, in terms of how it allocates its money?

What are the implications for fiscal space?

This section illustrates the impact of current support for HIV/AIDS activities on the amount of fiscal space which is likely to be available at the country level. The basic premise is that donor funding will move on from current initiatives - support will move on to cover new areas or to expand provision (rather than funding existing levels of provision). The recurrent costs of existing provision will then have to be met

19 Fiscal space means the amount of money Governments are likely to have available to spend in coming years from all source – domestic, donors and borrowing. In the context of fiscal space for health, this includes re-allocations from other areas of public spending.

from other funding sources, such as increases in the Government budget or flexible forms of donor funding such as general budget support.

The prospects for health spending in low and middle income countries are actually reasonably good (see Pearson 2007[20]). This suggests that countries may enjoy a large amount of fiscal space to implement their own balanced country-led strategies. Whether it is enough is another matter. Moreover, the current financial crisis raises major questions as to whether these findings (from April 2007) and the assumptions that support them are overly optimistic.

A number of possible hypothetical scenarios are considered, using plausible assumptions which are shown in the table below. The base case presents a country which is heavily dependant on aid (just under half of health spend is donor-funded and two-thirds of donor funding comes from the global initiatives supporting HIV/AIDS programmes). The key variables which were reviewed include the rate of economic growth, the amount that Government allocates to health, the degree of aid dependence and the extent to which non-GHP funding is earmarked to projects or provided as flexible budget support.

Overview of Key Assumptions – Fiscal Space Analysis

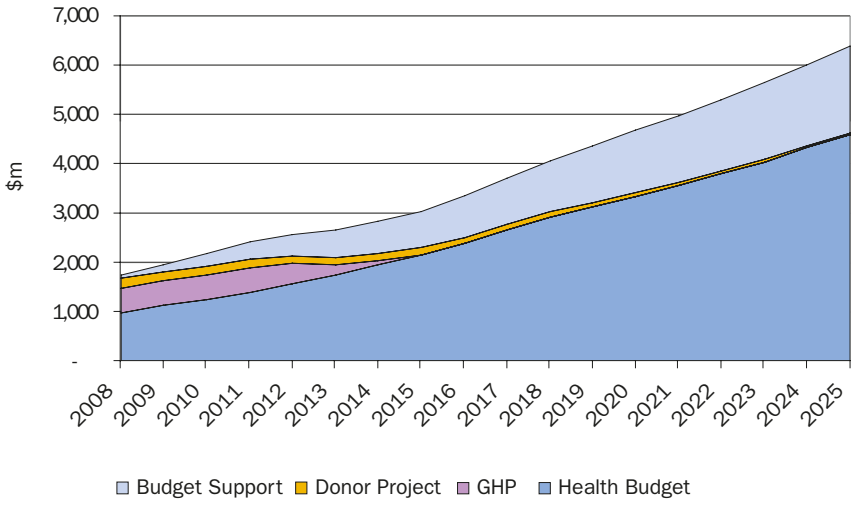
Scenario	Assumptions
Base Case	5% annual GDP growth 25% of GDP on public expenditure, increasing by 0.5% per annum to a maximum 10% of public spending to health, increasing by 0.5% per annum to a maximum of 15% $500 million GHP investment in 2008, declining to zero by 2015 $200 million donor project support, declining by $10 million per year $50 million general budget support channelled to health, increasing by $50 million per annum
High Growth	As base case except: 8% annual GDP growth
Low Growth	As base case except:2% annual GDP growth
Increasing Share to Health	As base case except: Share to health increases by 1% per annum to a maximum of 20% of public spending
Constant Share to Health	As base case except: Share to health remains at 10% of public spending
High Aid Dependence	As base case except: All Aid flows doubled
Low Aid Dependence	As base case except: All Aid flows halved
High % of Budget Support	As base case except: All but $10 million of non-GHP donor support is provided through budget support
Low % of Budget Support	As base case except: As base case except: All but $10m of non-GHP donor support is provided through projects

The chart below maps out the funding sources under the base case scenario. It

20 Pearson, M (2007) Funding flows for health: what might the future hold? HLSP.

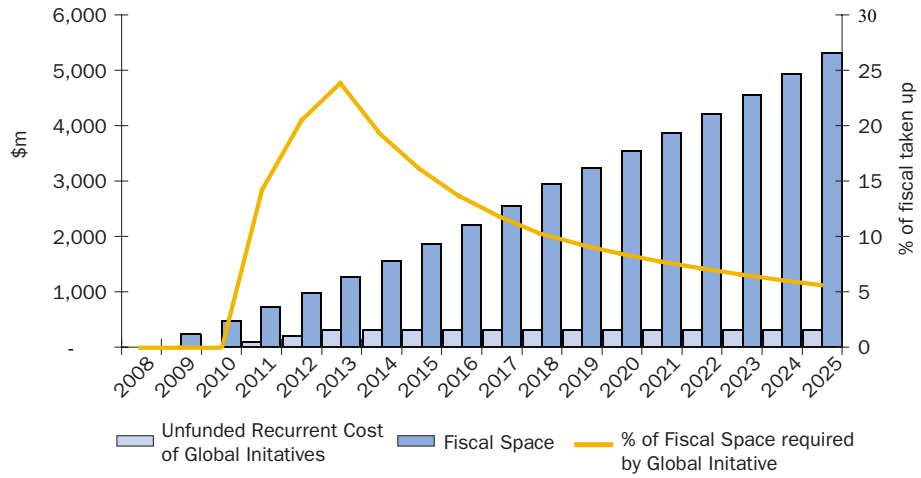
illustrates the decline of donor support for HIV/AIDS (it declines rapidly and is phased out within 5 years); growth in the budget from domestic resources; and a gradual shift from project to budget support.

Base Case: Founding Sources for Health in Country X



The next chart compares the recurrent costs of the HIV/AIDS investments[21] with the expected increase in overall fiscal space. It also shows the share of fiscal space which is required to maintain the programmes. (Project support is excluded, as it is assumed to be earmarked to other programmes and therefore not available to cover these costs.) The chart shows that a large share of the financing burden falls on budget support. In the short term (to 2015) over 25% of the additional fiscal space is required to maintain the HIV/AIDS investments – this subsequently declines as fiscal space increases.

Base Case: Extent to Wich Global Intative Support Pre-empts Fiscal Space



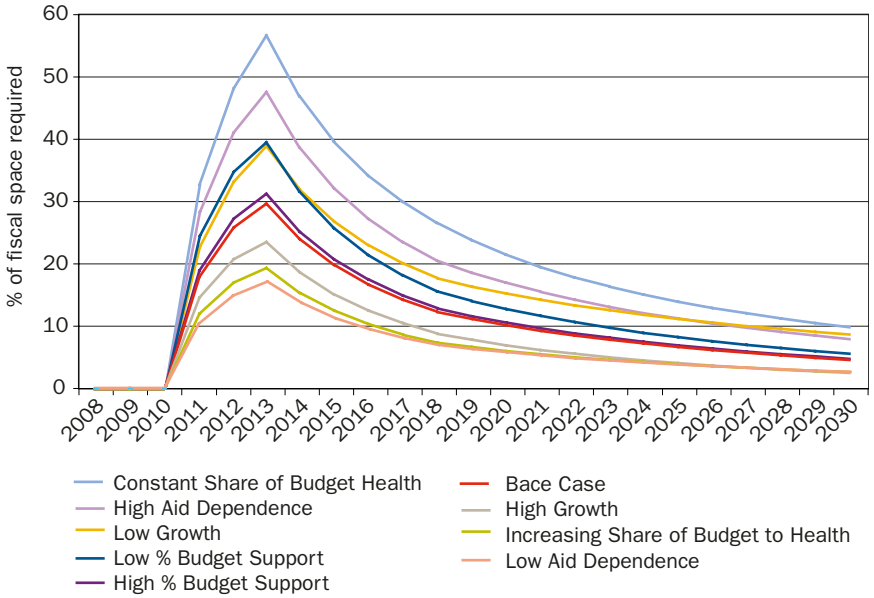
21 These recurrent costs are assumed to be 60% of the initial investment – this seems reasonable and perhaps even on the low side, given that around 50% of Global Fund spending is on drugs and a further 25% or so on staff costs.

The chart below shows the results of the sensitivity analysis based on the assumptions set out earlier. It shows, not surprisingly, that most fiscal space is pre-empted where:

- there is little movement towards budget support (the implication being that budget support is used to support programmes which, arguably should not have been started in the first place)
- the share of the Government budget going to health does not increase
- aid dependence is high
- and growth is low.

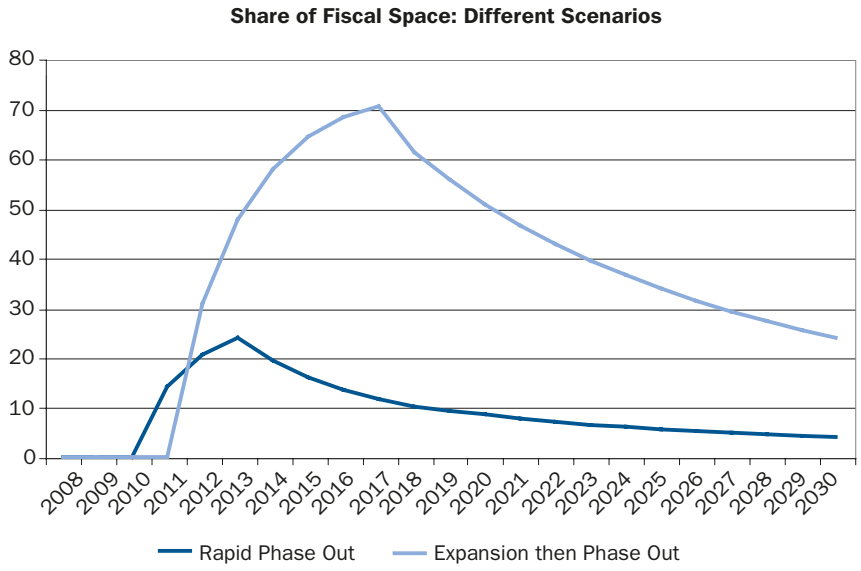
In some scenarios up to 60% of flexible funds are required to support the HIV/AIDS programmes, leaving only 20% of new funds to be used for other priorities.

Shares of Fiscal Space Pre-empted by Global Health Initiative Investments: Different Scenarios



Were the level of support for HIV/AIDS programmes to be increased, the share of fiscal space appropriated would be much larger. The chart below shows the impact of a large scale-up over the next 3 years[22], followed by a gradual phase out. It shows that up to 70% of additional fiscal space would be required to sustain the GHP legacy.

22 GHP support increasing from $500 million in 2008 to $3.5 billion by 2011, with a gradual phase out to 2018.



The overall conclusion is that that current levels of donor support are likely to have significant, long-lasting financial implications, even if they were to stop tomorrow.

Table 6 Evaluations – what do they say about effectiveness, efficiency and gender?

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Evaluation	**Level of effect assessed (or attempted to assess)**	**Main effects**	**Efficiency**	**Gender focus**	**What do you get if you put your money here?**
Who? – Multilaterals					
1. IHP+ 2008	Process	Some progress with Country Compacts. Potential in some countries to achieve harmonised donor support for a good-quality national health plan and its monitoring.	- (Spending at global and national levels.)	-	Compacts in some countries. A national plan being implemented and monitored in a less fragmented way. New initiative: effectiveness not yet proven.
2.UNAIDS, 2002 (NB Another evaluation of UNAIDS is currently in progress.)	Process ("national capacity to plan")	Support to national plans (but little on implementation) and UN co-ordination. Global advocacy and resource mobilisation. Some work on data. Share best practice.	Compromised because of role as a co-ordination-agency-without-teeth. Spending at global and national levels.	Two campaigns (youth, role of men) credited with "Challenging conventional thinking on gender" related to key HIV issues.	National AIDS plans; some global data; global advocacy, resource mobilisation, sharing best practice. Some UN co-ordination but without budgetary power.
3. UNFPA and IPPF Youth since ICPD 2004	Outcome (existence and quality of services)	UNFPA: in some countries valuable impact on policy, legislation and public awareness; many opportunities for leadership in service delivery and IEC missed. IPPF's Family Planning Associations: focus on service delivery – often with a fee. Good national work on service protocols and quality. Regional support weak.	UNFPA; little contribution to promoting accessible, quality services and information for young people (with exception of one country) IPPF: primarily service delivery organisations.	UNFPA: articulates importance of gender though not always able to translate this into effective work. FPAs: focus on women's reproductive health, so role of men largely neglected.	UNFPA: at best, an effective country advocate for reproductive rights/ health of young people. FPAs: service delivery and setting of standards, but not targeted at young people.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Evaluation	**Level of effect assessed (or attempted to assess)**	**Main effects**	**Efficiency**	**Gender focus**	**What do you get if you put your money here?**
4. UNFPA *An Evaluation of UNFPA Support for Preventing the Spread of HIV/AIDS.* 2002.	Output.	Enhanced availability of male and female condoms. Activities too ad hoc and not sufficiently based on evidence, need or monitoring (so little information on results). Thinly spread over ca 130 countries.	Too ad hoc to be efficiently targeted at needs and results. Thinly spread amongst many projects and countries.	Some support for advocacy on gender issues. Too little emphasis on men's needs and behaviour – although crucial to HIV/AIDS.	Significant role in condom supply. Ad hoc and poorly monitored HIV/AIDS activities.
5. UNFPA Meta-Evaluation of Evaluations 2005	Process	Assessment of UNFPA's evaluation capacity as a means to strengthening evaluation. UNFPA judged not to have a strong evaluation culture; recommendations made for improvement.	Evaluations often pay for themselves in terms of improvements made. A particular problem of evaluations was lack of focus on coverage, overall and by the poor.	63% of evaluations were rated as unsatisfactory or missing in relation to gender mainstreaming.	Poor evaluation capacity in relation to reproductive health. (66% of evaluation sample rated "unsatisfactory" or "incomplete".) (But existence of this report a promising sign?)
6. UNICEF Supply Function 2007	Outcome (excellent clarity about what can and cannot be evaluated)	Appropriate supplies have wide coverage in emergency and development situations – but not always targeted at the poorest and poor arrival dates. Use/impact not systematically assessed. Supplies more effective when integrated into a wider programme; when locally applicable because of innovation and customisation; and when delivered alongside IE&C.	Competitive prices achieved through bulk buying; but significant weaknesses and inefficiencies in supply chain, despite recent improvements. Need to modernise integrated supply chain systems and tools. Service delivery points involved in key processes – notably assessment of vaccine stock levels.	Not systematically addressed – passing mention to work in schools and hygiene that has an explicit gender dimension.	An effective supplier that could be more efficient. Little development of country capacity.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Evaluation	**Level of effect assessed (or attempted to assess)**	**Main effects**	**Efficiency**	**Gender focus**	**What do you get if you put your money here?**
7. World Bank HNP Evolution 2008	Input (this is an analytical commentary on the 2007 Bank health policy)	Identifies Bank's comparative advantages as: providing policy & technical advice to countries & partners on "structural & systems constraints" to better health outcomes for the poor; economic & evaluation analytic capacity; inter-sectoral approach; and capacity to implement large programs. In health: health systems and financial protection issues that underpin MDGs. Recognises need for systems/disease balance. Strategy not built on evidence of own work as last systematic evaluation was in 1999.	-	Minor reference: "Role in strengthening educational and economic opportunities for females and in addressing gender disparities."	Multi-sectoral and economic viewpoint. (demography; prioritisation) In health: intention for Bank to focus on health systems and financial protection. Understands need for systems/disease balance but also needs to "follow the money". Regards M&E as central.
8. World Bank: Health Benefits of Water Supply and Sanitation (WSS) Projects: Review of World Bank Lending Portfolio 2008	Impact (in practice, little evidence – this is about whether projects measure health outcomes)	"Health benefits of the World Bank's WSS investments remain obscure. While half of the projects cited potential health benefits and 89% financed infrastructure that plausibly could have improved health, only 1 in 10 had an explicit objective to improve health for which it was accountable….. Projects approved more recently (2002-6) are *less* likely to target behaviour change, which is critical in transforming infrastructure improvements into sustainable health improvements."	Missing an opportunity for greater efficiency as marginal cost of greater emphasis on health benefits is relatively low.	-	Little information and **missed opportunities** in terms of health from spending on water and sanitation.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Evaluation	**Level of effect assessed (or attempted to assess)**	**Main effects**	**Efficiency**	**Gender focus**	**What do you get if you put your money here?**
9. WHO 3-by-5 ART initiative 2006	Outcome	3-fold increase in people on ART in 2 years. (no attribution) WHO focus on technical guidance, knowledge management etc. Effective Pre-qualification Project to increase supply of good-quality drugs. Established ART as an essential public health intervention. Did not focus on equity. Target setting an effective mechanism nationally and globally for a stage of development. Too little attention and money (and targets) for prevention. Internal monitoring weak. Little development of evidence about service arrangements. WHO effect vary varied between countries.	Played part in increase in utilisation of ART. Uncertain funding and under-spending. Many missed opportunities for co-operation, partnership and joint monitoring. (Which leads to fragmented TA.) Also for joint programming with other disease areas. WHO's own monitoring systems inadequate.	"Gender and equity considerations are not yet routinely influencing how services are delivered."	Initiatives like this can get results in terms of significantly increased coverage. But little systematic monitoring or co-ordination. WHO has comparative advantage in technical guidance – effectiveness varied between countries; evaluation found this to be an under-funded area.
10. Multi-multilateral (UNDP, UNFPA, WB, WHO) Special Programme of Research, Development and Research Training in Human Reproduction (HRP) 2008	Impact (through use of research findings and related follow-up actions re policies, commodities etc.)	Good knowledge products with demonstrable effect in increasing evidenced based policies and clinical practice. Contributed to decline in MMR. Good record for providing relevant technical information about reproductive health to countries. Changed global advice on antenatal care. Practical recommendations and follow-up (in terms of commodity production and distribution) about safe abortion. Crucial influence on China's family planning policy. Global monitoring of RH still overly complex.	Evaluation rated HRP as highly cost-effective. Depends on multi-bi earmarked funding. (Shortfall in ca 2004-5 when move to non-earmarked funding of WHO.) In country, has enabled increased use of cost-effective interventions and reduced costs to clients. Effective at resource mobilisation and sharing costs – e.g. main experts support it voluntarily.	"HRP works to ensure that gender issues, especially the perspectives of women, are reflected in both its research and research capability strengthening activities."	Cost-effective production and dissemination of reproductive health research (i.e. global public goods), with ability to follow up through initial implementation stage. Track record of influencing change in China. Some unfinished business – i.e. gap between evidence and public perception re IUDs (intra-uterine devices).

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Evaluation	**Level of effect assessed (or attempted to assess)**	**Main effects**	**Efficiency**	**Gender focus**	**What do you get if you put your money here?**
Bilaterals					
Tanzania see "SWAps" below					
11. Nigeria Routine immunisation and MNCH DFID/Norad 2009	Outcome (limited because early in project lifespan)	High risk because deep-seated systems issues that may not change. Some initial improvements in capacity and immunisation, though data poor. Idea is to create pressure for better performance and accountability through demonstrating improved services.	Uses project approach to direct resources to service delivery.	-	Possibility of improvements in basic health care in a chronically under-performing system, accepting that the likelihood of significant scale up is high risk.
12. An evaluation of lessons from the Vietnam-Sweden Health Co-operation 1994-2000. 2003.	Process/ (limited) output	Development of effective Health Policy Unit in MOH, but still reliant on aid money. Mixed results in support to Disadvantaged Areas – strengthen village health worker role; limited national buy-in. Policies and regulations about pharmaceuticals – but limited implementation. Raise profile of donor co-ordination – but MOH resistant.	"Not attempted to assess cost-efficiency"	-	Through a long-term investment: Local capacity strengthened in key areas (policy, teaching hospitals) but always vulnerable to ongoing funding etc. and some areas resistance to change. Access to Disadvantaged Areas. Drug policies. Less effective links at provincial level.
Global Health Partnerships					

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Evaluation	**Level of effect assessed (or attempted to assess)**	**Main effects**	**Efficiency**	**Gender focus**	**What do you get if you put your money here?**
13. GAVI Phase 1 Evaluation. 2008.	Impact	- Significantly increased access to immunisation, and expanded use of new vaccines. Using "statistical attribution", 2.4 million children were immunized with DTP3, and 40.2 million immunized with HepB3. (Deaths averted also calculated.) - Not developed effective approaches for facilitating support to underperforming countries. - ISS and NVS support favoured LICUS, lower coverage, and lower income countries. Disparities in immunisation coverage based on urban/rural residence and gender were reduced - changes can be correlated to GAVI funding. No reduction in disparities based on mother's education or birth order. Great variability country by country. - Mixed results in influencing vaccine pricing and supply. Additional suppliers becoming involved. Prices for the two main new vaccines did not decline. - Little work on important in-country introduction issues (such as cold chain, storage or logistics). - Successful advocacy, especially at global level. (Aligning with MDG4, IFFIm, AMC funding for Pneumococcal vaccine.)	- Cost per pertussis death averted $933. Can't calculate for HepB/Hib/YF. Lack of cost data by vaccine prevents GAVI from evaluating cost effectiveness of its support. Limited use of impact and cost-effectiveness information when adding new vaccines or funding windows.	"Disparities in immunisation coverage based on.... gender were reduced during Phase 1, and changes can be correlated to GAVI funding."	More people vaccinated. Global advocacy and fund-raising. Provides forum for partners that is linked to availability of finances. Incorporated innovative ideas. Some improvements in vaccine supply and price.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Evaluation	**Level of effect assessed (or attempted to assess)**	**Main effects**	**Efficiency**	**Gender focus**	**What do you get if you put your money here?**
14. GAVI Accelerated Development and Introduction Plans (ADIPs) and Hib Initiative (HI). 2007	Impact	- accelerated the process of introduction of pneumococcal conjugate and rotavirus vaccines and thus saved lives and averted hospitalisations. - the newer HI has "facilitated decision making in a number of countries". - more suppliers investing in key products - leverage considerably more funds	Potentially highly cost-effective, assuming that effective delivery systems available. ADIP/HI money not used on direct benefits to clients – money on global work; clinical trials; disease burden and surveillance etc.	-	Vaccines available in developing countries more quickly. Good platform for fund-raising for vaccines.
15. GAVI Injection Safety Support. 2009	Output Did not look at effect on health status - noted that part of rationale for INS is not to deter people from immunisation.	44 of the 46 commodity-recipient countries sustained the use of AD syringes and safety boxes after the end of GAVI INS support. 54% were fully financing their commodities with government support, 15% used a combination of government and donor funding; 26% percent were donor dependent. 74% of the countries had a budget line item for procurement of AD syringes and safety boxes at time of evaluation. AD syringe use was considerably higher in GAVI countries than in non-GAVI, lower-middle-income countries. (But several countries in WHO European and Americas Regions maintained that syringe re-use not a problem and therefore they did not want AD syringes.) More comprehensive approach with systematic training of health workers, plans for AD syringe disposal etc. would have been beneficial.	Time-limited with planned phase out. Costs then go to government/donors. Money largely used directly on service delivery.	-	A commodity distributed for pre-set time-span and then taken over by government planning systems. (therefore is "catalytic".) For this cheap (but high volume) item, 41% still needed donor funding after GAVI support ended.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Evaluation	**Level of effect assessed (or attempted to assess)**	**Main effects**	**Efficiency**	**Gender focus**	**What do you get if you put your money here?**
16. GFATM Five-year Evaluation Synthesis Report	Outcome/impact	-mobilises additional international resources -increased service delivery, coverage and decreased disease burden (limited projections of impact) - particular increases in HIV and malaria (VCT, ACT, PMTCT, ITNs, intermittent preventive treatment during pregnancy) - brain drain to non-public sector -scale up limited by health system capacity. - Issues with cost-effectiveness of interventions and sustainability - equity not assessed - performance based culture, but based on short term outputs - Problems with data availability and quality	- disbursed huge sums of money for service delivery improvements - fragmentations amongst three diseases has led to inefficiencies	"The monitoring of gender, sexual minorities, urban-rural, wealth, education, and other types of equity as part of grant performance or impact assessment was identified as a major gap by this evaluation."	Increased service delivery especially for HIV/AIDS and malaria. Limited by strength of the health system.
17. GFATM Community perspective from South Africa 2006	Process/output	Significant funds reach community level groups. Community organisations change to meet the funding criteria. Some true community-rooted groups inexperienced in getting funds. Lack of co-ordination means duplication and gaps in service provision and not necessarily related to felt needs. Transforming culture of volunteerism. Many community organisations lurch from project to project funding without developing core capacity.	Some inefficiency because under-managed "feeding frenzy" for funds.	-	Money reaches community groups for HIV/AIDS but could be organised more systematically.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Evaluation	**Level of effect assessed (or attempted to assess)**	**Main effects**	**Efficiency**	**Gender focus**	**What do you get if you put your money here?**
18. Averting Maternal Death and Disability (AMDD) Columbia University grant from Bill and Melinda Gates Foundation. 2004	Outcome.	Substantial impact on improving maternal health – though at this stage population impact could not be measured. Documented increases in utilisation of Emergency Obstetric Care and timely resolution of complications. Significant reductions in case fatality rates – directly attributable to improvements in the availability and quality of services. Demonstrated possibility of catalyzing systemic change by improving one critical part of the system –i.e. capacity of a threshold number of health facilities to deliver comprehensive and basic emergency obstetric care services. Leverage more resources at national level. Covered 387 facilities (of which funded 159 upgradings) with budget of $26 million/5years.	Well managed through a flexible, loose structure. Could have been somewhat more aggregation and support for weaker partners. Unclear how much of budget directly on service delivery.	Women are the immediate beneficiaries. "Promotes respect for the rights of health care providers regardless of gender, level of training, and ethnicity."	Effective focus on emergency obstetric services at (selected) national, district and sub-district levels. Demonstrated a small investment can make a difference in reducing maternal mortality in the right setting and under certain conditions, but the critical hospital-based services imply relatively high costs. Important demonstration effect. Possibility in some countries that this can be scaled up. Technical status enhanced by link with reputable university. Limited community focus.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Evaluation	**Level of effect assessed (or attempted to assess)**	**Main effects**	**Efficiency**	**Gender focus**	**What do you get if you put your money here?**
International NGOs					
19. Family Care International at 20, 2007	Output	Effective at global advocacy related to maternal, sexual and reproductive health. Effective at presenting and distributing reliable information. Little strategic coherence – e.g. global/ national links. Some effective country programmes, but some weak. Received "skilled delivery attendant" grant from Gates for work in 3 African countries. Strong on practical collaborations.	No evidence – annual budget only ca $6 million. Do work directly with health facilities.	Not assessed systematically in this report. Report highlighted ground-breaking work in Bolivia with Amazonian indigenous peoples. "Through collaborative work with women leaders & indigenous organisations, they have introduced potentially polemical issues of sexual & reproductive health & rights, gender & violence, within a holistic and inter-cultural perspective."	A New York-based INGO with good advocacy record. Country programmes of mixed effectiveness.
20. International HIV/AIDS Alliance 2006	Outcome (but in practice outcome information "anecdotal and fragmented")	Strong advocate for civil society involvement in HIV/AIDS. Strong resource mobilisation. Helped enable huge scale-up in funding to NGOs for HIV/AIDS. Outcome and impact information "anecdotal and fragmented". Support to countries could be more systematically organised. Training of and by LOs is key activity but not assessed for effectiveness. Weak in support to (and documentation of) later stages of project cycle, as well as core functions of Linking Organisations (LOs).	Nine-fold growth in 5 years. Good at getting money to communities, though does not track whether money spent on management or delivery.	-	Strong global advocacy and resource mobilisation. A global organisation which can channel funds to in-country LOs and provide TA to strengthen them. LOs in turn perform the same services to NGOs in-country – many LOs have good reputation and sound financial accountability systems. Weaker at implementation stages.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Evaluation	**Level of effect assessed (or attempted to assess)**	**Main effects**	**Efficiency**	**Gender focus**	**What do you get if you put your money here?**
21. IPPF. Reaching Poor People with Services in SRH. 2006	Outcome	Provides good quality services to poor people – who chose them because of low fees/high quality and respect for privacy. Outreach services most effective in reaching the poor. Weak on advocacy. Projects generally not taken to scale or integrated with other PHC activities.	Most money spent on service provision.	Strength is in "traditional" FP/SRH service provision rather than adding new areas of gender-related need. Evaluation recommends time-specific commitment for gender equality on Board and with staff.	Provision of good quality family planning, sexual and reproductive health services. Respected in many countries. Weak advocacy.
See also #3 above, UNFPA/IPPF					
Partnerships and umbrellas					
22. Multi-country Evaluation of Integrated Management of Childhood Illness (from Health Policy and Planning 2005)	Impact	Quality and effectiveness of care increases when training implemented to appropriate standard and continuity of coverage by trained staff None of the 6 studied countries sustained supervision. Effect only as great as coverage and utilisation of government facilities. Requires concomitant community based and systems interventions. Scale up weak. Suits high child mortality countries – no neonatal interventions.	Potential to be cost-effective but this reduced if only part of the package implemented Concentrating only on public service provision misses opportunities in private sector and community and places too much reliance on one strategy.	-	Effective, quality care for children in some parts of a country with high child mortality. Increased utilisation (sometimes). Limited effects without a major push on health systems issues, plus work with private sector and at community level.
23.Partnership for Maternal, Newborn and Child Health 2008	Process	Some advocacy/awareness-raising successes. Valued forum for technical exchanges. In-country work added little value. Not seen as a "big player", not a funding body, multi-partner coalition often perceived as a weakness.	Inefficiencies in governance processes. Weak management. Under-spending.	-	Evaluation identified little added value of the Partnership. Initially some advocacy push. Convening of experts.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Evaluation	**Level of effect assessed (or attempted to assess)**	**Main effects**	**Efficiency**	**Gender focus**	**What do you get if you put your money here?**
24. Roll Back Malaria, 2002	Output	Strengths in advocacy, resource mobilisation (though causation unclear), consensus-building around priority interventions (at least the simpler ones) Lack of good data on global trends Loose governance structure causes problems, with a few country exceptions Programme plans tend to be separate from other national plans, piecemeal technical interventions and TA, un-innovative, lack of focus on HR (though this beginning to change at time of evaluation).	"Sub-optimal" efficiency because little real impact at country level. Value added at country level low because "loose ties" meant RBM couldn't act decisively when lack of co-ordination etc.	-	A raised profile for malaria. Better technical support and co-ordination in relatively few countries.
25. Stop TB, 2003	Process (not a "performance evaluation")	Fostered global political commitment to TB. Developed Global Plan and made significant progress with technical interventions in many areas (diagnostics, drugs, vaccines). Tension between loosely-knit structures and need for business-approach, transparency, accountability. WHO a supportive technical host. Global Drug Facility (successful commodity distribution to countries) bundles grant-making, procurement and partner mobilisation for TA – this is successful. Success needs to move beyond TB world and national level in 2nd phase.	Adds value at relatively low new cost and promotes very cost-effective technologies Could improve financial and performance reporting.	Only mentioned in terms of Board membership.	An effective body in supporting national TB plans and practical technical components of implementation. (Evaluation called it "a formidable record".) Effective operator at global level to progress with various TB inputs. Some underlying governance/management concerns.
SWAps					

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Evaluation	**Level of effect assessed (or attempted to assess)**	**Main effects**	**Efficiency**	**Gender focus**	**What do you get if you put your money here?**
26. A review of health sector wide approaches in Africa. Veronica Walford, 2007	Outcome. ("It is hard to judge SWAps' impact on health outcomes but several countries can demonstrate marked improvements in important MDG indicators, including areas supported by vertical programmes, with less progress on some of the most challenging areas such as maternal mortality.")	Improvements in planning, policies, resource allocation and co-ordination. Part of long-term process of developing an effective, integrated health system – specific service delivery improvements vulnerable to delay because of central-SWAp issues such as disagreement over a particular reform.	Effect on transaction costs not proven.	"SWAps …… have provided a forum to incorporate issues such as gender, reaching the poorest and reproductive health in broader policy and planning, rather than leaving these as specialist niches." {Where there is a partner to bring these issues to the table.}	In "SWAp-suitable" countries, improvements in planning, policies, resource allocation and co-ordination. Part of long-term process of developing an effective, integrated health system – not generally most effective way of getting quick service delivery/public health gains. Specific service delivery improvements vulnerable to delay. Ca 3 years to get a SWAp up and running.
27. *Exploring SWAp's contribution to the efficient allocation and use of resources in the health sector in Zambia* Chansa et al, Health Policy and Planning 2008	Process.	Small improvements in administrative efficiency; high transaction costs; budget execution did not improve with the SWAp; funding levels improved at district level but declined for hospitals.	"Despite strong commitment to implement the SWAp in Zambia, the envisaged efficiency improvements do not seem to have been attained."	-	Not a quick way to reduce transaction costs; may be effective at getting resources to district health administrations. Effectiveness reduce when donor funds unpredictable.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Evaluation	**Level of effect assessed (or attempted to assess)**	**Main effects**	**Efficiency**	**Gender focus**	**What do you get if you put your money here?**
28. Joint External Evaluation of the Health Sector in Tanzania, 1999-2006. 2007.	Impact	Improved child health and other outcomes, but not in maternal and neonatal health. Some PHC quality improvement. Improved sector coherence and consistency. Bifurcated priority setting – within SWAp and disease-specific funding opportunities. Unequal access. Inadequate HR management though skill improvement at district level is a strength.	Transparent resource allocation formula to districts for operation of health services. SWAp allows better value for money – but not yet optimal. District services could be more efficient by increasing staff productivity, rationalising workloads, and introducing performance based pay.	"There has been no apparent systematic attention to issues of gender equity during the evaluation period."	Sector-wide plans and coherent development of district health services that allows improvements in quality of services and some impact achievements.
For what? Commodities					
See also #6 above – UNICEF Supply Function evaluation.					
29. Case studies related to Affordable Medicines – Malaria. 2008.	Output	- subsidy programs can lead to significant increases in purchase of ACTs among individuals seeking treatment at private outlets (displacing ineffective treatments) in some countries (worked best in Africa). - Type of outlet determines coverage - quality of care varies with type of outlet - key issue is prescription-only status of ACTs and the associated restrictions on outlets.	Not known	-	Increased use of effective treatment for malaria.

Table 7 Evaluations – harmonisation/alignment, technical co-operation, sustainability and health systems

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Evaluation	**Harmonisation and alignment**	**Technical co-operation (TA, research, institutional)**	**Sustainability (financial, institutional)**	**Relationship to health systems (HR, supplies etc.)**	**Miscellaneous comments**
Who? – Multilaterals					
1. IHP+ 2008	Adds momentum to improved H&A in some countries, mostly by building on existing country structures and SWAps. Some progress with Compacts.	Workplan talks of Country Health Sector Teams – but still in infancy. Plan is to facilitate demand-led TA.	Issue at the moment is sustainability of the IHP+ itself – needs to demonstrate its effectiveness.	Holistic viewpoint	Very early stage review. Some partners improving H&A. others not –influence of IHP+ on this unclear. Crux is how partners will be held to account. Requires partners to invest in doing business differently.
2. UNAIDS, 2002 (NB Another evaluation of UNAIDS is currently in progress.)	Strong at global level on policy etc; some in-country successes with Partnership Forums; in most countries focus on planning.	Project-type focus on national strategic plans, with few links outside this "box" (e.g. to implementation).	-	-	Main strength is global advocacy and resource mobilisation. Added value in developing some cross-country links – horizontal learning and economies of scale.
3. UNFPA and IPPF Youth since ICPD 2004	UNFPA. Good liaison with UN agencies; maintains parallel financing; weak links with civil societies. UNFPA/IPPF co-ordination generally weak.	UNFPA: better prioritisation when linked to high profile socio-cultural research. TA support from own staff "enormously variable" Stronger on technical areas than using M&E.	Low because both organisations rely on non-core project funds for their youth work. UNFPA: good practice in some countries in handing over to government.		Neither organisation had taken youth work to its heart.
4. UNFPA An Evaluation of UNFPA Support for Preventing the Spread of HIV/ AIDS. 2002.	Focus on within-UN co-ordination. Exception is commodity supply, where liaison with others.	Insufficient in-house technical expertise in HIV/AIDS.	Sustainability mostly "not a consideration of project design". Good practices (services, training) sometimes adopted by government.	-	UNFPA has important role in condom procurement, supply and distribution. Evaluation (which otherwise very critical) judged its involvement in condom availability "essential".

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5. UNFPA Meta-Evaluation of Evaluations 2005	-	Mixed national and international teams seemed to produce the best evaluations.	-	-	Addresses evaluation culture within a UN agency.
6. UNICEF Supply Function 2007	Practical examples of within UN liaison (work to remove import levies; consolidated cash transfers). But little evidence of UN reform in respect of Supplies.	No consistent support to capacity building in supplies.	Increasing number of Long Term Agreements with suppliers.		Dilemma – overall supply function might be more efficient if UNICEF did more unilaterally about in-country distribution and monitoring use of its products. But is this an appropriate role?
7. World Bank HNP Evolution 2008	Very involved with GHPs. Became more of a "team player" between 1997 and 2007.	Policy dialogue sector and economic analyses etc became relatively more significant as Bank's position as "top health funder" declined.	-	Recognition of need to balance systems and disease work, though not about how to do/measure this. Importance of information systems stressed.	Clear awareness of need for systems/ disease balance. (Perhaps too much on disease-specific work in previous decade?) Multi-sector and economic focus, so Bank well-placed to look at resource allocation to and within health. Could play particular role re population – economic "demographic dividend" and links to family planning.
8. World Bank: Health Benefits of Water Supply and Sanitation (WSS) Projects: Review of World Bank Lending Portfolio 2008	-	-	-	-	Even where information is available, attribution from better water/sanitation to better health is difficult.

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Evaluation	**Harmonisation and alignment**	**Technical co-operation (TA, research, institutional)**	**Sustainability (financial, institutional)**	**Relationship to health systems (HR, supplies etc.)**	**Miscellaneous comments**
9. WHO 3-by-5 ART initiative 2006	In practice limited –major focus on bilateral relationship with Ministries of Health. UN agencies in competition.	WHO not an implementing agency and does not have budget for funding much external TA. Weakly positioned relative to richer partners to operationalise technical. WHO role re guidelines and specific technical support (e.g. HIV drug-resistance surveillance) sometimes done to excellent standard, but insufficient funding. Inter-divisional TA within WHO on Prequalification Project was good practice.	Initiative itself never established firm funding base. Such a major increase in provision inevitably raises questions of national sustainability.	Vertical programme with few horizontal linkages.	A classic historical case of urgent scale-up, comparative advantage and unclear accountability lines?
10. Multi-multilateral (UNDP, UNFPA, WB, WHO) Special Programme of Research, Development and Research Training in Human Reproduction (HRP) 2008		Since 1979 role in establishing and strengthening network of research institutes. Support to build capacity of SRH researchers in China. Good collaborative arrangements, especially with National Population and Family Planning Commission of China.			Exceptionally positive evaluation – but of 6 non-random case studies. Needs to be contextualised with other documents. Collaboration with Concept Foundation re availability of medical abortion product in public sector.
Bilaterals					

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Evaluation	**Harmonisation and alignment**	**Technical co-operation (TA, research, institutional)**	**Sustainability (financial, institutional)**	**Relationship to health systems (HR, supplies etc.)**	**Miscellaneous comments**
Tanzania see "SWAps" below					
11. Nigeria Routine immunisation and MNCH DFID/Norad 2009	Aims to improve co-ordination in relation to immunisation and MNCH.	Aims to improve state and local government capacity in all stages of planning/implementation of some priority interventions.	High risk but sustainability considered from outset. Trying to balance outcomes with institutional strengthening.	Evidence-based work on government allocations to priority interventions. Working on issue of acute shortage of adequately trained staff. Tackling programme/ systems balance head-on.	Unusual "bilateral" project but with funding in 2 parts from 2 sources. Addressing prioritisation and identification of appropriate service delivery strategies.
12. An evaluation of lessons from the Vietnam-Sweden Health Co-operation 1994-2000. 2003.	Instrumental in establishing (Donor) Project Co-ordination Department but little local will for effective co-ordination.	Long-term institutional and technical support. (Full technical independence of teaching hospitals took 20 years.) Need to have a flexible approach because some areas "go nowhere". Approach weakened by systems issues – shortage of qualified staff, poor incentive structure, high turnover of management and centralisation. Quality of international TA improved as trust developed. Competence-building in policy and planning has an impact in medium term. Policy Unit itself now using local TA.	Still insufficient on-budget support for areas of long-term support – Policy Unit; teaching hospitals.	Horizontal/system-wide approach. Basic HR issues hampered effectiveness.	Long-term engagement in institutional development and policy support. Significant policy work on drugs used in private sector. "Time and patience have proved to be an asset and quality of {this support}."
Global Health Partnerships					

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Evaluation	**Harmonisation and alignment**	**Technical co-operation (TA, research, institutional)**	**Sustainability (financial, institutional)**	**Relationship to health systems (HR, supplies etc.)**	**Miscellaneous comments**
13. GAVI Phase 1 Evaluation. 2008.	"GAVI was generally harmonisation neutral – it did not create fragmentation nor did it improve harmonisation; it fitted into health systems that were well-harmonized and less-harmonized." Relies on governments and development partners – but not always clear who responsible for what. But much partner good-will and welcomed forum linked to availability of money.	Much country variation in identifying and meeting TA needs. Short-term technical needs generally met. But inadequate technical support for long-term management and capacity building. Countries with strong Technical Working Groups (collaborative partners providing strong technical oversight and input in strategic planning) tended to perform better. Inadequate follow-up by Secretariat to address known problems. No established mechanism to provide ongoing technical assistance to countries that require it.	Good efforts but limited progress. Fewer bilaterals willing to take over immunisation costs. IFFIm, AMC etc involve such huge amounts that sustainability has to be a long-term consideration. Need to match GAVI's short term goals with country responsibilities and realistic projections about GAVI's capacity to maintain funding. Limited use of impact and cost-effectiveness information when adding new vaccines. Important because immunisation program costs projected to average 3.7% of government health expenditures in 2005-2010. For countries that introduced DTPHepB, those costs are 6.0%; for countries that introduced DTP-HepB+Hib, 9.2%. Partnership based on goodwill may be difficult to sustain?	Very focussed on immunisation. (This evaluation was for the pre-HSS phase.)	Interesting discussion about OECD indicators and scores of aid effectiveness –e.g. a country's rational decision to use UNICEF-procured vaccines receives a negative score.

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14. GAVI Accelerated Development and Introduction Plans (ADIPs) and Hib Initiative (HI). 2007	-	Very focussed technical issues. In a sense, whole programme is about developing global technical expertise in relation to a particular issue.	Not really – is about stimulating introduction of vaccines for which donors will largely pay in the first instance.	No work on health systems.	Idea can be adapted to other technologies? Gives ideas for more work – scanning pipeline for "ADIP"-ready technologies; in-country work on "technology-readiness"/ability to implement. But perhaps this would work better for a range of technologies – i.e. not just vaccines.
15. GAVI Injection Safety Support. 2009.	-	More TA may have been helpful, e.g. related to waste disposal and local manufacture.	See table 1 - 44 of the 46 commodity-recipient countries sustained use of AD syringes and safety boxes after end of GAVI INS support. 54% were fully financing their commodities with government support, 15% used a combination of government and donor funding; 26% were donor dependent. Excellent discussion of definitions, including replacement and financial sustainability.	Very narrowly focussed programme.	In one country (Uzbekistan) decentralised procurement decisions meant not uniform national response. This highlighted both a potential pitfall of decentralised procurement & the need to adapt aid strategies where necessary. Peer country comparisons generated some healthy competition.

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16. GFATM Five-year Evaluation Synthesis Report	"the Global Fund's model has often inadvertently created parallel systems, due to lack of alignment and harmonisation at the country and global levels, which have created inefficiencies in implementation"	Great unmet need for TA. Functional systems to provide effective TA not in place. Particular issue of TA for medium-term capacity building. No clear division of labour. (Global Fund, World Bank, UNAIDS, WHO, UNICEF, Stop TB Partnership, Roll Back Malaria)	Concerns over financial and institutional sustainability. "Cause for concern regarding sustainability of the programs despite the increased availability of global financing for the three diseases." Institutional sustainability also an issue because of parallel Global Fund systems, Particular issue is "discordant salary scales that contributed to an internal "brain drain" from public to non-public sectors."	"Within the limitations described, the Five-Year Evaluation found that health systems capacity is an important statistical predictor of grant performance." Evidence of "a relationship between investment in human resources and improvement in grant performance". "Going forward, the weaknesses of existing health systems critically limit the performance potential of the Global Fund." Some distortions where basic non-ATM commodities unavailable whilst ATM well-funded.	
17. GFATM Community perspective from South Africa 2006	Funding model seems to encourage competition rather than collaboration.	-	Many community organisations reliant on project funding – difficult to build up the organisations in a coherent way.		

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18. Averting Maternal Death and Disability (AMDD) Columbia University grant from Bill and Melinda Gates Foundation. 2004.	-	Extensive and effective technical assistance to develop capacity to provide effective emergency obstetrical care. Very focussed: clear technical framework of sequenced interventions- useful gold-standard, with variations possible. Highly credible academic lead which built on existing collaborative relationships. Technical support worked least well in weakest countries. Three main modes of technical support: 1. Internal to the implementing partners – direct recruitment of a clinical expert. (UNICEF received support from its regional and headquarters staff.) 2. Implementing agencies could request TA from "technical partner" organisations. Technical partners developed tools. 3. Columbia University developed a "technical monitor" system - specialists who visited implementing projects on a regular basis to assist at key stages and to monitor progress.	"The sustainability of the impacts is less certain without further commitment to scaling up."	"To maximize impact, while maintaining a powerful focus on EmOC, new programs should address critical obstacles to accessing services, such as inadequate transport, limited communications, lack of community awareness and mobilisation, non-functioning referral systems, and other key barriers."	

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International NGOs					
19. Family Care International at 20, 2007	Organisation regarded as a good "non-territorial" team player.	Potential for good technical assistance, but no overall strategy to promote this. Provides TA and capacity building for local NGOs – works best when FCI not in competition for funds at national level.	-	-	FCI at cross-roads – whether to scale up or to remain a small organisation.
20. International HIV/AIDS Alliance 2006	Good at developing partnerships. HQ and LOs suffer from having to deal with multiple donor proposal and monitoring formats etc.	Well-targeted and effective support from the Alliance Secretariat has been highly instrumental in establishing the reputation and status of LOs and in strengthening their ability to attract donor funds directly. (including TA on systems and procedures for financial management and administration, onward granting and accountability) TA much weaker during for project implementation.	Unrestricted funds have declined as proportion of total budget – sustainability depends on continued access to time-limited grants. Support to country Linking Organisations geared to make them independent/sustainable.	-	
21. IPPF. Reaching Poor People with Services in SRH. 2006	Service provision generally aligned with government priorities.	Some TA provided to and by country organisations. TA could focus more on advocacy.	Sustainable provision of contraceptives (because generate income). Problematic sustainability for less core functions, partly because of projectised funding.	-	
See also #3 above, UNFPA/IPPF					
Partnerships and umbrellas					

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22. Multi-country Evaluation of Integrated Management of Childhood Illness (from Health Policy and Planning 2005)	-	Technical support limited by wider systems issues – would have helped to have more understanding of these at onset. Technical support lacks credibility if not tailored to local epidemiology.	Systems issues make it difficult to sustain effects. In particular, high staff turnover and weak ongoing supervision seriously dissipated effects of technical training.	"The full weight of health system limitations on IMCI implementation was not appreciated at the outset, and only now is it clear that solutions to largest problems in political commitment, human resources, financing, integrated or at least co-ordinated programme management and effective decentralisation are essential underpinnings of efforts to reduce child mortality."	Major empirical study that documents links between targeted interventions and health systems.
23. Partnership for Maternal, Newborn and Child Health 2008	Not an effective lead in improving H&A.	Not provided in practice.	Depends on Partnership establishing a credible niche for itself.	-	
24. Roll Back Malaria, 2002	The "loose partnership" basis of RBM made it ineffective in securing practical improvements to co-ordination at country level.	Countries receive inadequate and sometimes inconsistent technical advice: a. Lack of clarity over technical roles of WHO versus Secretariat (& other partners) b Lack of satisfactory mechanisms for consensus around key 'technical' issues requiring multi-disciplinary solutions c. In the African region, roles of WHO HQ & AFRO not well coordinated	Sustainability depended on Roll Back malaria being able to demonstrate health results (in terms of health outcomes) within ca 3 years.		NB This evaluation is from 2002. Realised importance of private sector at early stage.

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Evaluation	**Harmonisation and alignment**	**Technical co-operation (TA, research, institutional)**	**Sustainability (financial, institutional)**	**Relationship to health systems (HR, supplies etc.)**	**Miscellaneous comments**
25. Stop TB, 2003	-	Global Drug Facility has "unique bundled model comprising grant-making, Procurement and partner mobilisation for technical assistance" – this is critical to its success. Partnership supplied technical support through visits, meetings and training. (much from WHO) Efforts to see TA as part of wider goals – e.g. better national TB plans, better proposals to Global Fund.	Funding base uncertain, especially given growth of Global Fund.	Recognises need to strengthen health systems and the high cost of this.	NB This evaluation is from 2003. Interesting to compare with Roll Back Malaria – why so much more effective?
SWAps					
26. A review of health sector wide approaches in Africa. Veronica Walford, 2007	SWAps contribute to H&A in terms of: focus on sector strategies and plans linked to MTEF or budget; increase on-budget commitments; to varying extents, use of country financial management & procurement systems; common arrangements for annual reviews, M&E, and diagnostic work.		Aims at institutional sustainability through joint decision-making with government. Difficult to sustain SWAps over time – can lose momentum and vulnerable to changes in government and development partners' personnel.	Holistic view.	Attribution to a SWAp alone difficult and even more difficult to aggregate across different SWAps.

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27. Exploring SWAp's contribution to the efficient allocation and use of resources in the health sector in Zambia Chansa et al, Health Policy and Planning 2008	An incomplete SWAp plus other donors with own systems combine to have huge transaction costs.	-	-	-	Conclusion: Despite strong commitment to implement SWAp in Zambia, envisaged efficiency improvements not attained. Possibly because SWAp not fully developed or not all parties completely embraced it. SWAp not ruled out as a coordination model.
28. Joint External Evaluation of the Health Sector in Tanzania, 1999-2006. 2007.	H&A improved in Tanzania, with structures for formal dialogue. But structures cumbersome and could be streamlined. Non-state providers largely excluded from planning and co-ordination.	Not discussed in detail, as (perhaps wrongly) not perceived as an important part of SWAp. Regarded as decreasing national ownership. But some partners liked TA as it gave them better access to government.		Focus on working through systems. HR issues identified as the major ongoing constraint.	
For what? Commodities					
29. Case studies related to Affordable Medicines – Malaria. 2008.	-	-	Potentially good because relatively simple implementation model.	Focuses on interaction between public and private sectors.	Fundamental tension between access and quality in private sector. The prescription-only status of ACTs and associated restrictions on outlets must be at the center of discussions both in countries and globally.

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