

DONOR AND MUTUAL ACCOUNTABILITY IN SCALING UP FOR BETTER HEALTH

NOTE: This report was commissioned to contribute to setting up a proposed multi-donor secretariat. After the report was submitted, it was decided not to proceed with this proposal. However, the recommendations here relating to accountability remain broadly applicable, even though institutional arrangements would need to be adjusted. Main points of the recommendations are shown in bold.

Disclaimer

This report does not necessarily represent the views of World Health Organization, the World Bank or others involved in the High-Level Forum on the Health MDGs and its follow up processes.

INTRODUCTION AND BACKGROUND:

This report suggests a framework for accountability and aid effectiveness for the initiative on “Scaling Up for Better Health”. The report addresses donor accountability, as does the Paris Declaration on Aid Effectiveness, within a broader framework of mutual accountability¹. The framework covers: donors --- bilateral, multilateral institutions and foundations -- as well as the global partnerships that they fund; partner countries; and the proposed secretariat. Accountability is used here to cover both “how” --structures of accountability – and “what” accountable for what.

The report and its recommendations draw on a variety of sources. These include: interviews; reports and country case studies from the High Level Forums on Health and follow-up work on Scaling up for Better Health; analyses of experience of global programmes at the country level in health and education; ; and the Paris Declaration and other relevant DAC guidelines on aid effectiveness. These guidelines include good practice principles developed for global health partnerships and for global programmes in general, as well as good practice principles for fragile states and capacity development².

¹ Paris Declaration: <http://www.oecd.org/dataoecd/11/41/34428351.pdf>. The “Concept Note for Scaling up for Better Health” referred to “development of a framework of accountability for all development partners.”

² “Paris Declaration on Aid Effectiveness”, OECD/DAC 2005, <http://www.oecd.org/dataoecd/11/41/34428351.pdf>. “Best Practice Principles for Global Health Partnership Activities at Country Level”, High Level Forum on the Health MDGs 2005, <http://www.hlfhealthmdgs.org/Documents/GlobalHealthPartnerships.pdf>. (For other documents of the High Level Forums on the Health MDGs see <http://www.hlfhealthmdgs.org/>.) Draft “Good Practice Guidance on Integration of Global Programmes at the Country Level”, OECD/DAC 2007, www.oecd.org/dataoecd/29/3/38435815.pdf. “Principles for Good International Engagement in Fragile States”, OECD/DAC 2005, <http://www.oecd.org/dataoecd/4/25/35238282.pdf>. “The Challenge of Capacity Development: Working Toward Good Practice”, OECD 2006, <http://www.oecd.org/dataoecd/4/36/36326495.pdf>. The report draws heavily on DAC documents on aid effectiveness because they have attracted broad buy-in from the donor community, and in the case of the

The accountability framework is intended to support increases in the amount and effectiveness of aid for health and so to improved health outcomes. As Richard Manning, the Chair of the DAC, has reiterated, the rationale for the DAC, and for donor collaboration in general, is not to produce policies and studies but to change behaviour and so improve development results on the ground. The focus is on the needs of low-income countries, particularly but not exclusively in Africa, since that is where the needs for scaling up are greatest, as are likely shortfalls from health-related MDGs. The recommendations recognise the risk, and high cost, of attempting to reinvent the wheel – and so are cautious about suggesting additional accountability structures or monitoring systems, particularly given the major and costly efforts at donor harmonisation and alignment already under way.

There is ample evidence -- in the papers for the Paris High Level Forum on Aid Effectiveness, the High Level Forums on Health and the MDGs, and the Scaling up Initiative -- of the high administrative burden that un-harmonised and un-aligned aid puts on partner-country administrations and programmes. To cite just one example regarding alignment, though, only 14 percent of aid for health is through the government budget in Rwanda, a country widely viewed as a strong performer.

Accountability of donors, as of partner countries, is most important at the country level. This in turn requires, in the case of donors, actions by donor capitals and headquarters to empower and encourage their field-level staff.³ It also requires supportive collective action at the global level. Given that the broader study of which this is a part focuses on background and recommendations for the proposed multi-donor secretariat of the Scaling Up Initiative, this report reverses that order of importance and starts at the global level.

GLOBAL MECHANISMS FOR ACCOUNTABILITY:

Seek strong involvement at the political level of donor governments – including through the G8 and the Development Committee -- in endorsement and accountability of the Scaling Up Initiative and of its multi-donor secretariat. The experience of implementation of the Paris Declaration to date reemphasises the important for aid effectiveness of action by donor capitals and headquarters – individually and collectively -- to set appropriate policies, incentives, monitoring and accountability. These policies and incentives are set by development ministries and agencies, but also by finance ministries, which play lead roles in the G8 and the Development Committee as well as, for

Paris Declaration by over 100 donor and partner countries, international organisations and civil society organisations.

³ The issue of the linked roles of donor field offices and capitals applies to aid effectiveness as a whole, of which accountability is one aspect. The Working Party on Aid Effectiveness of the OECD's Development Committee deals with this broader set of issues, including internal incentives for donor donor staff. www.oecd.org/dac/effectiveness.

example, in enabling longer-term aid commitments. Their involvement in the accountability process of the Scaling Up Initiative is important for sustainable support and results.

(See the footnote for a discussion of the role and accountability of the proposed multi-donor secretariat.⁴)

A key partnership (of the secretariat) of the Scaling Up Initiative on accountability of donors should be with the OECD Development Assistance Committee (OECD/DAC). The complementarity and potential for synergy between the Scaling up Initiative and the OECD/DAC have become clear from the increasing level of contact between the two in 2006. This culminated in the meeting in Paris on December 4 on Aid Effectiveness in Health under the aegis of the new “OECD Global Forum on Development” convened by the DAC and the OECD Development Centre. The DAC Working Party on Aid Effectiveness has indicated considerable interest in picking up the suggestion of the Working Group that health be treated as a mutually-beneficial “tracer” (illustrative) sector for looking at implementation of the Paris Declaration at the sectoral level. While the DAC does not have the resources to look at aid effectiveness issues sector by sector, health has a good deal to offer as a “tracer”: the strong interest in scaling up in health; the complexity of the health sector, including the wide variety of providers of aid and of health-care services at the national level; and the

⁴ ***Give the proposed multi-donor secretariat an important role in the accountability structure of the Scaling up Initiative but avoid duplicating or displacing existing accountability structures.*** The secretariat would have, as does the FTI secretariat, the mandate to use tools such as transparent reporting, benchmarking, and stimulating moral suasion among peers to encourage changes needed to improve aid and development effectiveness. On accountability, it should focus its work at the global level and, on request, on improving mutual accountability processes at the country level. This, along with assistance to partner countries on scaling up more generally, is at the heart of the secretariat’s *raison d’être*. **To maximise effectiveness, the secretariat should avoid duplication of what is – or feasible could be – better done by existing accountability and other related structures at the global or country levels.** The secretariat should not duplicate work by the World Bank on health systems, by WHO on technical aspects of health, or by the DAC Secretariat on data on aid.. More generally, key international partners – such as the World Bank, WHO and the DAC Secretariat – should work in partnership, rather than duplicating each others’ work. There is also a need for co-ordination of these key partners with other relevant initiatives – including the Health Metrics Network, “PARIS21” (strengthening statistical capacity), the “Aid Management Platform” of the Development Gateway (management information system for countries to better manage and coordinate aid), the Health Financing Task Force, and (follow-up to) the Health Resources Tracking Working Group.

The secretariat also needs to be accountable itself. (Its governance structure will be largely covered in the report on institutional arrangements and will not be covered here.) There should be an interim evaluation after two years, based on agreed ex-ante indicators. They should include number of countries assisted, user surveys of satisfaction from both partner countries and donors, and the quality and quantity of work on knowledge management and best practice, including case studies. The key objective of this interim evaluation would be to contribute to the fine-tuning of the secretariat’s mandate and work. A fuller evaluation, including of possible phase-out of the secretariat, should come in four years.

emphasis put on aid effectiveness – and particularly on the Paris Declaration -- in the health sector by the HLF and Scaling Up processes.

The partnership of the Scaling Up Initiative with the OECD DAC, drawing on respective comparative advantages, should cover the following areas: focus on health as a tracer sector in the Accra HLF on Aid Effectiveness in September 2008; work on accountability with the Working Party on Aid Effectiveness and with the division of the Aid Effectiveness Division of the DAC Secretariat that supports it; and partnership with the DAC Secretariat's Division of Statistics and Analysis (STAT) on aid flows (to have an annual series going beyond "ODA", including covering flows from foundations at the global level and from global funds at the country level). [Note: in the absence of a multi-donor secretariat, the new "Senior Co-ordinator" for health in the DAC Secretariat can help assure links between the DAC Secretariat and key partners, including the World Bank and WHO.]

MUTUAL ACCOUNTABILITY AT THE COUNTRY LEVEL:

The report of the initial survey of implementation of the Paris Declaration, based on 31 country surveys, provides useful background relevant to the Scaling up Initiative and the work of the multi-donor Secretariat⁵. The report indicates mixed progress to date. On the positive side, a number of countries, supported by key donors, were using the Paris Declaration and its indicators to drive forward the aid effectiveness agenda. There was also substantial buy-in from donors and to some extent from global partnerships as well. On the negative side, progress did not meet the high expectations that the Paris process had set in place. There was a general impression that the rhetoric was well ahead of action and concern expressed about the high up-front cost in time and effort required to improve harmonisation and alignment.

The Scaling Up Initiative should, at the country level as at the global level, minimise the creation of new accountability structures. These existing structures at the country level in health include health "round tables" of donors and governments and SWAp groups. ***Increased use should be made of the emerging good practice of setting out mutual commitments, as well as best-efforts intentions, in "Memoranda of Understanding" between donors and governments. At the national level, accountability structures that should be more and better used include: Poverty Reduction Strategies (PRS) and related medium term expenditure frameworks (MTEF) and annual budgets; Consultative Groups – preferably in the form of "Results and Resources Meetings", which focus more explicitly on mutual accountability.*** Similarly, where there are independent external accountability advisors, they could also look at health as an important "tracer" sector for

⁵ "Report on Implementing and Monitoring the Paris Declaration", presented to the DAC Senior Level Meeting on 6 December 2006.

assessing and seeing how to increase the development effectiveness of aid. (This would be far preferable to having a separate set of external advisors sector by sector, which would be unwieldy and wasteful.) There is increasing interest in the role of such independent advisors, which are now in use in a few countries including Tanzania, Cameroon, and Mozambique.

More generally, the Scaling Up Initiative should keep a close eye on the marginal cost of harmonisation and alignment in health. They should also aim to find some “quick wins” in the quality and financing of country programmes to demonstrate progress, building on work done to date. But they should from the start focus on the closely related issues of capacity and health systems, with their longer term benefits for effectiveness and sustainability. And they should keep a sharp focus on health results as the objective, recognising that improving process, important as it is, is only an instrument to achieving results.

Accountability in Scaling Up should cover the full range of indicators of the Paris Declaration – ownership, alignment, harmonisation, managing for results and accountability. All are relevant to Scaling up for Better Health. To take one example, accountability on alignment should include use of acceptable procurement systems by donors and strengthening of procurement systems by partner countries. ***The monitorable indicators of the Paris Declaration should be key elements of accountability. The targets for those initiatives should be taken as initial targets for the Scaling Up Initiative.*** (An example is “reduce by two-thirds the stock of parallel project implementation units”; this is important for shifting the balance from donor-driven projects to national health systems.) It may be feasible to improve on the indicators and targets; but they have the advantage of broad buy-in by donors and partner countries, negotiated after considerable effort, as well as an on-going monitoring process. This is independent of whether there should be a standard set of indicators on the health sector per se, as has been done in the case of the Fast Track Initiative for Education for All. That broader question is considered in the companion report on a Comprehensive Analytic Framework.

Within the framework of the Paris Declaration, there should be a special focus on a subset of issues regarding donor financing and global partnerships. [Note, these recommendations do not depend on the existence of a multi-donor secretariat.]

- ***Donor financing: Donor accountability for financing is crucial. It should cover volume, the share flowing through government budgets, and the related issues of predictability, volatility, and sustainability.*** There is a substantial gap between what is needed and what donors have thus far agreed to do in the Paris Declaration; the gap is that much bigger in implementation at the country level. The Rwanda case study for the scaling up initiative sets what might be considered the “gold standard” for what can

be expected from donors. It goes well beyond what donors have agreed to thus far in the DAC – for example on making forward commitments of aid. But it would be useful for health and for aid as a whole to make an extra effort as part of treating health as a tracer sector for increased accountability for donor financing. The discussion below suggests in some cases specific accountability indicators, as a means of advancing the discussion and helping to move to action. If these indicators can be improved on without significant delay, so much the better. At the individual country level, partner countries and donors may wish to add, subtract or modify these indicators and their associated monitorable targets.

- The Paris Declaration focussed on aid effectiveness rather than volume, which it treated as being covered by Monterrey-related processes. However, the Scaling up Initiative should deal with aid volume more explicitly. The issue at the level of each country is the adequacy of financing of the health sector. This in turn depends on the quality of the programme in relation to need, link of the programme to national strategies and budgeting processes, absorptive capacity, competing needs in other sectors, and “fiscal space”. ***Adequacy of financing needs to be considered country by country, by the partner country and its donor partners, as well as, in the case of fiscal space, by the IMF. Donors should be accountable for performance in relation to the agreed programme. The IMF should also be accountable for the consistency with which it applies, across countries and over time, its policies on facilitating scaling up where sustainable finance is available***⁶. Accountability on volume also includes donor willingness to support under-funded country programmes (including so-called “donor orphans”). The FTI secretariat plays such a role (as well as contributing to the response through its “Catalytic Fund”). The secretariat should play a lead role in flagging cases of apparent under-funding, for further investigation at the country level.
- **Share flowing through the budget:** Donor aid tends to bypass government budgets and so to weaken the development of public sector institutions and capacity. The example cited of Rwanda, a relatively good performer with only 14% of aid to health flowing through the budget, is striking. There is agreement among donors on the importance of overall national health systems. This is not to question the importance of civil society (including NGOs), or of the private sector, in health care delivery. Funding through government budgets is not inconsistent with government financing of multi-provider delivery systems. ***The Paris Declaration target -- halving the proportion of aid flows to government sector not reported on government's***

⁶ A useful guide to these policies and their application is contained in “Macroeconomic Challenges of Scaling Up Aid to Africa”, IMF 2006 <http://www.imf.org/external/pubs/ft/afr/aid/2006/eng/aid.pdf>.

budget(s) (with at least 85% reported on budget – should be taken as a “stretch” target, even though this will be a big stretch.

- **Predictability, volatility and sustainability:** These are different but closely related issues. Predictability refers to knowledge of what aid donors will provide in the medium term, with clear understanding of contingencies that could change that amount; volatility refers to abrupt changes within or between years; and sustainability to feasibility of longer-run financing. But the three are closely related and are crucial to governments’ taking the politically risky step of adding significantly to public sector employment in health and of building up public expectations of health services. ***On predictability, the Scaling Up Initiative should serve as a “tracer” for ongoing broader DAC efforts to get donors both to commit to longer-term financing and to give indications of likely future commitments. The increase in the average duration (tenor) of financing in health by country (and overall by donor) would be a useful indicator of progress on predictability, with targets to be agreed, as feasible, on a country by country basis.*** The Paris Declaration’s target for volatility – “halve the proportion of aid not disbursed within the fiscal year for which it was scheduled” should also be applied to Scaling Up. In some countries it may be feasible to go further⁷. Sustainability is a particularly difficult issue in the case of global partnerships, discussed separately, where programmes financed by global partnerships can create moral and political claims on a large share of future recurrent health budgets. **The principle of economy in results indicators suggests using the same indicator as for predictability.**
- **Global partnerships:** A range of recent studies of global health partnerships and of global programmes/partnerships in general have noted the growing importance of global partnerships in the international aid architecture. They have noted a number of positive contributions from these programmes to addressing issues of global concern. They have also noted a series of problems of integration at the country level, focusing generally around lack of alignment with – and imposition of donor preferences on – priorities and programmes of partner countries, as well as high transaction costs and lack of harmonisation with other donors.
 - ***Accountability of global partnerships should be based on implementation of the “Good Practice Principles for Global Health Partnerships as well as on the complementary “Good Practice Guidance on Integrating Global Programmes at the Country Level” that extends them in two critical dimensions:***

⁷ Consideration might also be given to experimenting with an indicator that measures the share of aid for health that is indicated three years ahead – whether through firm multi-year commitments or good-faith indications. However, the principle of economy in results indicators – to permit focus and avoid indicator overload – suggests giving this low priority.

- selectivity in funding of new global programmes; and building in basic principles of aid effectiveness up front in their design.***
- ***There should also be annual scorecards – at the country and global levels – for each major global program that reports on progress in achieving an agreed set of indicators from the Paris Declaration and the good practices.*** GFATM has produced a useful aggregate scorecard based on the Paris Declaration that serves as a good practice here.
 - An interesting suggestion emerged from the interview process regarding accountability of global partnerships for the distortionary effects they can have on national health systems: an “overhead charge” to be funded by global programmes and used for overall health systems⁸. This idea merits further consideration as a contribution to the much-debated role of global partnerships in health systems. To avoid possible distortions or fragmentation in country health systems, global partnerships would have to contribute to SWAs or similar multi-donor support of health systems, rather than to financing their own health systems projects. The risks, though, is that global partnerships would insist on having their own health-system projects and that donors would increase further the share of aid for health going to global programmes, arguing that they were also supporting national health systems.

Fragile states: Work done for the High Level Forum in Abuja (December 2004) amply shows the importance of fragile states, as well as practical steps for increasing aid effectiveness even in these cases of weak capacity and ownership⁹. They account for about one seventh of the population of developing countries but more than twice that share of those who will not meet health-related MDGs. Research results show that some fragile states are under-funded not only on the basis of need but on the basis of the usual donor allocation criteria of performance, population and poverty. These countries often need extra help to prepare programmes of a quality that will permit some scaling up. ***Donor accountability in health in the case of fragile states should be guided by the “Principles for Good International Engagement in Fragile States”, with their focus on balancing short-term results with support for longer-run capacity and governance***¹⁰.

⁸ This idea, from Ruth Levine and Maureen Lewis, was initially expressed in, “Addressing the Challenge of HIV/AIDS: Macroeconomic, Fiscal and Institutional Issues, by Maureen Lewis; Center for Global Development Working Paper Number 58 April 2005.

⁹ “Achieving the Health MDGs in Fragile States”, <http://www.hlfhealthmdgs.org/Documents/FragileStates.pdf>; “Harmonisation and Alignment in Fragile States”, <http://www.hlfhealthmdgs.org/HLF2%20presentations/Session%206-%20Isenman.ppt>; Health HLF, Abuja, December 2004

¹⁰ www.oecd.org/dataoecd/61/45/38368714.pdf.

Role of donor capitals and headquarters: The importance of policies and incentives set by donor capitals and headquarters in empowering and facilitating – or not – progress made by their staffs at the country level has already been noted. ***Accountability, as in the case of the Paris Declaration, should be considered donor by donor as well as globally.*** As in the case of the Paris Declaration, this accountability will have to be addressed through self-reporting as well as by aggregation of data from the country level. ***The self-reporting should include changes in incentives and policies as well as monitorable indicators such as the share of joint missions.*** The Secretariat can provide supporting analysis, but it will be reluctant to criticize individual donors, particularly those on whom it relies for support. **The Scaling Up Initiative should keep collective action and peer pressure among donors in order to encourage continuing progress.**

Partner country accountability structures and relevant donor support: Scaling up is a joint effort. The Paris Declaration includes key relevant commitments by partner countries, starting with “ownership” of their own programmes, effective leadership of donor assistance, and strengthening of systems and capacity. Partner countries’ own accountability structures in health are important first and foremost to help achieve their health objectives. They are also important also in providing credibility and reassurance to donors, who have their own structures of accountability to parliaments and to their own publics. Partner country accountability systems are all the more important as donors are moving increasingly from reliance on traditional conditionality or on specific projects with substantial donor intervention to more flexible and longer-term forms of financing, such as budget support or the European Union’s “MDG Contracting”.

Donors and the Scaling Up Initiative should make maximum feasible use of partner countries’ own accountability systems, and should support country-led efforts to strengthen these systems and related capacities. This includes reliance on these systems for procurement or financial management, as called for in the Paris Declaration, which also calls on partner countries to have “monitorable performance assessment frameworks in place”. ***It is important that this support for accountability should itself be harmonised and not a source of competition among donors.***

There is considerable debate within the evaluation community about relative emphasis on inputs, outputs and outcomes in indicators of evaluation and accountability.

- Experience from the DAC’s Joint Venture on Managing for Development Results suggests that ***accountability frameworks should place relative emphasis on intermediate outputs*** – for example the number of those treated or vaccinated – plausibly within the control of agencies carrying out relevant programmes. ***These intermediate outputs should also measure progress in strengthening capacity, to help assure***

sustainability of results. Relevant needs for capacity range from technical areas of health to financial management and monitoring and evaluation. There is as yet no general agreement on reasonable indicators of capacity to offer as good practice to partner countries (beyond reducing the number of Project Implementation Units).. This is a priority area for further work. In the interim, a combination of human resource indicators (e.g. change in net trained doctors or nurses) or process indicators (e.g. treating success in integrating health into PRSs and MTEPs) should be considered.

- **Some attention should also be paid to outcomes, such as reduced infant and child mortality (an MDG goal), in spite of difficulties in attribution of causality among the many factors influencing mortality.** This is important, for example, in choice among programme priorities, which should be evidence-based – in terms of burden of disease and cost-effectiveness in addressing them -- to the extent feasible. Outcomes are easier to measure in the case of vertical programmes, where declines in incidence or in related mortality can be measured in areas covered. However, it is important to use selective indicators of outcomes relevant to specific country health priorities wherever feasible.
- **Similarly, attention needs to be paid to traditional concerns for responsible use of resources (inputs) and for avoiding waste and corruption.** This requires, for example, taking financial and programme audits seriously.

In sum, it is a question of balance. Outputs should get considerable attention but neither ultimate objectives – outcomes – nor traditional prudent management of resources – inputs – can be neglected.

Partner country accountability systems, and relevant support from donors, should increasingly include local accountability mechanisms. Analysis of determinants of programme effectiveness is calling increasing attention to the role of getting feedback from, and involving, users. This helps to increase programme responsiveness and transparency, mobilise and strengthen latent capacity, and reduce waste and corruption – thus increasing programme effectiveness and credibility¹¹. Tools that have been applied in the case of health include user surveys or “report cards”, and membership on boards of hospitals. These tools can help to take account of the specific context of each country (and within each country) and to address constructively such difficult problems in health as absenteeism and ghost workers. They can also help move these sensitive issues from being a reason for donors to hold back on scaling up (or to cancel programmes in midstream) to becoming an integral part of the partner country’s own health sector programme that donors support.

¹¹ **World Development Report 2004: Making Services Work for Poor People.** Oxford University Press, 2003. Maureen Lewis, “Governance and Corruption in Public Health Care Systems”, CGD Working Paper 78. Washington, DC: Center for Global Development, 2006.