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Title: Feasibility and Potential Role of a Common Analytical  
Framework for Health

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## Executive Summary

A common framework would be worth establishing if helps countries scale up their efforts towards the MDGs. It will add value if it supports processes which contribute to a shared understanding of what the potential constraints are at the country level - whether they fall inside or outside the health sector – and supports measures to address them. The way any framework is applied will be as important as the framework itself. There is as yet, however, little consensus on the purpose of any common framework.

In terms of approach:

- Any framework should be indicative rather than prescriptive – development partners and Governments should focus on the issues which are important in their setting and set locally relevant indicators and targets drawing from a broad menu developed globally through ongoing processes.
- Normative approaches are not suitable. Contexts differ too much, the evidence base is not strong and there is little likelihood anyway that agreement could be reached on a core list of targets
- Coverage should be broad. The starting point should be outcomes – the MDG targets. More emphasis should be placed on outputs and rather less on process; constraints both inside and outside the sector should be considered. More attention needs to be given to previously neglected issues such as the role of the private sector and the links between the Health and Finance Ministries.
- The focus should be on identifying the key issues up front – detailed work including the development of possible indicators can follow later on
- The framework should build on and draw from existing work – notably from the Health Metrics Network, attempts to adapt the Track Record approach to health and the potential use of the health sector as a pilot for DAC monitoring of progress on harmonisation and alignment.
- Whilst there is a lot of common ground there are still diverging opinions on exactly what the framework might be for. Although not necessarily inconsistent this may cause tensions. These include the emphasis placed on sector performance as opposed to aid effectiveness.
- A Secretariat could play a key role in gaining agreement over the key overarching questions and drawing in inputs from the ongoing work. Ultimately it could play an important surveillance role – identifying problems before they emerge and publicising them when the do
- The general consensus is that no dedicated funding should be attached to this initiative. Rather it should prove its worth first with the case for funding reviewed at a later date.

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## 1. Introduction

The international health community is trying to identify the best ways of scaling up aid to the health sector in order to meet the MDGs. Aid flows for health have increased dramatically in recent years and lack of resources is often not the most pressing issue. Seeking additional resources and establishing new financing mechanisms are not seen as the answer – making better use of what is available has assumed much greater significance.

Although donors have been criticised for not doing enough they point to a lack of knowledge and evidence on where, and under what conditions, additional resources could usefully be spent. In some cases this has resulted in resources being channelled by default through the UN or the Global Health Partnerships rather than being informed by a clear analysis of whether this is the most effective channel and whether the environment in country supports effective scaling up. There is a demand for tools or frameworks which can help answer such questions.

The High Level Forum identified a number of factors constraining progress towards the MDGs including:

- the lack of robust sectoral strategies, plans and budgets;
- weak linkages between the health sector and broader development processes (public sector reform, poverty reduction strategies, macroeconomic and fiscal planning etc.);
- weak domestic resource mobilisation;
- limited attention to the staffing and systems issues that impede service delivery;
- inadequate monitoring systems for tracking resource flows, progress and outcomes;
- limited progress in translating global commitments on aid effectiveness into concrete action at country level - most particularly in relation to the provision of predictable long-term financing; and
- lack of a multisectoral approach to achieving health outcomes.

Further, it highlighted the particular problems faced by fragile states and the need to develop common approaches - both across and within agencies - to working on these issues.

This paper assesses the case for developing a common analytical framework and considers what role it might play paying particular attention to the experience of the Fast Track Initiative in the education sector. Originally, it was anticipated that such any framework for health might be linked to a new financing instrument. The general consensus, however, is that this should not be the case at least at the outset – rather there are hopes that it could stimulate the provision of additional pooled funding should the approach prove worthwhile.

The paper considers first what a common framework might be used for. It then looks at what it might include taking into account ongoing work in this area and using relevant examples. ToRs are at annex 1.

## 2. What is a common analytical framework for?

A common framework might be used for a number of purposes:

- **scanning/selection:** to identify countries or regions whose plans and strategies meet agreed standards against defined criteria. For example the FTI accredits sector plans which are seen as being “appropriate” and therefore worth funding. Such approach could consist of a simple yes/no decision (as is the case for FTI). In principle it could also be developed into a more sensitive grading system which distinguishes between adequate and excellent plans and prospects for their implementation which will be important where needs exceed available resources.
- **to establish a common understanding of what is important:** the process of agreeing criteria can be important in improving transparency by ensuring that both donors and Governments have a common understanding on how their performance might be assessed. This might include sensitive issues such as corruption and absenteeism which, as one interviewee put it, “only ever get discussed over cocktails”. It would act as a basis for understanding where the real constraints lie. Rwanda, for example scores well on most indicators but key constraints include the transactions costs imposed by multiple donors supporting largely off budget interventions. Such criteria might be used as a basis for dialogue or even more formally as terms of reference for annual reviews. It could also help identify whether the constraints are inside the sector (PFM, HR related) or outside the sector (links to PRSP and budgetary support to the sector) and thus shed light on where any key decisions need to be made. Alternatively, it could be used as a basis for identifying what works and answering key development questions. This raises a number of questions: Should it be comprehensive or just focus on a few key issues or neglected issues? Should it focus on performance or commitments/intentions? How important are process issues such as the quality of the partnership arrangements compared to results? Should it look at obligations of both Governments and donors (the issue of mutual accountability is addressed in a separate paper)
- **to establish a baseline and monitor progress:** At one extreme the approach could be used to assess progress against a series of agreed global benchmarks which would allow cross country comparisons to be made. Alternatively, the framework could be used to assess progress against a set of measures agreed at the country level which would allow an assessment to be made as to whether progress was being made but would not allow cross country comparisons.
- **as a basis for resource allocation:** a framework could be used to directly influence donor resource allocation decisions. Such an approach requires comparability between countries The World Bank’s CPIA assessment directly feeds into the allocation of IDA resources. Such an approach raises a number of questions. Should resources be allocated on the basis of efficiency (performance based) or should they be allocated on the basis of need (equity based)?

### 3. Who is it for?

Donors and Government will typically be looking for different things as described in the table below

**Table 1: Key Questions**

Donors	Governments
<ul style="list-style-type: none"> <li>• will it help us identify what the major constraints to progress are?</li> <li>• does it help us understand the impact of our actions and help identify plausible links between reforms and results</li> <li>• can it provide a platform on which we can identify appropriate solutions?</li> </ul>	<ul style="list-style-type: none"> <li>• will this make our life simpler?</li> <li>• will we be rewarded if we do well?</li> <li>• will we be supported if we're trying to do well?</li> <li>• how have others managed elsewhere, what can we learn from them?</li> </ul>

### 4. What might be the benefits?

Objectives might include:

- common agreement on key issues which affect health sector performance and a basis for identifying which factors are responsible for performance gaps in particular settings
- ensuring a wider buy in from key stakeholders
- creating a (more) neutral, objective basis on which sector discussions can take place, to highlight difficult issues in a more sensitive way
- to help break the current logjam (“we can’t just go on saying how complex the sector is”)
- identifying where funds might be used effectively as a means of encouraging additional and more aligned investment
- to provide reasonable protection for countries who are implementing sound plans by providing flexible, predictable funding

### 5. What would a common analytical framework need to include?

The health sector is complex and the constraints preventing rapid scaling up are multiple and vary widely between countries and regions. In this context how is it possible to reconcile the tension between capturing what is important and having a framework which is manageable i.e. relatively simple and not too expensive to implement?

This raises a number of questions:

- which **dimensions** need to be considered? policy and financing environment, partnership arrangements – coordination/progress towards Paris targets/TA pooling, national planning processes – links to PRSP or equivalent,
- what **types of indicators** might be used: inputs, outputs, processes, health system performance indicators, population health outcomes? qualitative, quantitative?

- should it be **comprehensive or targeted/selective**: whilst a framework might be applied consistently between countries it may not make sense to apply it an identical way in every setting. Some issues will be critical in some settings but not in others. This being the case should the encourage targeting of specific issues within a broad framework?
- **whose performance** or commitment should be measured: Government or donors or both?
- should there be **normative standards** (e.g. CMH \$35 per head; Abuja 15% of budget to health). Should they be set at global, regional and country level? Should there be minimum standards or ranges?
- how important is **consistency** between countries/regions?

## 6. Does the FTI Provide Any Useful Pointers?

The FTI was launched in 2002 as a global partnership to accelerate progress towards the universal primary education MDG. FTI endorses sector plans against a range of criteria set out below and described in more detail in the box).

- evidence of **country ownership**
- **content**: credibility and adequacy of strategies to address key issues
- policy commitments and annual targets for the indicative framework
- unit cost estimates and their consistency with long term **sustainability**
- physical implementation, risks and capacity
- **monitoring and evaluation**

As part of this assessment it considers progress against targets for a range of key indicators – set out in the **Indicative Framework** - which is based on the findings of an analysis of the key characteristics of countries which have performed consistently well over time.

The table below sets out the FTI indicative framework setting out the broad themes covered and also sets out how such an approach might translate to the health sector (for illustrative purposes only).

### Box 1: FTI Summary of Assessment Guidelines

Section A: Extent of country ownership and consistency between strategies and targets and those in PRSP  
 Section B: Identification of key constraints  
 Section C: Spending trends and existence of an adequately costed plan?  
 Section D: Budgetary processes and sustainability. Is there an MTEF – what steps are being taken to move in this direction?  
 Are issues related to the sustainability of GHP funding fully considered in the MTEF  
 Section E: Is there capacity to absorb and use additional funds effectively?  
 Are there disbursement bottlenecks? If so, why? How are they being addressed?  
 Is the choice of aid instruments appropriate? What steps are required to move towards more flexible and predictable funding flows which are more closely aligned to country systems  
 Section F: Existence of an adequate performance framework  
 Adapted from Guidelines for Technical Assessment of the Primary Education component of an Education Sector Plan

**Table 2: FTI Indicative Framework and Possible Translation to the Health Sector**

Theme	Area	Education FTI	Health FTI???
Service Delivery	Human Resource Productivity	Teachers earn 3.5 X GNP pc	Health worker salaries as % of GDP pc?
	Human Resources	Pupil: Teacher 40:1	Doctor/Nurses per '000 population
	Non Salary Spending	33% of recurrent costs	recurrent spending as % of total, drug expenditure as % of total??
	Efficiency	Average repetition rate	rational drug prescribing
	Inputs	Annual hours of instruction 850hr +	Average number of inpatient/outpatient contacts per capita
	Public Private Mix	Private enrolment < 10%	% of population into poverty as a result of health expenditure
Infrastructure	Efficiency	Unit construction < \$10,000	Less relevant?? or % of population <5 kms from a health post
Financing	Revenue Raising Commitment	14-18% of revenue	Not sector specific so education target could be relevant to any sector
	Commitment	20% of Government budget to health	Abuja 15% target ?? Or \$ per head target CMH \$35 per head, Millenium Project country specific targets?
	Allocation of resources	42-64% on primary education	Share to PHC, balance of resources between key programmes e.g. share of resources to HIV/AIDS
Access and Utilisation	Service uptake	100% enrolment of boys and girls into first grade	Immunisation rates, access to ARVs etc

Although the FTI targets are set globally they are relatively fluid emphasising minimum targets and ranges.

FTI aims to ensure accredited countries with sufficient donors to attract more and better aid (though it does not guarantee this with earmarked funding for non donor orphans). Donor orphans have access to dedicated, transitional funding through the Catalytic Fund whilst the Education Program Development Fund (EPDF) provides technical support to help countries develop sound plans and achieve accredited status. Around 20 countries had endorsed education plans (as at January 2006); the aim is to increase this to around 60 by 2008.

### Relevance of FTI to Health

Could or should health implement and FTI-type approach? There are a number of contextual factors which make such an approach in health more challenging:

- the lack of a common global policy endorsed a high political levels to unite around (as is the case for Education for All policy set out at the Dakar Conference))
- education has a fairly well agreed division of labour and the immediate issue was lack of resources rather than concerns about aid effectiveness. In health the field is overcrowded with a proliferation of global health partnerships and significant fragmentation and duplication with lack of resources an important but often secondary consideration.

- the greater complexity of the health sector (compared to a sub sector in education) and the drawbacks to focusing on a sub sector (such as primary health) given the importance of secondary and tertiary care for achieving the MDGs e.g. access to emergency obstetric care for maternal health outcomes
- the financing requirements are of a different order of magnitude
- health already has a number of benchmarks and minimum standards which arguably already contribute to problems of lack of flexibility and balance and may be counterproductive. e.g. \$35 per head

Lessons and messages for health from the FTI experience would include the need:

- for the approach to learn from the strong country based and oriented model adopted by FTI
- for a sound governance structure with clear roles of the respective agencies based on comparative advantage. FTI has been built on trust with quite loose ad hoc agreements – this may not be appropriate elsewhere
- to emphasise both harmonisation *and* alignment (not just the former)
- to ensure the approach is Government not donor led
- the focus is on capacity development rather than donor appraisal
- to ensure benchmarks, if any, are locally derived and owned. Indicative benchmarks need to be kept fluid to accommodate most countries – but with minimum benchmarks
- for any framework to be used as a basis for dialogue not as part of a tick box approach
- for impact on donor investment patterns to be monitored. There may be problems of attribution and substitution risk – if this is an issue it may create problems
- realism in terms of time frames: the Catalytic Fund was designed as a short term bridging fund. It is now recognised that it needs to be much more long term and possibly have more open eligibility
- realism in terms of results: any targets set need to be achievable given good performance
- clarity on the balance between performance and equity. The tendency is likely to set overly ambitious targets which raise the bar too high for fragile states
- agreement on guidelines is essential
- incentives on both sides. Government needs to see the exercise is offering them benefits donors need to see it as leading to “more than the usual plan”
- the approach needs champions (Canada and Dutch took on this role for FTI)

## 7. What Relevant Work is Ongoing?

Many frameworks are currently in place, or under development, and address a wide range of issues. Some of these are described briefly below

### **Dutch Track Record Approach**

This approach was established in the mid 1990s to assess whether a country was eligible for macro support but has since been expanded to assess the level of alignment which is feasible, to identify appropriate aid modalities and to aid country selection. The EU Working Group on health sector budget support has been developing a Track Record for Health which is seen as feeding into the overall Track Record assessment

In short, the approach comprises four clusters: performance, inputs and environment policy, planning/budgeting, management/administration and good governance and dialogue. Each is made up of a number of cluster components each of which has a range of possible indicators both quantitative and qualitative. Each is rated on a scale ranging from a (good) to d (poor) and scores are aggregated. Current plans are to refine this tool and to adjust, and test, it in a number of pilot countries.

### World Bank CPIA

This approach is used at the macro level to identify “good policies and institutions (which) lead, over time, to favourable growth and poverty reduction outcomes” and also to feed into resource allocation decisions. The framework assesses progress against a range of 16 indicators. The process has become increasingly transparent (with greater public disclosure of results) and has direct links to the Bank’s resource allocation processes (which increases the need for consistency). One of the indicators “Building Human Resources” refers specially to health<sup>1</sup> and covers issues of financial protection, access to services and effectiveness of Government. Within this the approach distinguishes between HIV/AIDS, TB and malaria and other services. The approach has also been adopted by other multilateral agencies who use the framework although they apply it in different ways. This approach and other Bank approaches of to assessing governance conditions provide useful context for health systems analysis.

### OECD DAC Framework for Harmonisation and Alignment

A total of 12 indicators have been identified; 9 are to be monitored by survey; 3 by alternative means. None are health specific though all are, of course, relevant to the aid effectiveness debate. Thought is currently being given by DAC to using health as a pilot sector.

### Health Metrics Network

HMN aims to “increase the availability and use of timely and accurate health information by catalysing the joint funding and development of core country health information systems” and in doing so to enable regular reporting on the status of health systems which meet the needs of all users through a common approach incorporating:

- a “parsimonious” set of **core indicators** covering financing, human resources, information, governance and policy/stewardship, service delivery (infrastructure, procurement, logistics and supply and quality), service coverage (including equity and sub national assessments). The aim is to include targets where possible and

#### Box 2: CPIA Criteria

##### A. Economic Management

1. Macroeconomic Management
2. Fiscal Policy
3. Debt Policy

##### B. Structural Policies

4. Trade
5. Financial Sector
6. Business Regulatory Environment

##### C. Policies for Social Inclusion/Equity

7. Gender Equality
8. Equity of Public Resource Use
9. Building Human Resources
10. Social Protection and Labour
11. Policies and Institutions for Environmental Sustainability

##### D. Public Sector Management and Institutions

12. Property Rights and Rule-based Governance
13. Quality of Budgetary and Financial Management
14. Efficiency of Revenue Mobilization
15. Quality of Public Administration
16. Transparency, Accountability, and Corruption

<sup>1</sup> Health accounts for 2/3, education 1/3

- to ensure comparability over time and between countries and to focus on distributional issues as well as national averages
- a clear **measurement strategy** including the incorporation of health systems monitoring into health information systems

Current thinking is that it is, in general, feasible, to develop small lists of core indicators in the key areas but that the complexity will often require the use of multiple methods and poor data availability will often require significant investment in collection capacity. It seems to be accepted that in some areas such as financing it is quite easy to identify a possible range of indicators some of which may allow comparability (e.g. in relation to financial risk protection). In other areas notably governance there is less clarity on what indicators might be

**WHO EMRO** has developed a framework<sup>2</sup> for assessing health governance which has been piloted in Pakistan, Egypt and Lebanon.

### **World Bank: Supporting the Africa Action Plan (AAF) through Results and Resources Consultative Groups**

The AAP is a “comprehensive strategy paper that lays out the World Bank's proposed plan for facilitating country-led economic and social development across Africa, through a collaborative approach between donors and governments”. In order to develop common approaches to support country led strategies and develop tools and methodologies to compare approaches there are plans to overhaul the Consultative Group mechanism to annual resource and results meetings as a means of strengthening partnership on the MDG and harmonisation agendas and to develop stronger links between resources and results thus creating a stronger demand for the establishment of common frameworks for analysis

## **8. Possible Options**

There are a whole range of possible approaches. This section maps out three for the basis of discussion. It incorporates the two extreme cases of keeping things as they are and adopting an extreme central planning approach with the favoured middle ground option.

**Option 1: Business as Usual:** This involves maintaining the status quo with resource allocated on the basis of country level decisions made by individual donors

**Option 2: Global Central Planning Approach:** This might involve the agreement of a set of agreed indicators - along the lines of those set out in table 2 - and the establishment of mechanisms which direct resources towards countries which develop plans considered capable of assuring progress against these indicators. This could take the form of a central FTI-type initiative or a less formal arrangement not requiring the establishment of a separate fund. Dedicated funds could be made available in low capacity settings to develop good plans and resources allocated according to estimates of the funding required to achieve the global targets.

**Option 3: Middle Ground:** This might involve the development of a light touch framework which spells out the key questions – to ensure they are addressed – but does not dictate how these questions are addressed nor what targets are set at the

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<sup>2</sup> strategic vision, participation and consensus orientation, rule of law, transparency, responsiveness, equity and inclusiveness, effectiveness and efficiency, accountability, intelligences and information, ethics

country level. In this case a framework would provide a clear signal as to what issues are considered important but would leave space from countries to develop plans most suited to their own particular circumstances and leave donors flexibility to respond as they see fit.

## 9. Summary of Findings

There is little support for a normative approach. The general view is that it is not appropriate given that the production frontier in the sector is driven largely by local context and not through a mechanical relationship between a series of identifiable variables. Leaving this aside there are also practical issues of actually agreeing what any targets might be and further developing the evidence base to support it. Thus rather than set a target for the number of doctors or nurses per head of population the framework might more usefully identify the key underlying questions and provide a menu of possible indicators and not necessarily predetermine which indicators should be used and what the targets should be. In terms of human resources, therefore, a broad question might be “what steps are being taken to strengthen human resource capacity and to enhance productivity?” A menu of indicators might include the quantity of available staff which might be extremely relevant where absolute lack of staff is the most pressing issue. In other settings, however, issues of skill mix, geographical or programme wise distribution of staff, problems related to productivity perhaps resulting from low salaries or other issues may be better at explaining any performance gaps. Any framework should, therefore, not be seen as an exercise in global central planning. Rather, it is an attempt to facilitate the development of country plans by creating a broad framework within which country relevant performance indicators and targets can be identified, set and monitored.

Further risks of adopting a normative approach include the risk of setting the bar too high. Unrealistic targets for public spending on health, for example, can prove counterproductive in that they can divert attention away from the need to prioritise the extra \$1-\$2 per head each year countries are actually likely to receive and on how to ensure better value for money from private expenditure on health. This issue is particularly true for fragile states where global or even regional targets may not be achievable. If targets were to be set they would need to be realistic for all those expected to achieve them.

The approach should be targeted rather than comprehensive. Whilst a framework might be need to be broad to capture the key constraints to scaling up it would need to be targeted to make it manageable at the country level. Dialogue would, therefore, not need to cover all areas identified in the framework but focus instead on those that really matter.

Efforts to develop a common framework need to be phased. They should focus initially on identifying the key high level questions with detailed work to follow later on (and building on existing work). The FTI assessment guidelines are a good starting point in this respect though they do not focus much attention on aid effectiveness issues. Examples of broader questions which would be relevant for any annual review might include

- What steps are being taken to improve access to essential services by the poor?
- Is the overall programme-wise allocation of resources consistent with the prevailing disease pattern?

- Is there a clear rationale for the geographical allocation of financial and human resources?
- What are the main constraints to improving value for money from private spending and how are they being addressed

Comparability between countries is generally not seen as important for its own sake although it is useful and might be possible for some indicators. However, relevance rather than comparability should be the primary criteria for choosing indicators.

The FTI approach provides some very valuable lessons but any framework for health would need to capture health specific constraints some of which do not apply to the education sector. These might include the balance of efforts between diseases as well as the predictability and flexibility of donor support. There are also questions as to whether the relationship between Health and Finance Ministries is fully captured in existing frameworks.

The framework should build on existing work notably that being carried out by the Health Metrics Network on health system performance. The ongoing work on developing a Sector Track Record approach will also provide useful inputs in terms of partnership processes. The OECD DAC is also considering applying its targets to the health sector. At the same time there are also concerns that some issues are still being neglected. The role of the private sector, although now acknowledged in health strategies is rarely given the attention it deserves. As there is would be no specific funding attached to this initiative it may not be particularly attractive at the country level - it is important, therefore, that any approach adopted adds value to existing work and seen as an extra hurdle to be negotiated.

Fragile states face particular challenges in that whilst needs are greatest capacity tends to be weakest. Global benchmarks may be inappropriate in such settings and information systems may be too weak to substantiate progress. Whilst any high level questions set out in a framework might still be relevant the ways in which they are applied will vary at the country level again emphasising the need for a flexible approach which rewards effort even of from a low base. In such settings for example, quick and dirty approaches may be more appropriate than ideal approaches such as national health accounts.

There is still some lack of consensus on what the ultimate purpose of the framework is. In some cases this is down to the relative importance placed on ends (outputs and outcomes) rather than means (processes). It is fairly clear that the MDGs should form the basis of any approach given their global acceptance and relevance. However, there is much less consensus on health system performance components but a generally thinking that less emphasis should be placed on processes (many argued that overemphasis on process rather than results has contributed to the slow progress over the last decade) and more emphasis on outputs. Differing emphasis is also placed on the relative importance of system performance and improving development effectiveness. Though not necessarily competing objectives differing perceptions need to be acknowledged and handled.

The role of the Secretariat is dealt with in detail in a separate paper. However, a number of potential roles did emerge through discussions. Firstly, the Secretariat might play a useful surveillance role – acting as an early warning system to identify issues such as those raised in recent work in Ethiopia and Rwanda before they escalate. It would also have a key advocacy role reflecting the concerns that little has still happened despite accumulating evidence of “collective donor misbehaviour” in these settings. The role of the Secretariat in promoting lesson learning between

countries was also emphasised. For example, countries need to know how best, and how far, they can push donors to align. .

Similarly, in the absence of dedicated funding for capacity development, the Secretariat might also play a useful signalling role in trying to ensure resources are available to support the development of plans when efforts at the country level are not working out. The Secretariat might also potential use any framework to support the Global Health Partnerships in their resource allocation decisions (e.g. the GAVI HSS window).

On one level the Global Health Partnerships would welcome the establishment of any common framework to the extent that it sheds light on health systems shortcomings and allows them to tailor their efforts towards addressing such issues. What is less clear is the extent to which any tensions between the earmarked nature of GHP funding and their increasingly acknowledged tendency to distort resource allocation patterns at the country level would run and a common framework which highlighted issues related to the balance of efforts between particular diseases would be resolved.

## **Annex 1: Term of Reference**

- Identify relevant on-going work on this issue
- consider what key elements the CAF should cover (including normative as well as 'institutional' aspects e.g., is the sector plan reflected in the PRSP?)
- Identify political constraints to the acceptance of a CAF across the full range of health partners, including GHPs??
- Make recommendations on whether and how a CAF could be used by donors; specifically, how it could be used to trigger disbursements in any new financing mechanisms proposed by consultancy 1.
- Draw on lessons from FTI-Education, and make recommendations as to whether a similar approach is feasible / appropriate in health.
- Discuss limitations of a CAF approach in fragile states
- Discuss limitations posed by paucity of health data / information in many low-income countries
- Make recommendations on the utility or otherwise of such an instrument.

## Other Frameworks worth mentioning?

### WHO World Health Report 2000

WHR 2000 identified

- **three overall goals** for health systems: improving health and reducing health inequalities; enhancing responsiveness to the legitimate expectations of the population”; assuring fairness of financial contributions and:
- **four functions** that a system needs to deliver them: service provision; resource generation; financing and stewardship.

The **Global Fund’s M&E Toolkit** sets out a range of health system strengthening indicators (alongside a range of disease specific indicators. These relate to service delivery, human resources, community systems strengthening, information systems and operational research, infrastructure and supply and procurement management. The Funds framework for assessing the systems effects of the Fund monitors additionality, effects of product prices, partnerships and sustainability including indicators some of which are Fund specific, others which are of broader interest.

### World Bank – PRSP Sourcebook

#### Normative guidelines – international commitments

Abuja Declaration - 15% of Government budget to health  
\$35 per head – to provide a basic package – Millennium Project estimates are making it country specific

#### African Union Model<sup>3</sup>

- leveraging institutional environments (policies, legislation, strategies and resources)
- translating policies, legislations, plans and resources into large-scale accelerated action
- packaging interventions by service delivery model
- removing health system bottlenecks
- joint phasing of health systems strengthening and expansion of intervention packages
- “real-time” monitoring of progress

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<sup>3</sup> A Strategic Framework for Reaching the Millennium Development Goal on Child Survival in Africa: Through Health System Strengthening and Implementation at Scale of Integrated Packages of High-Impact and Low-Cost Health and Nutrition Interventions