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Better results through effective development co-operation:

the heart of the work we do

April 2013

World Health Organization

THE WORLD BANK

Aligning for better results

WHO Library Cataloguing-in-Publication Data

Better results through effective development co-operation: the heart of the work we do.

1.National Health Programs - economics. 2.Public-Private Sector Partnerships. 3.Health Planning. I.World Health Organization. II.International Health Partnership.

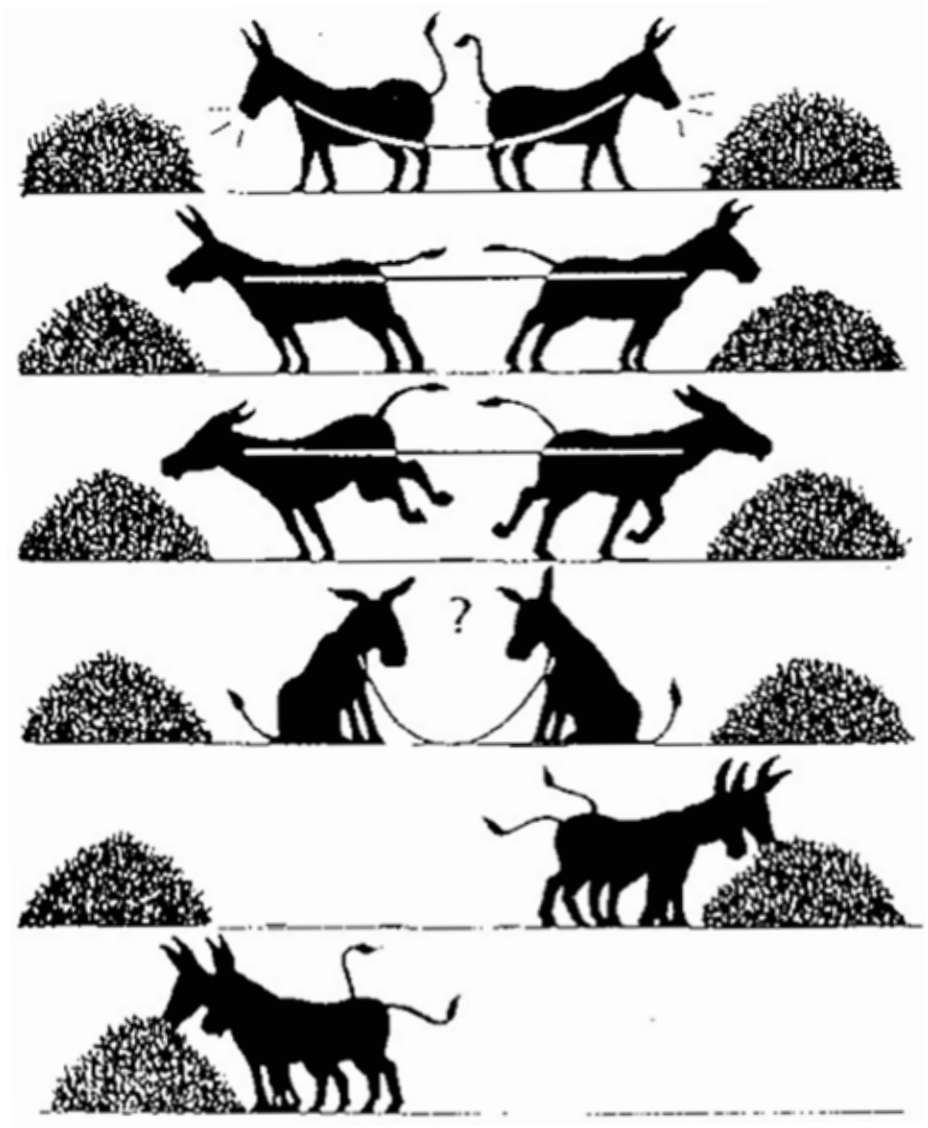
ISBN 978 92 4 150704 2 (NLM classification: WA 540)

Printed by the WHO Document Production Services, Geneva, Switzerland.

Acknowledgements

Dr Catriona Waddington of HLSP prepared this paper, with inputs from Teniin Gakuruh (Sierra Leone), Bert Voetberg (World Bank), Finn Schleimann (World Bank), Phyllida Travis (WHO) and Alison Dunn (In the Write Space).

Designed by Jillian Reichenbach Ott (Genève Design).



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Better results through effective development co-operation – the heart of the work we do

The problems caused by unco-ordinated development co-operation are well known: duplications and gaps in overall support, high administrative costs for governments, and distorted national priorities. However the solutions are often seen as ineffective, bureaucratic and unrealistic. This paper illustrates, with examples, that there are practical and effective ways of working together to enhance results in the health sector.

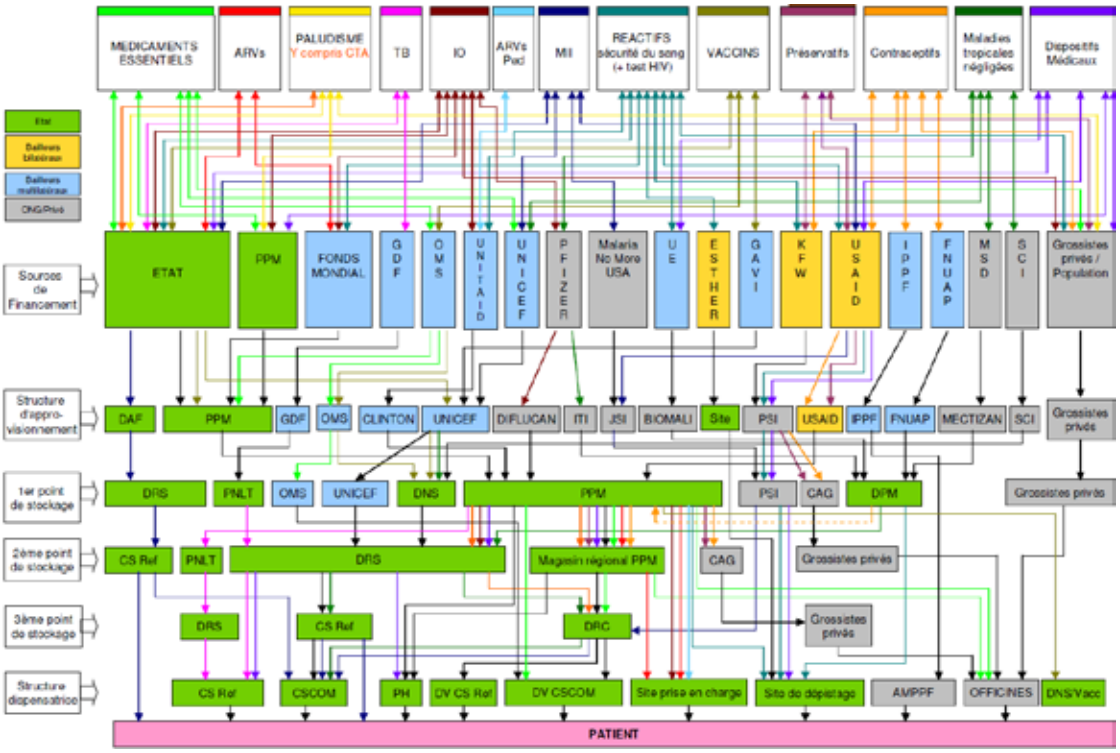
The problem: fragmented development co-operation

Development co-operation can cause problems when there is insufficient co-ordination. It can also undermine effective government ownership and leadership. For example:

- In 2009/10, 76 percent of activities funded by development partners were reflected in the Ethiopian Ministry of Health's plan and 39 percent of spending was reflected in the sector's overall budget. At first glance this may look positive, but consider the problems this causes. 24 percent of support could not be included in the annual plan and there was not enough advance information to include 61 percent of official development assistance in the annual budget. This is nothing to do with pooling money together in one combined fund; this is simply having the information available to be able to produce a comprehensive plan and budget. (1)
- The Government of Mali and a number of development partners made a concerted effort in the mid-2000s to improve public sector pharmaceutical logistics. By 2007, 85 percent of essential medicines were available in the public sector. One of the challenges facing the public sector was the complicated array of supply structures. Figure 1 illustrates how a lack of collaboration made the job of hard-pressed public sector managers unnecessarily complicated. (2) In the language of the Paris Principles for aid effectiveness, supply systems in Mali were neither harmonised nor aligned.
- The strategic plan for health in Malawi describes problems caused in the past by unpredictable aid: "Untimely [i.e. delayed] disbursement of donor funds has forced the Government of Malawi to borrow from the domestic market at high interest rates, which increases the cost of health service delivery." (3)

Despite the efforts of the three governments, these examples from Ethiopia, Mali and Malawi are all sub-optimal situations (duplicative systems, inefficient budget allocations) brought about by a lack of collective action and collective responsibility. Better co-ordination could have achieved more with the same amount of money - better planning and implementation, and improved availability of funds and supplies. Scarce resources, in terms of skilled managers and health workers, had to concentrate on managing the development co-operation, rather than managing the sector. Accountability for results was unclear because the same health officials were in effect trying to please multiple masters at the same time.

Figure 1: Supply systems for pharmaceutical products in Mali, January 2008



Source: MoH/ Pharmacy and Medicine Directorate with the support of WHO, mapping and in-depth evaluation of the supply and distribution system for medicines and other health products in Mali, August 2008

Solutions are available: effective development co-operation brings results

At the global level there are a number of international statements describing what needs to be done to improve development co-operation. Notable examples are the Paris Declaration on Aid Effectiveness from 2005, the Busan Partnership for Effective Development Co-operation (2010) and, in health, the International Health Partnership + Global Compact (2007).

Paris, Busan and IHP+ all make the same overall points:

- the importance of working together to agree and implement a government-led national plan (alignment)
- co-ordinated **monitoring and evaluation o**f the plan's implementation
- **minimizing the number of separate systems** for activities such as procurement, audit, financial management and technical assistance (harmonization)
- **partners holding each other to account f**or the ways in which they operate (mutual accountability).

How does this work out in practice in countries? Here are two examples of these principles being put into practice and achieving good results through co-ordinated support for the development of large-scale, sustainable services.

The **Lady Health Worker (LHW) Program in Pakistan** began as a federal government program in 1993. By 2009 it employed almost 90,000 salaried LHWs. Families in areas served by LHWs are more likely to receive priority primary care interventions than those in other areas and it is the poorest families which gain most from living in a LHW catchment area. 23 percent of the Program's funding came from external donors between 2003/4 and 2007/8. The vast majority of this donor financing was in the form of budget support or access to a national Technical Assistance procurement agency. This spending was controlled by the Program and institutionalized in its systems.[1](4)

1 In budget support, money goes from the funder to the Finance Ministry; it is then distributed as part of general government expenditure. The national Technical Assistance procurement agency was an internationally-funded resource which the Lady Health Worker Program could access for technical support.

Box 1: Pakistan's Lady Health Worker (LHW) Program: good results, especially for the poor

A rigorous statistical analysis compared households living in areas served by LHWs with households not in a LHW catchment area. Household members served by a lady health worker were:

- 11 percentage points more likely to be using a modern family planning method
- 13 percentage points more likely to have had tetanus toxoid during a recent pregnancy
- 15 percentage points more likely to be fully immunised (children under three years of age)

Positive impacts were greater for poorer households. For example, children in the poorest families served by LHWs were 22 percentage points more likely to be vaccinated than children from a similar economic background in unserved areas. (4)

In **Nepal**, priorities in the first Health Sector Program (2004-10) included reducing maternal mortality and increasing the rate of **births attended by skilled personnel.** In addition to investments in good-quality delivery services, a donor-funded pilot project investigated the impact of a free delivery scheme complemented by cash incentives for mothers and service providers. When an evaluation in mid 2010 documented impressive results of this pilot, the Ministry of Health and Population wanted to scale up the intervention as quickly as possible. By the end of 2011 the intervention was available in all 76 districts and service data was showing very significant increases in the percentage of deliveries with a skilled attendant. This rapid scale-up was possible because of the co-ordination and financing mechanisms which were already in place, notably a Joint Financing Arrangement (JFA) signed by the Government of Nepal and eight development partners which together accounted for a significant percentage of international support to Nepal's health sector. The JFA created a financial resource that gave the Ministry of Health and Population the flexibility to make decisions that were clearly in line with agreed priorities. It committed signatories to support the Ministry's implementation of the national health plan and activities to achieve the MDGs. (5)

These examples from Pakistan and Nepal are both cases of co-operative action that enabled large-scale, pro-poor implementation with a high likelihood of sustainability because the services were managed through government systems. It is appropriate that government took the lead in both examples of scaling up because it is governments that are most likely to have the institutions and resources to oversee (if not directly deliver) services on a long-term basis. In the language of aid effectiveness and the Paris Declaration, these are examples of good practice in terms of *alignment* with government priorities and procedures.

Governments are not perfect: effective development co-operation can work in many types of environment

Of course, neither of the examples above was implemented in as straightforward and unambiguously successful a way as the brief descriptions might suggest. Both encountered significant operational challenges and shortcomings with monitoring. In each case development partners had to work within the complexities of the local political economy: in many ways it would have been simpler to support well-defined projects with clear boundaries and provable results. The principles of development co-operation effectiveness do not ignore the shortcomings of government systems and the complexities of political economies. The point is that working with governments gives the best chance of sustainable success. The burden of proof should be on development partners to explain why they do *not* collaborate.

Effective development co-operation is not just about promoting government ownership and leadership and not every country has a government which is interested in national development. In such circumstances, it is every bit as important for development partners to collaborate. For example, even when Somalia had no functioning government, there was an active Common Humanitarian Fund with 13 financiers and an Advisory Board consisting of four NGOs, four UN agencies and two donor agencies. (6)

Effective support does not always mean using government systems. A judgment call needs to be made about the capacity of those systems. Where there is low capacity, there is still a great deal of scope for harmonizing support through shared systems, for example through Multi-Donor Trust Funds or Joint Financing Arrangements.

How does it actually work? Tools for effective co-operation

Co-operation is easier said than done when each development partner has its own procedures and agendas. A number of tools are described here which balance the importance of collaborative working with individual partner needs. However before looking at the details of each tool, there is an important issue about **mindsets and attitudes** that needs to be addressed. Development co-operation cannot work effectively if each partner thinks of itself in isolated terms: "This is what my organization funds; this is how my organization implements things and this is what my organization has achieved". Of course each development partner will keep its own identifty, but at some point there also needs to be "we" and "us": "this is how we do things in this country and this is what we have achieved together". This idea is reflected in the phrase "contribution not attribution". Individual partners can claim that they have *contributed* to jointly resourced health results, but they cannot claim full *attribution* unless they have been working on a purely stand-alone project. Such completely separate projects are rare in practice, as most sizeable health programs involve government health facilities and health workers. If there is no "we" and "us" way of thinking, it is back to the examples of inefficiency and waste given at the start of this paper.

Once it is accepted that at some point partner-specific ways of working have to be brought together into a coherent whole at the country level, the tools described below can be useful. Many of these tools emerged out of the Sector-wide Approach (SWAp), as SWAps developed and gradually formalized mechanisms for joint working. [2]

National Health Strategies (or Plans) are the foundations on which global health interventions should be based. They specify long-term areas of activity and the desired health outcomes. Support for a single National Strategy is a core principle of effective development co-operation; all parties should agree on the broad outcomes and priority actions. To achieve this, development partners should be involved in the development of the National Health Strategy and to have confidence that the strategy is robust and will meet the stated health goals. One tool to support this is JANS, the Joint Assessment of National Health Strategies. The JANS tool examines the soundness and feasibility of a strategy and provides a structure for the involvement of multiple partners. Tools are also available to help structure joint monitoring, evaluation and review of National Health strategies. (7)

2 SWAps are partnerships between governments, development partners and other national actors, coalescing around their joint support of national health strategies or programmes. A SWAp calls for a partnership in which government and development agencies change their relationships (to clearer government leadership). They interact more together in the formulation of policy, and less on the details of its implementation. (11)

Joint Financing Arrangements (JFAs) are a flexible tool which describe structures for multi-partner collaboration. They are a practical way of operationalizing the principles of effective development co-operation, as they set out one set of procedures for management, montoring and dialogue. They can be used in a broad range of circumstances including budget support, sector support and more specific joint programmatic support, whether pooled or not. Generic templates can be adapted to suit local circumstances. JFAs are useful in circumstances where full alignment with the partner government's budgetary and accountability system is difficult. The JFA can represent a more gradual approach that contains and manages risks, for example by requesting some additional reporting about the use of the JFA funds. Ideally a JFA will be amended over time, as there is improvement in the alignment with the budget and accountability systems and legislation of the partner government. A good JFA encourages co-ordination and reduces the administrative costs for all partners. (8)

Common Monitoring and Evaluation (M&E) frameworks enable partners to work towards the same results, using the same indicators. The focus should be on strengthening the capacity of the M&E system related to the National Health Strategy, not on developing parallel systems. Consistent use of one set of indicators also reinforces accountability: progress with achieving the objectives of the National Health Strategy can be tracked over time. (See reference (9) for guidance on M&E frameworks.)

Joint Annual Reviews (JARs) use the common M&E framework to measure progress towards achieving the targets set out in multi-year strategies and plans. They are an opportunity for partners to work together to identify opportunities and constraints and to make recommendations for the next planning cycle. Countries differ greatly in the extent to which JARs are institutionalized. Improving the JAR process is a practical way to strengthen development co-operation.

Compacts and **Codes of Conduct** are written commitments made by government and development partners that describe how they will work together to improve health outcomes. They set out how partners will work together more effectively to improve development co-operation effectiveness and deliver priorities in the national health strategy. They are commonly signed by government and external development partners, but increasingly also by other important local partners such as civil society or private sector organizations. Compacts and codes of conduct can improve partner alignment with country systems; bring new partners into health sector coordination efforts; address the fragmentation and volatility of aid, and reduce transaction costs. They can be used as a tool for mutual accountability, by introducing indicators for tracking progress against agreed commitments. (10)

Once there is a willingness to collaborate, there are a number of tools (such as the ones described above) to help with practicalities. The next section illustrates how some of these tools are used in practice.

Government leadership: a prerequisite for sustained results

"Aid effectiveness is about something qualitatively different from projects. It is about the beating heart of government ownership and commitment." (Senior manager who has worked both in a Ministry of Health and an international development agency)

It is of course reasonable to expect that development assistance improves health status. But processes matter too. Some processes for managing Overseas Development Assistance (ODA) are, in effect, a cost to government, whereas others contribute positively by strengthening government leadership and stewardship.

- In **Sierra Leone**, active government involvement in the development of a multi-donor Country Compact and Joint Funding Arrangement have helped develop government leadership of the sector, which was made difficult by the proliferation of funding and implementing partners and a Ministry weakened by a decade of war. Examples of positive outcomes include the government's free health care initiative and a 'C4' partner co-ordination mechanism. 'C4' is the Cholera Control & Command Centre, which has improved the response to cholera emergencies.
- The multi-donor Health Sector Pool Fund in **Liberia** is important because after 14 years of highly destructive civil war, it provides a pot of money which enables the Ministry of Health and Social Welfare to allocate resources flexibly to target priority needs, fund unfunded priorities in the national health plan and strengthen health systems. Good government stewardship – in terms of prioritizing and accountability – is at the heart of the Fund. The Fund supports the Office of Financial Management and Internal Audit and has expectations about how they will perform in terms of managing the Fund itself. A recent external evaluation noted how the Fund contributes to the credibility and legitimacy of the Ministry in the eyes of citizens. This is an important achievement in itself. Moreover the evaluation even suggests that the Fund could potentially provide a foundation for future health financing because this relies on citizens' willingness to contribute to a system that they trust. (12)
- In **Mali**, there is regular joint monitoring with a focus on 35 consistent indicators. This practice of monitoring a set of performance indicators linked to annual targets has improved the quality of information provided and the analyses carried out by the Ministry of Health. Sectoral budget support and the preparation of the IHP+ Compact have strengthened collaboration between the Ministry of Health and the Ministry of Economy and Finance. A recent study speculated that these improved relations and the more strategic use of information may well have contributed to the significant increase in the proportion of government expenditure allocated to the health sector in recent years. (13)

Positive processes that improve the all-important functions of government leadership and stewardship are valuable. This is particularly important in fragile states, which are very significant in terms of development co-operation effectiveness. The share of the world's poor living in fragile states is expected to rise rapidly, from under 30 percent in 2005 to more than half by 2015; the percentage of total ODA going to fragile states has been rising steadily since 2003. (14) An important aspect of ODA in fragile situations is to strengthen the functioning and accountability of governments. Examples from countries such as Liberia and Sierra Leone demonstrate that aid can be used to improve governance even in difficult circumstances.

So what needs to change?

What needs to change so that development co-operation is more effective? The six messages below apply to all types of development partners. However particular mention needs to be made of development agencies because evidence suggests that many have entered into commitments (including the Paris Declaration, Busan and IHP) that will not be met without a significant mindset shift. According to the 2012 Annual Performance Report of the International Health Partnership +: "Development Partners as a whole have to date not realized the 'step change' in aid effectiveness that was anticipated when IHP+ was launched." (15) The eight messages here illustrate what this 'step change' entails.

1. More than anything, development co-operation effectiveness is a **mindset:** an understanding of the importance of collaboration among partners and of the importance of, whenever appropriate, strengthening rather than bypassing government. Without this, we have inefficient development co-operation and missed opportunities to improve people's health. If activities such as joint planning and monitoring are seen merely in terms of short-term impact, there is likely to be disappointment; a longer term vision is important when dealing with the inevitable challenges of joint working.

   So the question for all partners is: **what opportunities are there to work with others? Can I take the first step?**

2. **Make full use of the variety of modalities which further development co-operation effectiveness.** Do not use the excuse that a specific modality does not suit a particular situation. The choice of modalities and tools is wide: joint monitoring activities, an agreed list of indicators for monitoring a particular program, joint Project Implementation Units, multi-donor trust funds, Joint Financing Arrangements.....

3. The message for top management in all types of development partner organisations is this: ensure that **communication and incentives within individual organisations** promote the effectiveness of development co-operation. For governments, this means Ministries of Finance that will help line ministries negotiate for harmonised and aligned support and Offices of the President that will engage in robust discussions with partners about effective co-operation. For development agencies, it means rewarding staff who can work effectively within both local national arrangements and the structure of the agency. Local collaboration means working together with mutual trust. Such a relationship requires give and take. In-country staff must be given reasonable levels of delegated authority to make this work. An inappropriate ruling from one donor's headquarters can have a disproportionately disruptive effect on a multi-partner in-country arrangement.

4. **Contribution, not attribution**. All partners justifiably want to be able to demonstrate their achievements. Regular performance monitoring – preferably institutionalized within government systems – is to everyone's benefit. In the same way that there is joint planning and joint monitoring, there needs to be a shared approach to the attribution of results. Achievements can be assigned to broad programs (as happened with the LHW Program in Pakistan) and this can then be linked to the contributions individual partners have made. In this way development partners can still point to what their funding has achieved, but without ignoring the role of other partners. In practice this requires agreement about the methodologies for measuring impact and developing a comprehensive budget. The alternative - attributing complex impacts to individual funders - can lead to a number of problems including exaggeration through double counting and over-verticalization because disease-specific programs deliver greater (and more easily identifiable) short-term gains than system-wide support. (16)

5. The failings of governments receive a good deal of publicity. Attention should also be paid to **celebrating good news stories:** a government that is trusted by its citizens to start a health insurance scheme; a Ministry of Health which can negotiate for more funding from the Finance Ministry; central hospitals which improve value-for-money by providing good quality care to more patients without an increase in their budgets.

   Development agencies sometimes argue that taxpayers in donor countries 'need' to hear simplistic statements about how much the national development agency has achieved. ("Your development agency prevented xxxx number of maternal deaths.") This claim needs to be challenged. Obviously taxpayers should have information about the impact of their country's aid program, but this does not need to be overly simplistic. A recent review of public attitudes to aid in the UK revealed that while some citizens did not support aid, many had a "considerable appetite for greater understanding of development and for more complex stories of how change and progress happens...people would like to hear about how and why it works, why it doesn't always work and the reasons aid alone cannot achieve development targets." (17) Similarly in Denmark, politicians and citizens generally accepted Denmark's move towards sector program support and the language of contribution, rather than attribution.

6. **Use government systems when they have passed a global 'fit-for-purpose' test.** There are several countries where recognised World Bank assessments have judged public financial management to be adequate, but where most development partners do not use those systems. Both governments and development partners need to be more consistent about this, though clearly the main change here needs to come from individual agencies. (18)

7. **Respond more effectively to demands for government and CSO capacity strengthening.** There is a need for assistance to strengthen government capacity in a wide range of areas, including better quality assessments, better data, financial management and procurement systems, and human resource development. CSOs need more support to enhance their engagement in health policy at country and global level.

8. **Enable greater South-South collaboration**. There is growing country experience on ways of working with multiple partners to achieve better health results. South-South collaboration should be encouraged as an efficient mechanism for sharing lessons learnt. (19)

This paper has demonstrated that there *are* practical and effective ways of working together to enhance results in the health sector. Acceptance of multi-partner joint working brings rich opportunities to support scaled up, pro-poor programs with positive results which stand a good chance of being sustained for many years to come.

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19. The last two action points are taken directly from the *Message to International Health Partnership+ (IHP+) Leaders From Participants in the Fourth Annual IHP+ Country Health Teams Meeting Nairobi, Kenya, December 2012.*

Notes :

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ISBN 978 92 4 150704 2