

# Aid architecture

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# Swap –Sector wide approaches

- Developed on principles of partnership and collaboration and the goal of achieving sustained improvements in the sector
- All significant funding for the sector supports a single policy and expenditure program
- Government provides leadership for the programme

# Swap –Sector wide approaches

- Common implementation and management approaches are applied across the sector by all partners
- Over time, the programme progresses towards relying on government procedures to disburse and account for all funds

# Other Acronyms/language

- PBA's –programme based approaches-like Swaps but can be wider than the sector e.g. Public sector reform
- Sector policy dialogue –early Swaps



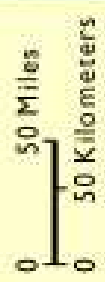
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26° N

24° N

22° N

Tropic of Cancer



INDIA

WEST BENGAL

**Bangladesh**

86° E

88° E

90° E

NEPAL

INDIA

Bay of Bengal

Mouths of the Ganges

MYANMAR (BURMA)

Teknaf

Brahmaputra

Khasi Hills

Dhaka

Narayanganj

Chittagong

Chittagong Hills

Ganges

Jamuna

Bogra

Naogaon

Sirajganj

Rajshahi

Nawabganj

Pabna

Cox's Bazar

Kushtia

Chuadanga

Faridpur

Rajbari

Jessore

Madaripur

Barisal

Pirojpur

Jhalakati

Patuakhali

Comilla

Chandpur

Noakhali

Rangamati

Khulna

Satkhira

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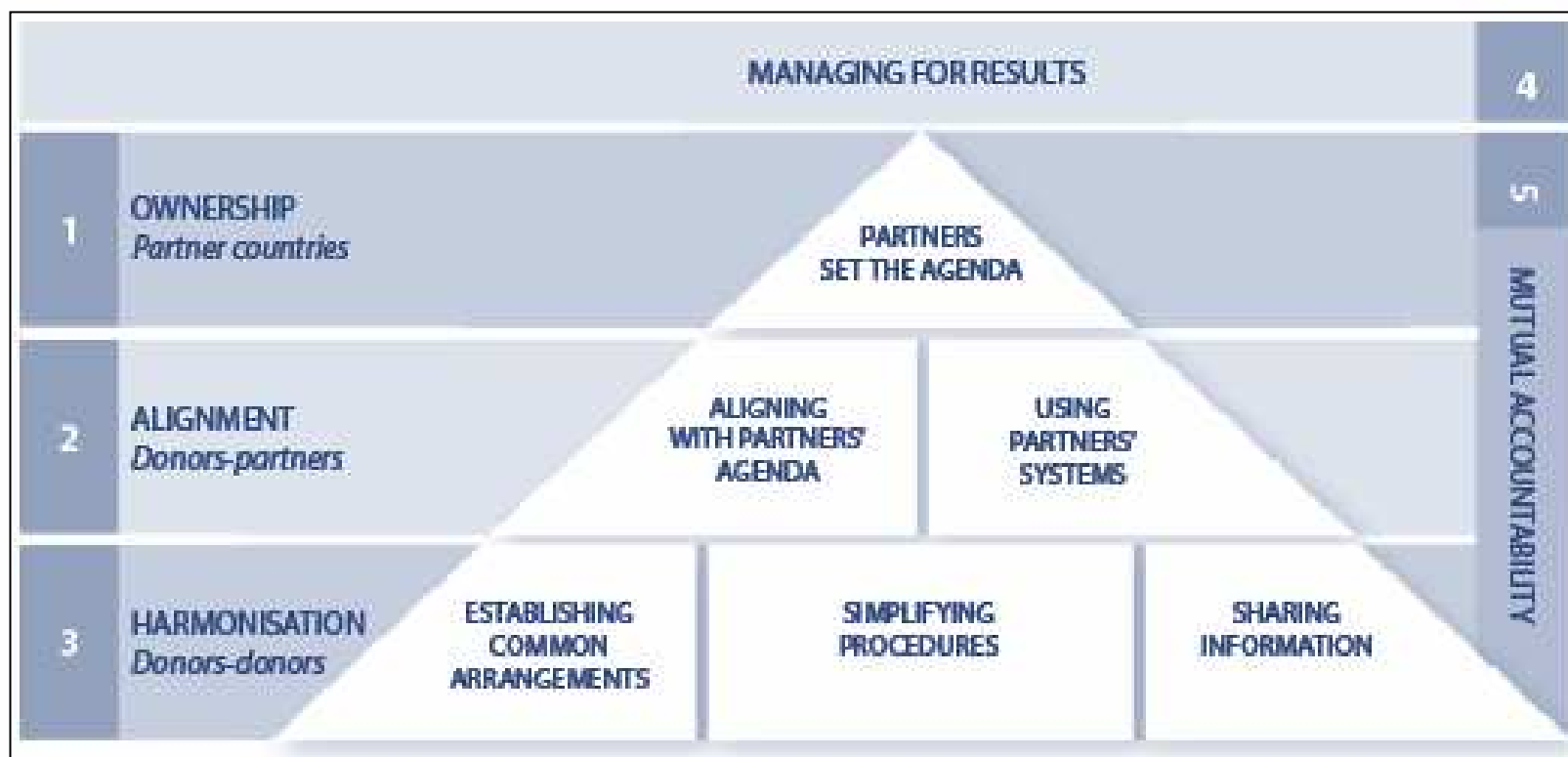
Chittagong

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## The Aid Effectiveness Pyramid



# Bangladesh

- Among oldest health sector programmes in the world
- The Swap supports the Health Nutrition and population sector plans HNPS
- HNPS: worth \$4 billion over 5 years, of which \$750 million worth of DP funds are placed in pool fund

# Some Facts

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- Population - 132 millions
- 900 persons per square kilometre
- 98% Bengalis
- Urban population - 20%
- 40% under 15
- Population growth rate 1.6%

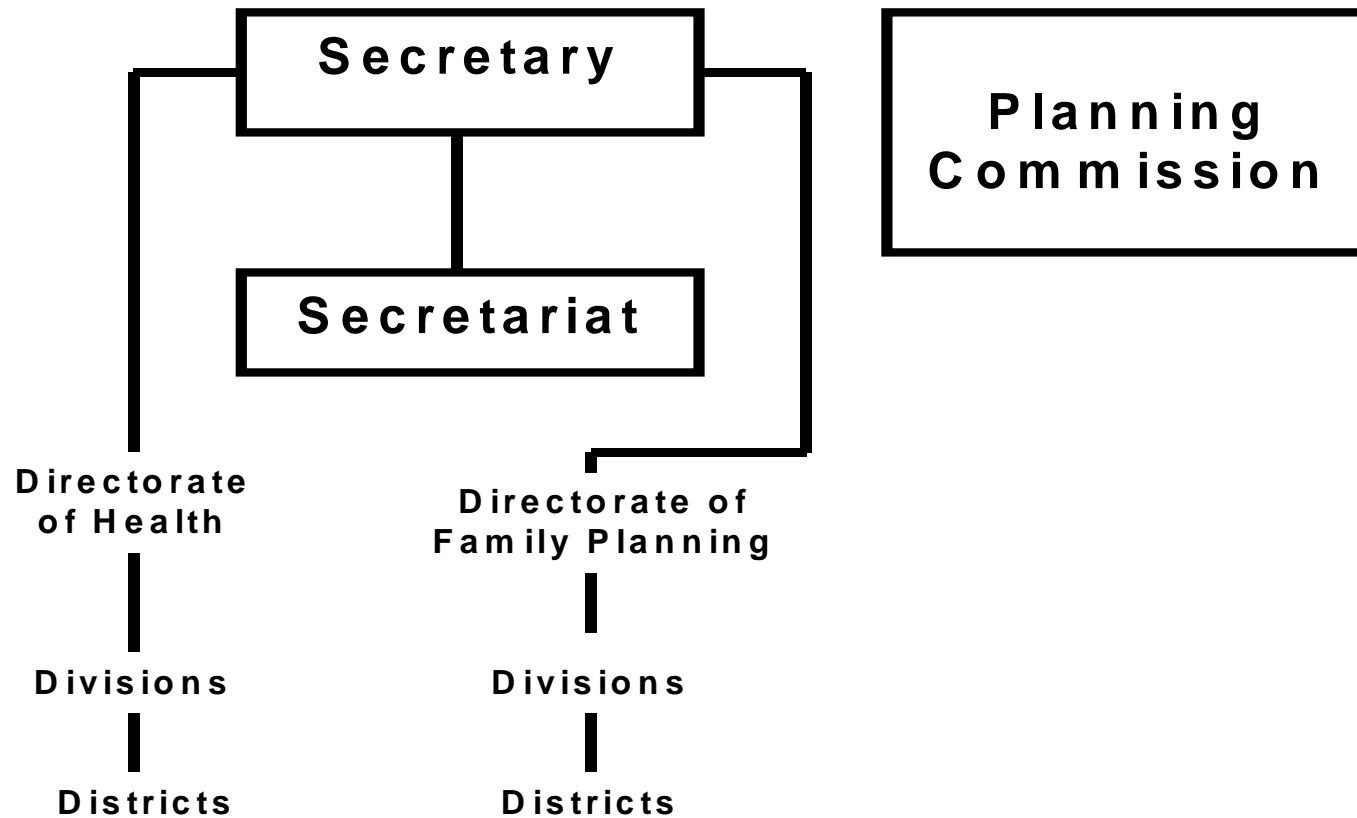
## More Facts

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- Per capita GDP - \$275
- Per capita health expenditure - \$11
- Govt/EDPs Expenditure - \$4
- Household expenditure - \$7

# Health Sector Reform in Bangladesh

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# HSR Initiatives

## 1998 - 2003

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- SWrap
- Merge Health and FP Services
- Decentralise
- Introduce Essential Service Package

# Key milestones

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- 1996/7 Preparation of a Health Sector Strategy agreed by EDPs and GoB
- 1997 Capacity appraisal. Setting up of Project Preparation Cell
- 1997/8 Preparation of detailed Project Implementation Plan
- **July 1998 Start of HPSP. 140 projects integrated into one programme with 28 operational plans headed by line directors**

# Swap

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- GoB ownership
- Donors to be development partners (investors not donors)
- Involvement of GOB, NGO and Private sectors
- Unification of financial systems
- Unification of Performance management

# Planning/ Support

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- PIP
- 28 centralised operational plans
- Log Frame methodology
- Identify sources of funding
- Output based
- Management Change Unit

# What has worked

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- Major transfer of ownership
- Vision for structure gradually being implemented
- Considerable capacity building
- Management change unit
- Project completion unit

# What has not worked

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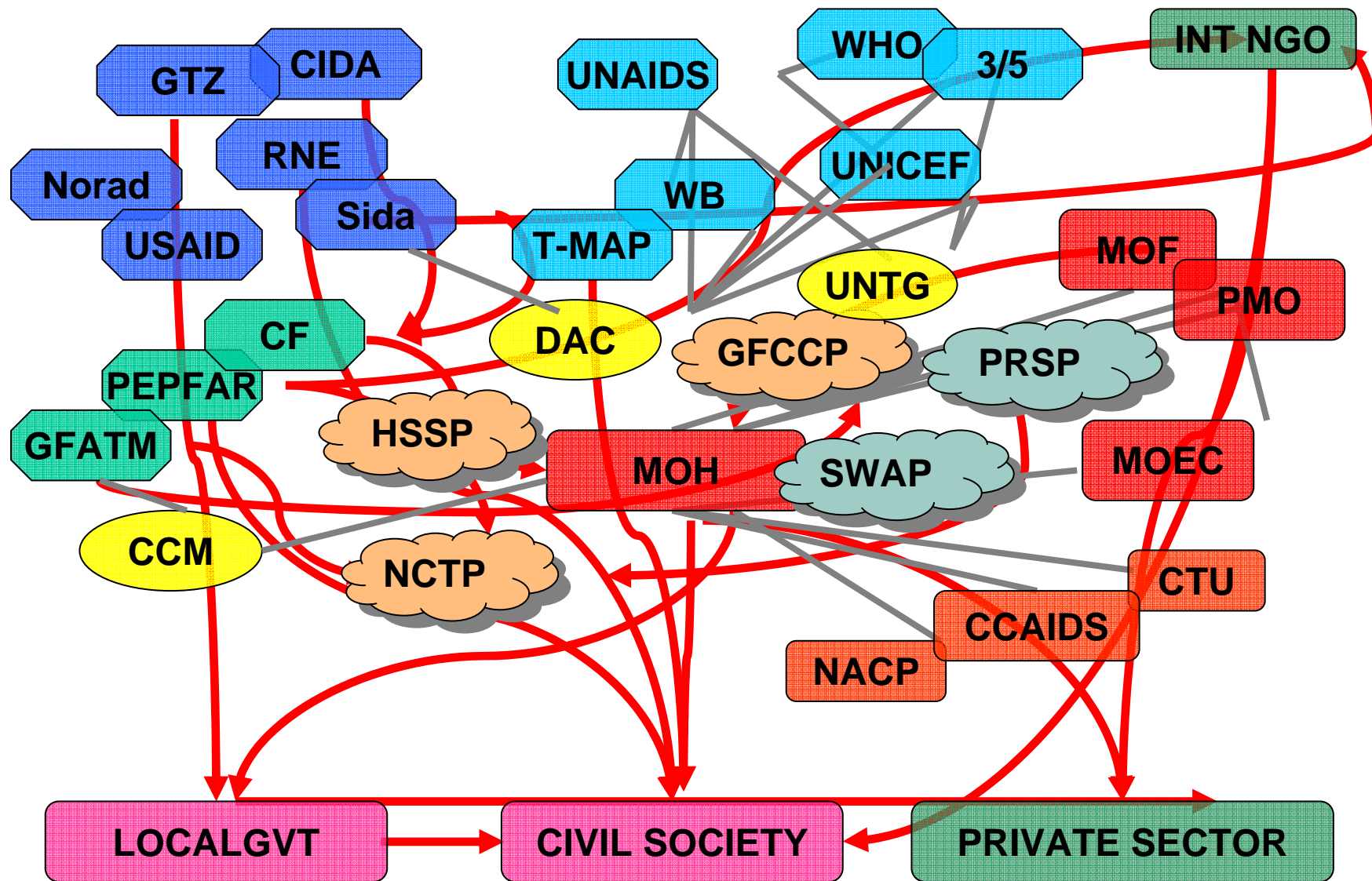
- Procurement
- Involvement of NGOs
- Improvement of health service delivery
- Shift of resources to poor
- Gender

# Key problems

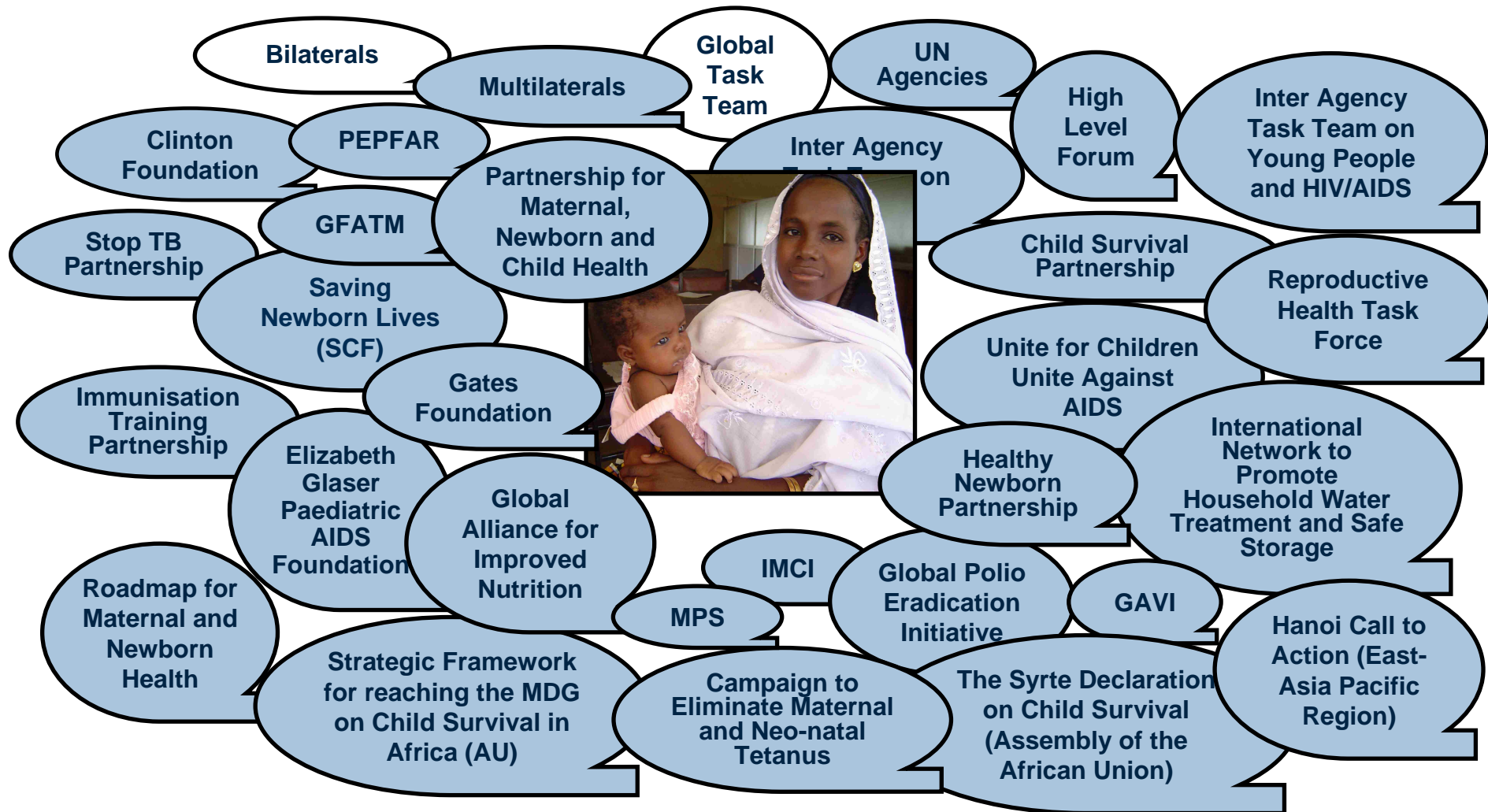
- Staff turnover in planning commission and finance ministry
- Staff turnover in development partners
- MAJOR TURNOVER IN GOVERNMENT – ELECTION BROUGHT IN NEW PARTY

# The aid effectiveness challenge...

(source: Millennium Project 2005)



# MNCH: (some) initiatives and actors



# Aid Architecture -timescale

- 1996 First Swap Ghana
- 1997-9 Second Swap Bangladesh
  
- 2005 Paris declaration on Aid Effectiveness

# **Paris Declaration on Aid effectiveness March 2005**

- All DAC members
- Ownership, alignment ,harmonisation
- Follow country processes and systems
- Majority of all aid through programme based approaches by 2010

# Paris Principles -Ownership

Partner Countries exercise leadership over development policies and strategies and coordinate development action

# Paris Principles-Alignment

- Donors base their support on national development strategies, institutions and procedures

# Paris principles -Harmonisation

- Donors actions are more harmonised ,transparent and collectively effective

# Paris Principles –managing for results

Focussing on desired results and using information to improve decision making.

## Paris principles-Mutual accountability

- Countries –involve parliament in development strategy and budgets
- Donors are transparent about Aid flows
- Jointly assess progress

# Global Partnerships

- Global coordination mechanisms
- Often disease or programme specific
- Improvement of access to products
- Product development
- Raise Finance
- Public advocacy

# Health Sector Funding in Uganda

| <b>Financial year</b> | <b>Govt. of Uganda</b> | <b>Donors</b>      | <b>Health as % of GoU budget</b> |
|-----------------------|------------------------|--------------------|----------------------------------|
| <b>04/05</b>          | <b>\$ 219.56 m</b>     | <b>\$ 254.85 m</b> | <b>9.7</b>                       |
| <b>05/06</b>          | <b>\$ 229.88 m</b>     | <b>\$ 507.26 m</b> | <b>9.0</b>                       |
| <b>07/08</b>          | <b>-</b>               | <b>-</b>           | <b>( 8.3 )<br/>projected</b>     |

Source: Claes Ortendahl –personal communication

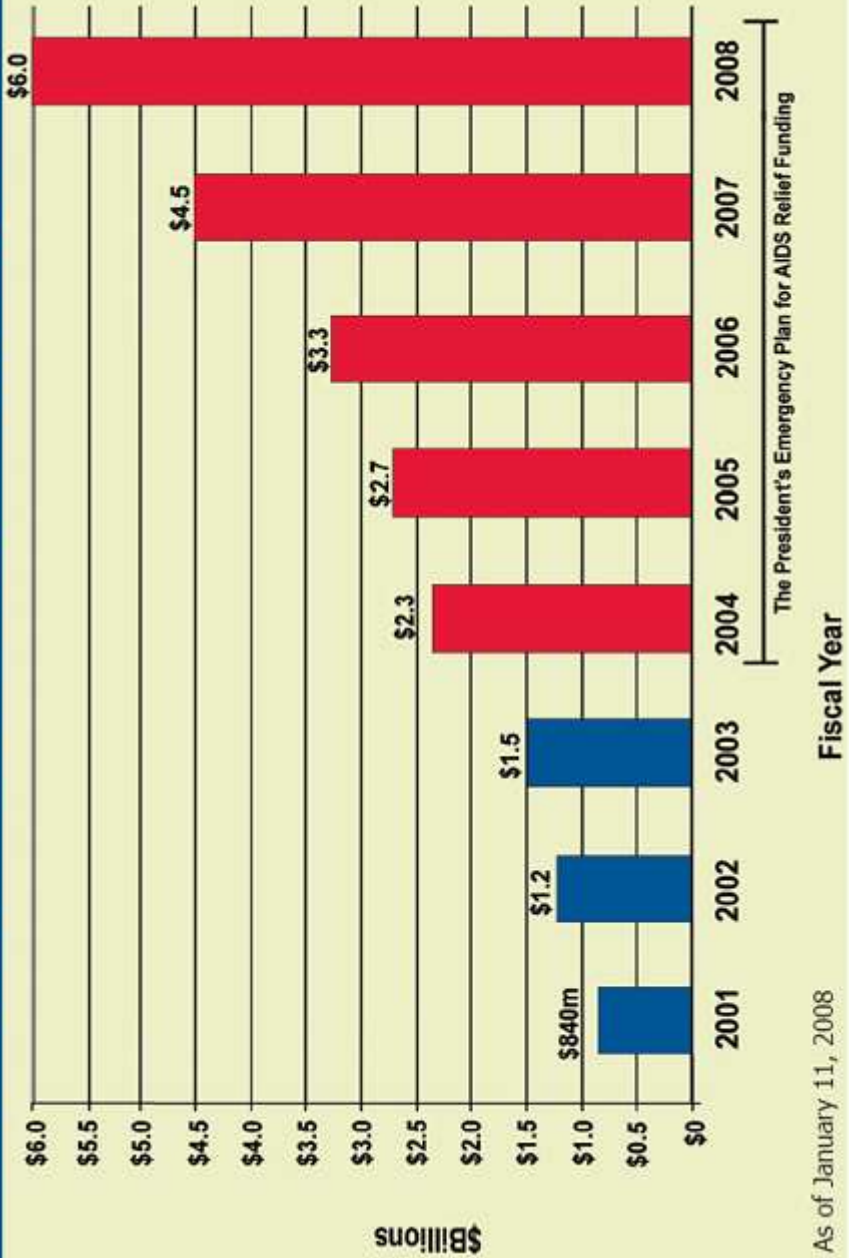
# Why?

- Donors give money for different reasons
- Massive explosion in donors and multi lateral bodies
- It is often easier to come up with new ideas than implement the old
- Politicians have 3 yr time frames
- New ideas tend to come from Geneva/Paris/London/Washington etc – rather than from LDCs

# Aid architecture is much more complex

- Many more bilaterals
- Many more global partnerships
- Many more UN bodies

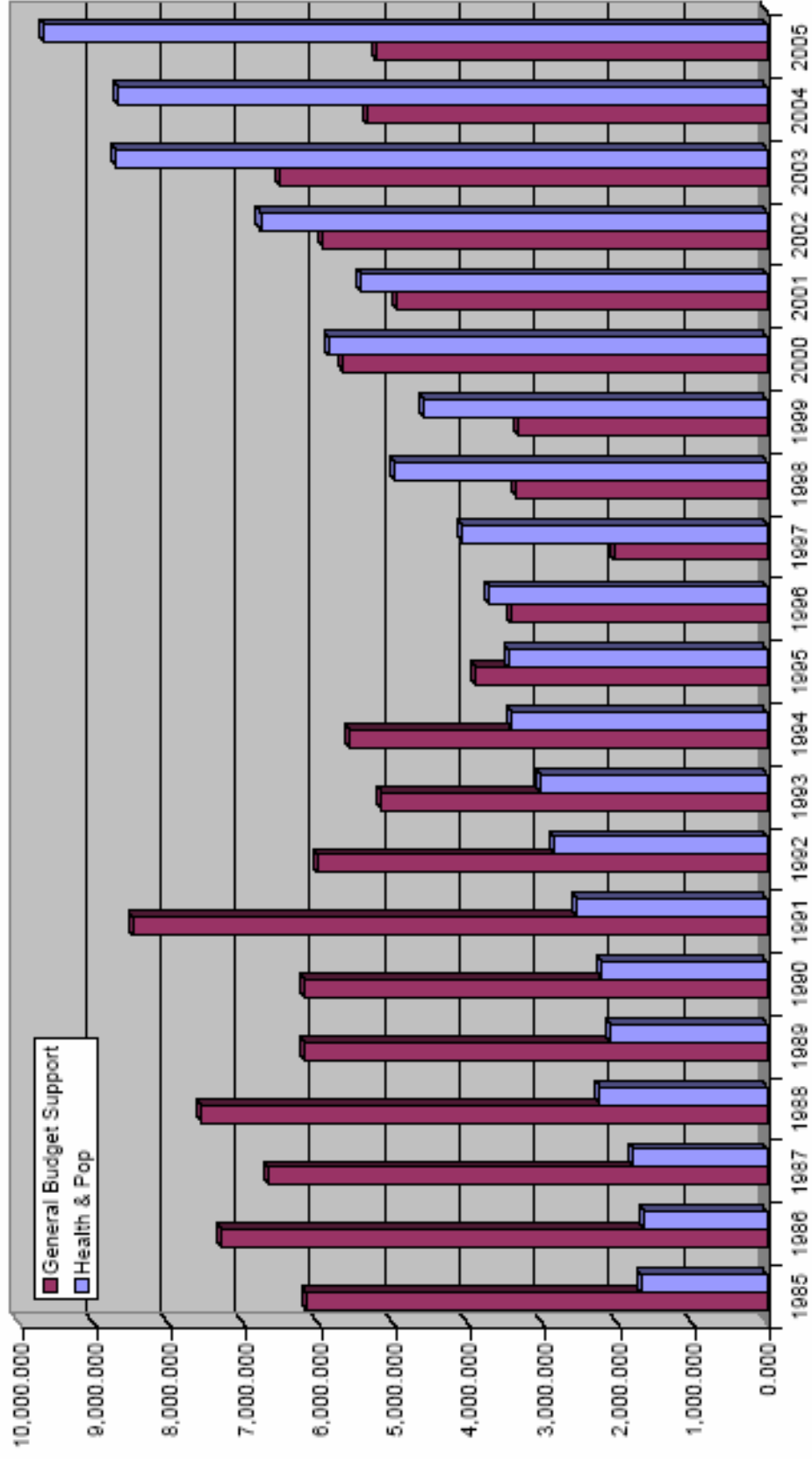
# Total USG Contribution to Global HIV/AIDS: 2001-2008 (in Billions)

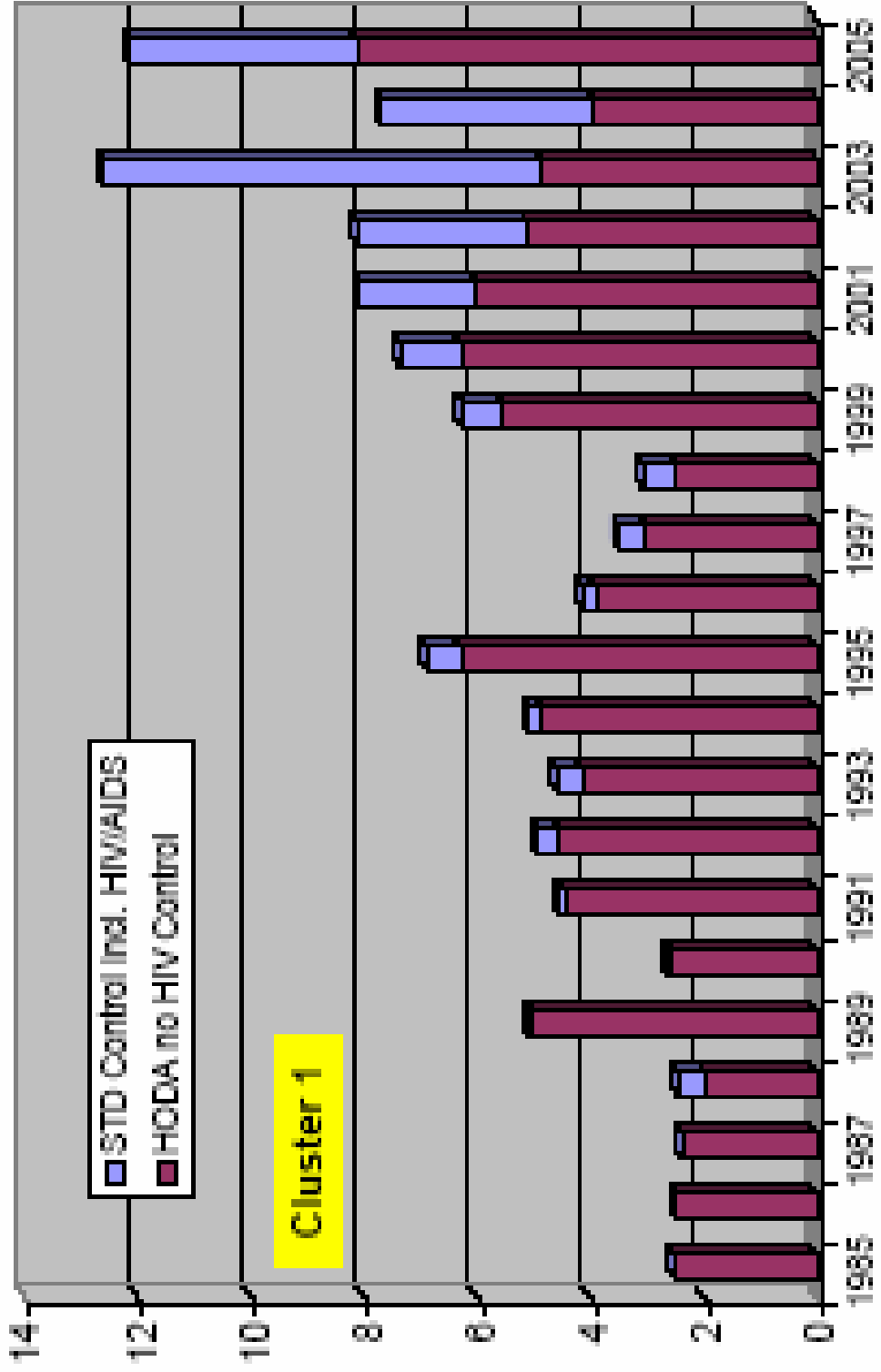


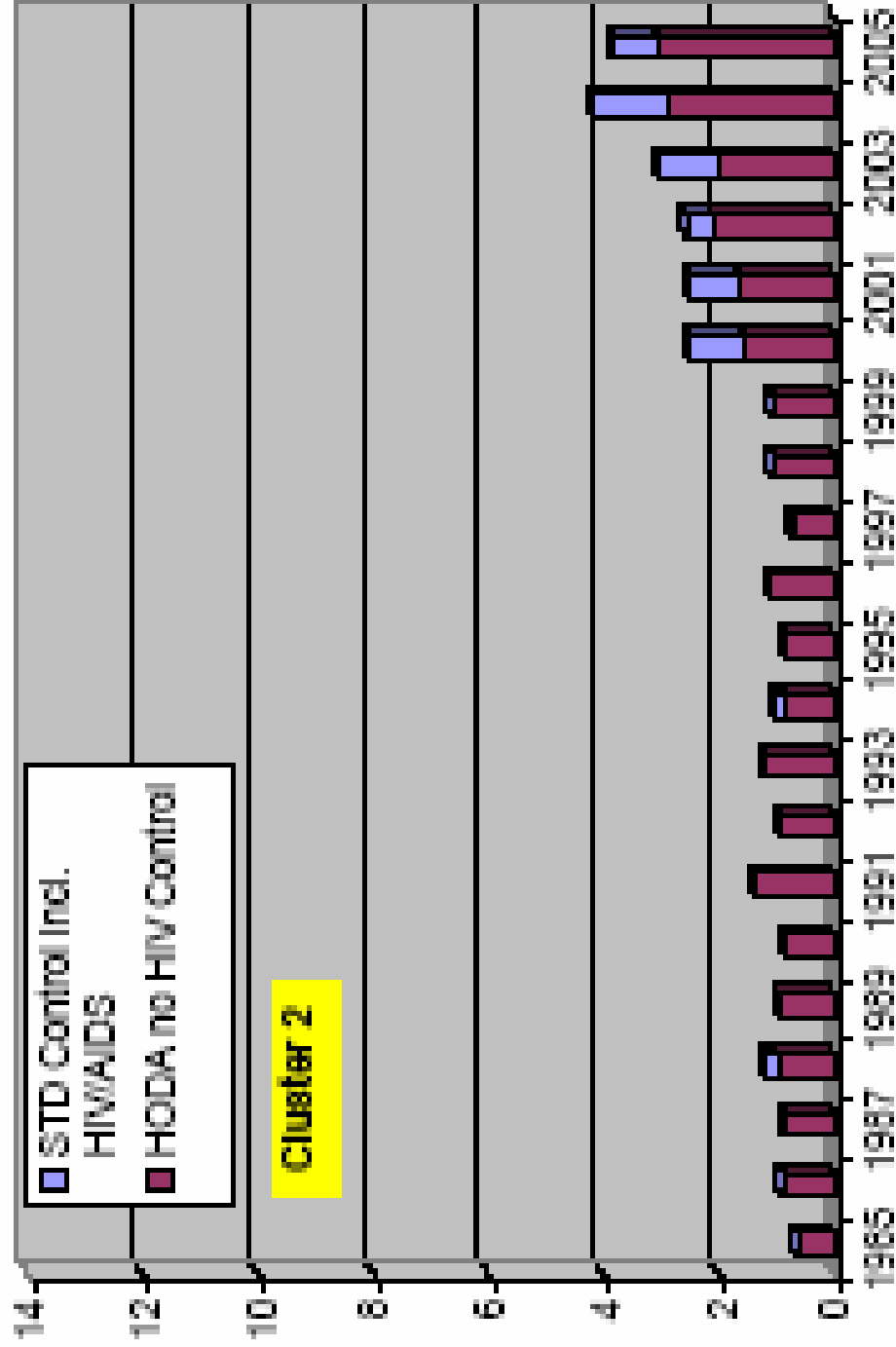
# Rwanda Case Study (WB/HLF):

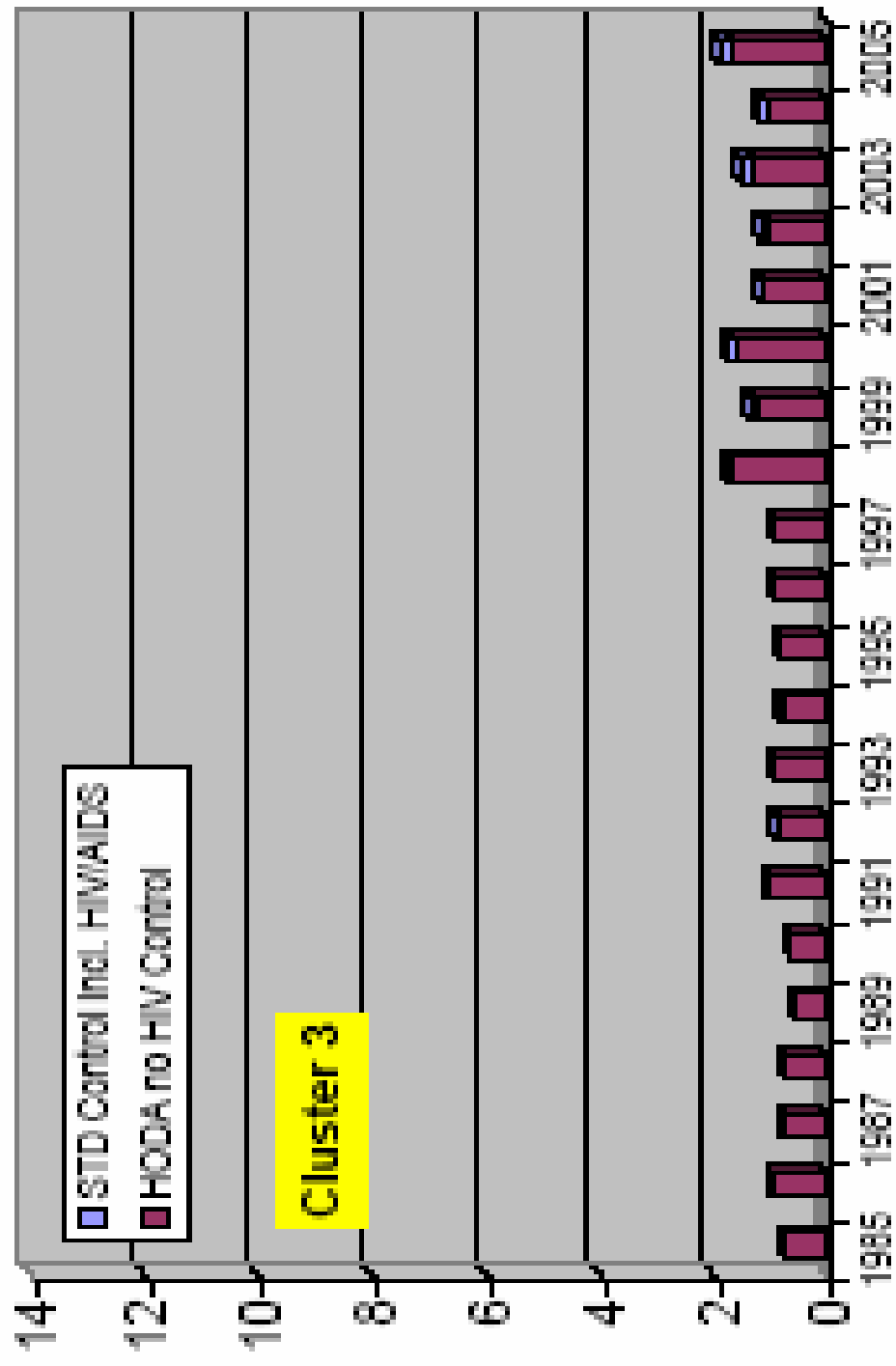
- Costed health strategy and plan.
- Good PRSP and Budget support
- Currently spends \$10 per capita. Needs additional \$20 per capita to achieve plan
- 15% of external assistance goes through Govt.
- 40 external DPs
- HIV/AIDS \$47million / IMCI \$1 million

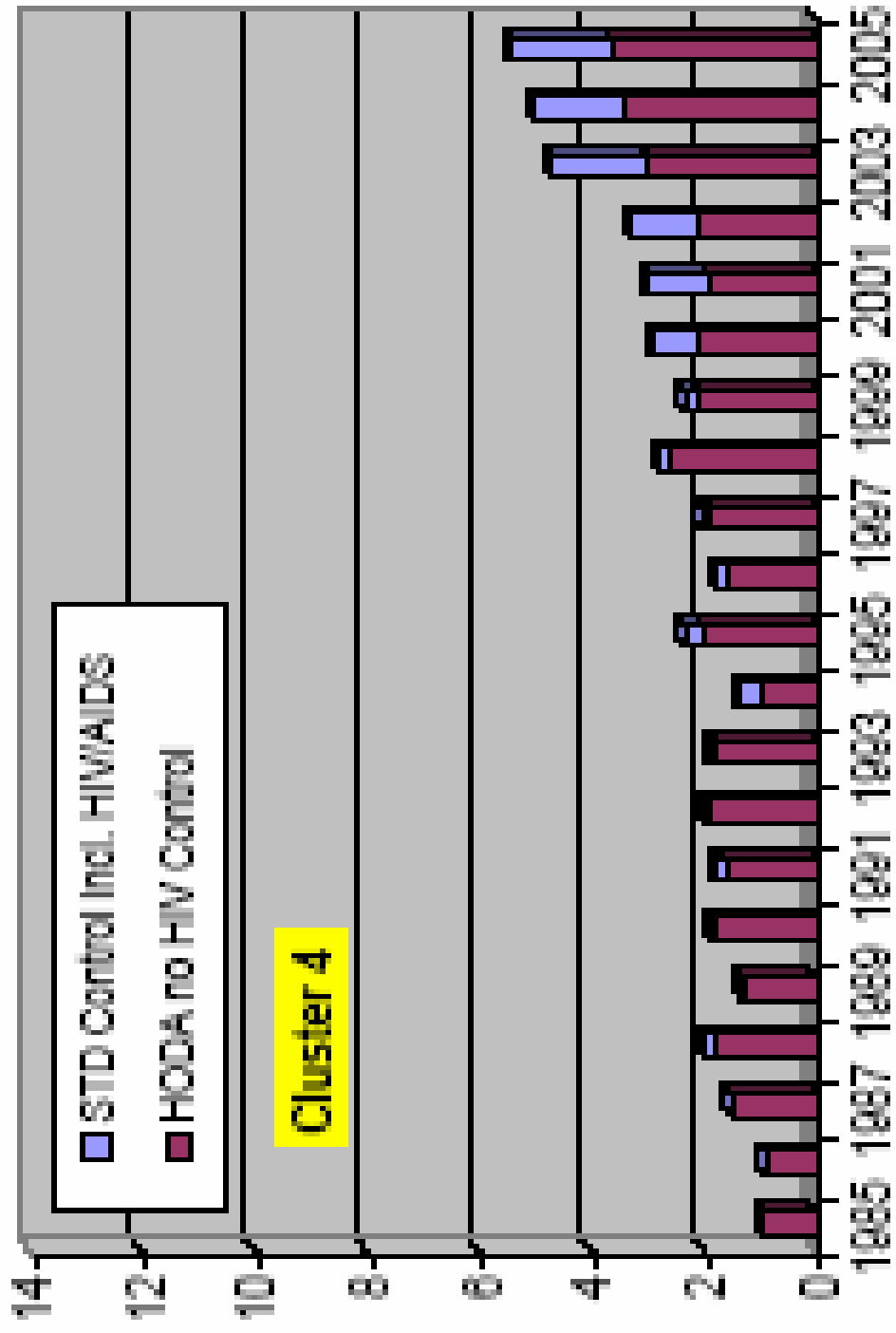
1985-2005 - General Budget Support vs Health and Pop (US\$ 000)











# New funders

1994-2007

- Gates \$7.8billion

1996-2004

- 22 Bilaterals \$12.2billion

# Conclusions and summary points

- HIV/AIDS and STD control are capturing a growing share of HODA, reducing the amount that countries can allocate flexibly. This is likely to be a constraint on health systems strengthening and on scaling up the delivery of services.
- The amount of aid channelled through sector and budget support programmes remains low, despite recognition that this is one of the most efficient forms of channelling aid.

# Conclusions and summary points

- the discretion to make spending decisions at country level is decreasing, as global and regional priorities dominate aid allocation..
- The allocation of health aid between countries in similar circumstances grossly favours some countries at the expenses of others: countries with comparable levels of health need receive remarkably different levels of aid.
- countries with large populations are relatively disadvantaged relative to smaller countries..

# Aid Architecture in Health

- Well documented explosion in GHPs
- Fragmentation in global governance
- Paris declaration
- Post Paris initiatives

- We should move towards a model of health aid delivery structured around the country priorities, in line with the Paris Declaration. This would mean a country-led discussion where various global concerns could be put on the table, merged and co-ordinated with national priorities
- Better co-ordination is needed at global level to ensure these "donor orphans" are recognized and supported

# Recent Developments in global health governance 1

- Paris Declaration
- High level Forum
- Best practice principles for GHPs
- GAVI and GFATM health systems windows
- NORADs MDG 4& 5 initiative
- Global surveillance and response network
- Framework convention on tobacco control

# Recent Developments in global health governance-2

- One UN reform programme
- H 8 group of countries
- International health Partnership

# Implications for WHO-global level

- Transaction costs of being a host for GHPs
- Transaction costs of participation in GHPs
- Duplication of GHPs with technical programmes
- Ability to maintain lead technical role when substantial \$ in External GHPs

# Implications for WHO-global level

- Need to engage in one UN while ensuring its role as lead technical health agency is not compromised
- Need to be able to meet expectations as joint health systems lead (with WB) for IHP

# Implications for WHO-country level

- Need to provide leadership for IHP
  - lead independent technical agency to support governments for H&A ( Swap with teeth)
- Need to work through implications of one UN by active participation in pilots
  - Ensure technical role is not compromised