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**Development Assistance for Health in Tanzania:
Has the Sector Wide Approach achieved the principles of aid
effectiveness?**

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Thesis submitted in accordance with the requirements for the degree of

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Department of Global Health and Development

Faculty of Public Health and Policy

LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE

Funded by the Economic and Social Research Council

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Social and Mathematical Epidemiology

I, Melisa Martínez Álvarez, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

A handwritten signature in black ink. The word "Melisa" is written in a cursive style, with a large loop above the 'M' and a long horizontal stroke extending to the right from the end of the word.

Melisa Martínez Álvarez

ABSTRACT

Increasing levels of development assistance have been coupled with increased attention to its effectiveness, resulting in a series of international declarations outlining an agenda of five principles of aid effectiveness: ownership, alignment, harmonisation, management for results and mutual accountability. This PhD thesis examines whether the Tanzanian health Sector Wide Approach (SWAP) has achieved these principles.

It uses a case study approach, mixing quantitative and qualitative methods. It first maps out the health policy and financial landscape of Tanzania since the introduction of the SWAP. The thesis then explores the international aid effectiveness agenda and develops a set of indicators to assess its achievement in the Tanzanian health SWAP. This includes analysing external and domestic health financing flows over the last ten years; document review of key processes and in-depth interviews. The application of this indicator framework shows mixed results. Better progress is found towards indicators from international declarations, which are based on having aid-management processes in place, than towards those developed as defined by local stakeholders. Institutional factors, including the incentives of the institutions and individuals involved in aid relationships, as well as the political context within which aid relationships take place, are found to be key in explaining these results.

A political economy approach is then undertaken to characterise and explore these factors further. Individual and institutional incentives are found to be unaligned with aid effectiveness principles. Furthermore, the structure of the SWAP is technocratic, excludes important stakeholders and does not fully reflect the political context and power dynamics of aid relationships. This thesis finds fatigue and disengagement with the SWAP and the aid effectiveness agenda, and recommends that the international community engage in SWAP as a process of institutional reform rather than just a technocratic solution to development assistance. Principles of aid effectiveness should allow for greater adaptation to national

contexts. More research is needed to further integrate political and economic elements of frameworks to analyse aid relationships and deepen our understanding of how best to achieve institutional reform and improve aid effectiveness.

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ABBREVIATIONS

BFC	Basket Fund Committee
CAQDAS	Computer Assisted Qualitative Data Analysis Software
CCHP	Comprehensive Council Health Plan
CHMT	Council Health Management Team
CRS	Creditor Reporting System
CSO	Civil Society Organisation
DAC	Development Assistance Committee
DAH	Development Assistance for Health
DAH-G	Development Assistance for Health channelled through the Government
DALY	Disability-Adjusted Life Year
DP	Development Partner
DPG	Development Partner Group
DPG-H	Development Partner Group for Health
FBO	Faith-Based Organisation
GBS	General Budget Support
GDP	Gross Domestic Product
GHE-A	Government Health Expenditure as an agent
GHE-S	Government Health Expenditure as a source
GHI	Global Health Initiative
GoT	Government of Tanzania
HBF	Health Basket Fund
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome

HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
IDA	International Development Association
IHI	Ifakara Health Institute
IHME	Institute for Health Metrics and Evaluation
IHP	International Health Partnership
IMF	International Monetary Fund
JAHSR	Joint Annual Health Sector Review
JAST	Joint Assistance Strategy for Tanzania
LGA	Local Government Organisation
LSHTM	London School of Hygiene and Tropical Medicine
MDG	Millennium Development Goal
MoF	Ministry of Finance
MoHSW	Ministry of Health and Social Welfare
MOU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NGO	Non-Government Organisation
NHA	National Health Accounts
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
PA	Principal Agent
PBA	Programme-Based Approaches
PEPFAR	United States President's Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PFM	Public Financial Management

PIU	Parallel Implementation Units
PMO-RALG	Prime Minister’s Office Regional Administration and Local Government
POPSM	President’s Office Public Service Management
RHMT	Regional Health Management Team
STI	Sexually Transmitted Infection
SWAP	Sector Wide Approach
TACAIDS	Tanzania Commission for AIDS
TNCM	Tanzania National Coordination Mechanism
TAS	Tanzanian Assistance Strategy
TGE	Total Government Expenditure
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
US	United States
USD	US Dollars
WHO	World Health Organisation

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1 INTRODUCTION

There has been a long history of high-income countries providing development assistance to low- and middle-income countries, most pledging to devote 0.7 per cent of their Gross Domestic Product (GDP) for this purpose (1). Although most countries have not met their target, the amount of development assistance has risen exponentially over the past ten years.

The history of development assistance has taken many turns, with infrastructure and 'hard' sectors being favoured in the earlier decades, and 'softer' social sectors preferred in the first decade of this century. The health sector has received particularly generous funding, having quintupled from US\$5.82 billion in 1990 to US\$27.73 billion in 2011 (2). The amount of Development Assistance for Health (DAH) roughly remained at the 1995 level until 2000—the new millennium saw a surge in DAH. This increase in funds has been accompanied by a proliferation of actors who provide, manage and spend DAH (3), who deliver development assistance for health using different funding modalities, including project, programme aid, sector wide approaches and budget support (4).

However, the global financial crisis has taken its toll, and after peaking in 2010, the amount of total DAH globally fell in 2011; it has not been a dramatic fall, but it has certainly confirmed worries regarding the sustainability of continuous increases in funding (5).

Increases in development assistance and worries about its sustainability, together with the increasingly complex and dynamic aid architecture, have resulted in widespread interest in the effectiveness of development assistance, with a growing literature seeking to assess whether it has had any impact on growth and social development. This PhD thesis seeks to contribute to this emerging literature by assessing the implementation of the aid effectiveness agenda in the Tanzanian health Sector Wide Approach (SWAP).

1.1 Aim

The aim of this PhD study is to develop and apply methods to assess and explain the achievement of the global aid effectiveness agenda at the country level, using the Tanzanian health Sector Wide Approach as a case study.

1.2 Objectives

The specific objectives of the thesis are:

1. To describe the history and the current structure of the Tanzanian health SWAP policy landscape
2. To analyse health financing flows (domestic and external) to Tanzania during the time period of 2000-2010
3. To develop a set of indicators to measure whether the implementation of the Tanzanian SWAP is consistent with the principles outlined in the global aid effectiveness agenda
4. To apply the indicators developed to assess the extent to which aid effectiveness principles have been achieved
5. To explain the achievement of the aid effectiveness agenda through an analysis of institutional factors and relationships between the actors present in the Tanzanian health SWAP using a political economy framework
6. To develop policy recommendations based on the findings for national policymakers implementing SWAPs, development partners and researchers at the national and global level

1.3 Structure of the thesis

After this introduction, this thesis reports on the results of a literature review conducted to describe the DAH architecture, explore how aid effectiveness has been previously assessed and ascertain the state of the current knowledge on the key factors affecting the effectiveness of DAH and strategies to deal with these (Chapter 2). Chapter 3 then provides an account of the methods used to carry out this study. Chapter 4 describes the conceptual framework underpinning this study. This is followed by a description of the Tanzanian health sector landscape, including key policies and a map of all the actors active in the sector in Chapter 5. Chapters 6-9 then give an account of the results of this PhD research. Chapter 6 provides a map of the health sector financing in Tanzania. Chapter 7 develops an analysis framework to assess whether the Tanzanian health sector wide approach has followed the aid effectiveness agenda. This framework is then applied in Chapter 8. Chapter 9 then utilises the political economy framework outlined in Chapter 3 to explore the institutional factors that may explain the results found. Chapter 10 brings together the findings from all of the study objectives and discusses their relevance and contribution to the literature, and the limitations of the research, before finishing by making recommendations to policymakers and researchers at the national and global level.

2 LITERATURE REVIEW

2.1 Introduction

The aim of this literature review was to examine the current evidence regarding the effectiveness of aid in the health sector, including the measures of effectiveness and analysis methods used, the reasons for lack of effectiveness and knowledge gaps. As we shall see below, this literature shows mixed results, hindered by methodological difficulties and lack of data.

After this introduction this chapter describes the methods used to conduct the literature review, followed by a description of the Development Assistance for Health (DAH) system, including actors and funding trends. The chapter then provides an outline of the methodological challenges in assessing the effectiveness of DAH, a review of the different approaches that have been used to study DAH and the current evidence on whether it works. The chapter then outlines the factors hindering the effectiveness of DAH and reviews the policies adopted by the international community to address concerns about the effectiveness of aid (including DAH). The chapter concludes with a discussion of knowledge gaps.

2.2 Methods

Two broad searches were carried out to identify the methodology and frameworks that have been used to assess DAH and the key factors affecting the effectiveness of aid in general and DAH in particular. These broad searches found a number of key factors hindering aid effectiveness, broadly falling under two categories: how aid is given and institutional factors. Broad searches were followed by more specific searches of each factor, to examine for each factor, its causes, the implications it has on the effectiveness of DAH and what, if anything, has been done about each factor.

Both peer-reviewed and grey literature was searched to avoid publication bias. Three databases (EconLit, Global Health and Web of Science) and several sources of grey literature were searched, including the Eldis and EThOs databases, the Center for Global Development, the Organisation for Economic Co-operation and Development (OECD) and selected module course readings from the London School of Economics and School for Oriental and African Studies. In addition, references of articles were checked and the relevant ones incorporated, using a snowballing technique. When searching for the factors affecting DAH effectiveness, keywords for aid and DAH were used in order to maximise the information obtained (for instance on the consequences or causes of each factor).

Table 2.1: Search terms used for the literature review

Search	Keywords
DAH effectiveness	Aid effectiveness, development assistance, overseas development assistance, ODA, foreign aid, development assistance for health, DAH, Health ODA, International development assistance, IDA
Methodology	Aid effectiveness, development assistance, overseas development assistance, ODA, foreign aid, development assistance for health, DAH, Health ODA, International development assistance, IDA, measure*, method*, assess*, eval*, method*, agency theory, political economy, framework, institutio*, anthropol*, logic model, process evaluation
Accountability	Aid, development assistance, overseas development assistance, ODA, development assistance for health, DAH , accountability, transparency
Allocation	Aid, development assistance, overseas development assistance, ODA, development assistance for health, DAH , Health financing, priority, distribution
Fragmentation	Aid, development assistance, overseas development assistance, ODA, development assistance for health, DAH , fragment*, proliferat*, harmoni*
Fungibility	Aid effectiveness, development assistance, overseas development assistance, ODA, foreign aid, development assistance for health, DAH, Health ODA, International development assistance, IDA, fungibility, domestic expenditure, health
Incentives	Aid, development assistance, overseas development assistance, ODA, development assistance for health, DAH , economics, incentive,
Ownership	Aid, development assistance, overseas development assistance, ODA, development assistance for health, DAH , ownership
Predictability	Aid, development assistance, overseas development assistance, ODA, development assistance for health, DAH , predictab*, budget, commitment, disbursement
Tanzania	Aid effectiveness, development assistance, overseas development assistance, ODA, foreign aid, development assistance for health, DAH, Health ODA, International development assistance, IDA, fungibility, domestic expenditure, health, Tanzania
SWAP	Sector Wide Approach, SWAP, health, harmonisation, coordination, Paris Declaration, Busan, basket, pooled funds, funding mechanism

Table 2.1 shows the search terms used. Search terms were used on their own or in combinations in the abstract, title and topic fields. The literature review was conducted in two stages, first between October 2010 and April 2011 without setting any date limits, to design the study (this has been written up as a Working Paper for the University of United Nations World Institute for Development Economics Research (UNU-WIDER), see Appendix A¹). The literature review was then updated in December 2013, using the same search terms but limiting the dates to 2011-2013.

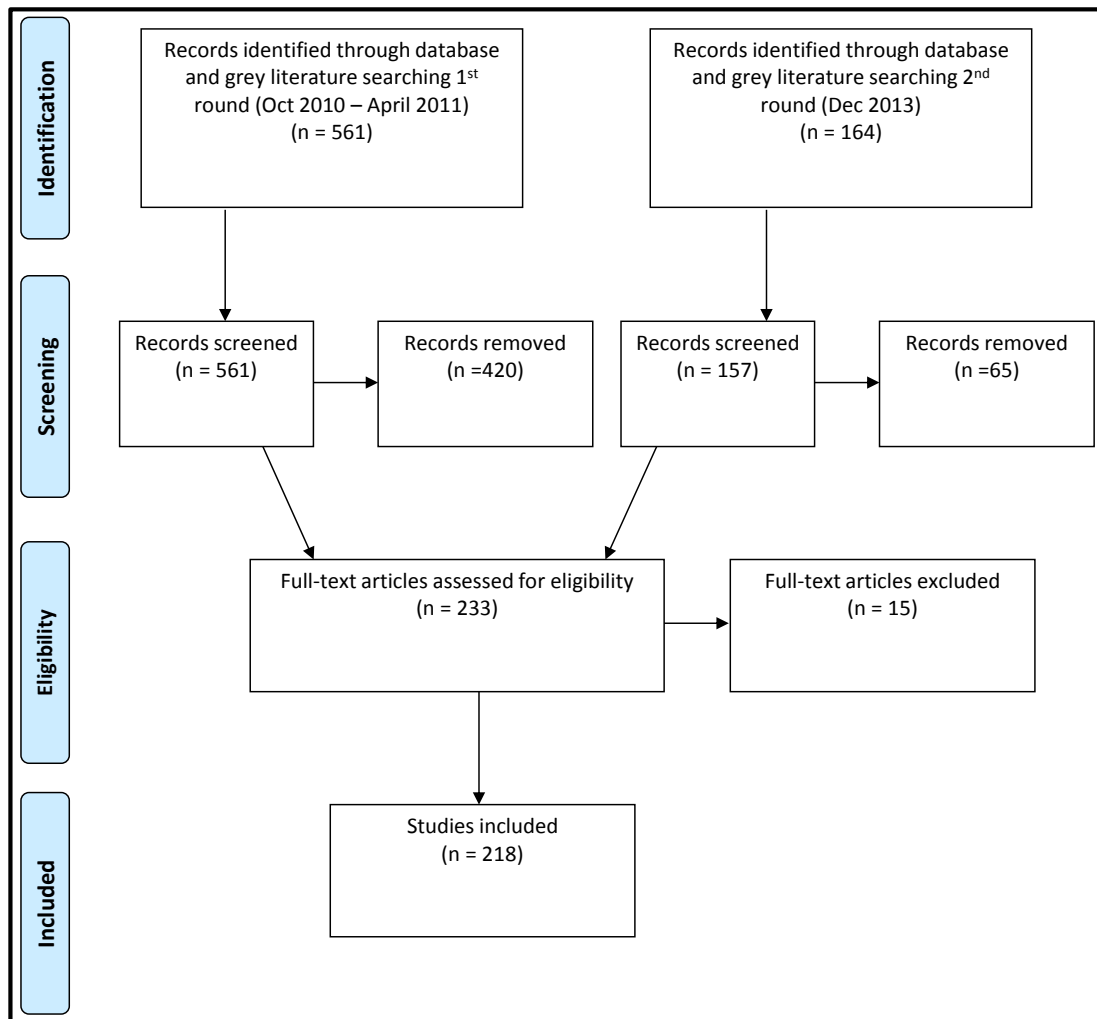
Abstracts were reviewed and included following a set of inclusion and exclusion criteria. Articles were selected if they discussed DAH and were in English, French and Spanish². Two exclusion criteria were adopted. First, studies on humanitarian aid were excluded, as the focus of this work was on assistance for development. Second, studies that did not specifically look at DAH effectiveness (but studied aid in general) were excluded from the methodological search (when reviewing the specific factors affecting the effectiveness of DAH, if no articles were found for a specific factor, inclusion criteria were broadened to include articles or reports studying development assistance in general). All types of studies were included in order to be as comprehensive as possible, given the limited literature available on this subject. In addition, no limits were set on the date of publication of studies.

The diagram shown on Figure 2.1 below shows the number of articles identified and included in the review. From the initial search (conducted in 2010-2011), 561 articles and reports were retrieved and 141 included. The second search (conducted in 2013) retrieved an additional 157 articles and reports, of which 92 were included. A total of 218 studies were included in the review.

¹ MMA wrote sections 1, 3, 4 and 5; AA wrote section 2 and contributed to section 4.1. Section 6 was written jointly.

² Languages readily understood

Figure 2.1: Articles identified, reviewed and included³



2.3 The DAH system

This section describes the DAH system, including funding flows, the different agencies involved, the channels through which DAH funds are delivered and the current status of the literature on them.

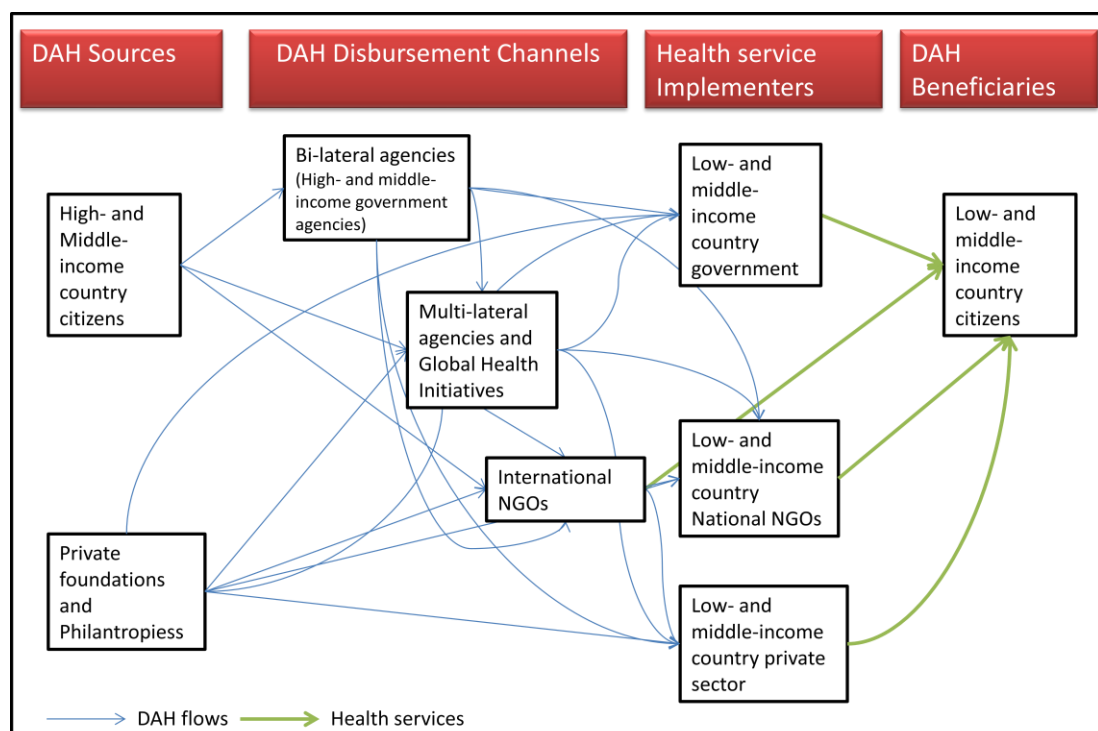
DAH has consistently increased from the early 1990s, but has experienced exponential growth from the year 2000, peaking at \$28.2 billion in 2010 (5). Growth has been attributed to three diseases (HIV/AIDS, Tuberculosis and Malaria), and new initiatives, such as the GAVI Alliance in Support of Childhood Vaccination (5). However, there have been

³ Diagram adapted from the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) initiative (<http://www.prisma-statement.org/>)

fears about the un-sustainability of increases in funding, as total DAH was \$27.4 billion in 2011 and \$28.1 in 2012 (5).

DAH funds are disbursed and channelled through a variety of agencies, making up an increasingly complex architecture. Figure 2.2 below shows schematically the different players and funding flows of DAH, with blue lines representing DAH flows and green lines health services.

Figure 2.2: The DAH system



Actors involved in DAH can be classified as sources, channels, implementers and beneficiaries. DAH sources are members of the general public in high- and middle-income countries, private foundations or philanthropies. Citizens of high- and middle-income countries provide DAH in the form of taxes to their governments or through voluntary donations to international non-government organisations and multi-lateral organisations, which act as channels. Private philanthropies also contribute to these channels, and in addition directly fund recipient country Non-Government Organisations (NGOs) and the

private for-profit sector, as well as private foundations. Governments of aid-giving countries either channel DAH themselves (as bi-lateral agencies) or through other channels, such as multi-lateral organisations, international and national NGOs and the private sector. According to figures from the Institute for Health Metrics and Evaluation (IHME), in 2010 38.7% of all DAH was delivered through NGOs, 25% through government entities and the rest through multi-lateral agencies (5). Citizens of the United States (US) and Canada provided more funding through NGOs (about half of all DAH flows) than European countries, which channelled more funds through bi-lateral and multi-lateral agencies (5). Bi-lateral and multi-lateral organisations deliver DAH funds to implementers of health services, which include recipient country governments, NGOs and the private sector, who in turn provide health services to beneficiaries. International NGOs and some multi-laterals, such as the World Health Organisation, also provide health services themselves (5). The rest of this section provides a description of the agencies involved in channelling DAH funds (Development Partners (DPs)), as they are the focus of this thesis.

Bi-lateral development partners

Bi-lateral DAH is characterised as being from a donor country to a recipient, and has been praised for fostering political and economic ties between donor and recipient countries (6). Bi-lateral channels of DAH have traditionally been governments of high-income countries, particularly from Western Europe, North America, Australia and New Zealand, belonging to the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD-DAC). The latest report from the IHME found that the amount of DAH channelled through bi-lateral agents has decreased by 4.4% in 2012 (5). The report found that the US was the largest donor of DAH in 2010, providing \$10 billion (35.6% of total DAH for that year). European countries showed mixed trends, probably as a result of the turbulent economic climate in the region. The UK was the second biggest provider of DAH,

giving \$2.3 billion in 2010 or 8.2% of the total; however, this figure represented a decrease relative to 2009. Between 2009 and 2010, DAH from Norway increased slightly (by 0.5%), but Spain, Germany and Netherlands all decreased their DAH contributions by 25.4%, 9.5% and 5.9% respectively. Non-European OECD countries (Japan, Canada and Australia) increased their DAH contributions significantly in 2010. Projections for 2012 and beyond do not look optimistic, however, with the IHME report quoting that most countries have dropped their overall Official Development Assistance (ODA) amounts; with similar patterns expected from DAH.

There has been recent attention in the literature to new and emerging donors, who do not belong to the OECD-DAC, but are increasingly engaging in South to South co-operation. So far the evidence indicates that there are no significant differences between new and old DPs in their distribution of aid, except that new DPs appear to be less influenced by the level of corruption of the recipient country when making decisions about aid allocation (7) and that some, such as China, favour infrastructure, whereas DAC DPs prefer social sectors (8). However, differences have been found with regards to aid management practices. Non-DAC DPs mainly engage in project assistance and technical co-operation (9), with Chinese assistance programmed through high level discussions and sometimes visible projects, whilst DAC DPs favour (although do not fully rely on) development assistance strategies, budget support and pooled funds (8). In addition, DAC DPs operate under a set of aid effectiveness declarations (see below), which non-DAC have not fully endorsed (for instance, the Chinese government has no interference and tying of aid as explicit principles of aid, whereas DAC DPs have committed (although not fully achieved) to untying of aid (8)).

Non-DAC DPs have been praised for bringing in extra funds and providing more flexible assistance, and have the advantage of being able to provide significantly valuable expertise,

some of them being aid recipients until recently themselves (or still receiving aid) (10). However, there are concerns they are increasing fragmentation, they provide high levels of tied aid, do not engage in the dialogue with partner countries and are unwilling to harmonize with other DPs (9). On the other hand, questions have been raised as to whether this means non-DAC DPs are less effective (11), or indeed whether they should be classified as one homogeneous group (12). For instance, in a study comparing China and DAC DPs in Nigeria and Angola, Brautigam found that Chinese assistance has been more streamlined and faster at reaching its targets than DAC DPs (8). Further, a study conducted in Cambodia found that non-DAC DPs are not just different from DAC DPs, but are also a diverse group in terms of aid strategies and adherence to DAC norms and principles (12). There is therefore a need for concrete case studies to explore how emerging DPs compare to traditional DAC DPs on the ground (11).

A new form of co-operation, known as triangular (or tri-lateral) co-operation, has emerged, where traditional DAC DPs provide assistance to support southern DPs' programmes, given their technical advantage. An example of this is Germany's support for Brazilian HIV programmes across Latin America (9). There has been little academic literature on triangular cooperation, although it has the potential to improve aid effectiveness by harnessing experiences of southern partners, challenging northern DPs and having a better balance of power between providers and receivers of assistance (13). However, these advantages remain to be proved, and there are concerns that trilateral cooperation may have higher transaction costs (13).

Multi-lateral agencies and Global Health Initiatives (GHIs)

Multi-lateral organisations channelled about 36% of all DAH in 2010 (5); they are characterised by consisting of multiple members, and have been praised for being less influenced by the politics of their members than bi-lateral agencies (6). Traditional multi-

lateral organisations include United Nations (UN) agencies and development banks. There are several UN agencies involved in health, including the World Health Organisation (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA). DAH provided by UN agencies grew by 3.4 % in 2012; however, expenditure by WHO fell by 2% in 2012, amounting to \$2.1 billion (5). Development banks include the World Bank and regional banks, such as the African, Asian and Inter-American Development Banks. The World Bank provides DAH in the form of grants and non-concessional loans through its International Development Association (IDA)⁴. DAH expenditure by the World Bank grew by 22% in 2012, spending \$912 million through IDA (5). Regional development banks, on the other hand, decreased their DAH contributions by 17% from 2011 to 2012, distributing a total of \$234 million (5).

Since the year 2000, there has been a proliferation of new initiatives known as Global Health Initiatives, which focus on a single disease or group of diseases. The two most prominent GHIs are the Global Fund for AIDS, Tuberculosis and Malaria (the Global Fund henceforth) and the GAVI Alliance in Support of Childhood Vaccination (GAVI), although there are many others. GAVI's funding increased by nearly 42% from 2011 to 2012, disbursing \$1.8 billion (5). Support for the Global Fund has been less consistent, with its funds decreasing by 17% in 2011, but increasing again by 12.3% in 2012 to make up \$3.1 billion. The emergence of GHIs has received attention in the literature. For instance, a study of two large GHIs in Uganda found that despite government preference for aid to be delivered as general or sector budget support, GHIs delivered their funds as disease-specific projects (14). Conversely, a study comparing different multi-lateral agencies, found that the

⁴ IDA lends money on concessional terms (with little or no interest) or through grants. The World Bank also spent \$1.3 billion in 2012 through the International Bank for Reconstruction and Development (IBRD), which provides non-concessional loans and advice (see <http://www.worldbank.org/ida/what-is-ida.html>)

Global Fund and GAVI were more responsive to civil society needs than development banks, something the authors associate with the different political and civil societal processes leading to the formation of these agencies (15). The debate about the merits of GHIs is part of a broader debate on whether DAH should be delivered as vertical and horizontal programmes, which is reviewed in section 2.5 below.

International NGOs, private sector and philanthropic organisations

International NGOs receive funding from citizens, philanthropic organisations and bi-lateral and multi-lateral organisations (Figure 2.2). The role of these NGOs in disbursing DAH has become more prominent in recent years. However, data from NGOs are harder to obtain, because their funding comes from multiple sources (3) and they do not systematically report DAH flows in a standard manner the way bi-lateral and multi-lateral organisations do (2). Data compiled by the IHME shows that US NGOs experienced a surge in DAH funding from the mid-1990s, peaking in 2009 at \$3.7 billion, but have decreased in subsequent years, having been badly affected by the financial crisis (5). These falls in funding were mostly from governments and private foundations (particularly the Bill and Melinda Gates Foundation) (5).

Private and philanthropic organisations are funded by wealthy contributors; they do not receive funds from citizens or governments (16) and have become important players in recent years. There is no centralised system for tracking DAH flows from private and philanthropic organisations (16), although some do report to global DAH databases and publish financial reports on their websites. For instance, according to its website, the Bill

and Melinda Gates foundation spent almost \$2 billion in global health grants in 2011, the main support being towards vaccines, HIV/AIDS and malaria⁵.

The private sector has also been an important source of DAH funds, particularly from pharmaceutical companies (3), with the International Federation of Pharmaceutical Manufacturers & Associations Health Partnerships Directory listing 220 partnerships of pharmaceutical companies with 160 countries⁶. The private sector is also increasingly used to channel DAH through public-private partnerships, particularly by traditional (OECD) DPs (17).

The DAH system is therefore one of increasing complexity, with a growing amount of funds delivered from a variety of sources, through numerous channels to aid recipients. This is further complicated by the dynamic nature of the DAH system, with the amount of funds fluctuating in recent years and worries about sustainability, new actors emerging and traditional actors adapting to the evolving nature of the system. The rest of this chapter describes the efforts undertaken by the international and research communities to assess and improve the DAH system.

2.4 Frameworks and methods for examining aid effectiveness

This section reviews the different methods and frameworks that have been used in the literature to study the effectiveness of DAH, highlighting the methodological difficulties these studies face. The DAH studies found in this literature review were classified according to four dimensions: the criteria used to assess DAH (effectiveness with regard to *what*), geography (single or multiple country studies), methods (quantitative versus qualitative) and the framework they use (policy, economic, realist/logic model). This section is structured around the first dimension – the criteria studies use to assess DAH. These

⁵ <http://www.gatesfoundation.org/Who-We-Are/General-Information/Financials/2011-Annual-Snapshot-of-Grants-Paid>

⁶ <http://partnerships.ifpma.org/pages/>

criteria include: inputs (financial resources), process (relationships and institutions), outputs (human resources for health, healthcare utilisation) and outcomes (mortality, disease burden), based on the logic model proposed by Cummings to assess aid effectiveness (18). For each of these criteria, the types of studies, methods and frameworks that have been used to assess DAH are described.

The intuitive approach to study DAH effectiveness would be to compare trends in health outcomes (typically mortality) and development assistance. This has mainly been done through the use of quantitative methods. A commonly used outcome is infant mortality, which has been used by Mishra and Newhouse (2007) to assess the links between DP expenditure and infant mortality (19), by Wilson (2011) to test the effect DAH has on infant and child mortality (20) and Burnside and Dollar (1999) to examine the effect of ODA on infant mortality (21). There has also been one study assessing health outcomes in a single country, conducted by Masanja et al. (2008) in Tanzania, to assess the effect of increasing health expenditure (including DAH) on child mortality (22). In addition, Bendavid and colleagues assessed the impact of DAH provided by a single agency (the United States President's Emergency Plan for AIDS Relief (PEPFAR)) on all-cause adult mortality (23). Finally, a series of cross-country regressions have assessed the outcomes of DAH targeted to specific priorities, for instance the impact of funding for HIV/AIDS on the outcomes of treatment and prevention of HIV and other Sexually Transmitted Infections (STIs) (24), the effect of investment in malaria on child mortality (25) and the impact of investment in maternal and newborn health on newborn survival (26).

However, a recent systematic review on the effects of funding for HIV and Tuberculosis, found few studies that could demonstrate impact, as most studies focused on statistical association rather than contribution or causation (27). There are inherent difficulties in attributing changes in health outcomes to DAH. The first and most important problem is

the lack of good-quality data, as recipient countries often have weak health management and information systems, with incomplete and inaccurate data on health care expenditure, utilisation and health outcomes. Second, questions as to whether aid benefits recipient countries are confounded by endogeneity problems, including reverse causality. This is the case for ‘donor darling’ countries with a large number of DPs along with large per capita development assistance. Indeed, Cassen (1986) and Wilson (2011) have noted the tendency for aid to follow well-performing countries (20, 28). This may indicate that DP countries would like to see their aid work and claim credit for good performing countries, where aid follows good performance while lack of aid follows bad performance. Third, improvements in health outcomes may be lagged as results may take time to be seen (29).

Finally, given the diversity of factors that influence health, there are difficulties with attributing improvements (or indeed lack of) to DAH. This is further complicated by the difficulty of establishing a counterfactual, without which it is not possible to assess what would have happened in the absence of DAH. Cross-country regressions using panel data can overcome some of these problems. However, linking inputs to outcomes has also been criticised for ignoring the “heterogeneity of aid motives, the limitations of the tools of analysis and the complex causality chain linking external aid to final outcomes” (30).

Perhaps due to these methodological difficulties, DAH effectiveness has also been assessed in terms of inputs. This has been done through the use of quantitative methods in several cross-country studies evaluating the distribution of DAH according to need – either defined as Gross Domestic Product (GDP) (31) or disease burden (31-33), or through single country case studies assessing the distribution of DAH inputs according to different health sector activities, including drugs, infrastructure and human resources (34). Some problems arise when contrasting total DAH with GDP per capita, as a few newly emerging middle-income countries—such as India, Pakistan and China—have large populations, and are home to

over 50% of the world's poor (35). Similarly, there have been calls to better target DAH in the Latin America and Caribbean region, which has received a decreasing amount of DAH since the turn of the millennium, and although not the poorest region in the world, it is the most unequal (36).

Other studies have evaluated DAH inputs using different indicators of aid quality. For instance, a study in Uganda assessed DAH in terms of the channels used to disburse funds and the degree of alignment to Ugandan sector priorities (37). Similarly, studies have assessed DAH inputs according to their degree of harmonisation and alignment to country priorities in Zambia (38) or of multi-lateral DAH flows globally (39). In addition, the degree of DAH fragmentation has also been used to assess DAH quality, either quantitatively through cross-country statistical models (40-49) and single country case studies (44), or qualitatively through the use of policy models in Bangladesh (50) and in a three-country study of Ghana, South Africa and Tanzania (51). Finally, the predictability of ODA funds has been assessed quantitatively through cross-country regressions (52), with single country case studies of DAH conducted in Uganda (53) and Zambia (54).

Very few studies were found that assess DAH effectiveness with respect to outputs. With the exception of Flaxman et al., which assessed the distribution of insecticide-treated bed nets across 44 countries in Africa (55), all of the studies found in this review have undertaken a case study approach. One such study used qualitative policy analysis to assess the impact of GHIs on human resources and anti-retroviral rollout in Zambia (56). Another involved a four country case study (Ethiopia, Lao People's Democratic Republic, Liberia and Mozambique) to assess the efficiency and effectiveness of aid flows to human resources for health, including the allocation of DAH and its predictability (57). Finally, a study of the Malawian health Sector Wide Approach (SWAP) assessed the technical efficiency of the essential health package (58).

Finally, a branch of the DAH literature has focused on the process of aid-giving, particularly on the relationships between the institutions involved, including who delivers DAH and how, and the fiscal response of the recipient countries. Purely quantitative cross-country studies, often using statistical models, have been used to assess accountability (59-61), quality of governance (62-63) and fungibility (64-69) of development assistance, both at the central government, and the health sector and sub-sector levels. However, some of these studies have been criticised for relying on data that are not complete or accurate enough (70), the methodology used both to estimate missing values (multiple imputation) and to obtain the results (regression) (71) and for being biased for not distinguishing between on- and off-budget DAH (72). From a more qualitative perspective, the effectiveness of development assistance has been explored from a political economy angle (73-75), including complexity theory (76) and a utility maximization framework (77). Policy models have also been developed to evaluate the Paris Declaration on Aid Effectiveness (78). In addition, individual frameworks have been developed to study accountability (79-84). At a more in-depth level, agency theory frameworks have been used (6, 85), often to explore the relationship between DPs and recipient governments (86) and DPs' incentives (87). At the qualitative end of the spectrum, purely anthropological studies have been conducted to explore aid relationships (88-89).

A few studies have used aid effectiveness declarations as a framework to evaluate DAH in Mali (90) and the Democratic Republic of Congo (91), or to examine DP-government relationships in the context of HIV/AIDS and health systems governance (92). In addition, Ojaka et al. conducted a case study of a civil society organisation (AMREF) to analyse two HIV programmes in Kenya using the Paris Declaration as a framework of aid effectiveness (93). Finally, the principles of the Paris Declaration have been used to assess the quality of Spanish ODA (94) and interventions targeting Millennium Development Goal (MDG) 5 (95).

A final strand of the aid management literature focuses on single DP agencies. For instance, Brown et al. analysed the World Bank's policy impact using literature reviews and participant observation in relation to the concepts of partnership and country ownership (96), Rosser and Bremmer (2013) used a political economy framework to assess the World Bank's performance in Timor-Leste (97) and Nixon explored the reasons for Canada's changes in HIV funding (98).

These studies have been criticised for being too process-driven and for lacking generalisability due to the contextual nature of the findings (99). In contrast, others have highlighted the importance of understanding institutional factors, especially of understanding the incentives, interests and politics within the health sector to better understand aid relationships (100) and have called for more research into these, particularly from political economy angle (101).

This review of the literature only found one study that used mixed methods to study aid effectiveness linking inputs (quantitatively) and processes (qualitatively) in Vietnam (100).

In summary, there is no ideal method to assess the effectiveness of DAH. Evaluating DAH against outcomes is difficult, but evaluations focusing on inputs, outputs and process may not be able to assess the impact of DAH on health. Cross-country regressions can use a breadth of data to highlight issues, but lack details on the local context, institutions and the political and historical background. In contrast, in-depth case studies often lack quality data and are sometimes restricted by the context specific nature of the factors studied, limiting their generalisability.

2.5 Factors affecting the effectiveness of DAH

This section summarises the current knowledge on the key factors hindering the effectiveness of DAH, which include its distribution across countries and priorities, the

funding modality used, the fragmentation of DAH, the fiscal response of recipient countries (fungibility) and institutional factors, particularly a lack of accountability between institutions and towards beneficiaries. For each factor, the current state of knowledge on the causes and implications it has on DAH effectiveness is discussed.

2.5.1 DAH levels and allocation

The amount of DAH has increased dramatically over the past decade. However, this increase has been uneven both between countries and across different health priorities. This section describes the current literature on the distribution of DAH across different countries and health priorities, including a brief account of the debate on the relative merits of horizontal and vertical funds. This is followed a discussion of the reasons behind DAH allocation patterns.

There has been recent interest in the literature on the patterns of DAH allocation across countries. The 2010 IHME Financing Global Health report highlights that the share of DAH allocated to sub-Saharan Africa has increased steadily (albeit departing from low levels of investments) to account for 29% of all DAH in 2008. This makes it the best-funded region in the world (102) and also reflects the severe deficits in health service provision, poor health outcomes in the region and the HIV/AIDS epidemic. A few studies have explored whether DAH is allocated in response to need. A cross-country analysis found no correlation between countries' GDP per capita and the amount of per capita DAH they received, indicating that aid is not targeted to poorer countries, although this trend is improving (31). However, one might argue that the motive of DAH is to improve health, begging the question of whether DAH is targeted to countries with the highest disease burden. The literature highlights some (but not full) correlation between countries' burden of disease and the level of funding they receive (31-32). For instance, a study carried out by Boussalis and Peiffer in 2011 on the determinants of HIV/AIDS allocation found population, per

capita GDP and HIV prevalence to be important determinants of the distribution of DAH (103). In addition, the Countdown to 2015 project, which assesses annual trends in funding towards maternal, newborn and child health in 74 priority countries, found that initially, countries with higher under-five mortality received higher amounts of DAH, but there was no correlation between DAH and maternal mortality (33). However, the targeting of DAH towards countries with higher maternal and child mortality has improved from 2005 (104).

Studies have also evaluated the distribution of DAH towards different priorities. For instance, Ravishankar et al. found that of the US\$13.8 billion DAH in 2007 for which project-level information was available, US\$4.9 billion was spent on HIV/AIDS, compared with US\$0.6 billion on tuberculosis, US\$0.7 billion on malaria, and US\$0.9 billion on health sector support (31). Further, Nugent (2010) found that non-communicable diseases received US\$0.78 per disability-adjusted life year (DALY) in 2007, compared to US\$23.9 per DALY attributable to HIV, tuberculosis, and malaria (105). In a separate study of DAH allocation in 27 low- and middle-income countries, Esser et al. found no correlation between public or private aid flows and disease burden, and a weak but significant correlation of public ODA with health priorities (106). Finally, an assessment of distribution of DAH according to need performed in Uganda found differences in the goods and services that DAH funded; for instance, more funding was allocated to the procurement of drugs than to human resources or infrastructure (34).

The literature therefore suggests there is some targeting of DAH according to need (disease burden), which is improving globally. However, more progress is needed as some conditions and population groups remain neglected. In addition, and linked to discussions on DAH distribution, there has been an active debate in the literature regarding the relative merits of vertical, disease-focused programme funding, and horizontal health system approaches, not least because despite a generally downward trend in the overall amount

of DAH funding globally, agencies providing vertical funds (mainly GHIs) have managed to maintain growth in their level of financing (5). This literature shows mixed results (107), although the evidence on which the debate has been based is scarce.

Proponents for 'vertical' disease-focused programmes have argued that the urgency of tackling the spread of some diseases means specific programmes have to be designed and implemented for them (108-109). In addition, Dodd and Lane (2010) propose that global health partnerships have been successful in raising and delivering funds and can provide longer-term funding, suggesting this is something from which other DPs should learn (110).

On the other hand, others studies have found the evidence to be mixed. For instance, a case study of Global Fund-funded HIV/AIDS projects' interactions with the health system in Ghana found that whilst Global Fund projects have integrated successfully into some health systems components (financing, planning, service delivery and demand generation), parallel monitoring and evaluation and governance structures had also emerged, resulting in inefficiencies (111). These findings have been supported by a subsequent study, which found that PEPFAR had little or no influence on health outcomes not targeted specifically (112) and by a multi-country review carried out by the World Health Organization's Positive Synergies Collaborative Group (2009), which found that there were significant gaps in the data and that while access to services targeted by GHIs increased, there was mixed evidence regarding access to other services (109). In addition, although GHIs were found to have an overall positive influence on health sector governance, there were worries that the performance-based approach employed by GHIs may distort these indicators towards their specific targets (109). Similarly, a seven-country study by Spicer et al. (2010) found that although GHIs (the Global Fund in particular) have had positive effects on coordination at the national level, they increased the complexity of the aid architecture, undermined alignment and lacked harmonization, especially at the sub-national level (113).

Finally, some studies have found vertical funding to be detrimental to the effectiveness of aid, for instance by highlighting that broader health systems constraints slow down progress towards making improvements in these diseases, and in health more generally (107, 114-116). In addition, a case study examining vertical funds, health systems and the SWAP in Mozambique found that vertical programmes gave rise to coordination difficulties, inequalities between the health system components that were financed and those that were not and health worker migration from public sector (117).

A third 'middle' way between horizontal and vertical approaches has been put forward, known as the 'diagonal' approach. This approach consists of using single disease projects and programmes to address broader health systems issues, such as human resources, drug supply and financing (118). Examples of the diagonal approach include the Global Fund's health systems strengthening programmes⁷ and PEPFAR's investments in human resources, supply chains and health systems infrastructure (119). However, there are worries that unless accompanied by an increase in funding, this new approach will fail (120).

This section has so far shown that aid does not always follow need, across countries or priorities. Further, there are disagreements in the literature on whether DAH should be delivered through vertical disease-focused approaches or as horizontal programmes addressing health systems needs. A final strand of the DAH distribution literature focuses on the factors explaining DAH allocation decisions. A study of DAH distribution in 109 recipient countries between 1995-2006 found that countries with more political rights, as well as those with high levels of corruptions receive significantly more DAH, which the author argues may suggest DAH is used to reward political reforms (62). Similar findings were obtained from a study of the factors influencing the allocation of ODA in 146

⁷ <http://www.theglobalfund.org/en/about/diseases/hss/>

countries in the time period of 1990-2007, which found that both recipient need (in terms of size of population and income) and DP interests (including governance and being a former colony) explained ODA distribution patterns (121). In contrast, the above-mentioned study by Boussalis and Peiffer found little evidence of political relationships and the quality of policy environment having much effect on distribution (103).

With regard to DAH allocation to different priorities, two recent studies highlight the political dimensions of priority setting at the global level, where for instance, funding for non-communicable disease control has been largely ignored in the “corridors of power”, despite epidemiological evidence of need (122), whereas the reasons for the emphasis on HIV/AIDS has been explained through the use of a global crisis model, where the response was perceived as one of urgency that needed immediate action, at the cost of broader socio-economic causes and sustainability concerns (123).

Discussions in the literature also indicate that DPs may have non-altruistic motives for giving aid. Countries may use DAH as a strategy within their foreign and security policy (124); for instance, to control infectious diseases that pose a threat to DPs’ national security (125-126). In addition, there is some evidence that priorities are set to serve the interest of DP countries’ foreign policy and trade agenda (127). This is corroborated by an analysis of India’s funding patterns between 2008-2010 across 125 recipient countries, which also found that India gives aid for political and self interest reasons (128). Finally, a study by Stuckler et al. of DAH funding patterns from 15 OECD DP countries in times of financial crises, cautions against ideological political shifts that may affect global and national DAH allocation decisions (129).

There therefore seems to be a mixture of factors explaining DAH distribution patterns, involving a combination of need, political interests and power relations. The current distribution of DAH affects its effectiveness in two ways. First, resources may not be

directed to where they are most needed, limiting potential impact and decreasing efficiency. Second, the popularity of some countries and priorities means that DPs and implementing agencies crowd around them, resulting in DP fragmentation, duplication and competition. Further, vertical funding may hinder coordination and there is a danger these funds only benefit targeted diseases. However, most of the literature evaluates global distribution patterns of DAH, with very little discussion of allocation of DAH within individual countries, taking into account their needs and resource constraints.

2.5.2 Fragmentation

Increased levels of development funding have resulted in the proliferation of the number of DPs and the amount of projects and programmes they fund. This phenomenon is known as fragmentation, and it affects countries differently. A study by Frot and Santiso (2010) found that poor and stable democratic countries, such as Tanzania, which had 1,601 aid projects in 2007, suffer most from fragmentation (44).

Fragmentation of DAH reduces its effectiveness by increasing the transaction costs of aid delivery (130), and thereby decreasing efficiency. Transaction costs are defined as “all the economic costs associated with aid management that add no value to aid delivery” (131), and have been classified by Acharya et al. (2006) as direct and indirect costs (40). Direct transaction costs are a result of both the large number of DPs, which require substantial amounts of senior officials’ time, and the amount of projects they fund, which generates a considerable managing and reporting burden for governmental authorities (40). Indirect costs include aid agencies attracting public servants away from the government, thereby exacerbating staff shortages (41); time and money spent by DPs on technical assistance and training of local staff, which results in reduced worker productivity (40, 132); limited DP capacity to exert pressure on recipient governments as acting alone amongst other DPs (133), together with a lack of DP individual sense of responsibility (45); recipient

government having to balance out many different interests; and more difficult DP coordination resulting in duplication. A recent study found that DPs could save up to \$2.5 billion per year if they reduced fragmentation by becoming more specialised in recipient countries (130). Most studies in the literature examine fragmentation patterns globally, however, across a panel of recipient countries or DP agencies. A single country case study in Cambodia found that fragmentation does not necessarily need to be reduced, as for instance in the context of emerging DPs, it was found that they provided novel ways of managing aid and resulted in healthy competition with traditional DPs (12). This was also found by Frot and Santiso, who developed a DP monopoly index and showed that some countries suffer from too little fragmentation, where power is concentrated among too few DPs.

Generally, however, fragmentation is considered to be detrimental to the effectiveness of aid, due to its effect on transaction costs. As a result, DPs have committed to decreasing their fragmentation by becoming more concentrated across countries and sectors. They have so far had limited success, as a study of country concentration of 23 DPs over 18 years found that despite the different commitments to recipient country concentration there has been little achievement in this practice, something the authors attribute to the political motivations behind aid-giving (134). A deeper understanding of the factors driving fragmentation and how these can be addressed is needed to reduce fragmentation. In addition, more country-level case studies would help to determine the effects of fragmentation at the recipient country level, and whether the absolute goal should be to reduce fragmentation.

2.5.3 Funding modality

DPs shown in Figure 2.2 disburse funding using different modalities, depending on the degree of earmarking and trust in country systems. Project aid is the most earmarked type

of aid. Projects are discrete interventions delivered either through the government or parallel systems. In project-based aid, DPs have control over the design, monitoring, disbursement and accountability procedures, and NGOs or the private sector are in charge of implementation (4). Projects are also sometimes delivered using government systems, where DPs control the policy conditions and the sector in which the project is situated, but the funds are disbursed and accounted for using government systems (4). All types of development partners disburse some of their funds as projects, but GHIs in particular use this funding modality to disburse funds.

The literature assessing the merits of project-based modalities shows mixed results. On one hand, projects have been shown to achieve outcomes and meet their objectives. A series of case studies conducted by the What Works Group at the Center for Global Development found that a World Bank funded project in China averted 30,000 cases of tuberculosis per year. The project's success was associated with high levels of political commitment at all levels of government and the use of creative incentives to both patients and providers (135). Further, a recent study by Bendavid and colleagues found that between 2004 and 2008, all-cause adult mortality declined more in PEPFAR focus countries than in non-focus countries (23). However, the authors were not able to determine whether PEPFAR was associated with mortality effects outside reductions in HIV-specific deaths (*ibid.*).

On the other hand, other studies have criticised project-based aid for lacking sustainability (136), having high transaction costs (137-138), as they are harder to coordinate and there is a risk of duplication, and hindering partner country ownership (139).

An analysis of projects financed by the World Bank throughout the years 1983-2009 found that the success of projects was correlated with overall country performance (140). In addition, it highlighted that the true impact of projects only becomes apparent over time, and later evaluations tend to be less optimistic, therefore raising concerns regarding the

sustainability of projects (140). The evaluation found that some factors, such as high preparation costs and low country ownership, were associated with lower impact of projects. On the other hand, smaller size, good management and supervision were correlated with a higher impact of projects. However, the authors of the analysis do acknowledge that a significant proportion of the variation observed in project performance cannot be explained by these factors, highlighting the importance of the local context on project outcomes (140).

Overall, however, concerns regarding sustainability, increased burden and difficulties in coordination have meant project-based modalities are generally considered detrimental to DAH effectiveness. Other modalities, including pooled funds and budget support, have been introduced from the early 2000s to address these concerns. These modalities are discussed in section 2.6.2 below.

2.5.4 Predictability

By its very nature, DAH is discretionary spending for DPs, and as such can be extremely unpredictable. Predictability is defined by the OECD as the disbursement of committed funds in a timely manner, as well as the provision of long-term indicative figures of aid flows (141). DPs often fail in both dimensions (142). A panel regression of 60 low-income countries for the time period 1990-2005 found that, on average, levels of annual aid disbursements differed greatly from commitments, particularly in sub-Saharan Africa (52). It also found that this relationship had only shown small improvements over time. Perhaps surprisingly, a lack of predictability was found both as shortfalls and as excesses in the amounts of funds received compared to those expected, with sub-Saharan African countries more likely to receive excess disbursements (ibid). This finding has been corroborated in single-country studies of DAH in Uganda (53) and Zambia (54). Other

studies have found significant differences between countries (143), and that the poorest countries are particularly affected by the unpredictability of DAH (52).

Predictability does not only imply DPs keeping to their commitments, but also encompasses stability of funding and long term commitments. Studies focusing on unpredictability as uncertainty about future funding have also found evidence that it takes place and has detrimental effects on the recipient governments. In a recent study of 80 low-income countries between 1984-2004, Kangoye found that aid was unpredictable, and that it was statistically correlated with corruption, particularly when aid was delivered as programmes as opposed to projects, and in countries with weaker institutions (144). A recent study by Bulíř and Hamann (2008) in 76 countries from 1975 to 2003 also found that aid is more volatile than domestic revenue, and that foreign aid disbursement cycles did not coincide with recipient government shocks or funding shortfalls (142).

Different reasons are found in the literature for the lack of predictability of aid flows. A survey of DPs found that unmet policy conditions, DP administrative problems, recipient government delays in meeting conditions and political problems in the DP country all contributed to a lack of predictability (143). However, Celasum and Walliser (2008) found that only 25 per cent of unpredictability was explained by recipient country stability and levels of aid disbursed. They blamed the rest on 'fickle' DP behaviour (52).

Lack of predictability can hinder aid effectiveness in several ways. First, it hinders recipient governments' ability to plan their budgets (53). This is a particularly important problem in the health sector, as health systems development is a long-term process, where many costs are recurrent, resulting in governments being reluctant to scale up activities (110, 145). Furthermore, aid that is larger than planned for may not be incorporated into the budget, and expenditure may be delayed (52). Second, lack of predictability has resulted in recipient ministries of finance being unwilling to allow long-term health spending

commitments (146), hence contributing to fungibility (see below). Third, unpredictable aid undermines recipient governments' budgets by forcing adjustments in expenditure and changes in original allocations during budget execution, hindering the achievement of government objectives, and disrupting the implementation of poverty reduction strategies (147). Despite these, this review found a dearth of empirical papers specifically assessing the extent and impact of unpredictability of DAH on recipient country systems.

2.5.5 Fungibility

The issue of fungibility is often hotly debated in discussions concerning the effectiveness of DAH. Fungibility is the process by which the recipient government "*offsets donor spending for a particular purpose by reducing its own expenditures on the same purpose... therefore aid substitutes rather than supplements local spending*" (4). The existence of fungibility of development assistance has been documented extensively in the literature from as early as 1993 (148-149). Fungibility can occur at the macroeconomic (150-151), sector (64, 67, 150) and sub-sector (68, 150) levels. Although the data available on health sector spending in low-income countries is often scarce and of bad quality, several studies have found that it is particularly affected by fungibility. Estimates of the extent of fungibility in the health sector for every dollar spent vary from a decrease in US\$0.27-\$1.65 (64, 67, 150) to a US\$1.50 increase (19). In addition, two recent studies assessing fungibility at the health sub-sector level – of DAH targeted towards HIV/AIDS – found no evidence overall of fungibility of development assistance for HIV/AIDS (152-153).

Although the general conclusion is that globally DAH is fungible, merely documenting whether it takes place is insufficient. First, little is known about why or how fungibility occurs (66, 154). Some studies have shown that low levels of recipient country income (64), fragmentation (150), lack of predictability and the short-nature of DAH flows (64, 150) have been associated with increased fungibility, but there is still a dearth of data on the

mechanisms through which fungibility occurs (152). There have been suggestions that fungibility may be a government's way of reallocating funding to other priorities, to anticipate the long-term unreliability of DAH, or to smooth DAH by spreading it across different years (64), a practice advised by the International Monetary Fund (IMF) (155). Fungibility may also be seen as an indication that the recipient governments are aware of the DAH coming into the country, which may explain why funds channelled through NGOs do not result in fungibility (as governments are less aware of NGO funding levels) (156). Finally, fungibility may be a result of low absorption capacity of the recipient government (157).

Second, there is no consensus in the literature on whether fungibility is necessarily a bad thing that diminishes the effectiveness of aid. On the one hand, some studies suggest fungibility decreases aid effectiveness because external funds do not result in additional expenditure on health (67), or indeed by increasing corruption if DAH is displaced from the government coffers (66). Worryingly, a recent study by Dieleman et al. has shown that when DAH levels fall they are not replaced by the recipient government, causing long-term damage to health sector expenditure (158). On the other hand, two separate studies have shown that there is no evidence of a difference between the impact fungible and non-fungible aid has on growth (159) or on under-five mortality (69). Indeed, Waddington (2004) has suggested fungibility may lower the effectiveness of earmarking, but not necessarily the effectiveness of DAH (160). Others have argued that DPs should acknowledge sovereign governments will make their own funding allocations (161), and that fungibility may be a rational response to DAH, resulting from DPs' and recipients' differing priorities (150, 160, 162). Finally, some studies have concluded that fungibility is too narrow a concept to analyse aid effectiveness (163), and that it may distract from the real issues of coordination and DP harmonisation (162, 164).

Consequently, there have been concerns regarding the policy decisions made from cross-country analyses (71, 154, 156), with studies acknowledging that there is heterogeneity across countries (154, 165) and little is known on what DPs can do to prevent fungibility, if anything (164) (suggestions include modifying the channel and mechanisms of DAH disbursement (166)). More research is therefore needed to investigate the heterogeneity observed across countries, in particular the drivers and consequences of fungibility at the country level.

2.5.6 Institutional factors and accountability

The process of giving aid is in itself often a subject of study. The focus of this literature is often not on a particular actor or agency, but on the system of relationships DAH generates. A variety of actors are involved in the delivery and use of DAH, as shown on Figure 2.2. These actors form dynamic and interactive relationships, which are shaped by differing underlying incentives, motivations and information and power asymmetries, often resulting in lack of accountability (73, 76, 167-170). This section will explore the notions of accountability, incentives and information and power asymmetries that characterise DAH relationships.

Accountability is understood as the 'means by which individuals and organizations are held responsible for their actions' (171). It is considered vital to the effectiveness of DAH, and has been repeatedly called for in the various declarations and commitments to aid effectiveness (172-173). Accountability should happen at all stages of the aid process, from decision-making, through to implementation, monitoring, and evaluation (174). There are four components of a well-functioning accountability system: a clear statement of goals (175), transparency of decision-making and use of funds (170, 176-177), an appraisal process with published results (175-176), and mechanisms for holding those responsible to account (175).

In theory, beneficiaries should hold DPs and implementing agencies to account, DPs should be accountable to their constituents and DPs and implementing agencies should be mutually accountable to one other for the distribution and outcomes of DAH. The rest of this section describes the factors hindering accountability in these sets of relationships.

Repeated calls for mutual accountability between DPs and recipient governments have proven difficult to implement in practice. Several reasons have been put forward in the literature for this. First, the DAH system faces the problem of being a 'global public good', where every country can benefit from improved health indicators and development in general (168), which may result in DPs eluding individual responsibilities, as the rewards will be shared amongst all DPs. Second, DPs' main accountability line is to their funders (178), and they may therefore feel less responsibility towards the recipient government for their actions. This is particularly problematic if the interests of beneficiaries and funders are in conflict. Further, accountability lines within DPs mean that country offices are accountable to their headquarters, rather than the recipient government (6). Third, DP incentives are also often skewed towards spending of funds rather than achieving results, a trend known as the 'money-moving syndrome', which hinders accountability to beneficiaries. In a study of World Bank funding, Monkam found this to be the case, concluding that in cases where DP employees are more focused on meeting disbursement targets than on achieving results, aid quantity becomes more important than quality. Further the author theorised that this may be even more the case for bi-lateral agencies, as they may be more susceptible to end of year pressures to spend resources (179-180).

Recipient governments also fail to be accountable to DPs. Lack of trust in recipients' accountability mechanisms has resulted in a range of responses, each with their own limitations. DPs may set up parallel systems, which undermine the government (50), or attach conditions on how assistance is managed and accounted for, which limits the

predictability of aid and country ownership. DPs may also attempt to improve governments' systems through technical assistance, which has been blamed for wasting resources on international consultants or for luring government employees away from their jobs for training purposes with *per diems* or salary top-ups (132). Alternatively, DPs may choose to engage in projects, where they can have more control, rather than rely on government systems.

Studies have also shown that accountability is hindered by power inequality between DPs and recipients (76), as DPs have control over resources, and can withdraw them at any point if they feel the recipient governments are not adhering to the conditions attached to the DAH (81). In contrast, there is no mechanism for sanctioning DPs if they default on their commitments (76). Having said this, DPs also face the Samaritan's dilemma, which arises when the cost of enforcing conditionality (i.e. withdrawing DAH) is higher than the cost of the conditions not being met (73).

Recipient governments and those implementing DAH funded services may not be fully accountable to their beneficiaries due to a phenomenon known as the 'broken feedback loop', whereby the people paying for the services are different to those receiving them (181). Moreover, aid has sometimes been shown to weaken government accountability to its citizens. In a review of national accountability mechanisms in Tanzania and the effect DPs have on them, Tripp found that DPs undermine accountability of the government by allowing the government to use the budget for political means, undermining accountability in the decentralisation processes by supporting the removal of unpopular taxes that reduced the income of district councils, and by encouraging privatisation without fully engaging in political realities (182). Accountability to beneficiaries is slowly improving, however, largely due to the advocacy efforts of increasingly stronger civil society organisations, both in donor and recipient countries (183).

The literature has thus far shown that the incentives of the actors involved in aid are not conducive to accountability, there is a broken feedback loop between those receiving health services and those paying for them, there are political motivations to disbursing DAH, and that power imbalances between DP and recipient governments and DPs can disrupt domestic accountability processes. However, there is no consensus on how to design a system of incentives that is conducive to accountability to beneficiaries, how to improve the power balance and increase DP accountability to recipient government and beneficiaries and how and whether DPs should engage in recipient country political processes. Further, although there is an increasing number of empirical papers of these issues, the literature is dominated by theoretical discussions.

2.6 Policy response

This section reviews the policy response of the international community to improve the effectiveness of aid, by first describing the aid effectiveness agenda, followed by a discussion of new aid modalities and coordination mechanisms through which the agenda is implemented.

2.6.1 The global aid effectiveness agenda

The international community has acknowledged the problems associated with aid and has taken steps to improve its effectiveness through holding several high level forums where DPs, recipients and representatives of civil society have signed international declarations on aid effectiveness. These declarations essentially attempt to enhance the effectiveness of aid by reforming the approach to aid management in several ways. First, by recognising the importance of recipients' ownership of aid projects and their results, and of aligning DP and recipient country priorities, which is expected to improve the distribution of DAH and reduce fungibility (162). Second, driven by disappointment with conditionalities attached to aid, the new approach to aid has an increased emphasis in managing for results, aimed at

modifying incentives away from assessing inputs into outputs and outcomes (99, 184) (although this move has sometimes been criticised for pre-determining the expected results and how they will be measured, as well as for increasing DP control (76)). Finally, there has been a shift towards increased accountability for results from both development partners and recipients of aid.

The main aid effectiveness declarations include the Monterrey Consensus on Financing for Development in 2002, the Rome Declaration on Harmonization in 2003 and the Joint Marrakech Memorandum on Managing for Results. The most important declaration so far, however, has been the Paris Declaration on Aid Effectiveness of 2005, where governments of aid-giving and receiving countries and DPs agreed on five principles of “good practice”: ownership, alignment, harmonization, managing for results and mutual accountability. These five principles aimed at improving aid effectiveness through three dimensions: efficiency of aid delivery, management of aid and strengthening partnerships (185). The Paris Declaration had a deadline of 2010 to achieve the five principles, and a set of indicators to measure the achievement of each principle. The mid-term evaluation of the Paris Declaration conducted in 2008 found that although some progress was being made, it was not fast enough (186), which led to the signing of the Accra Agenda for Action in 2008, to accelerate progress towards ownership, inclusive partnerships and results.

The deadline of the Paris Declaration is now up, and its final evaluation found that overall the quality of the management of aid has improved, in particular the relationships and dialogue between DPs and recipients, but highlights the uneven progress across countries and DPs, a lack of transparency and the burden of aid management as impeding progress. Importantly, it calls for more realistic expectations of the contribution of aid to development (185).

Some studies in the literature have also assessed the implementation of the Paris Declaration at the country level. A study of stakeholder perceptions of implementation of the Paris Declaration in the Democratic Republic of Congo found there has been little progress, and calls for increased accountability and government ownership (91). In addition, a study assessing the implementation of the Paris Declaration in Colombia found it posed a threat to civil society and may have been used by the government to push DPs away from country politics (187). However, other studies have highlighted the importance of the principles in improving collective action of a highly fragmented aid system (188), and have suggested the Paris Declaration should also be applied to civil society and non-government organisations (93).

Given the health sector's numerous actors and channels of aid delivery, the international community signed a declaration specific to health: the International Health Partnership (IHP+). The IHP+ was signed in London in 2007 with the aim of implementing the Paris Declaration in the health sector. A recent review of the implementation of the IHP+ found that whilst there has been progress in national planning processes and the use of programme based approaches (see below), there has been insufficient improvement in the use of country financial and procurement systems and in unifying performance assessment frameworks (189). The evaluation further concluded that the health sector is ahead of other sectors, given its mechanisms for promoting harmonisation, alignment and the monitoring frameworks, but in-country capacity should be strengthened in order to achieve further progress (189).

The Paris Declaration was followed by the Fourth High-Level Forum on Aid Effectiveness, which took place in Busan in November 2011. Busan represented a shift from aid to development effectiveness, and a recognition of the importance of new DPs and South-South co-operation (190). However, the principles of aid effectiveness agreed at this Forum

are not too dissimilar from previous declarations. Partners committed to ownership of development priorities by recipient countries, a focus on results, inclusive development partnerships and transparency, and accountability between DPs and recipient countries. Up until the Paris Declaration, the aid effectiveness agenda was signed by a mix of donor and recipient countries, as well as international organisations. An improvement of the Busan Partnership was the increased role of civil society, which was a participant rather than an observer (191). Conversely, new DPs did not adopt the Busan Partnership, but agreed instead to use its commitments and principles as a reference for South-South co-operation on a “voluntary basis”. Although many see the engagement of new DPs in the forum as progress, there is clearly some way to go before they are fully integrated in aid effectiveness declarations. Tanzania is a signatory of the Paris and Busan declarations, but is not a partner of the IHP+. In addition, there have been calls for decision-making to be more bottom up and for clearer definitions of what “development” means at the country level, so that changes in language equate changes in mindset (191).

Despite evaluations of the different aid effectiveness declarations having been undertaken by the OECD and in some studies in the literature, current indicator frameworks have been criticised for being narrow in scope and not including measures of behaviour change or development results (90). Further, they do not take into account that development strategies are “translated” and interpreted differently in different contexts, which has been shown in a study of Uganda, Zambia and Bangladesh (192).

2.6.2 Shift in funding modalities and DAH coordination mechanisms

Discontent with traditional aid approaches, concerns regarding the sustainability of DAH delivered as vertical projects and their potential for weakening country systems have driven the international community to favour programme-based approaches. This shift was at the heart of the Paris Declaration in 2005 and is still being pursued by many DPs. DPs

committed to giving two-thirds of their aid in the form of Programme-Based Approaches (PBAs) by 2010 in the Paris Declaration on Aid Effectiveness in 2005. PBAs are defined by the OECD as having the following characteristics (141):

1. Being lead by the partner country
2. Having a single, comprehensive programme and budget framework
3. Promoting DP coordination and harmonization of DP procedures for budgeting, management, procurement and reporting
4. Increasing use of partner country systems

PBAs encompass basket funding, SWAPs and budget support. They also include project aid that is delivered as part of a SWAP (141). The mid-term evaluation of the Paris Declaration found that the proportion of aid delivered as PBAs had only increased from 43 per cent of all aid in 2005 to 47 per cent in 2007 (141). The final evaluation of the Paris Declaration found that with a few exceptions—such as Uganda—there had been no rapid or linear move towards PBAs, with most of the evaluated countries and DPs delivering aid using mixed modalities (185). Further, the evaluation found a general reluctance on the part of the DPs to move towards these approaches, mainly due to the slow pace of public reforms, which contributed to high fragmentation of aid (185). Nonetheless, the evaluation also found that although PBAs require more effort than traditional project aid, they resulted in higher policy influence by the DPs (for instance, in better targeting of expenditure on poorer communities), and better understanding of performance-based approaches by the partner governments, which led the evaluators to reinforce the suitability of PBAs as the core target of the Paris Declaration, and to recommend they be included in further declarations and policy discussions (185).

The rest of this section discusses the current evidence on budget support, pooled funds and sector-wide approaches.

Budget support and pooled funds

Budget support is a disbursement mechanism that is characterized by having little or no earmarking (4). There are two types of budget support: general and sector budget support. General Budget Support (GBS) involves DPs providing aid directly to the government's budget, linked to a poverty reduction strategy (193). This approach provides maximum autonomy to the recipient country in terms of how aid is used, as it is not specifically earmarked for health or any other sector. The success of budget support has been shown to be dependent on the governance and policy environment of the partner country (30). The concerns with this approach relate to the risk of corruption and misuse of funds (30). Between 2002 and 2006 only 6.4 per cent of all aid was allocated as budget support (194), reflecting DPs' concerns and unwillingness to engage in this aid modality. However, the popularity of budget support has since been reported to be growing, particularly amongst European DPs (139). A study of general budget support in seven countries over 1994-2004 found a positive association with government ownership, accountability and capacity for public financial management (195). In addition, general budget support was found to improve DP harmonization and alignment (195). Despite the authors of the study taking measures to deal with a lack of counterfactual and avoid reverse causality (by carefully developing a theory of change (196)), these results may still be biased by these. However, these findings have been corroborated in further studies (136, 139, 197).

Although DPs do not decide how GBS funds are distributed across sectors, negotiations of general budget support by DPs can serve to increase the budget allocation to the health sector. Despite this, this literature review only found one study assessing the effects of GBS on the health sector through a cross-country panel data from 82 low- and middle-income countries during the time period of 2002-2007 (198). Somewhat surprisingly, the study showed that GBS has had no impact (positive or negative) on health expenditure (198).

The second type of budget support is sector budget support. This modality still involves DPs providing aid to the recipient government's budget, but funds are earmarked to a particular sector, often the health and education sectors. A study of ten sectors (including health) in six African countries found that sector budget support had improved the efficiency of public resource use by supporting planning, budgeting, management and accountability processes (199). However, it also found that although access to services had been greatly expanded, the quality and equity in the delivery of these services had not (199). Another study of sector budget support in four sectors (including health) in Mali, Tunisia and Zambia found that it had not resulted in higher harmonisation amongst DPs, who still delivered funds off-budget, and as such had not succeeded in lowering transaction costs (200). However, this study may have been confounded by a lack of counterfactual, as transaction costs may have been higher if there had been no budget support.

Finally, basket funds are a type of sectoral budget support that is often used in the health sector to fund primary health care at the local level (4). Basket funds are delivered using the government's financial management systems, but are more earmarked than sector budget support, with development partners often specifying what the funds are spent on and having additional reporting requirements than in sector budget support (which relies on governments' accounting systems). This review found little literature on basket funds, although they are often studied within sector wide approaches, which are reviewed below.

Sector wide approaches

SWAPs arose in the mid 1990s as a result of the prevailing discontent with project aid (201). Although there is no agreed definition of precisely what SWAPs involve, in essence, a SWAP represents a partnership between DPs working in the same sector and the partner government, often led by the health ministry of the partner government (202). The terms of this partnership are usually agreed in advance, and vary between different countries

(192). SWAPs are often associated with delivering aid as budget support and basket funds, with the aim of supporting partner ownership and country systems, improving DP coordination and lowering the transaction costs of aid (192, 202).

Foster described the sector-wide approach as having four dimensions (203) (which are similar to those of PBAs):

1. Single sector policy and expenditure programme
2. Under government leadership
3. Adopting common approaches across the sector
4. Progressing to using government disbursement and accountability procedures

There have been a few studies of the implementation of SWAPs in the health sector. A five country case study undertaken by the Overseas Development Institute in 1999 in Mozambique, Uganda, Tanzania, Cambodia and Vietnam found that health SWAPs were integrated into budget planning process, the use of common procedures was key to reducing costs, joint reviews were in place (although their success depended on DPs using them) and links between policy and implementation were growing because governments had resources to implement health sector plans (204). However, the study highlighted concerns that DPs were still undertaking their own monitoring, the management complexity of moving from projects to single sector programme was straining government capacity and the largest DPs were not participating (204).

A later evaluation of SWAP implementation in the health sector in six countries (Bangladesh, Ghana, Kyrgyz Republic, Malawi, Nepal and Tanzania) found the SWAP was successful in putting in place tools and processes for health sector coordination and oversight (such as medium term expenditure framework, dialogue structures and procedures for strengthening country systems), the SWAP dialogue was led by the

government, DPs formed consortia and government and DPs undertook joint planning and assessment. However, the study also raised concerns regarding the lack of DP accountability, the fact that the objectives of national health programmes were only modestly achieved due to weak monitoring and evaluation, and the excessive emphasis on disbursement systems rather than focusing on results (205).

Finally, in a review of the literature on the implementation of SWAPs in the health sector, Peters et al. found that SWAPs have deviated from their original expectations of strengthening relationships between governments and DPs. However, they found that SWAPs have contributed to the development of national health policies and expenditure frameworks, strengthened institutional capacity and reduced fragmentation. They also found that government leadership varied widely across different countries, and that SWAPs were often undermined by DPs bypassing SWAP arrangements through global health initiatives to address global priorities (206). Nevertheless, SWAPs have been met with great optimism in smaller single-country case studies, and have been labelled as a promising vehicle for achieving aid effectiveness principles in the Solomon Islands (207), for attracting more and better aligned DAH in Tajikistan (208), as a vehicle for achieving health sector reform and increased coordination in Ghana (209), as a contributor to an increase in women delivering using skilled birth attendants in Tanzania (210) and as an effective mechanism to deliver cost-effective interventions that improve health service delivery in Malawi (58).

Although the evidence on the impact of the sector wide approach on the health sector is mixed, it is important to take into account that the SWAP mechanism involves a reform in the way aid is given and in the relationship between the DPs and the government, which means it will take time for the impact to be seen (202). For instance, a smaller evaluation of the health SWAP in Zambia attributed the lack of success on the fact that the SWAP was

not fully developed and DPs had not fully embraced it (211). In addition, the SWAP is an approach to aid management, but its implementation varies between different countries, as the local political and cultural context have been found to influence the 'shape' of the SWAP, and hence its effectiveness (192).

Finally, studies have found gaps in our understanding are undermining the effectiveness of the SWAP approach. These include a better understanding of the political economy (205); for instance, on how to achieve stronger national ownership and innovative institutional arrangements to balance both targeted initiatives and health systems funds (212). In addition, Leiderer (2013) has recently highlighted the implementation of the aid effectiveness agenda has been "sketchy", criticising the lack of rigorous evidence on the impact of "Paris-compliant aid modalities" (38). Lastly, McNee (2012) has highlighted the importance of assessing government and DP incentives that are compromising the SWAP through the use of the aid effectiveness agenda as an analytical frame (213).

2.7 Discussion

This chapter has provided a review of the literature on the effectiveness of development assistance for health. It has first provided an overview of the DAH architecture, showing that increasing flows have been accompanied by an increasingly complex system of actors and instruments for DAH delivery. The chapter then reviewed the inherent methodological difficulties found when trying to ascertain the impact of aid on the health sector, including quality of data, reverse causality and the generalisability of context-specific findings. Moreover, despite studies assessing the effectiveness of DAH using different methods, disciplines and frameworks, this review has found the research community has yet to find an ideal methodological approach to tackling the complex nature of DAH, with all available approaches having important shortcomings.

This literature review has also summarised the current knowledge on key impediments to effective development assistance for health, including allocation of resources, DP fragmentation, funding modalities, fungibility of funding and institutional issues associated with the process of aid delivery. The policy response of the international community to tackle these factors has also been discussed, including the international aid effectiveness agenda, the shift from project aid to programme-based approaches and the adoption of sector-wide approaches in the health sector.

One thing that has become clear is the importance of the local context, and that successful projects and programmes tend to be those that adapt best to the local circumstances and where there is real ownership by the local partners. In addition, there is a need to examine how the global issues affecting aid effectiveness identified in this review interact at the country level, such as for instance, whether DAH is allocated according to country (rather than global) need, the contextual factors driving fungibility or the burden of a fragmented aid architecture.

This literature review has also shown that addressing politico-institutional factors is key to improving the effectiveness of DAH. However, there is a dearth of evidence of whether the aid effectiveness agenda has addressed these factors. In general, there has been little assessment of the extent to which aid effectiveness principles in international declarations have been achieved or not, partly because there are no agreed indicators for measuring achievement. Further, little is known about whether they actually result in more effective aid, or indeed if the approaches and modalities designed to implement the aid effectiveness agenda have achieved this in practice, particularly at the country level.

It is important that these issues receive more attention, as given the lack of clear evidence, and the difficulties in establishing whether DAH is effective, there is a danger that the international community fluctuates between different approaches without evaluating what

has worked or failed and why. This thesis aims to contribute to this gap in the literature by using a political economy conceptual framework to assess whether the SWAP has achieved the aid effectiveness agenda in the Tanzanian health SWAP through the use of locally-relevant indicators.

3 METHODOLOGY

This chapter describes the methodology used to conduct this study. It first describes the study approach, including the study design, the time period, the use of mixed methods and epistemology and reflexivity. It then describes the quantitative and qualitative methods used before outlining the ethical considerations and procedures followed.

3.1 Study approach

3.1.1 Study design

A single country, single sector case study design was adopted for this research. This approach has been recommended by the World Bank's series on Evaluating Development Effectiveness (214), and has the advantage of providing political, historical and societal context. It also allows for the study of policy responses to factors hindering aid effectiveness as highlighted in Chapter 2 in more depth, thereby complementing cross-country approaches, common in the aid effectiveness literature. There are some criticisms of the case-study approach, the most important being its lack of generalisability (215). By giving importance to the local context, case studies may produce findings that are not applicable to other contexts. However, they allow for the development of or contribution to theory, and therefore provide "analytic" and conceptual (216) rather than statistical generalisability (215). Furthermore, Flyvbjerg calls this lack of generalisability a myth, and argues that even in the natural sciences, theories can be informed from a single experiment carefully chosen, that case studies sometimes allow for more discoveries if intensely studied rather than larger sample sizes and that if the purpose of "science" is to generate knowledge, this can be done without achieving generalisability (217).

The health sector has been chosen for this case study as it has received much attention in the past decade due to the links between health and development and as a result of the

recognition of health as a human right (218); in addition, health is the direct focus of three of the eight Millennium Development Goals⁸ (MDGs). Furthermore, the generous external funding received by the health sector makes it highly aid-dependent and particularly vulnerable to the factors hindering the effectiveness of Development Assistance for Health (DAH), including fragmentation, fungibility and need for coordination. Tanzania was selected as the case study country because it is one of the top recipients of DAH globally and is heavily dependent on external health funding (which accounted for 40% of total health expenditure in 2009 (219)). In addition, Tanzania has a long history of democratic institutions, is a signatory to all major international declarations on aid effectiveness and (at least on paper) has kept its promises, and has been hailed as a success story in aid (182). In the Tanzanian health sector, Development Partners (DPs) and the government have been working under a sector-wide approach since 1998, DPs have structures for coordination, and have been providing development assistance in the form of the health basket fund and budget support for the past ten years. The Tanzanian health sector therefore makes it an ideal setting to study the application of principles of aid effectiveness⁹.

3.1.2 Time period

The Tanzanian aid landscape has undergone important changes in the last decade, with the adoption of the Paris Declaration, the design of national aid effectiveness and health sector strategies (including the Joint Assistance Strategy for Tanzania, the National Health Policy and the Health Sector Strategic Plan) and the introduction of the health Sector Wide Approach (SWAP). It was therefore important to reflect these political events by considering changes in the delivery and use of DAH over time, rather than at a single point.

⁸ MDG4: to reduce child mortality rates, MDG5: to improve maternal health, MDG6: to combat HIV/AIDS, malaria and other diseases.

⁹ The use of Tanzania in this thesis refers to Mainland Tanzania, as Zanzibar has separate government and development partner structures

As much as was possible, the timeframe used for this study was from the launch of the SWAP in 1998 until the present day. Quantitative data were obtained from the year 2000 (although for some indicators data were only available for later years), as earlier data was either deemed too inaccurate (for external financing) or was not available (for domestic flows). Interviewees were selected to represent actors with a current and/or historical experience of the SWAP. Documents reviewed span the whole timeframe of the SWAP. Non-participant observation and field notes only encompass the timeframe of the fieldwork.

3.1.3 Mixed methods

Addressing the objectives of this study required the use of different methods, as shown in Table 3.1 below.

Table 3.1: Study objectives and methods used for each

Objective	Type of method used
1. History and current structure of the Tanzanian health sector	Document review In-depth interviews
2. DAH flows to Tanzania during the time period of 2000-2010	Quantitative
3. Develop indicators to assess the global aid effectiveness agenda	Document and literature review In-depth interviews
4. Assess the extent to which the Tanzanian health SWAP has achieved the aid effectiveness principles	Document and literature review In-depth interviews Non-participant observation Quantitative
5. Explore institutional factors and relationships in the Tanzanian health SWAP to explain the degree of achievement of the agenda	Document and literature review In-depth interviews Non-participant observation

There has been some debate in both social science and health research literature about the mixing of quantitative and qualitative methods. Mixed methods have been criticised for

lacking coherence (220) and rigour (221), not being developed enough to be robust as yet (222), coming from contradicting paradigms (223) and favouring quantitative methods at the cost of qualitative ones (223-224). On the other hand, mixed methods approaches have been praised for their ability to generate more complete data that can be used to corroborate results (225) and to generate further insights on the findings from one method (226). Recent studies have also shown the potential for mixed methods to be driven by qualitative methods (and to indeed enhance them) (224, 227). The overall consensus is on the need for good quality of mixed methods study designs and for transparency about the integration of methods, as well as clarity of the protocol followed for each of the components (221). The rest of this section aims to achieve this by providing a detailed account of the study design and the approach used to mix the different quantitative and qualitative methods used in this thesis.

The reason for using mixed methods was three-fold. First, the methods were driven by the research questions. An approach was taken where the quantitative and qualitative methods were seen as being complementary and as forming part of a “research toolkit” (228) or palette (227), available to answer different research questions. In this way, evaluating the attainment of the aid effectiveness agenda required the analysis of trends in health financing quantitatively, as well as a deeper understanding of the relationships that make up the health SWAP, which can only be achieved through the use of qualitative methods. Second, some triangulation of multiple sources of evidence provided a more complete in-depth picture (215). Finally, the different methods were complementary. Focusing on a single country, combined with data constraints found in low income countries, means the amount and quality of quantitative data collected was not sufficient to determine causation. Qualitative data were used instead to add depth to the quantitative trends observed, to understand the contextual factors in which they occurred and develop explanations for the quantitative trends found.

The rest of this section describes how the different methods were mixed. Methods can be integrated at different stages: at the paradigm level (epistemology), sampling, data collection, analysis and interpretation (229). In this study some integration took place during the analysis section, but results were mainly integrated at the interpretation stage.

Epistemology

This study is rooted within the discipline of development studies applied to public health; it borrows methods and theories from health economics and health policy. Using a mixed-methods inter-disciplinary approach is not without difficulty, and does result in tensions between different epistemological positions. Epistemology is a branch of philosophy that is concerned with theories of knowledge and assumptions about the truth. Different epistemological positions range from a positivist approach that assumes that there is one objective and neutral reality that can be observed and measured, unchanged by the researcher (230-231), to a constructionist approach, which assumes there is no one absolute truth, but rather truth is constructed through people's social interactions, and research can only represent people's perceptions of reality (232). Quantitative research, often including economic and some health systems research, is typically rooted within a positivist tradition (230). On the other hand, qualitative approaches, such as anthropology, are often based on constructionist philosophy. In the middle of the spectrum sit realist approaches. Realism assumes that a reality independent of the researcher exists that can be known, but researchers' interpretations of this reality cannot be value-free (233).

There has been some debate in the literature on whether mixed methods research should address epistemological differences between the different methods. Some studies advocate for a pragmatic approach, ignoring epistemological assumptions and letting research questions and results justify the approach (234). However, others have voiced concerns that if carried out in this way, mixed methods research is a "Trojan Horse for

positivism” (223), and that indeed different methods can be rooted in the same epistemological position (227). The latter is the view adopted here.

This study is informed by a subtle realist perspective, where it is assumed that reality exists independent of the researcher, but “knowledge is based on assumptions and purposes and is a human construction” (233). Positivism is rejected here because it is acknowledged that researchers are not value-free and therefore cannot produce objective accounts of reality. A constructivist approach is not taken because we assume there is a reality independent of the researcher, rather than multiple realities constructed by the researcher and the researched (91). A purely (or naïve) realist approach is also rejected because we believe that although there is one reality independent of our beliefs, we cannot come into contact with it. Instead, a subtle realist perspective is adopted because we assume phenomena exist independent of our claims, but acknowledge that we can only attempt to represent, rather than reproduce the phenomena we are studying, which we can only achieve through our cultural assumptions (91). The analysis undertaken in this PhD recognises that the data and results are not independent of the societal context in which the research takes place, or the researcher’s assumptions and views. This applies to the quantitative as well as the qualitative parts of the study. Although quantitative methods are often classified as positivist, in this study it is acknowledged the categories constructed and the interpretation of the analysis is inevitably subjective. Data generated for the qualitative parts of the study are also not value-free, in particular when bringing together the findings from the different parts of the study and making recommendations.

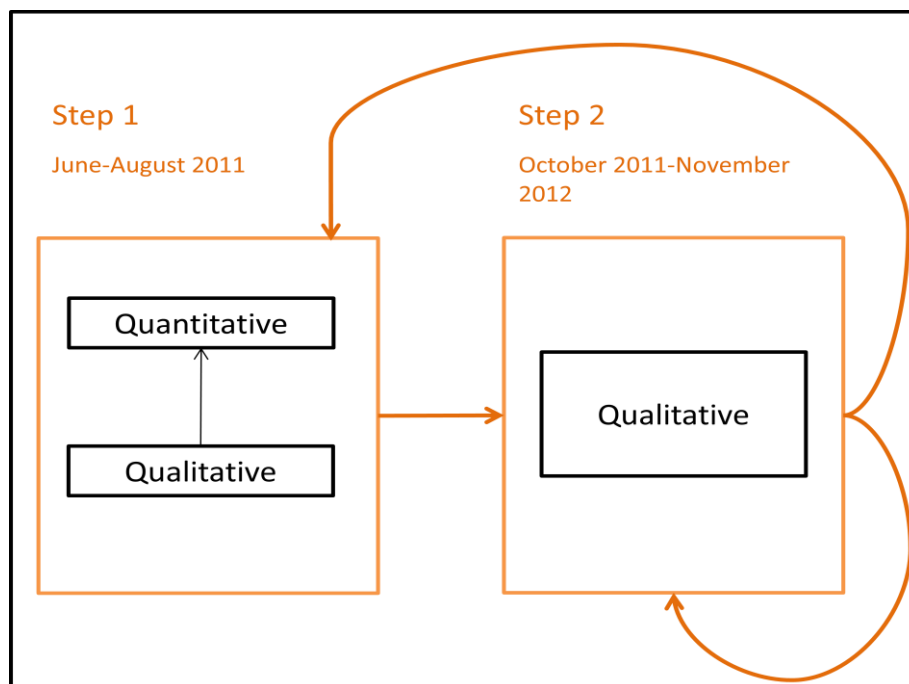
Data collection

Different strategies can be used to combine quantitative and qualitative methods. A modified sequential transformative strategy was used here, as described by Creswell (2003) (222). This strategy involves carrying out the two methods in sequential stages of data

collection, and provides a degree of flexibility to investigate findings as they emerge (222). There were two periods of data collection (Figure 3.1), during which several iterations of both methodologies took place. The first exercise of data generation took place during a two week pre-fieldwork visit to Dar es Salaam in June 2011, where key informant interviews were undertaken. A scoping exercise to search for all the global sources of financial expenditure (quantitative data) took place over the subsequent two months.

The second stage of data collection took place during the main period of fieldwork, from October 2011 to September 2012. This involved collecting quantitative financial data on DAH and domestic expenditure on health, and generating qualitative data through document review, non-participant observation and in-depth interviews.

Figure 3.1: Steps of data collection



Data analysis and interpretation

Integration of the different methods took place during data analysis and interpretation. The integration technique used here was influenced by the works of O’Cathain et al. (221, 235) and Mason (227). O’Cathain et al. describe three different methods for integrating mixed

methods: triangulation, following a thread and developing a mixed methods matrix (235). Mason, on the other hand, suggests methods should be meshed or linked, providing multi-dimensional explanations to multi-dimensional problems (227, 236).

Some integration took place during the analysis, where there was some cross-checking between methods to explore emerging themes from one method using another (“following a thread”). There was significant flexibility in the approach, which allowed for new issues to emerge. In this way, issues deemed more important were researched in more depth through the different methods. For instance, at the beginning of data analysis it became apparent that the indicators and definitions used to evaluate aid effectiveness principles in international policy documents had ambiguous meanings and were interpreted differently by different stakeholders. This led to the modification of the analysis framework to explore stakeholder understanding of aid effectiveness principles and the development of a set of locally relevant and meaningful definitions and quantitative and qualitative indicators. This set of indicators was then used to analyse the quantitative and qualitative parts of the analysis. Following a thread was also carried out through the different qualitative methods. For instance, SWAP policy documents state the number and frequency of meetings that should take place, although observation of some of these meetings revealed that the frequency and attendance was lower than expected; following this up through in-depth interviews revealed this was indeed an issue of great concern for DPs.

The key stage at which integration took place in this study, however, was during the interpretation. When the different methods were addressing different questions, these were reported separately. On the other hand, when the different methods were addressing the same issue, they were reported as providing different layers of an account, with some degree of triangulation. As O’Cathain et al. and Sandelowski point out, triangulation can be defined in two ways: as a process to corroborate findings from one method with another or

the use of different methods to obtain a more complete picture (235, 237). Although there was some corroboration of results – for instance DPs that took place in interviews were sometimes shown preliminary results on health financing trends to check their accuracy – the main objective of triangulation here was complementarity and to test “inter-method discrepancy”. This was not just done between quantitative and qualitative methods, but also between the different qualitative methods. When different methods contradicted each other, this was reported and explored in more depth. For instance, using the example of fungibility, government stakeholders contradicted the results of the quantitative analysis; however, when analysing how resource allocation took place, it became apparent that they did not view fungibility as a deliberate policy of the government, but rather as a part of a rational way of allocating resources.

3.1.4 Reflexivity

Consistent with a subtle realist approach’s assumptions about reality being understood through the social constructions of the researcher, it is important to examine how the researcher may influence the results of the research, which is known as reflexivity (238). The researcher can influence the outcomes of research both through his/her background and beliefs. In this section I address how both my background and beliefs may have influenced my PhD findings. Addressing the former first, I am white, female and younger than all the people that took part in the study. During the time of fieldwork I was affiliated with the London School of Hygiene and Tropical Medicine (LSHTM) and the Ifakara Health Institute (IHI). This had different effects on different study participants. For those of Tanzanian origin, being foreign raised a level of distrust about what would happen to the data and the purposes of the research. This affected my ability to collect quantitative data as well as to attend meetings and to elicit data through interviews. Being affiliated with a local institution – IHI – opened doors into the government, but many participants still

viewed me as a DP representative, and as a result may have felt less comfortable sharing information with me. My relative youth meant I was viewed by non-Tanzanian stakeholders as inexperienced but also less threatening. During my stay in Tanzania, I learned conversational Swahili, but did not acquire a level of proficiency that allowed me to conduct my research in the language. Aside from the polite greetings, all communication related to the research took place in English. All research participants spoke fluent English; however, it may have had an influence on how comfortable they were in participating in the research and the level of trust they had on me as a researcher.

My background and ideology may have also had an influence on data collection, analysis and interpretation. I have an undergraduate degree in Biology and a Masters degree in Control of Infectious Diseases. My philosophical position has changed during the period of doctoral research from positivist to pragmatist and subtle realist. My ethical and political beliefs include social justice and human rights, including access to health care and good-standard living conditions. These are common to health systems researchers; however, they may have had an influence on my interpretation of results and attitude towards study participants. Further, my field notes show an increasingly pessimistic tone as the fieldwork went on, which was reflected in early drafts of results. Although since being back in London I have been able to get some distance from the field, feelings of disappointment with the “aid world” may have still influenced my interpretation and analysis of data.

3.2 Quantitative Methods

This section describes quantitative part of the study, including the analytical framework, the different types of health financing data available, data sources used and the coding methodology. The section ends with a description of the method used to analyse the quantitative data.

3.2.1 Analytical framework

Quantitative methods were used to describe the Tanzanian health financing landscape in the time period of 2000-2010 and to assess the quantitative indicators of the aid effectiveness agenda. A different analytical framework was used for each of these two objectives.

In order to construct a financing map of the Tanzanian health sector, financing flows were classified by source (domestic versus DAH), source of DAH and sub-sector distribution. Pitt et al. advise researchers to choose analytical frameworks carefully when examining DAH flows, as some items cannot be compared directly (239). In line with this view, in this study care has been taken to select a coherent list of indicators that are comparable over time. These are:

1. Health expenditure distribution by source of funding
 - a. Trends in Government Health Expenditure as a source (GHE-S) (total government expenditure on health coming from the government coffers), both as absolute terms and as a proportion of Total Government Expenditure (TGE)
 - b. Trends in DAH, both in absolute terms and as a proportion of total ODA
2. DAH distribution by source of funding
 - a. Trends in bi-lateral, multi-lateral and private foundations and philanthropies, both in absolute terms and as proportion of total DAH
 - b. DAH by DP, both in absolute terms and as proportion of total DAH
3. DAH distribution by sub-sector
 - a. Trends in DAH distributed as horizontal, diagonal and vertical programmes (in absolute terms and as a proportion of total DAH)

- b. Trends in disease-specific priorities (in absolute terms and as a proportion of total DAH)
- c. HIV/AIDS funding by source (domestic versus external, and by DP)

The method and rationale used to select the quantitative indicators to assess the aid effectiveness agenda are described in section 3.3 below and in Chapter 7. The indicators selected are:

1. Fungibility – Trends in GHE-S and Development Assistance for health delivered through the government (DAH-G):
 - a. As absolute numbers
 - b. As a proportion of total government expenditure on health
 - c. As a proportion of total government expenditure
 - d. Per capita
2. DAH funding channels
 - a. Trends in DAH delivered through and outside the government (as absolute amounts and as proportions of total DAH)
 - b. Trends in DAH delivered through and outside the government by DP
3. DAH funding modalities
 - a. Trends in DAH delivered through pooled funds (basket funds and budget support)
4. DAH fragmentation
 - a. Trends in number of DPs
 - b. Trends in the proportion of DPs accounting for less than 10% of all DAH
 - c. Trends in the number of projects (by DP and disease priority)
 - d. Trends in average size of project (by DP and disease priority)

A range of alternative analytical frameworks were considered but had to be dropped due to data constraints. These included exploring DAH allocation by level of care (primary, secondary and tertiary); classifying DAH according to the health system activity it funded, such as health policy, infrastructure and human resources (available data only allowed between 30-60% of projects to be classified in this way); and the predictability of DAH flows through comparing commitments with disbursements (only 2624 projects - approximately half – had both commitment and disbursement data).

The rest of this section describes the methods and data used to calculate these indicators.

3.2.2 Types of health financing data

Powell-Jackson and Mills (2007) describe four types of health financing data that can be tracked: budgets, commitments, disbursements and expenditure (240). Budgets indicate the resources planned to be spent; they are least reliable as there is no guarantee that they have been spent. Commitments represent a promise to spend money (241); they are more accurate than budgets, may indicate future trends and show willingness to fund. However, committed funds are not always disbursed due to structural factors and they are usually reported as a “lump sum” on a single year, even if projects are funded over multiple years (239). Disbursements, in contrast, show resources given to the recipient in a calendar year (242); they reflect real value of funding, but for DAH they are only relatively complete since 2002 (239). Expenditures represent the “value of goods and services consumed within a country during a calendar year” (240), they are the most accurate measure of funding, but also the hardest to obtain, as audited accounts are not always available in a timely manner. Most aid-tracking studies and available databases report on either disbursements or commitments. Domestic data were available as budgets and expenditures. In this study disbursements were used for DAH, as they represent actual funds, and wherever possible, expenditures were used for government funding flows (either as source or agent).

3.2.3 Data sources

Global level data

At the global level there are three main databases tracking DAH: Creditor Reporting System (CRS), the DAH database compiled by the Institute for Health Metrics and Evaluation (IHME) and AidData. An overview of the strengths and limitations of these sources of data for DAH tracking is provided elsewhere (240, 243-244), and summarised below.

The CRS is managed by the Organisation for Economic Co-operation and Development's Development (OECD). It is the most widely used database for tracking aid flows. It provides project level data (project name and description, channel of fund delivery, commitment and disbursement levels) by year and by DP for all donor countries belonging to the Development Assistance Committee (DAC), United Nations (UN), World Bank and some Global Health Initiatives. It has the advantage of having standardised methods and definitions used for reporting (242), which are used by Development Partners (DPs) to report twice annually. The CRS avoids double counting by not reporting bi-lateral contributions to the regular budgets of multi-lateral organisations (244). The limitations of the CRS database include that it does not allow for multiple coding of a single project, and therefore multi-purpose projects are classified under a single code (for instance, a project targeting HIV, malaria and human resources may be coded under HIV and sexually transmitted infections). In addition, the CRS does not include data from all DPs, with emerging DPs such as China, Arab states, India, the Clinton Foundation and European Non-government Organisations (NGOs) being largely absent. As DPs self-report to the CRS, the amount of detail in the database varies considerably. Data incompleteness varies across fields, but is particularly problematic for the project name and description and the channel of delivery. Further, some projects are multi-sector and it is not possible to know from the available data how much goes to each sector. It is also not possible to assign General

Budget Support (GBS) to specific sectors such as health (245). Finally, many projects are regional projects and the allocation to specific countries is not shown.

The AidData and IHME databases are based on the CRS, but include data on a wider range of DPs. AidData includes data from non-DAC bi-laterals and other multi-laterals and has a more user-friendly interface, which increases the usability of the data (244). However, data collection is less standardised and there is potential for double-counting of aid flows, as data are collected directly from multilateral agencies (244). A recent journal issue featured a series of articles using this database (246). The IHME DAH Database (Country and Regional Recipient Level) provides data on bi-lateral and multi-lateral organisations, as well as private foundations. It codes DAH flows according to different disease areas but does not provide disaggregated project descriptions, so it is difficult to perform analyses using these data on topics areas other than those already present in the database (244).

DAH data can also be obtained directly from DP websites, budgets and reports.

Country level data

At the national level in Tanzania, there are a number of different sources of health financing data. These report both on financing sources and expenditures. Sources of health expenditure are divided into tax and non-tax revenue. Health expenditures are divided into recurrent expenditures, which are those that occur every year (and are further sub-divided into Personal Emoluments (salaries) and Other Charges (operating costs)), and development expenditures, which include new infrastructure and other investments that do not recur each year (247). Expenditure of foreign funds is coded as development expenditure; however, a significant part of it is still delivered off-budget and not captured by the government's budget system. Therefore, national-level sources based on the

government's budget may miss some foreign funds. Data are reported in financial, rather than calendar, years, which in Tanzania run from the 1st of July to the 30th of June.

In Tanzania health expenditure data (domestic and foreign) is found in the National Health Accounts (NHA¹⁰), Public Expenditure Reviews (PER), budget books and budget speeches. The NHA have been institutionalised and are conducted by the Ministry of Health and Social Welfare (MoHSW) every three-four of years. They use a matrix where expenditures are classified by source, agent, health provider and function (248). They also have sub-accounts for HIV/AIDS, reproductive health, malaria and child health. Within the time frame of this study three NHA exercises were undertaken: 2002/03, 2005/06 and 2009/10. NHA relies on primary and secondary data; ideally data used in the NHA should be readily available, but surveys are often conducted to fill in data gaps, especially in relation to out of pocket payments (240).

PERs of the Tanzanian health sector have been undertaken annually by the MoHSW (sometimes with input from technical assistants) from the financial year 1999/2000 (249). They assess trends in total health spending by year, both as approved estimates and actual expenditure by financing source, by level of government (central, regional and council), development and recurrent expenditure and by sub-sector distribution (including human resources or level of care, although these vary in different years). PERs are based on data collected from central government agencies (including the MoHSW, the Ministry of Finance (MoF), the Prime Minister's Office, Regional Administration and Local Government (PMO-RALG), and the National Health Insurance Fund) and Local Government Authorities (LGAs). LGA data comes from the Comprehensive Council Health Plans (CCHPs) and Technical and Financial Implementation Reports and are often supplemented with surveys of a sample of districts (250). Multi-sector PERs have also been undertaken for HIV/AIDS from the financial

¹⁰ These are also available globally by compiling country's NHA reports (<http://www.who.int/nha/en/>)

year 2001/2002, commissioned by the Tanzania Commission for Aids (TACAIDS) under the annual public expenditure review process of the Ministry of Finance.

In addition, the budget books report government expenditure data at the end of each financial year. They include expenditure by sector at the central, regional and local level, broken down by type of activity and expenditure (development and recurrent). These are publically available online for the time period of 2007-2010¹¹. Data from the budget books needs to be used with caution as they are not audited (the budget books are eventually closed and then audited, but this final version is harder to access and was not used in this study). Finally, the annual budget speech¹² outlines total government budget and expenditure by source and type of expenditure for the previous year. Data from budget speeches represent audited expenditures.

The table below summarises the advantages and disadvantages of the different data sources as well as which sources were selected for each health financing indicator.

¹¹ <http://openmicrodata.wordpress.com/2011/02/11/tanzania-budget-data/>

¹² Available from: <http://parliament.go.tz/index.php/budget/index/all/all/2013-2014/minister>

Table 3.2: Data sources

Data source	Available indicators	Benefits	Drawbacks	Selected
CRS	DAH DAH-G ODA	<ul style="list-style-type: none"> • Data disaggregated by project/transaction • Standardised methods and definitions • Avoids double counting 	<ul style="list-style-type: none"> • Only DAC DPs • Data missing • Multi-purpose, multi-sector and multi-country projects 	DAH DAH-G
IHME	DAH	<ul style="list-style-type: none"> • Data from private foundations and American NGOs 	<ul style="list-style-type: none"> • No disaggregated project descriptions • Can only use database coding 	DAH
AidData	DAH	<ul style="list-style-type: none"> • DAC and non-DAC DPs • Interface more user-friendly 	<ul style="list-style-type: none"> • Does not avoid double counting • Data collection less standardised 	DAH
DP websites	DAH	<ul style="list-style-type: none"> • Data sometimes more complete than in global databases 	<ul style="list-style-type: none"> • Time consuming • Data availability variable across different DPs 	DAH
NHA	GHE-S	<ul style="list-style-type: none"> • Routine reporting and ad-hoc surveys (more flows captured) 	<ul style="list-style-type: none"> • Only three exercises in time period of study 	No
PER	GHE-S	<ul style="list-style-type: none"> • Available from 2001 	<ul style="list-style-type: none"> • Does not capture all DAH flows • Does not allow for re-coding 	GEH-S
Budget books	TGE	<ul style="list-style-type: none"> • Very detailed and disaggregated budget and disbursement data at the project level 	<ul style="list-style-type: none"> • Available from 2007 	No
Budget speech	TGE	<ul style="list-style-type: none"> • Available from 2001 	<ul style="list-style-type: none"> • Data not disaggregated at the project level, presented as totals 	TGE

Data sources selected

This study compared the various data sources to select the most complete data for the study. In some cases a combination was used to maximise on completeness. In order to

select the most suitable data, the different sources were plotted to visualise differences between them and facilitate the selection of the most appropriate sources for analysis. These graphs are shown in Chapter 6. AidData disbursements were converted from current US Dollars (USD) to constant 2010 USD using OECD deflators¹³ for consistency with the CRS database. The analysis found that the CRS was the most complete database, although AidData contained data for non-DAC DPs and IHME for private foundations, which were missing from the CRS. To compare figures from global sources with those reported by the NHA, NHA figures were converted to USD at the average annual exchange rate provided by the Bank of Tanzania as reported by the WHO Global Health Expenditure database¹⁴ and adjusted for inflation by using OECD-DAC deflators¹⁵.

Therefore, a database was compiled from the three global data sources to analyse DAH trends. Data were primarily obtained from the CRS database by extracting all transactions to Tanzania from all DPs for the time period of 2000-2010. The CRS database does include regional projects; however, these were not included as it was not possible to accurately identify the amounts of aid from these going to Tanzania specifically. This means the amount of DAH will be under-estimated. The AidData and IHME databases were then used to complement these data with information from DPs not included in the CRS (Brazil, Poland and Czech Republic from AidData and Bill and Melinda Gates Foundation from IHME). Once data had been extracted from each of the databases, they were merged. Where currencies were not in constant 2010 USD they were converted to USD at the exchange rate relevant for the time period and then adjusted to 2010 USD using OECD-DAC deflators. DAH was not extracted from the PER as it was not disaggregated into individual

¹³ Available from: http://www.oecd-ilibrary.org/development/development-co-operation-report-2012/deflators-for-resource-flows-from-dac-donors-2010-100_dcr-2012-table79-en

¹⁴ <http://apps.who.int/nha/database/DataExplorer.aspx?ws=0&d=1>

¹⁵ Available from: http://www.oecd-ilibrary.org/development/development-co-operation-report-2012/deflators-for-resource-flows-from-dac-donors-2010-100_dcr-2012-table79-en

projects or sub-sector priorities, and did not provide the required information for this to be done manually.

Although this approach maximises the number of DPs included, there are some key omissions. For instance, the CRS database does not include spending by the World Health Organisation (WHO). A review of WHO strategic documents found that in 2002 out of the total budget of \$13.7 million, \$10.8 million came from “other sources” (as opposed to its core budget). Therefore, it is hoped that a large proportion of WHO funding would be captured on contributions from other DPs. To avoid double counting, no WHO information was added from other sources.

Government health expenditure data were extracted from the PER. This is because it offered the most complete set of data. Total government expenditure was extracted from the budget speeches, as again they provided the most complete picture. NHA data were not used because they were only available for three points in the time period (comparison of PER with NHA showed that they were similar, see Chapter 6 for graphs). The NHA does estimate expenditures for the years in between NHA exercises; however, these are less reliable (67) and were therefore not included. Data on other indicators from the budget books were not used because these were only available electronically from the year 2007 and matched the data from the budget speech, which were available from 2001.

3.2.4 Definitions and coding methodology

Health was defined in line with the World Health Report (2000) (also used in the NHA) as “all the activities whose primary purpose is to promote, restore or maintain health” (251). DAH was defined by adapting Ravishankar et al.’s definition (31) as all financial and in-kind contributions from channels of assistance by official agencies (bi- and multi-lateral

agencies, global health initiatives, NGOs and private foundations) to Tanzania with the aim to achieve either health improvements or to finance health related global public goods such as research and development, disease surveillance, monitoring and evaluation, and data collection. This includes loans on concessional terms, which charge below-market interest rates. Research funded by DAH channels of assistance were counted as DAH, whereas health research by other institutions whose primary purpose was not development assistance was not included (so for instance, the Bill and Melinda Gates Foundation was included). All health sector activities (such as the provision of curative and preventative services), family planning, as well as education, nutrition and water and sanitation activities whose primary objective was health were included. Humanitarian aid provided to Tanzania is usually in the form of food aid and help for refugees and was excluded. World Bank debt relief projects were also excluded.

Domestic expenditure was used directly in the format available in the PER and budget speeches and did not require further manipulation. However, the extraction and analysis of DAH data required a number of steps to ensure projects were correctly identified as DAH, to re-code projects by source, channel (agent) and generate additional codes for sub-sector distribution.

Pitt et al. outline three different approaches to coding aid projects: line-by-line, keyword or using the databases' own codes (239). Line-by-line coding is the most accurate (albeit labour intensive), although keyword searches are more transparent and replicable (239). Doing a country level analysis restricted the number of projects, and therefore, a mixture of line-by-line and keyword coding was used here, to maximise specificity and feasibility. The rest of this section describes how DAH projects were identified and coded according to source, channel and sub-sector priorities. All coding was done manually using Microsoft Excel to create new numerical codes for each of the categories as described below. The

coding frameworks were reviewed and approved by two of the supervisors of this thesis (AV and JB).

Measurement of DAH

To ensure that all DAH projects were correctly identified, the following steps were performed. First, all projects from the following CRS sector codes were included: health general, basic health and population policies/programmes and reproductive health. A keyword search¹⁶ was then carried out on the retrieved projects to remove those related to the census. This was followed by a keyword search on the rest of the database. Different keywords were tested and all of those that returned health projects were used: “health”, “HIV”, “tuberculosis”, “tb”, “malaria”, “matern”, “disease”, “STD” and “medic”. These were translated into German, Dutch, Spanish and French to ensure all languages of the CRS database were included. All of the projects that resulted from the keyword search were reviewed line-by-line and those meeting the inclusion criteria were included. Finally, all selected projects were reviewed line-by-line to ensure they were correctly classified as DAH. Performing the keyword search highlighted a number of purpose codes that consistently contained health projects¹⁷. A line-by-line search was subsequently undertaken on each of these purpose codes. Data from the IHME DAH database is not available at the project level, and therefore no re-coding was possible. All health-relevant

¹⁶ Keywords used were “census” and “cens”

¹⁷ Basic life skills for youth and adults, advanced technical and managerial training, water supply and sanitation - large systems, basic drinking water supply and basic sanitation, waste management/disposal, education and training in water supply and sanitation, economic and development policy/planning, women’s equality organisations and institutions, social/ welfare services, multisector aid for basic social services, Social mitigation of HIV/AIDS, multisector aid, multisector education/training, research/scientific institutions, food aid/food security programmes, administrative costs, support to national NGOs, support to local and regional NGOs and sectors not specified

purpose codes from the AidData database were included¹⁸, and projects checked line by line.

A final consideration was whether or not to include GBS. These funds are not often included as health sector funds in the literature, except for the Countdown project and Stierman, who allocate GBS according to the proportion of government expenditure that is spent on health (37, 252). Foster developed a methodology for assigning GBS to the education sector, based on the share of government expenditure to the education sector as a proportion of government spending on ODA-eligible sectors (i.e. excluding expenditure on defence and security) (253). It was not possible to obtain government expenditure on defence and security in this study. Advice was sought from national-level financing experts, who reported that it was not possible to track GBS at the sector level.

“... it’s crazy to think of attribution, if you drop a bucket full of water into a lake, how do you identify where that bucket went in the lake, did it go down the falls?”
(DP)

The Countdown methodology was therefore followed and GBS was allocated to the health sector using the proportion of government expenditure on health over the time period of study. This may be an over- or under-estimate of the actual amount going in as government budgetary allocations may have been affected by the conditions for spending in social sectors attached to GBS, which could have resulted in higher amounts going into the health sector, or the health sector may not be able to absorb all the increase of funding, resulting in lower allocations.

¹⁸ The following AidData purpose codes were included: Basic drinking water supply, basic drinking water supply and basic sanitation, basic health care, basic health infrastructure, basic life skills of youth and adults, basic nutrition, basic sanitation, family planning, health, health education, health personnel development, health policy and admin management, health combination (get full), infectious and parasitic diseases, infectious disease control, malaria, medical education, medical research, medical services, personnel development population and reprod., population and reprod., population and reprod. Admin and policy, reproductive health care, STD control including HIV/AIDS, Tuberculosis control

DAH distribution by source and channel of delivery

The NHA analysis framework, which classifies DAH by source and channel of delivery, was used (248). Sources provide the funds and agents channel them or use them to pay for health activities. Sources of DAH were divided into bi-lateral (including the European Commission), multi-lateral (development banks, global health initiatives and United Nations agencies) and private foundations/philanthropies (Bill and Melinda Gates Foundation and Bloomberg).

Channel of delivery is one of the least complete fields on the CRS database, despite its importance to evaluate the coordination of funds and use of country systems, two key principles of aid effectiveness. The CRS database has three fields for channel of delivery: "Channel Code", "Channel name" and "Channel reported name". Channel code and channel name were essentially the same, the former a numeric code and the latter providing a description of the code (for instance code 12000 has channel name Recipient government). Channel reported name contained the name of the organisation through which the funds were disbursed. When either the "Channel name" or "channel reported name" had a value, these were classified as "Projects through the government", "Projects outside the government" (including NGOs and consultancies) and "Health Basket Fund". In addition, the estimated proportion of GBS to the health sector was also included as going through the government. Where the channel code was another DP, this was assumed to go outside of the government¹⁹.

Efforts were made to improve the completeness of available data, by going through the database line-by-line. For projects that did not contain information on channel name, the "channel reported name" field was reviewed. For projects where this field was blank, the "project title", "short description" and "long description" fields were reviewed for names of

¹⁹ The CRS asks DPs to report this in order to avoid double counting

the organisation through which the project was disbursed. This was supplemented by online searches, a review of DP documents and by asking local stakeholders. Being based in Tanzania for a year helped to identify the language used by the DPs and specific terms referring to different channels. To test the usefulness of re-coding fields in this way, the percentage of projects that was re-coded was calculated.

DAH sub-sector distribution

This is perhaps the most popular framework for DAH analysis, but also the most contentious. The approach adopted here was first to measure the amount of DAH that is delivered through the different modalities (earmarked vertical and diagonal programmes versus horizontal funds), and second to disaggregate vertical programmes to analyse DAH allocation to different disease priorities.

To assess DAH modalities, three new codes were created: “vertical”, “diagonal” and “horizontal”. Disease, condition or population specific DAH funds were classified as vertical (for instance, reproductive health and malaria), funds targeted at improving the health system, but delivered as a project were coded as diagonal (including projects for infrastructure, medical supplies and health workers not specific to a single disease), and finally, health basket funds and the proportion of GBS allocated to health were coded as horizontal funds (cutting across the sector). Some studies have estimated the proportion of pooled funds and budget support that is allocated to specific diseases (252, 254). This was not done here for two reasons. First, a big proportion of basket funds are spent on medical and drug supplies and local government authorities, rather than supporting specific conditions/diseases. Second, there was no way of estimating accurately the sub-division of horizontal funds according to disease priorities. Diagonal and horizontal funds are likely to be an under-estimation of health systems activities, however, as vertical disease specific programmes also invest in health systems components such as drug supply mechanisms

and human resources. Equally, a proportion of all other funds (health systems, pooled funding and budget support) also benefit vertical disease programmes.

Vertical programmes were then further disaggregated into one of 12 *priority* categories as shown on Table 3.3. This was done to assess the disease-specific distribution of DAH. Some categories already existed in the CRS (such as malaria and tuberculosis). Others were constructed here, such as HIV/AIDS (separating it from other sexually transmitted infections), combining reproductive and maternal health with child health (for ease of visualisation) and “blank” for projects that could not be assigned a single disease category. To do this, line-by-line coding was undertaken and projects/transactions were reclassified by reviewing the “project title”, “short description” and “long description” fields. As highlighted above, the CRS does not allow for multiple purpose codes. Different approaches have been taken in the literature to deal with this, either by attributing all the expenditure to one purpose (68), dividing the expenditure equally between the different purposes (5) or using an index to estimate expenditure based on assumptions and the literature (33). Here, rather than make any estimates based on assumptions, DP reports and budgets were reviewed to estimate the purpose of funding wherever possible. Where activities could not be assigned to a single category, they were coded as “multi-purpose”. Activities spanning multiple sectors or without information in the project title and description fields were classified as “blank”.

Table 3.3: Vertical disease priorities

Priority	Inclusion criteria
HIV	All activities for which the prevention and control of HIV/AIDS was the sole purpose. Activities including other Sexually Transmitted Infections were excluded.
Malaria	All activities for which the prevention and control of malaria was the sole purpose
Reproductive Maternal, Neonatal and Child Health	All projects specifically targeting reproductive, maternal, neonatal and child health. A modified version of the Countdown project definition is used. They define maternal and neonatal health activities as those “whose primary purpose is to restore, improve, and maintain the health of women and their newborn during pregnancy, childbirth, and the 7-day postnatal period”, in addition to sexual and reproductive health activities (255). The emphasis in this study was on a disease/condition rather than a population group. Therefore, and unlike Countdown methodology, interventions such as malaria in pregnancy and Prevention of Mother to Child Transmission were included in the malaria and HIV categories respectively ²⁰ . Immunisations were also included.
Sexually Transmitted Infections (STI)	All activities for which the prevention and control of Sexually Transmitted infections was the main purpose (excluding HIV/AIDS)
Tuberculosis	All activities for which the prevention and control of Tuberculosis was the main purpose
Immunisation	All activities relating to the storage and delivery of immunisations (excluding for tuberculosis)
Other Infectious Diseases	All activities whose main purpose is the prevention and control of infectious diseases, except malaria, HIV/AIDS, STIs, tuberculosis and those related to childbirth. Diarrhoeal, vector-borne, bacterial, viral and parasitic diseases are included.
Non-Communicable Diseases	All activities whose primary purpose was to restore, improve and maintain dental, mental and eye health; provide medical rehabilitation; control of non-infectious diseases and drug and substance abuse.
Nutrition	Only activities with a direct health focus were included. The OECD-DAC definition for basic nutrition was used: “direct feeding programmes (maternal feeding, breastfeeding and weaning foods, child feeding, school feeding); determination of

²⁰ This means Reproductive Health does not include any HIV/AIDS funding

	micro-nutrient deficiencies; provision of vitamin A, iodine, iron etc.; monitoring of nutritional status; nutrition and food hygiene education; household food security". (242)
Water and Sanitation	Only activities with a direct health focus were included. These included basic water supply and sanitation through low-cost technologies (handpumps, spring catchment, gravity-fed systems, rain water collection, storage tanks, small distribution systems, latrines, small-bore sewers and septic tanks and activities promoting hygiene, such as hand washing campaigns
Multi-Purpose	Activities that had more than one purpose within the health sector (for instance HIV and STI control)
Blank	Projects that could not be coded under any of the above categories. These included multi-sector projects, or those that had no information on "project title", "short description" and "long description"

To assess the differences coding made to the database all of the categories re-coded (DAH, channel of delivery and vertical priorities) were plotted before and after coding. For the two categories for which coding made the most differences (adding GBS to the health sector and channel of delivery) the percentage difference coding made was calculated.

Domestic financing

Two indicators were used to assess domestic expenditure: Total Government Expenditure (TGE) and Government Health Expenditure as a source (GHE-S). To compare domestic and external financing, GHE-S was also explored at the sub-sector level for HIV/AIDS, reproductive health and malaria.

TGE was obtained from the budget speech. Due to data constraints GHE-S is difficult to obtain. In their studies of fungibility, the IHME estimate it by deducting DAH delivered through the government from government expenditure on health as an agent (158). In this study GHE-S was obtained from the PER. However, in order to avoid double counting, the proportion of GBS allocated to the health sector was subtracted from the GHE-S figure found in the PER. In this way, it is hoped that the figures provided are as close as possible to the actual amount of domestic expenditure on health. Domestic HIV/AIDS expenditure was obtained from the HIV/AIDS PER.

Amounts were converted to US dollars using annual averages and converted to 2010 US dollars using OECD deflators. To account for population changes, both GHE-S and DAH-G were assessed as absolute amounts and per capita. Population figures were obtained from the World Bank²¹.

²¹ <http://data.worldbank.org/country/tanzania>

3.2.5 Analysis

The first objective of the quantitative part of this thesis was to draw a map of the Tanzanian health sector between 2000 and 2010. The indicators used in this part of the analysis (health financing source, DAH funding source and sub-sector distribution) were presented as trends, without further analyses performed to them.

In addition to describing the health financing landscape of Tanzania for the time period of 2000-2010, quantitative methods were also used to assess the principles of aid effectiveness through four indicators: fungibility, use of government systems, use of pooled funding modalities and fragmentation. The rest of this section describes how each of these indicators were analysed.

Lack of sufficient historical data on domestic and external health financing and difficulty in controlling confounders meant a causal relationship on whether DAH causes fungibility could not be established at the country level in Tanzania. The scope of this study is therefore limited to a descriptive account of domestic and external health expenditure trends as sources and agents (this was complemented through qualitative methods). To assess use of country systems and alignment to country strategies quantitatively, trends in the proportion of DAH channelled through the government and the proportion of DAH-G that was delivered as pooled modalities over the time period of 2001-2010 were assessed (domestic data were not available for 2000). This involved plotting these indicators as they were developed in the database.

Fragmentation was assessed through four indicators: Amount of DAH, number and average size of projects and proportion of DPs that together account for less than 10% of DAH for each year in the time period of 2000-2010 (256). Fragmentation was only assessed using the projects extracted from the CRS and AidData databases, as the IHME database does not

disaggregate DAH flows by project. The CRS database's activities often reflect single transactions rather than projects (even those that have a CRS unique identifier). To calculate the number and size of projects, the project title was used, which involved manually selecting these throughout the years. Projects are usually disbursed over multiple years. However, as they do not only incur transaction costs on the year they are committed, it was felt that this provided an appropriate measure of fragmentation. It does mean, however, that the number of projects shown in a given year is the number of projects "active" in that year. To assess the effect of the basket fund on fragmentation, the average size of projects was compared with and without including the health basket fund, and the percentage change was calculated. Disbursements through budget support were excluded from the analysis as they were delivered as part of the government system and as such did not incur extra transaction costs, as were those classified as debt relief and core contributions to NGOs (following the OECD methodology for assessing fragmentation (256)). Fragmentation levels were further assessed at the sub-sector level and by different DPs.

3.3 Qualitative Methods

A mix of qualitative methods was used to construct a map of health sector management in Tanzania, including budgeting processes, policy strategies and stakeholders involved; to develop and apply a set of indicators to assess the aid effectiveness agenda in the Tanzanian health SWAP; to understand quantitative financing trends and the use of different financing modalities; and, to explore the relationships present in the "aid system". Qualitative methods used in this study include document review, non-participant observation and key informant and in-depth interviews. This section describes how these

were carried out, followed by an account of the method used to analyse the data generated²².

3.3.1 Data generation

Document and literature review

Green & Thorogood (2009) describe the aims of document review as either to elicit background information or as part of the data for the study (216). In this study it was carried out for both purposes.

First, a number of documents were reviewed to understand the national and international political context, both in terms of health sector policies and development cooperation. In addition, the historical context of the SWAP was explored, including how it was set up, by whom and what relationships were at play, as well as the current policy and expenditure frameworks and accountability mechanisms.

A search was undertaken in Eldis, Google and Scholar Google using the following search terms: Tanzania, SWAP, health, DP, development partner and basket fund on their own and in combinations. This was complemented by a website search of DP websites, the Development Partner Group portal (including the Development Partner Group for Health), the Government of Tanzania, Ministry of Health and Social Welfare, Ministry of Finance and Economic Affairs and the Prime Minister's Office for Regional Administration and Local Government websites, and websites of civil society and non-government organisations (SIKIKI, REPOA and TWaweza). In addition, when interviewing study participants, they were asked to recommend documents. Snowballing was also used by checking through the references of documents selected. Documents were included if they described the SWAP,

²² The term data generation (rather than collection) is used consistent with a subtle realist perspective, which assumes data are generated through the researcher's interpretations

domestic and external health financing mechanisms and health policy strategies in Tanzania, were in English and were published in the time period of 1995-2012 (from the conception of the SWAP to the time when the search was conducted). A total of 53 documents were included. Tanzanian health sector policies, SWAP and basket fund documentation, international declarations and national assistance strategies were reviewed to understand the current context. Early SWAP and basket fund reports, studies and minutes of meetings of the SWAP and pre-SWAP discussions were reviewed for the purpose of understanding the historical context of the SWAP. Finally, joint annual health sector reviews, budget guidelines and technical and financial reports were reviewed to understand the sector financial and accountability mechanisms.

Using documents has the advantage of data being readily available; and in some cases documents are the only source of data on a particular topic (216). However, some limitations were also encountered, including availability of data, as often annual reports were not available for every year, and the reliability and accuracy of documents, such as minutes from meetings. Wherever possible, validity was cross-checked during interviews and non-participant observation, but it was more difficult to verify older documents as stakeholders were not able to recall beyond a certain period.

The second objective of the document and literature review was to inform the development of indicators to assess the aid effectiveness agenda. The aim here was to review definitions and assessments of aid effectiveness internationally and in national declarations in Tanzania, and their evolution over time; to review how principles of aid effectiveness have been assessed in the literature; and to explore how these principles were interpreted and implemented in practice within the Tanzanian health sector context. Key policy documents were reviewed, including international and Tanzanian declarations

on aid effectiveness²³, the SWAP Code of Conduct (2002 and 2007) and the Health Basket Fund Generic document (2009) and the Health Basket Memorandums of Understanding (2003 and 2008).

To search the literature, the Global Health, EconLit and Web of Science databases were searched. In addition, to avoid any publication bias, key websites were consulted for grey literature, including Eldis, the OECD and government and DPs' websites. The following search terms were used: aid, aid effectiveness, health, Paris Declaration, ownership, basket, results, results based management, harmonisation, coordination, accountability, sector-wide approach and SWAP. Terms were used alone and in combination. In order to obtain as wide a selection as possible no restriction was placed on sector or date of publication. Papers in English, Spanish and French (languages readily spoken) were included. Papers were only included if they had a definition of indicators to measure at least one of the aid effectiveness principles. Titles and abstracts were reviewed and for those found to be relevant the full text was downloaded and included in the review. Snowballing was used to find further relevant material by searching references of relevant articles and reports. In total 221 abstracts were reviewed, and 108 papers and reports were identified and included for full text review. The only information extracted from these papers was the definition of aid effectiveness principles and/or the indicators used to assess them.

A final source of documentary evidence was the field notes taken during the year-long fieldwork period and the two-week pre-fieldwork visit. These recorded informal conversations and interactions, news articles, as well as personal thoughts and reflexions

²³ International declarations: Monterrey Conference on Financing for Development, Rome Declaration on Harmonisation, Marrakech Memorandum of Managing for Results, Paris Declaration on Aid Effectiveness, Accra Agenda for Action, International Health Partnership, Busan Partnership for Effective Development. National declarations: Helleiner review, Tanzania Assistance Strategy and Joint Assistance Strategy of Tanzania

on the experiences during fieldwork. These helped understand the context, and fed into the design of the study tools and helped with the interpretation of the results.

Non-participant observation

The purpose of non-participant observation was threefold: first, to observe stakeholder behaviour and interactions between the different actors in their natural state (216); second, to triangulate/validate findings from document review, in-depth interviews and quantitative methods; and third, to identify, gain access to and develop relationships with key stakeholders that subsequently participated in the in-depth interviews. Nine meetings were attended and observed. These included DP coordination meetings as part of the Development Partner Group for Health (DPG-H) and the basket fund, meetings between DPs and the Ministry of Health and Social Welfare, and SWAP meetings, where all actors active in the health sector were present. In order to minimise influencing the content of the meetings attended, efforts were made to remain “inconspicuous” to the other participants. This was easier in some of the bigger meetings, but harder in meetings where participants sat around a table, or where there were a very small number of foreign participants. Non-participant observation took place throughout the period of fieldwork. During meetings detailed notes were taken of topics discussed and interactions between participants. Notes were typed up immediately to increase accuracy.

Key informant interviews

Key informant interviews were undertaken in June 2011 to identify the key stakeholders, refine the research objectives and design the interview tool, which was subsequently used to guide discussion in the in-depth interviews (see Appendix B). Twelve key informant interviews took place during this visit (table 3.4). Key informants were initially identified through online searches of health SWAP meetings and by contacting the participants in

them. Snowballing was then carried out to identify further key informants. These interviews were highly informative in terms of context, data sources and identification of relevant stakeholders. Key informant interviews were informal and were not recorded. During interviews, efforts were made to elicit key health policies and documents, identify important areas to investigate within the health SWAP and aid effectiveness and key actors. In addition, two further key informant interviews were carried out during the period of fieldwork. The rationale for conducting these during fieldwork was for practical reasons – neither of the informants was in the country at the time of the preliminary visit, but their knowledge of the Tanzanian health sector was key to conducting the fieldwork.

In-depth interviews

This section describes how the in-depth interviews were conducted in this study. It starts by describing the rationale for using in-depth interviews, before describing the development of the interview tool, the sampling strategies and how the interviews themselves were carried out.

In-depth interviews are *“a specific kind of interaction, in which the researcher and the interviewee produce language data about beliefs, behaviour, ways of classifying the world, or about how knowledge is categorized”* (216). Interviews were selected as a research method because of their ability to elicit information from respondents regarding their own experiences and social worlds (257). Concerns have been voiced regarding the validity of data generated through interviews, particularly linked to discussions of whether knowledge is a pre-existing phenomenon that can be retrieved or if it is constructed through the interview process, raising concerns regarding the stability and validity of the data (258). Kvale provides a metaphor to understand this distinction and describe two different types of interviewer. The first interviewer acts like a miner that “unearths” knowledge from the respondent as if it was a mineral ore from inside a mine. It assumes knowledge is hidden

inside the subject of research “unpolluted” by leading questions. In the second, the interviewer acts like a traveller on a journey exploring new territory and engaging in conversations with subjects about their own world, to produce an account in the form of reconstructed stories (259). In this study, guided by subtle realism, in-depth interviews were used both to elicit respondents’ views and opinions on the topics discussed, but also to elicit knowledge about how the aid system worked and description about events that had taken place (such as meetings during the policy dialogue). Using Kvale’s terminology, this may be viewed as the interviewer travelling inside a mine with the subject.

In-depth interviews were undertaken during the actual field work with health sector stakeholders to explore their perceptions of how the aid effectiveness agenda had been implemented in the Tanzanian health sector, including what the agenda (and its principles) meant to them, how they felt they should be measured, and to explore whether they felt aid effectiveness principles had been achieved and why/why not. In addition, in-depth interviews were used to explore relationships and incentives of the individuals interviewed and their organisations.

Development of the interview tool

The findings from the preliminary fieldwork visit were used to design the interview tool used to guide discussion in the in-depth interviews (see Appendix B). Preliminary findings from the quantitative data, document review, non-participant observation and informal conversations also fed into the design of the interview tool (interviews did not take place until six months into the fieldwork period).

Two principles were taken into account when designing the interview tool: structure and flexibility (231). The tool was semi-structured. It started with ice-breaker questions on the role of the participant and their organisation, which were followed by open questions on

the aid effectiveness agenda, the SWAP and choice of modality, priorities and relationships. The tool had a set of *probing* questions under each of these topics to achieve depth (see Appendix B) (231). The extent of *probing* and structure in the interview varied according to the interviewee. Probing questions were only used if the participant was unclear about the meaning of the questions or to guide discussion if responses were not elaborate.

The open nature of the questions allowed flexibility for the participant to bring in new themes. Care was taken to allow for these new themes to emerge. The key informant interviews conducted during the preliminary visit also acted as a pilot, where I reflected upon my interviewing style. I further listened to the recordings of interviews to try to improve my interviewing technique during the period when the interviews took place. For instance, in the initial interviews the manner of interviewing appeared rigid. However, upon reflection the interview technique became much more flexible, with fewer or no interruptions, to allow the interview to flow more naturally, rather than be concerned about whether all the topics in the interview guide were covered.

Sampling

Initially, interviewees were sampled purposefully to represent all the main actors active in the health sector and engaged in the health SWAP dialogue. Further participants were identified by using snowballing, until saturation was reached. Through this technique, two further stakeholder groups were identified: the Prime Minister's Office for Regional Administration and Local Government and civil society. Four key informants from the preparatory visit were identified as meeting the inclusion criteria and were therefore re-interviewed as shown below. Whilst this may have facilitated data collection, since these stakeholders were known and had already demonstrated a willingness to participate in the study, re-interviewing key informants as part of the in-depth interviews may have influenced the outcome of the interviews, as the key informants had provided input into

who the key stakeholders were (a criteria which they themselves met) and which questions were included in the interview guide, questions which they themselves subsequently answered (and may have therefore been better at answering). The preparatory visit revealed the importance of going beyond national level stakeholders (only carried out previously by Sundewall in Zambia (260)). As a result one sample regional health team and two district health teams within it were chosen purposively (based on geographic access and where there were pre-existing research contacts). At the regional and district level, the criteria for selecting respondents were those who participated in health planning and reporting exercises (the sample included members from all ranks, from regional and district medical officers to health workers).

Stakeholder access was greatly facilitated by being based at a local research institute (Ifakara Health Institute) and through the contacts of JB, who is an established researcher in Tanzania. No reward was offered for participating in the interview. However, one participant from a district asked to have a “tea”²⁴ before the interview. I do not believe this made any difference to the amount or validity of the data generated as part of this interview. The lack of reward in exchange for the interview meant one district-level stakeholder refused to participate. They were quite new to the post, so it is hoped that no important information was lost through their refusal. They did, however, have significant experience at the national level. Therefore, other national level respondents were included in the sample (current and past employees).

In total, 22 in-depth interviews were conducted with representatives from the MoHSW, the PMO-RALG, regional and council health management teams, civil society and DPs (see table 3.4).

²⁴ Tea can be used to refer to an actual cup of tea or a meal; in this case it was the latter

Table 3.4: Key informant and in-depth interview participants

Stakeholder type	Key Informant Interviews	In-depth interviews
	June 2011	April-July 2012
Government		
Ministry of Health and Social Welfare	2	3
Prime Minister's Office-Regional Administration and Local Government		1
Regional Health Management Team		3
Council Health Management Team		5
Total Government	2	12
Development Partner		
Bi-lateral	4	5
Multi-lateral		2
Total DP	4	7
Non-government		
Civil Society	2	1
Technical Assistants	2	2
Consultants / Academics	2	
Total Non-government	6	3
Total Interviews	12	22

The interviews

This section describes how the interviews were conducted. In-depth interviews were conducted between April and July 2012. They were conducted face-to-face to facilitate interaction between researcher and interviewee (231), in English and lasted for about an hour. Ritchie and Lewis define interviews as a conversation, with varying degrees of structure and “activeness” from the interviewer (231). In this study the amount of direction and structure in the interviews depended on the behaviour of the respondent. For some respondents, introductory questions such as “What changes have you observed since you

have worked in your role?" would elicit a response that would cover most of the points in the topic guide, and would only require some further probing questions for further explanations of some statements. My attitude in these interviews was more relaxed, although I tried to avoid stepping outside of my role as asker of questions to express my own opinions (such as is sometimes done in feminist approaches (231)). This was in order to avoid as much as possible influencing the outcome of the interview. It was not always easy to do, however, as respondents often asked for my views on the topics discussed. Going through interview transcripts and notes helped provide neutral answers to these questions, but this was something that I improved at as the fieldwork went on and I learned from conducting the interviews.

Some respondents, particularly some representatives from the government, were noticeably less at ease during interviews. In these cases, I played a more active role, asking questions more precisely and answering their frequent requests of clarification of the aims of the research or of a particular question. One respondent was particularly difficult to interview and spent considerable time during the interview answering phones and talking to colleagues who interrupted the interview. It was very difficult to obtain answers, although the notes from the interview contained important information. In addition, several steps were taken to compensate for this: non-participant observation revealed some of this person's attitudes and opinions, the sample size from the respondent's stakeholder group was extended to improve the inclusiveness of the sample, and themes that were deemed important from the interview notes were followed up with other stakeholders in subsequent interviews. Although at the time this interview was rather frustrating, upon reflection it appeared to convey some of the power relations that were at play and that were later described by DPs. The respondent did not want to disclose much information, but rather than say no to the interview upfront, they agreed to it, then made it very difficult to obtain information from them by asking me to come in at a time that was

very busy and prioritising phone calls and colleagues over the interview. In this way they had participated in the study, but had not contributed much information to it. This was the most extreme example, however, and the majority of respondents were open, frank and generous with their time.

On two separate occasions, the interviewee asked for a more junior colleague to be present during the interview. This was granted with different results. On one occasion the colleague greatly contributed by correcting several inaccuracies of the account of processes. On the other occasion the colleague made the discussion more difficult by interjecting and disagreeing. However, overall the interview was enriched by their contributions and the debates ensuing from their objections, despite the actual interview being harder to conduct.

Where the participants agreed, interviews were recorded and transcribed. Transcription was sub-contracted out to a trusted person. In order to assure quality and to familiarise myself with the data, I went through every transcript to ensure it matched the recording. The transcriptionist was based in the United States, which meant transcription was done overnight and transcripts readily available for review the day after the interview. Where participants did not agree to being recorded, notes were taken during the interview and typed up straight away. Some national participants (particularly from the government) did not agree to be recorded or quoted (in total only 11 interviews were recorded). This had an impact on the accuracy of my account of the results. To increase the representation of national voices in the account of results, the sample size from the government was increased. Their views are also presented in the narrative and in the absence of quotes.

3.3.2 Data analysis

Qualitative analysis takes place through a process in which analytical categories are developed to describe and explain the data (261). This process can be undertaken deductively, by applying a set of pre-determined categories to the data, or inductively, where categories “emerge” from the data (262). When considering the type analysis that would be most suitable for this study, several factors were taken into consideration, including the fact that this was a mixed methods study that bridges across disciplines, takes a subtle realist epistemological perspective and needs a flexible approach to data analysis, given the different purposes for which qualitative data were generated, meaning both inductive and deductive approaches were needed.

The framework approach (231) was found to be the most appropriate method of analysis. Framework analysis is a method for policy research developed by the UK National Centre for Social Research²⁵ that has become increasingly popular in health research (263). Framework approach allows for systematic analysis of data with enough flexibility to accommodate different epistemological positions, inductive and deductive approaches, and has recently been recommended for multi-disciplinary mixed methods research (263). Despite framework analysis being usually associated with deductive approaches to coding (261), it has recently been argued that it also allows for inductive coding (263). The framework approach involves five steps of data analysis: familiarisation with the data, development of an analytical framework, indexing, charting and mapping and interpretation (231, 261). This section describes how each of these steps was carried out.

²⁵ <http://www.natcen.ac.uk/>

Familiarisation with the data

The first step of analysis involved familiarisation with the data; this allowed for immersion within the data to get an initial feel for the main themes of the study. Familiarisation with the data was done in different ways. Although interview transcription was contracted out, one interview was transcribed to understand the process involved. In addition, once all the transcripts were received, each one was read whilst listening to the interview recording. Finally, field notes and notes from observation of meetings and interviews that were not transcribed were also read through.

Development of an analytical framework

An analytical framework is a list of the key issues, concepts and themes that can then be applied to index the whole data set (261). The analytical framework used here was developed through a process known as coding. A code is a conceptual label applied to a data excerpt (263). The process of developing an analytical framework involves creating a list of codes, which can subsequently be grouped into a coding tree of themes. A mix of deductive and inductive approaches was used here, depending on the purpose for which the data was analysed.

An initial analytical framework was developed from the topic guide and literature review. This already contained the five principles of the aid effectiveness agenda (ownership, alignment, harmonisation, results and accountability). Six transcripts were then chosen at random and coded inductively by reading them line-by-line and identify emerging codes from the data. The analytical framework was then modified to incorporate new codes that arose from this exercise. An example of a theme that emerged from the data was “dialogue”, which respondents often referred to when discussing the relationships between the government and DPs.

Codes were grouped into broader themes and sub-themes into a coding tree (shown in Appendix C). Each theme had a number of sub-themes, for example the theme “accountability” had ten sub-themes, including “accountability processes” and “consequences/enforcing accountability”. In addition, each theme had a sub-theme named “other” to allow for new sub-themes to emerge during the analysis of the whole data set. The development of the analytical framework was undertaken by highlighting text and writing notes manually, without the use of any Computer Assisted Qualitative Data Analysis Software (CAQDAS).

Indexing

The analytical framework was applied to label all of the data, including interview transcripts, notes from meetings and interviews, and documents; a process known as indexing. Sometimes a single data excerpt was allocated multiple indices. For instance, the same extract for a respondent describing whether a particular aid effectiveness principle had been met, such alignment, was coded as a definition for how the particular respondent defined that principle. The NVIVO CAQDAS software was used to do this. During this process, the analytical framework was refined by periodically checking the “other” category for each theme, and incorporating themes that re-occurred frequently. In this way, several iterations of indexing took place, until no themes arose and all of the data had been indexed.

Charting

The next step was to explore and re-categorise codes into broader themes or categories. To do this, the coded data were charted into a “framework matrix” using NVIVO. Framework

matrices are essentially tables plotting cases²⁶ (rows) against themes (columns). Each cell then contains the data corresponding to a particular case for each of the themes. Rather than using the original data, however, in this study the content of each cell was summarised. This step is important not only to synthesise the amount of data, but also to gain a deeper understanding of the data. There is a danger at this point of over-summarising and thereby losing some of the meaning of the data (263). To avoid this, there was constant cross-checking between the data and the summarised categories. When a cell contained an interesting quote, an asterisk was added to the description for ease of finding the original source in later stages of the analysis and in writing. One matrix framework was created for every key theme (a “thematic matrix”), where the columns were the sub-themes falling under the particular theme. This is a key step in the framework approach, as having thematic matrices allows for the movement between themes and across cases, facilitating subsequent understanding and interpretation of the data (231, 263).

Mapping and interpretation

In this final step of data analysis the thematic matrices were used to define, classify and categorise concepts, map different phenomena and identify relationships between different themes to provide explanatory accounts of the findings (261). To do this, several steps were undertaken, following the methodology described by Ritchie and Lewis (2003) (231).

Before this process began, the thematic matrices were extracted to Excel for ease of use, and explored by reading each theme and sub-theme moving across different cases to identify different concepts. A different Excel file was created for each theme, with individual sheets for each of the sub-themes (a cell of the framework matrix). Each sheet

²⁶ A case is a unit of analysis. In this study a case was defined as an individual interview, meeting or document.

contained a matrix with three columns (the rows were still the cases). The first column contained the synthesised content for the relevant sub-theme. After reading through the content of each sub-theme, different elements were identified and entered into the second column. Reading through these, in turn, allowed for broader categories to be generated (see Appendix D for an example). Categories were broad and reached across thematic charts, encompassing different elements and sub-themes. During this process of categorisation the original data were often re-visited to ensure the categories and elements were representative of data they were based on. Categories were reviewed and classified into broader categories.

The final part of the analysis involved mapping and interpretation to explore the relationships between concepts and the categories generated. This was done in two steps. First, linkages between different phenomena were identified, and phenomena were classified into different sub-groups. This was done by reading through the thematic matrices and the elements and the categories generated. Hypotheses of linkages between phenomena were tested across the whole dataset by going back to individual thematic charts, by reading across data by each individual cases or case sub-groups. For example, phenomena were found to vary according to the interview respondent, so respondents were classified into three stakeholder sub-groups (DP, government and non-government); also, the indicators developed to assess the aid effectiveness agenda were classified as those derived from this study and those identified from international declarations, as important differences were found between the indicators in the two sub-groups. Sometimes sub-groups were rejected, for instance it initially seemed that phenomena could be separated into SWAP, DP and government. However, this did not apply to all the elements of the study, so it was dropped.

Finally, explanatory accounts were generated by verifying associations and exploring why these associations exist. Sometimes explanations arose from explicit accounts found on the data (for instance a direct quote from a respondent), other times, they were derived through linkages between phenomena. When searching for explanations, original transcripts and synthesised data were reviewed, and potential associations were drawn into mind-maps and spider diagrams. When a hypothesis for an explanation was generated, it was first tested within a single case, then across cases in the same group and finally across cases in different sub-groups (following the constant comparative method described by Boeije (2002) (264)). Emerging hypotheses were then contrasted with theory and other empirical studies. This sometimes resulted in important changes to the study. For instance, it was by moving between the data and theory that this study found that institutional and political factors were key in explaining the extent to which the aid effectiveness agenda was achieved. This in turn led to the modification of the conceptual framework of the study described in Chapter 4, which was initially only based in economic theory, and was later altered to incorporate elements from policy analysis. In this way, the broader categories of “institutions”, “relationships” and “political context” were derived, as well as sub-categories including “incentives” and “structural factors”.

3.3.3 Validity and reliability

This section describes the steps taken to maximise the validity and reliability of this study. Validity is the precision and correctness of the research (231). Hammersley defined it in the context of subtle realism as the extent to which an account accurately represent the social phenomena to which it refers (265). Two approaches were undertaken to maximise the validity of the qualitative results. First, using constant comparative method helped ensure the internal validity (228) through testing hypotheses from one part of the data on the others. Second, care was taken to represent views from different stakeholders, particularly

when these differed. This was done through a process known as deviant case analysis (266), which involved exploring cases that both fitted and contradicted emerging patterns and explanations. Deviant cases were always reported, and sometimes further explorations of their views led to explanatory accounts on themselves. This was the case of one particular DP, whose answers consistently disagreed with all the other DPs, and often with the government. However, putting their answers together with policy documents and non-government respondents was pivotal in understanding some important findings of this study, such as the different levels of dialogue between DPs and government.

Reliability refers to the replicability of research findings (216, 231). There are debates in the literature regarding the possibility of replicating qualitative work, given its dynamic nature and particularly in subtle realism, where the role of the researcher's interpretations are viewed as influencing the results (233). Nevertheless, several steps were taken during fieldwork and analysis to maximise the reliability of the study. During fieldwork, careful notes were taken during non-participant observation, but also during interviews and immediately after any informal conversation relating to the study. Notes were typed up immediately (or as soon as was feasibly possible) to ensure accuracy. Each interview transcript was reviewed to ensure the accuracy of the transcription. To check the reliability of the analytical framework, a transcript was co-coded by a colleague; any disagreements were discussed and incorporated into the coding framework where appropriate. Finally, care was taken to select a representative sample of actors active in the health SWAP dialogue.

3.4 Ethical considerations

Ethical approval for this study was obtained from the following Institutional Review Boards:

- London School of Hygiene and Tropical Medicine (UK) (Ref: 6061)
- Ifakara Health Institute (Tanzania) (Ref: IHI/IRB/No. 22 – 2011)

- National Institute of Medical Research (Tanzania) (Ref: NIMR/HQ/R.8a/Vol. IX/1468)

Several steps were taken to ensure the study complied with ethics procedures:

Informed consent. Consent was obtained from each participant before the interview took place. This involved providing them with an information sheet (see Appendix E); where possible an electronic version was emailed in advance, although a paper copy was always provided at the interview. The purpose of the study and the interview were then discussed, as well as a description provided of how the data would be handled. This was followed by giving the participant time to ask any questions of clarification and finally the signing of the consent form. Some participants felt uneasy about signing the consent form, so some time was devoted to explaining its meaning and answer any questions related to it. Some participants preferred signing the consent form after the interview was conducted, as they felt more comfortable doing so after they knew what questions were asked and how they answered them. This option was offered to all. An information sheet was also circulated in advance of meeting observations.

Confidentiality. Quantitative data used consisted of public domestic and external financial flows and did not need procedures for confidentiality. Several steps were taken to ensure confidentiality of qualitative data. The transcriptionist hired signed a confidentiality agreement. All recordings and transcripts were given unique identifier numbers, and participants were referred to using only their identifiers. Data were stored in password-protected computers.

Anonymity. All quotes reported in the study were anonymised. Where participants gave their consent they were identified as belonging to one of two groups: DP or Non-government. Government participants did not agree to be quoted, and their views were

therefore only represented in the narrative. When participants disclosed something they were uncomfortable with, this was noted and was not included in the research or was quoted as *anonymous*, according to their preferences. Some of the *anonymous* quotes also belong to government officials. In addition, the findings of the meetings observed were not reported directly, but were used to help with the analysis and are incorporated into the narrative of the text to ensure the content of what was discussed remained confidential (consistent with the information sheet provided).

Participant discomfort. As this study did not include the discussion of any personal subjects, it was not anticipated to cause any participant discomfort. However, participants were informed of their right to withdraw from the study at any point during their interview or subsequently.

4 CONCEPTUAL FRAMEWORK

This chapter describes the theoretical basis underpinning this thesis. It starts by reviewing the different frameworks that have been employed to analyse aid institutions and relationships. It then describes the two theoretical approaches used in this study to frame aid relationships: principal agent theory and policy analysis. The chapter ends with a description of how the two approaches are integrated.

4.1 Introduction

There are a variety of frameworks that can be used to examine aid institutions and relationships, with varied theoretical foundations and underpinning values. In her work, Gulrajani divides the aid effectiveness literature into aid radicals (opponents of aid) and reformists (proponents of aid) (267). Aid radicals come from both the left and the right of the politico-economic spectrum (Table 4.1). On the left, radicals come from the field of critical development management, with key works by Cooke & Dar (268), Ferguson (269) and Escobar (270). Their work is influenced by neo-Marxist beliefs and, inspired by the work of Foucault, posits that aid justifies the existence of the aid industry and power over the South. On the right, radicals follow neo-liberal ideas and believe that aid creates dependency and crowds out investment. They propose market-based solutions are more conducive to development than aid. Key in this field is the work of the economists Easterly (271-272) and Moyo (273).

Reformists, on the other hand, are optimistic about aid and believe it can be effective if delivered in the right way. This literature is dominated by managerial theories based on improving efficiency. The global aid effectiveness agenda follows this logic (274), as does the work by economists Burnside and Dollar, who argue the effectiveness of aid is dependent on the institutional setup, fiscal policies and governance structures of the recipient country (275), and Sachs, who has argued that with the right policies and

interventions extreme poverty can be eradicated by 2025 (276). Non-managerial reformist literature includes the work of Eyben, who analyses aid relationships, power and accountability through the use of relationalist frameworks, and frames aid relationships as a complex web of interactions, rather than the linear setup assumed by managerial reformists (76, 277).

Table 4.1: Development studies literature on aid effectiveness

Critical		Reformist	
Left	Right	Managerial	Non-managerial
<ul style="list-style-type: none"> • Critical Development Management • Cooke & Dar 	<ul style="list-style-type: none"> • Free market • Easterly 	<ul style="list-style-type: none"> • Technocratic, efficiency-based approaches • Aid effectiveness agenda • Burnside & Dollar 	<ul style="list-style-type: none"> • Relationalism • Eyben

Sources: Author and (267, 274)

This thesis is rooted in the reformist literature. It adopts a conceptual framework that borrows elements from managerial and non-managerial approaches to frame the aid effectiveness agenda and to explore the institutions and relationships present in the dialogue between the Government of Tanzania (GoT) and Development Partners (DPs) within the Tanzanian health SWAP. Two analytical models are used. The first is rooted in the discipline of economics (principle agent theory), and examines the different incentives of the different actors of the aid architecture and how the aid effectiveness agenda can be framed as an effort to align these. The second analytical model lies in policy analysis, where aid relationships and the attainment of the agenda are explored in the context of power and the broader political arena in which they take place.

4.2 The managerialistic model: Principal agent theory

From an economic perspective, efficient aid is a key aim of aid effectiveness, and the agenda can be interpreted as intending to achieve the highest results from aid. Efficient aid is commonly defined as that which achieves the highest social welfare for the investments

made. Social welfare is primarily determined as welfare gained by the beneficiaries of the services that are funded by development assistance. There are different reasons why aid management may not be as efficient as it could be. For instance, the different actors involved in the aid system have their own utility function, and reasons for giving aid. In addition, these actors interact with one another and form relationships.

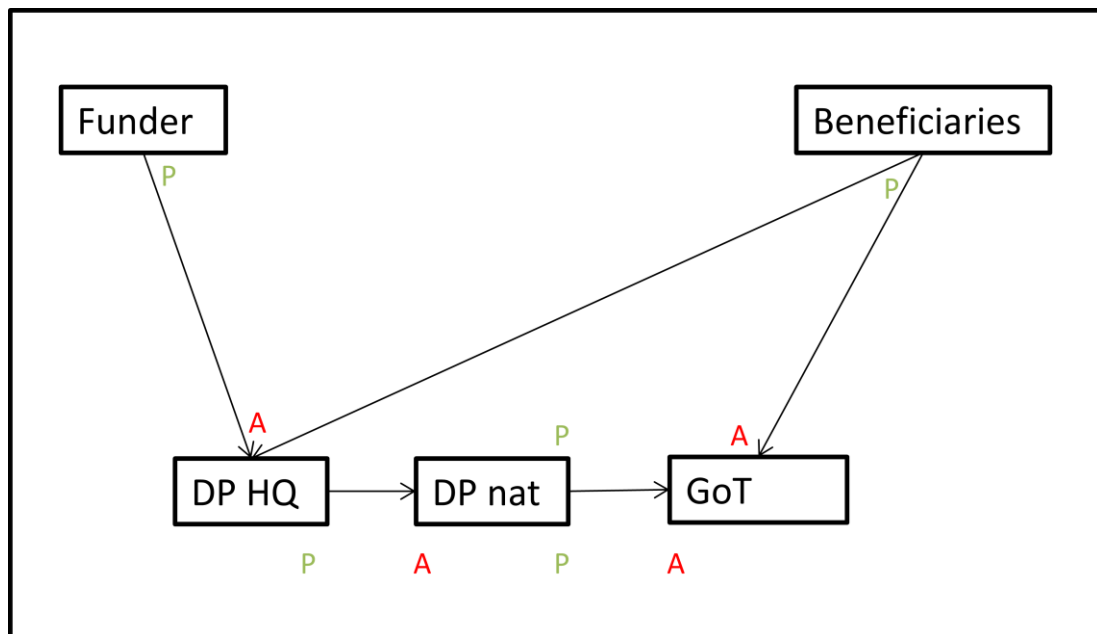
One branch of neo-institutional economics that can be used to assess aid relationships is **Principal Agent (PA) theory** (6). A principal agent situation arises in hierarchical structures, where the principal cannot take all the decisions and carry out all the tasks him/herself, and therefore delegates tasks to an agent. PA relationships are characterised by incentive misalignment and information asymmetries. Incentive misalignment occurs because the agent may have different objectives to the principal (278). Information asymmetries arise because the agent typically has specialised knowledge, meaning the principal can never completely monitor the agent's performance (278-279). Information asymmetry and misaligned incentives can result in inefficiency through moral hazard (if agents carry out tasks in a way that advances their own interests over those of the principal) and adverse selection (if the agent has information unavailable to the principal and manipulates it against the principal's interest) (6).

In a PA relationship, the principal bears the costs, but receives the benefits of the task, and needs to find a way to motivate the agent to act in a certain way, knowing that agent's actions cannot be fully monitored or enforced (6). In every PA relationship there is therefore a (implicit or explicit) contract, where principals negotiate the agents' rewards, knowing that their interests are not in full harmony (280).

A principal agent framework can be applied to explore aid relationships, both between DPs and recipient governments (macro-institutional) and within DP and government agencies (micro-institutional). Indeed, there are many PA relationships between the different actors

involved in the aid architecture in Tanzania, such as the relationship between DP headquarters and national offices. This is further complicated by the fact that there are multiple principals and agents with multiple objectives (6). Figure 4.1 shows a simplified schematic representation of the actors present in the aid system in Tanzania, and potential PA relationships between them, based on the theoretical framework developed by Martens et al (6).

Figure 4.1: Principal agent relationships in the aid system²⁷



For this study, aid relationships are classified into two distinct chains of relationships, which are then assessed to determine the extent and nature of any contractual relationships:

- (1) DP-GoT-Beneficiaries (macro-institutional). In a straightforward PA relationship the funder of a good or service and beneficiary would be the same (in this case the Tanzanian population would pay for and receive health services). However, in a health sector with a high level of development assistance, the GoT acts as an agent of both domestic beneficiaries and DPs, who share the role of principal. There may be information asymmetries between both principals (DPs and domestic beneficiaries)

²⁷ Acronyms: Development Partner Headquarters (DP HQ), Development Partner national office (DPnat), Government of Tanzania (GoT), P (Principal) and A (Agent).

and the agent (GoT); and a complex asymmetry of information if both agents have no route of direct information sharing between them. DPs may have their own incentives and reasons for giving aid, which may differ from the domestic beneficiaries'. This may result in incentive misalignment between the two principals. For example, bi-lateral DPs are in a sense also agents ultimately financed by taxpayers in developed countries (who therefore act as principals), and multi-laterals are financed by multiple funders (and therefore have multiple principals). This is further complicated by the fact that there is a multiplicity of DPs present in the Tanzanian health sector, who may have diverse objectives. The agent (GoT) may also have incentives that are not in line with either principal; in particular it may act as an agent for other principals (such as local elites), may have other political and civil service objectives to achieve and may not always fully act in the interests of the social welfare of its beneficiaries.

- (2) DP headquarters-DP national office-GoT (micro-institutional). Both the principal (DPs) and the agent (GoT) have hierarchical PA relationships within their organisations. Within the GoT, there are several hierarchical structures and delegation between employees, which also give rise to PA situations. For example, between the head of a department of the Ministry of Health and Social Welfare and his/her employees. Similarly, DPs also have hierarchical structures resulting in PA relationships, in particular the interests of headquarters and national offices may also be misaligned.

Principal-agent frameworks have been previously applied to understand aid relationships. The core of this literature has taken a macro-institutional perspective, examining conditionality contracts between DPs as principals and recipient government as agents (281-282). Oliveira-Cruz and McPake for instance, consider that the SWAP or GBS are themselves a contract and subject to PA relationships, where DPs agree to give funds if recipient governments undertake specific processes or achieve specified outcomes or outputs (281). They found that performance targets were often poorly defined and the

system to penalise bad performance was not applied by DPs, something the authors conclude is a result of DP's skewed objectives to disburse funds (281). These findings have been corroborated in two micro-institutional studies, analysing incentives to disburse in the World Bank (179) and analysing the relationships between DPs, consultants and the government in Ghana (82). Both these studies found DP incentives deterred them from using their power to enforce the "aid contract". Despite these studies, PA theory in the context of micro-institutional relationships has received relatively little attention in the literature. Martens et al. provide a theoretical model to analyse the whole "aid-giving" chain (6), which has been further developed into a conceptual framework proposed to analyse incentive problems faced by the US Agency for International Development (283), and to study the incentives involved in a hydropower station project funded by the Swedish International Development cooperation Agency in Zambia, where the author finds recipient incentives are not conducive to country ownership (73).

The literature up to now has delineated incentive problems that may hinder aid relationships, with some studies pointing to the incentive problems that may undermine the aid effectiveness agenda (38). This study extends this and is the first time PA theory is applied to understanding the global aid effectiveness agenda at the country level, assessing both macro- and micro-institutional factors.

In this study, the principles of the aid effectiveness agenda are viewed as a recognition that the complex structure of development assistance requires explicit efforts to align incentives and improve information flows between shared principals and their agents (Table 4.2). In addition, it is posited that the aid effectiveness agenda may lower transaction costs. Transaction costs are defined as the costs of negotiating, establishing and enforcing a contract (284), and are believed to lower the efficiency of aid by adding cost to aid management but providing no benefit to aid delivery (131). The aid effectiveness agenda can therefore be seen as an approach to enforce the "aid contract" by improving

incentive alignment, sharing of information and reducing transaction costs. Country ownership and managing for results are formal efforts that can help align incentives of DPs and beneficiaries, as well as those of the DPs and GoT as principal and agent. Harmonisation aims to align incentives of the multiple DPs. Harmonisation and alignment can also reduce transaction costs by improving information sharing amongst DPs (harmonisation) and between DPs and recipient government (alignment to government financial systems). Finally, mutual accountability and ownership facilitate sharing of information during the dialogue, as well as set out conditions to enforce the contract.

Table 4.2: Global aid effectiveness agenda principles enforcing of the “aid contract”

Principle	Definition²⁸	Incentives	Information	Transaction costs
Ownership	Partner countries exercise effective leadership over their development policies, and strategies and co-ordinate development actions	Align incentives of DP with beneficiaries (principal) Align incentives of principals with the agent (GoT)		
Alignment	DPs base their overall support on partner countries’ national development strategies, institutions and procedures		Joint systems can result in equal access to information	Reduction in transaction costs due to use of shared systems
Harmonisation	DPs’ actions are more harmonised, transparent and collectively effective	Align incentives of DPs (multiple principals)	DPs share information on their activities	Lower transaction costs as GoT only speaks to a representative of DPs
Managing for results	Managing resources and improving decision-making for results	Align incentives of DP with beneficiaries (principal) and of principals with the agent (GoT), by providing common goals	Measuring results provides information on what is achieved	
Accountability	DPs and partners are accountable for development results		Improves availability of information through the dialogue	

²⁸ Definitions taken from the Paris Declaration on Aid Effectiveness (2005)

However, while the aid effectiveness can be viewed as an explicit attempt to in part address some of the risks of complex principal agent relationships, it also can itself be undermined by the very same issues highlighted in principal agent theory. For example, understanding the degree of information asymmetry and incentive alignment between different actors involved in development assistance may help explain why or why not the principles of aid effectiveness are adhered to.

This study therefore uses the PA framework outlined here to assess the incentives of both the institutions and the individuals involved in the health SWAP and to explore the ability of principals to enforce the “aid contract”. The study then assesses whether the aid effectiveness agenda is an appropriate vehicle to address the extent of inefficiency caused by weak ‘principal agent’ aid relationships. It should be noted, that as the study was conducted in Tanzania, the funder-DP HQ relationship was not assessed. Further, it was not feasible to assess GoT-beneficiary relationships; these have therefore also been excluded from the analysis.

4.3 The non-managerialistic model: power and political context

PA theory implies a contract can be drawn to regulate the relationship between the principal and the agent, within a legal framework and enforceable by a “benevolent” court of justice (278) and thus is viewed by some in being a limited framework for the analysis of aid relationships. In their study of aid contracts, Azam & Laffont make the assumption that the existence of some “benevolent” court of justice implies DPs have the power to hold the government to account (285). However, there have been some concerns in the economic literature regarding the contractual nature of aid relationships. For instance, Mursheed highlights that given that there are multiple principals with different incentives, no one principal can succeed in offering the government – as an agent – incentives to carry out their task (286). Moreover, it may be in the interest of both principal and agent that aid

is effective, requiring cooperative behaviour for which it would be difficult to design a contract (286). In addition, non-managerial writers, such as Eyben, have highlighted that if aid is seen as a gift, resulting from solidarity, human rights and justice, then defining the DP-recipient relationship as purely contractual may be restrictive and may not encompass the perspective of aid as “transformative solidarity” or of “oppressive adverse incorporation into an unfair world” (287). Therefore a strict application of the PA theory to aid effectiveness may be considered reductionist.

This study therefore supplements the PA analysis with a **policy analysis** to help explore whether and how relationships are more complex than would be assumed by a straightforward PA framework, both in terms of the number actors active in the health sector (although not necessarily present in the dialogue) and how they interact with each other.

Policy analysis can be used to study the process of policy-making, and there have been calls to increase its use in the health sector, in particular to explore the (often neglected) political nature of decision-making and health sector reform (288-289). Policy analysis in the health sector has been conducted using different frameworks. In their seminal paper, Walt and Gilson (1994) argued for the use of a comprehensive framework for analysing the context, actors and process of policy-making, as well as the content of reforms in the health sector (290). In a review of the political determinants of HIV/AIDS policy, Dickinson and Buse (2008) used a framework based on institutions (defined as organisations), ideas (including arguments and evidence) and the interests and political incentives of stakeholders (288). At the same time, Buse (2008) has argued for the benefits of conducting prospective policy analysis, which allows for “immediate lesson-learning”, facilitating the incorporation of proposed strategies into the policy process (289). To allow for this, he developed a framework based on previous literature, consisting of four

dimensions: context (including the factors that influence policy change, such as situational, structural and cultural factors (based on (291)), formal and informal processes of decision-making (based on (292)), the players affected by the proposed interventions, and the power of different stakeholders (based on (293)).

Very few studies have been undertaken a policy analysis to study the application of the aid effectiveness agenda in the health sector. Shiffman (2009) developed a framework based on policy communities (defined as networks of individuals and organisations), ideas and institutions (defined as both organisational entities and a set of “rules, norms and strategies” (294)) to explore why certain issues gain importance in the global health agenda. This was taken further by Dodd and Olive (2011), who used a policy networks framework to assess aid effectiveness in the health sector in Vietnam (100). They do so by framing the aid effectiveness agenda as a policy community itself, with actors that interact in formal and informal networks, a knowledge base and a set of norms (such as the Paris Declaration) (100). Based on this, they frame the aid effectiveness agenda as a player rather than a referee, “competing with other policy communities for influence, resources and institutional space in the governance of health policy” (100). They suggest this framework helps in understanding the complexity of aid relationships (100).

The view of Dodd and Olive is rejected here, in favour of Eyben’s view of the aid effectiveness agenda as an attempt to shift power from aid givers to recipients (287). In this way, the aid effectiveness agenda is framed as an approach to aid management that is based as a set of rules that guide aid relationships. To explore aid relationships operating under this set of rules, a framework influenced by the policy analysis proposed by Buse (289) and Walt and Gilson (290) has been developed. This framework consists of three dimensions: actors, power and context.

One of Eyben's criticisms of the PA approach is that it assumes there are only two parties involved in each aid relationship, where in reality there many other actors involved or influencing aid relationships (277). The first dimension of the framework adopted for this study therefore involves mapping all the actors active in the health sector, including, but not restricted to, those participating in the health SWAP dialogue (and therefore those included in the "aid contract").

The second dimension involves an exploration of the power dynamics of the relationships between the identified actors. To explore power dynamics, it is important to define what is meant by power and how it can be exerted. Different definitions of power have been put forward in the literature in the context of aid relationships. In his study of power relations in the context of the Paris Declaration, Hyden defines "power to" as an ability to do something, under the assumption that there is consensus to achieve a global agenda (295). However, in the absence of political consensus, where different actors have different preferences and varying degrees of influence (as is the case in the Tanzanian health sector), it is more useful to define power as "power over", i.e. the ability of an actor to get another actor to act in a way it would not have otherwise done (296). In his study of how the SWAP has influenced decentralisation processes in Uganda, Jeppsson uses a power framework based on Foucault (297), defining power as a complex, fluid and impermanent concept, intertwined with knowledge and highly dependent on context (298). In terms of how power is exerted, Lukes identified three dimensions: power as decision making (who decides what policies are adopted, based on earlier work by Dahl (299)), non-decision making (stakeholders keeping items off political agendas) and thought control (influencing others by shaping their preferences) (300). Based on these three dimensions, Gaventa designed a framework for analysing how power is exerted (301). Part of this framework describes power as being visible, hidden and invisible. Visible power can be observed through decision-making mechanisms, in which there are winners and losers, hidden power can be

exerted by setting the agenda behind the scenes and invisible power involves social conditioning and ideology (301).

A modest approach is taken to explore power in the study. Informed by Gaventa's (301) and Buse's (289) frameworks, power dynamics are analysed through the formal and informal processes of decision-making. This is mainly done through visible mechanisms, but some investigation of hidden and invisible power is also conducted.

The final dimension is the political context. Aid relationships do not take place in a political vacuum. Walt and Gilson (1994) identified both a changing development and health context as influencing health sector reform (290). Different political processes may affect aid relationships, including elections and changes in the positioning of global actors. However, given that this study is undertaken from the perspective of Tanzania, the scope of the analysis of the political context is limited to the political situation of Tanzania, and that of DP headquarters, which may influence the implementation of the aid effectiveness agenda at the country level.

4.4 Integrating managerialistic (economic) and non-managerialistic (policy) models

The theoretical models described thus far underpin the thesis and place the thesis within the broader development, micro-economic and political literature. The last piece of analysis of this thesis draws on the analysis of the institutional and individual factors influencing the implementation of the aid effectiveness agenda (Chapter 9). For this part of the analysis, the managerialistic and non-managerialistic approaches are integrated into the conceptual framework.

Some of the works referenced earlier advocate for this approach; for instance Eyben herself acknowledges that aid practitioners' behaviour shows both substantialist and relationalist characteristics (287). Further, Buse recommends undertaking an eclectic

approach to policy analysis, and advocates for political economy factors to be given more importance, particularly in assessments of the health sector (289).

One way to explore both how institutional and individual factors influence the aid effectiveness agenda is through a stakeholder analysis. Stakeholder analysis is “*a systematic way of analyzing the relevant groups and individuals inside and outside government who might influence the process of policy choice*” (293). It is essentially a tool to generate data about actor behaviour, interests and relationships, as well as their influence on decision-making and implementation processes (302), and has been labelled as the most recommended tool for analysing the political dimensions of health sector reform (303).

Therefore, to explore the aid relationships of the Tanzanian health sector, a stakeholder analysis was undertaken, adapting Roberts et al.’s methodology (304), as described by Gilson et al. (303). This was done in four steps:

1. Mapping all the stakeholders who influence the aid dialogue, both from inside and outside of Tanzania
2. Identifying the incentives of stakeholders, both at the micro (employee) and macro (organisation) institutional levels
3. Exploring the power dynamics between these stakeholders with the aim of determining the extent that the relationship is contractual
4. Understanding the political context within which the aid effectiveness agenda is implemented and relationships and dialogue take place

The stakeholder analysis was undertaken through in-depth interviews, non-participant observation and document review as described in Chapter 3. The results from this analysis are reported in Chapter 9.

5 THE TANZANIAN HEALTH SECTOR

This chapter addresses the first objective of the thesis and describes the Tanzanian health sector landscape by providing an outline of the health profile, health system organisation, actors, financing and management procedures, including a description of Sector Wide Approach (SWAP) dialogue and coordination mechanisms.

5.1 Health profile

Despite receiving large sums of Development Assistance for Health (DAH), and significant health sector reforms over the past decade, Tanzania's health indicators show mixed progress. World Health Organisation (WHO) estimates of life expectancy are 58 for males and 61 for females (305). Communicable diseases are the main cause of mortality, accounting for 78% of deaths, followed by non-communicable diseases (13%) and injuries (8%) (305). Within the main communicable diseases, the incidence of malaria is 22,681 per 100,000 population, the HIV prevalence rate in the population aged 15-49 is 3383 per 100,000 population and the prevalence of tuberculosis is 177 per 100,000 population (305). The HIV prevalence rates in the population aged 15-49 have decreased from 6% in 2006 to 5.8% in 2011. In terms of risk factors for non-communicable diseases, 8.3% of men and 8.5% of women have raised blood glucose, 36.2% of men and 33.9% of women have raised blood pressure and 4% of men and 6.8% of women are obese (305). Under five mortality has decreased from 143 to 68 per 1000 live births in the last 15 years (305). Maternal mortality was 460 per 100,000 live births in 2010, which is high, although below the regional average of 480 (305); however, there are signs that it also has started to decline (306). Table 5.1 below shows the figures of key health indicators available for the time period of study.

Table 5.1: Tanzanian population health indicators

Indicator/Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Age-standardized mortality rate by cause (ages 30-70, per 100 000 population) - All causes ²⁹							1733				
Age-standardized mortality rate by cause (ages 30-70, per 100 000 population) – Cancer ³¹							113				
Age-standardized mortality rate by cause (ages 30-70, per 100 000 population) - Cardiovascular disease and diabetes ³¹							341				
Age-standardized mortality rate by cause (ages 30-70, per 100 000 population) - Chronic respiratory conditions ³¹							86				
Maternal mortality ratio (per 100 000 live births) ³¹				610					460		
Malaria - number of reported deaths ³¹	815	15251	19859	18322	20962	12593	12434	16776	15867	11806	7820
Deaths due to HIV/AIDS (per 100 000 population) ³¹											167
Prevalence of HIV among adults aged 15 to 49 (%) ³¹					6.0					5.1	
Under Five mortality rate ³⁰				112			91		81		

²⁹ Source: WHO United Republic of Tanzania Statistics Summary (available from <http://apps.who.int/gho/data/node.country.country-TZA>)

³⁰ <http://hdptz.esealtd.com/fileadmin/documents/Basket Documents 2011/Health Sector Performance Profile Report 2010.pdf>

5.2 The Tanzanian health system

The government is the main provider of health services in Tanzania, owning 74% of all health care facilities in 2013 (307). The health sector is made up of health centres, dispensaries, and district, regional, zonal, specialised and national hospitals. Other providers include the private sector and Faith-based providers, which own 14% and 12% of all health care facilities respectively³¹ (307). The Tanzanian health system suffers from acute staff shortages, with only 35% of health posts filled by a qualified health worker reported in 2009 (308). The number of physicians per 10,000 population in 2005 was 0.5 in 2012 (compared to a regional³² average of 2.5) and of nurses and midwives was 2.4 (well below the regional average of 9.1) in 2010 (305).

In terms of health service utilisation, according to the WHO 49% of births are attended by skilled birth personnel in 2010, 93% of one-year-olds are vaccinated against measles and the treatment success for smear-positive tuberculosis is 90% (305). In addition, immunisation coverage was at 75%, HIV testing increased from 6% to 28% of adults, and the proportion of households who own an insecticide treated net has increased from 23% in 2004 to 64% in 2010 (306).

5.3 Health policy

Tanzania has a Poverty Reduction Strategy known as MKUKUTA and a development strategy known as Vision 2025. These are implemented through successive Five Year Development Plans. All sector policies fall within these overarching strategies and are summarised in Table 5.2 below.

³¹ Faith-based providers receive subsidies from the Government, whereas private providers are self-financing

³² WHO Africa region

Table 5.2: Tanzanian health programmes, Memorandums of Understanding (MOUs) and policies

Year	Policy
1990-2002	National Health Policy
2003-2006	National Health Policy
2007-Present	National Health Policy
1999-2002	Health Sector Strategic Plan (HSSP) I
2003-2008	HSSP II
2009-2015	HSSP III
1994	Local Government Reform Programme (Decentralisation by devolution)
2007-2017	MMAM – Primary health services development programme
2008-2013	Human Resource for Health Strategic Plan
2006-2010	Tanzania National Health Research Priorities
2001	National AIDS Policy
2003-2007	National Multi-Sectoral Strategic Framework on HIV and AIDS
2008-2012	Second National Multi-Sectoral Strategic Framework on HIV and AIDS
2013-2017	Third National Multi-Sectoral Strategic Framework on HIV and AIDS
2008-2013	Health Sector HIV and AIDS strategy II
2000	National Package of Essential Health Interventions in Tanzania
2004-2008	National Adolescent Health and Development Strategy
2008-2015	National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania
2002-2006	SWAP Code of Conduct
2007-Present	SWAP Code of Conduct
2003-2008	Health Basket Memorandum of Understanding (MOU)
2008-2015	Health Basket Fund MOU

Source: HSSP III and author

Tanzania has had a National Health Policy from 1990, which provides the Government’s vision for a healthy society, through the provision of basic, quality health services that are affordable and sustainable. The National Health Policy has been periodically updated, with its latest version signed in 2007. The National Health Policy is operationalised by the Health Sector Strategic Plan (HSSP), of which there have been three spanning the time period of

1999-2015 (Table 5.2). The first HSSP, also known as the Programme of Work, was aimed at achieving health sector reform and putting systems in place (309). This was followed by the HSSP II, which covered the years of 2003-2008, and provided a strategy to ensure health service delivery was of a high quality, aimed at achieving the Millennium Development Goals (MDGs). The most recent HSSP was adopted in 2009 and will guide the health sector until 2015. It is rooted in the goals of the MKUKUTA and the MDGs. The HSSP III is divided into 11 strategies and has 42 indicators, which are assessed annually through the health sector performance profile report (307). In 2001 the Medium Term Expenditure Framework (MTEF) was introduced by the Ministry of Finance to guide planning and financing of the Ministry of Health and Social Welfare for three-year programmes of work (308).

5.4 Actors

Actors active in the health SWAP comprise development partners (DPs), government and non-government agencies. DPs include bi-lateral, multi-lateral agencies and private foundations. Government agencies come from all levels of government: central (Ministry of Finance (MoF), President's Office Public Service Management (POPSM) and Prime Minister's Office Regional Administration and Local Government (PMO-RALG), sector (Ministry of Health and Social Welfare (MoHSW)), regional and district. Non-government agencies include Faith-Based Organisations (FBOs), Civil Society Organisations (CSOs), Non-Government Organisations (NGOs) and the private, for profit sector. Table 5.3 below describes these agencies and their roles.

Table 5.3: Stakeholders in the Tanzanian health sector

National stakeholder	Role
Ministry of Finance (MoF)	<ul style="list-style-type: none"> • Decides the overall health budget • Channels DP and central government funds to MoHSW and PMO-RALG
Ministry of Health and Social Welfare (MoHSW)	<ul style="list-style-type: none"> • Formulates health policies • Has technical and regulatory role • Hosts the Medical Stores Department, which provides drugs and medical supplies to the districts • Responsible for national referral hospitals • Provides technical supervision to RHMTs and CHMTs
Prime Minister's Office Regional Administration and Local Government (PMO-RALG)	<ul style="list-style-type: none"> • Ministry for decentralisation. • Responsible for providing financing to RHMT and CHMT. • Provides financial and administrative supervision to RHMT and CHMT • Responsible for regional hospitals (through Regional Administrative Secretary)
Regional Health Management Team (RHMT)	<ul style="list-style-type: none"> • Headed by the Regional Medical Officer • Supervises, advises and monitors implementation of activities according to allocated planning at the council level
Council Health Management Team (CHMT)	<ul style="list-style-type: none"> • Headed by the District Medical Officer • Have ultimate responsibility for providing health services and supervising facilities • Carry out planning, budgeting and monitoring and evaluation of comprehensive council health plans (containing annual budgets and activities for the district in the health sector)
Council Health Service Boards	<ul style="list-style-type: none"> • Ensure the delivery of health services is appropriate, affordable, equitable and efficient • Submit health plans and budgets to the CHMT
Health Facility Governing Committees	<ul style="list-style-type: none"> • Ensure health services meet quality standards and satisfy need of local population • Discuss and approve plans, budgets and progress reports
President's Office Public Service Management (POPSM)	Have responsibility for human resources
Christian Social Services Commission	Provide social services including health
Private sector	Provide health services
Civil Society	Hold government to account for health resources
Development partners	<ul style="list-style-type: none"> • Provide funds to government and non-government agencies • Participate in government health sector dialogue • Provide technical assistance

5.5 Health sector funding management

Domestic funds are generated through taxation and out of pocket expenditures. External funding is provided through a mix of modalities: unmarked General Budget Support (GBS)

and earmarked health sector funding in the form of the Health Basket Fund (HBF) to the MoF; vertical projects directly with the MoHSW, RHMTs and CHMTs; and off-budget through NGOs.

The health basket fund was established in 1999 as part of the SWAP launch, where six DPs (Danida (Denmark), the UK's Department for International Development, Irish Aid, the Norwegian Agency for Development Cooperation (NORAD), the Swiss Agency for Development and Cooperation and the World Bank) some development partners signed a commitment for joint funding (310). It pools un-earmarked funds from the government and development partners, and is spent according to the priorities specified in the Health Sector Strategic Plan. By year 2008 there were eleven Development Partners contributing to the Health Basket Fund with Canada, Germany, Netherlands, the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF) having joined it (311). However, for the financial year 2013/14 there were only seven DPs left in the basket (Danida, Irish Aid, the Swiss Agency for Development and Cooperation, UNFPA, UNICEF, World Bank and the Canadian International Development Agency)³³. In addition, in 2001 nine development partners started providing development assistance in the form of General Budget Support (GBS).

The government health budget negotiations involve an annual process in which the MoF sets the budget "ceilings" for the sector. This is followed by the development of the budget guidelines, where priorities are decided upon, a process to which all ministries active in the health sector and DPs can contribute. The CHMT then use these budget guidelines to allocate their budget, known as the Comprehensive Council Health Plan (CCHP), which is approved by the RHMT and centrally to ensure priorities are in line with national ones.

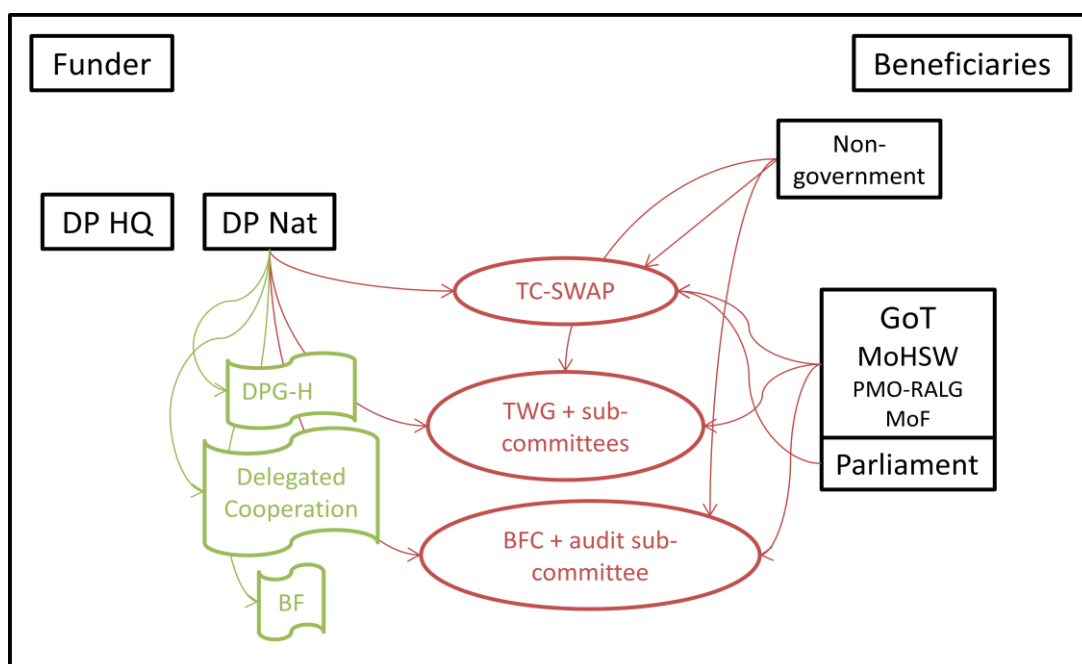
³³ Personal communication

Financial resources (GBS and HBF, together with taxation) are then managed at three levels within the health sector. The Ministry of Finance (MoF) receives the funding (domestic and external) and channels it to the MoHSW, the PMO-RALG and the CHMT. The MoHSW provides technical assistance, training and guidelines (but no direct funding) to the Regional and Council Health Management Teams (RHMT and CHMT respectively). The PMO-RALG provides financing to the RHMT and CHMT to deliver health services, subject to the provision of a yearly budget (CCHP), without going through the MoHSW. The CHMTs and RHMTs are then responsible for service delivery (through hospitals, health centres and dispensaries). The POPSM is in charge of allocating human resources, including those in the health sector.

5.6 The health SWAP

Development partners and the government have worked under a sector wide approach in the health sector since 1998, making it an early adopter of the approach. The aim of the SWAP is for DPs and government to work in partnership, in support of the government's national health and financing policies with harmonised procedures. The Tanzanian health sector is essentially managed through the SWAP, which consists of dialogue and coordination mechanisms (Figure 5.1). The aim of these mechanisms is to increase coordination between the government and development partners, increase government ownership and support and use country systems (310, 312). The SWAP therefore aims to improve efficiency, effectiveness and impact of DAH by strengthening transparency, improving predictability and allocation of financing, reducing transaction costs and administrative burden and improving coordination (313). The rest of this section describes the different SWAP mechanisms shown in Figure 5.1 below.

Figure 5.1: Health sector wide approach structure in Tanzania



Health sector planning and accounting for resource use is done through the policy dialogue, shown in red circles in Figure 5.1. DPs, central government (MoHSW, MoF and PMO-RALG), Parliament, and non-government agencies (including civil society and the private sector) all participate in principle. All of the actors in the SWAP meet twice annually to discuss broader policy issues. The core of the sector dialogue happens through the Joint Annual Health Sector Review (JAHSR), where health sector priorities are set and accounted for. Stakeholders review progress through a technical review and joint field visits, and then set milestones and new policies for the coming year in a subsequent policy meeting. The more technical decisions are taken through 13 Technical Working Groups (TWGs) that are chaired by the MOHSW and meet monthly.

DPs contributing to the basket fund discuss the allocation, use and reporting of basket resources during the Basket Fund Committee (BFC) and audit sub-committee meetings, which take place biannually and quarterly respectively, and are attended by both the MoHSW and the PMO-RALG. The BFC culminates in the signing of the Side Agreement, which takes place every year and outlines how the funds will be used and accounted for.

This triggers the disbursement of funds. Other (vertical) development assistance is, in theory, coordinated through the TWGs.

DPs working in the health sector coordinate through three mechanisms: the Development Partner Group for Health (DPG-H), the Basket Fund and delegated cooperation (green flag-shaped boxes in Figure 5.1). The Development Partner Group (DPG) was set up in 2004 with the aim of strengthening “development partnership and effectiveness of development cooperation” by working with the government of Tanzania and other national stakeholders (314). There is a DPG specifically for health, of which 17 bi-lateral and multi-lateral agencies are members. The Development Partner Group for Health (DPG-H)³⁴ is a key coordination mechanism, where SWAP DPs meet monthly to share information on their plans, prepare for meetings and agree on a “common front” before meeting with other actors in the SWAP dialogue. DPG-Health is organised through a Troika chairing structure, which involves a chairing structure composed of an out-going, present and in-coming chair. The DPG-H supports the National Health Policy, Health Sector Strategic Plans and the Medium Term Expenditure Framework. DPs active in HIV/AIDS have a similar DPG known as DPG-AIDS.

Similarly, DPs who contribute to the HBF meet and agree their position before negotiating with the government at the BFC. This means that DPs involved in the basket fund have a further forum for interaction with the government through the financial dialogue in the basket fund committee and the basket audit sub-committee. Finally, delegated cooperation is sometimes used to coordinate vertical projects, which involves DPs disbursing funds to each other to deliver a project on the ground. Although not always on budget, delegated cooperation is included in the SWAP dialogue.

³⁴ <http://hdptz.esealtd.com/index.php?id=6>

6 HEALTH FINANCING FLOWS IN TANZANIA

This chapter presents the results of the second objective of this thesis and describes domestic and external health financing flows in Tanzania during the time period of 2000-2010, corresponding with the methods outlined on pages 71-92. Results are presented in several parts. The chapter begins by making the case of the importance of assessing DAH financing trends from the perspective of the recipient country level, followed by a box summarising the key messages of the chapter. The chapter proceeds with a comparison of the different data sources currently available at the global and national level that can be used to track DP and government expenditure from a recipient country perspective to compile a comprehensive database of health financing flows. This is followed by a comparison of the different coding methods used by each source in order to improve the accuracy and categorisation of the data. The chapter then describes health expenditure as a proportion of total domestic and external expenditure, before analysing the distribution of DAH by source and sub-sector priority in order to draw a health financing map that will set the scene for the rest of the thesis. The chapter concludes with a discussion of the implications of findings for the funding of the Tanzanian health sector, as well as future resource tracking studies that use secondary data sources to seek to analyse expenditures at the country level.

6.1 Introduction

Rising levels of Development Assistance for Health (DAH) have resulted in an increased emphasis globally on accountability for how and where DAH funds are spent. This is reflected in the literature, with the publication of a growing number of articles tracking aid flows in the last few years. The focus of the aid-tracking literature is mainly on describing and analysing the distribution of DAH across countries using different comparative criteria, including country characteristics (36, 255, 315-316), poverty related equity measures of

need (31, 37, 252, 255, 317-321), burden of disease (3, 25-26, 31, 55, 104-105, 114, 239, 245, 252, 254, 316, 321-329), DAH source or modality (3, 31, 37, 255, 316, 330-331). These studies can be useful for holding Development Partners (DPs) accountable for the levels and allocation of DAH across countries.

Multi-country studies may be of less use to planning DAH in individual recipient countries. In particular, DAH tracking analyses are hindered by the quality of data on aid flows (including for example the lack of timeliness of data and reporting differences between DPs), giving rise to recent concerns about the level of analysis and recommendations made from them (239, 244). The extent of work required to clean and analyse the large DAH databases that exist may be robust in terms of aggregate analyses, but lack precision in terms of understanding how individual countries are allocating and using their DAH (239, 332). In addition, many of the studies have been criticised for excluding domestic expenditure when drawing their conclusions (although some do include both domestic and DAH expenditures (333)) and others have been seen as too narrow in terms of focusing on single priorities without taking into account the interdependence of health sector activities or being able to fully identify broader health systems funds that may contribute to health sector outcomes (239, 333).

Although informative at the global level, these limitations mean that these exercises may not be the best source for understanding how allocations of DAH are made at any individual country level. Therefore, in order to fully understand the DAH allocation, cross country analyses of the determinants DAH need to be complemented, and can be better understood, by analyses of health financing flows at the country level, to compare allocation across the different priorities, contrast external and domestic financing and provide an in-depth review of the quality and availability of data. The lessons learned in

developing such an approach can also facilitate recipient countries holding DPs to account on their commitments and aid management practices.

Box 1: Key messages of Chapter 6

- Health expenditure in Tanzania has increased between 2000 and 2010 from all sources, although it appears health is a bigger priority for DPs than for the government.
- DAH delivered horizontally and vertically has increased; however, increases in vertical priorities have outgrown horizontal ones. HIV/AIDS is the main priority.
- Tanzania has experienced changes in the composition of DPs in the time period of 2000-2010, with the arrival of new global health initiatives and differences in the proportion of bi-lateral and multi-lateral DPs. These differences are closely linked with DAH priorities.
- Global and national sources of health expenditure vary, and no one source is best. In this study a database was compiled from a combination of data sources. Future studies relying on secondary data could use the Creditor Reporting System for DAH analysis, National Health Accounts (NHA) for in-depth studies on financing that do not require time trends, and Public Expenditure Reviews (PER) (where available) for analysing funding trends.
- Care needs to be taken not to over-interpret data on health funding flows from global databases, as it is sometimes incomplete and sub-sector categories are difficult to separate. This is particularly the case with vertical and horizontal flows. It may be of more use for future studies to assess expenditure by level of health service delivery instead.
- There are currently simultaneous processes tracking health financing data at the country level in Tanzania. It would be more efficient if these processes were unified. For instance, it may be worth investing in the quality and standardisation of the PER than to develop new processes or producing the more resource-intensive NHA more frequently.

6.2 Comparison of data sources

The first step of the analysis of health financing flows in Tanzania was to undertake a data-scoping exercise to assess what sources were available, compare their accuracy and construct a comprehensive database using the methods outlined in Chapter 3 (hereafter referred to as the “study database”). Several different data sources were found. These include the Economic Co-operation and Development’s Development Creditor Reporting System (OECD-CRS), AidData, the DAH database of the Institute for Health Metrics and Evaluation (IHME), National Health Accounts (NHA), Public Expenditure Reviews (PER), budget books and budget speeches.

Figure 6.1 below shows a comparison between the different global and national data sources for Tanzanian health financing indicators and, after revising these, a comparison with the database constructed using a combination of sources. Overall, it shows that the results vary depending on which data source is used, particularly for total DAH and DAH channelled through the government (DAH-G). Total DAH varies between sources, with NHA showing the highest levels and AidData the lowest, and the CRS and IHME databases in the middle, with similar results to each other (Figure 6.1a). NHA rely on surveys of health financing sources and expenditure at the country level (including employers, medical insurers, non-government organisations and development partners (219)), so they would represent the most complete dataset, possibly identifying DPs that do not report to the OECD Development Assistance Committee (DAC). However, data are only in aggregated form and available for three points in the time period of study, so the data is less reliable in terms of understanding trends over time. The results obtained from AidData are unexpected as according to its specifications it should include all OECD-CRS projects³⁵. This

³⁵ http://aiddata.org/user-guide#data_sources_and_coverage

may be due to the fact that AidData and the CRS use different codes to classify projects. However, AidData also reports CRS codes, and using these to compare AidData and the CRS gave even more discordant results (data not shown).

For this research, the CRS database was therefore used as the starting point to obtain DAH flows because it is the most complete in terms of years available and projects disaggregated. It was complemented with data from AidData on non-DAC DPs and IHME on private foundations and philanthropies – to ensure that non OECD-DAC DPs were included. However, Figure 6.1a shows that by doing this the study database did not increase substantially. It was not possible to include additional DPs identified by the NHA because data were only available for three points during the time period of study and were not available in disaggregated form.

Figure 6.1b examines the sources for Total Government Expenditure (TGE), and shows that expenditure data reported retrospectively from budget speeches are the most complete and generally are very similar to the budget books and the PER. Therefore in this study, data on total government expenditure were obtained from the budget speeches, as they were comparable to the other data sources and were the most complete, thereby allowing for better comparison of trends over time.

Examining the amount of DAH going through the government (Figure 6.1c) we find higher amounts reported in our CRS-based study database³⁶ than in the PER. The green lines on the graph show the Health Basket Fund (HBF), which is similar between the two data sources, so this would suggest that the differences between CRS and PER are from the reporting of source of vertical funds going through the government. This may possibly be that the PER was not able to establish the split of financing in each development project

³⁶ GBS was not included in this to allow for comparison as it is not included in PER assessments, so real amount of DAH-G is higher

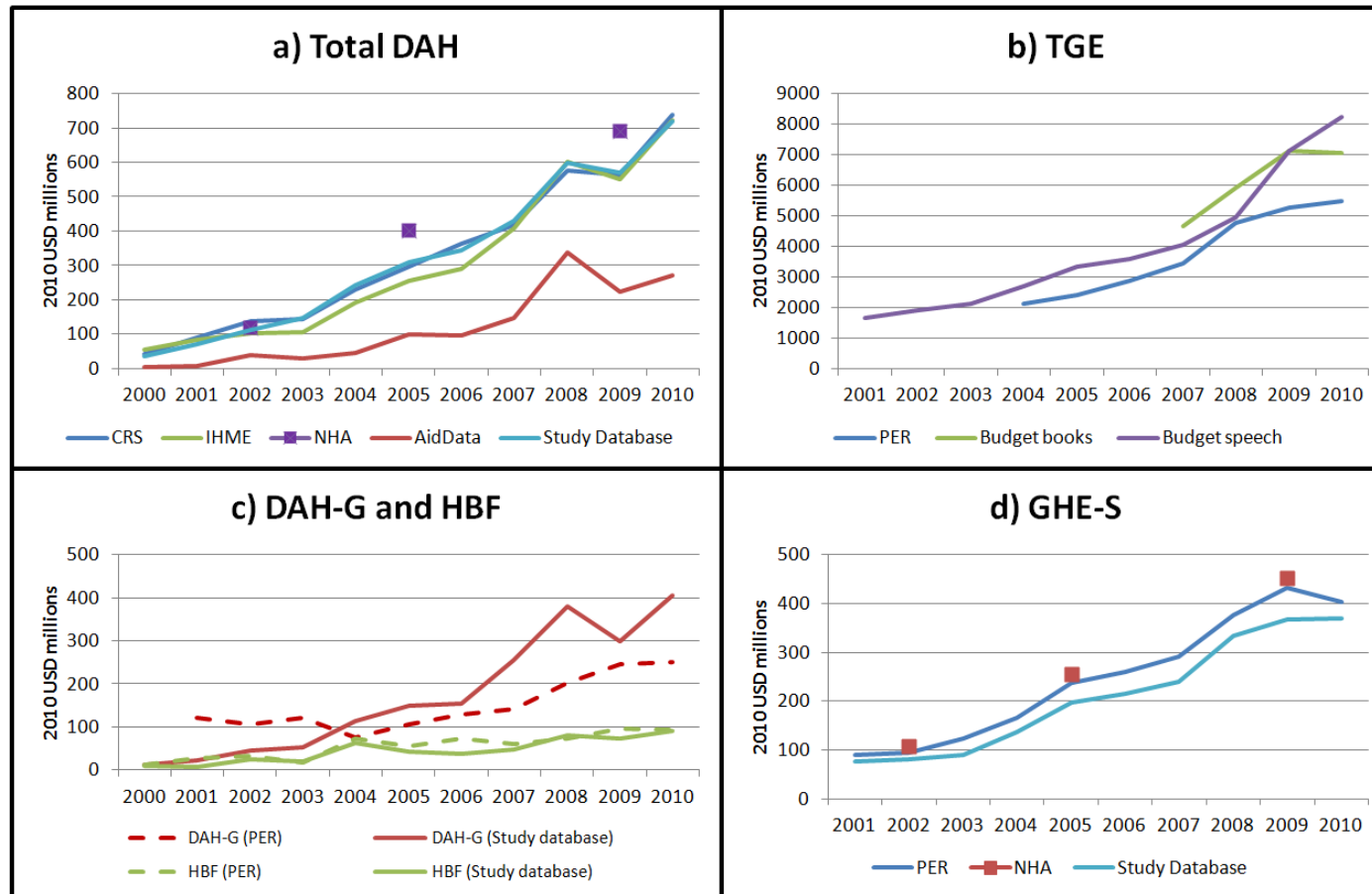
between the governments and DPs, from the records available within the government. CRS data were therefore used to assess DAH delivered through the government.

Finally, Figure 6.1d shows domestic health expenditure (Government Expenditure as a source (GHE-S)). The two sources for this are the NHA and the PER, which show similar trends. The structure of the budget books did not allow the extraction of domestic health expenditure³⁷. Data on government expenditure on health as a source were therefore obtained from the PER. GHE-S is higher in the PER and NHA than in the study database. This is because both NHA and PER include General Budget Support (GBS) as part of government expenditure. Conversely, in this study the proportion of GBS allocated to the health sector was estimated and subtracted from GHE-S (see below and page 84 in Chapter 3), therefore giving the lower figures observed.

Section 6.6 below shows the comparison of domestic and external expenditure on HIV/AIDS. Domestic expenditure for HIV/AIDS was obtained from the HIV/AIDS PER, as it included the most complete data available. As with other indicators of external funding, DAH targeted to HIV/AIDS was obtained from the study database, using the method outlined in pages 86-89 in Chapter 3. This was the only sub-sector comparison undertaken, as data for other priorities were not available to study trends (NHA includes data on reproductive health and malaria, but these were only available for three points in time and the definition used to assess reproductive health was different to that of the CRS, which would have made comparisons difficult).

³⁷ The budget books are classified by “votes”, in such a way that the Ministry of Health and Social Welfare (MoHSW), each region and district are given a vote number. It was therefore not possible to disaggregate health expenditure at the regional, district level or central level outside of the MoHSW

Figure 6.1: Comparison of the figures available from the different data sources for DAH, DAH-G, HBF, TGE and GHE-S³⁸



³⁸ DAH: Development Assistance for Health; TGE: Total Government Expenditure; DAH-G: Development Assistance for Health disbursed through the government; HBF: Health Basket Fund; GHE-S: Government Health Expenditure as a source

6.3 Data coding

Once the study DAH dataset was compiled from the different sources (CRS, AidData and IHME), it was re-coded following the methods outlined in Chapter 3. The reason for this was threefold: first, to ensure all projects falling under the health sector were correctly captured (including the portion of GBS allocated to health); second, to fill in the gaps in the CRS data to the extent possible; and, third, to re-categorise some expenditures into categories (such as HIV/AIDS and Reproductive, Maternal, Newborn and Child Health (RMNCH)).

Figure 6.2 below shows the difference in disbursement levels using coded and non-coded data for selected indicators. Figure 6.2a shows the results of re-coding health projects (blue bars) and Figure 6.2b shows the re-coding of DAH by sub-sector priority. Re-coding health projects did not make an important difference (dotted blue line Figure 6.2a). DAH in the CRS database was \$40.9 million, whereas after re-coding it was \$34.5 million in 2000. By 2010 the CRS figure was \$739.5 million whereas the re-coded figure was \$717.8 million. This suggests that most projects were correctly identified as falling under the health sector, although the re-coded database had consistently smaller amounts of DAH³⁹ (except in 2007, where it was slightly higher). However, including a proportion of GBS did make a difference (continuous green line), adding \$13 million in 2001⁴⁰ and consistently raising to \$67 million in 2010, before lowering again in 2010 to \$34 million, raising the total DAH amount to \$752 million. This is both due to a decrease in GBS and a slightly lower proportion of government expenditure on health.

³⁹ The projects removed mainly targeted animal health, gender and women's rights or where health projects in Zanzibar.

⁴⁰ Data on government expenditure was only available from 2001; as GBS estimates are based on the percentage of government spent on health, they are also only available from 2001

Re-coding single diseases, such as malaria and RMNH did not make a big difference to the estimated DAH sub-sector distribution (Figure 6.2b). This is in part explained by the fact that re-coding of multi-sector projects was only done when there was enough information to do this accurately (no assumptions were made or re-distribution of pooled funds or health systems projects and multi-sector projects were assigned a separate code and are shown separately in the rest of the chapter). However, re-coding at the sub-sector level was still a useful process in terms of the addition of new categories, such as RMNCH (combining RMNH, Child Health and Immunisations) and HIV/AIDS (separating it from other sexually transmitted infections). For instance, in 2010 the targeted to RMNH⁴¹ was \$26.3 million, going up to \$71.4 once projects were re-coded and child health was added. The method used to classify projects relied on keywords, and therefore only projects mentioning HIV/AIDS were included as HIV/AIDS projects. Projects targeting health systems components, which would also benefit HIV/AIDS or malaria, are not included (shown as “health systems” hereafter), and therefore the sub-sector categories shown here remain an underestimate of the real amount of DAH spent on each sub-sector priority.

The biggest difference the country based re-coding made to the database was in filling the gaps found in the channel of delivery (Figures 6.2c, 6.2d and 6.2e). The amount of DAH that had a channel name was much lower in the CRS original database (Figure 6.2c)⁴². Figures 6.2c and 6.2d show the proportion of DAH projects that had a channel name before and after re-coding. Even after all the line-by-line and keyword-based re-coding, it was not possible to identify the channel or sub-sector allocation of some projects. These were labelled as “blank”. There were marked differences between the different DPs quality of reporting, with bi-laterals generally including less detailed information and thereby being harder to re-code.

⁴¹ Reproductive Health did not include HIV/AIDS projects

⁴² GBS was not included in this, as the channel was known to be the government system

Figure 6.2: Comparison of Total DAH, channel of delivery and sub-sector priorities before and after re-coding

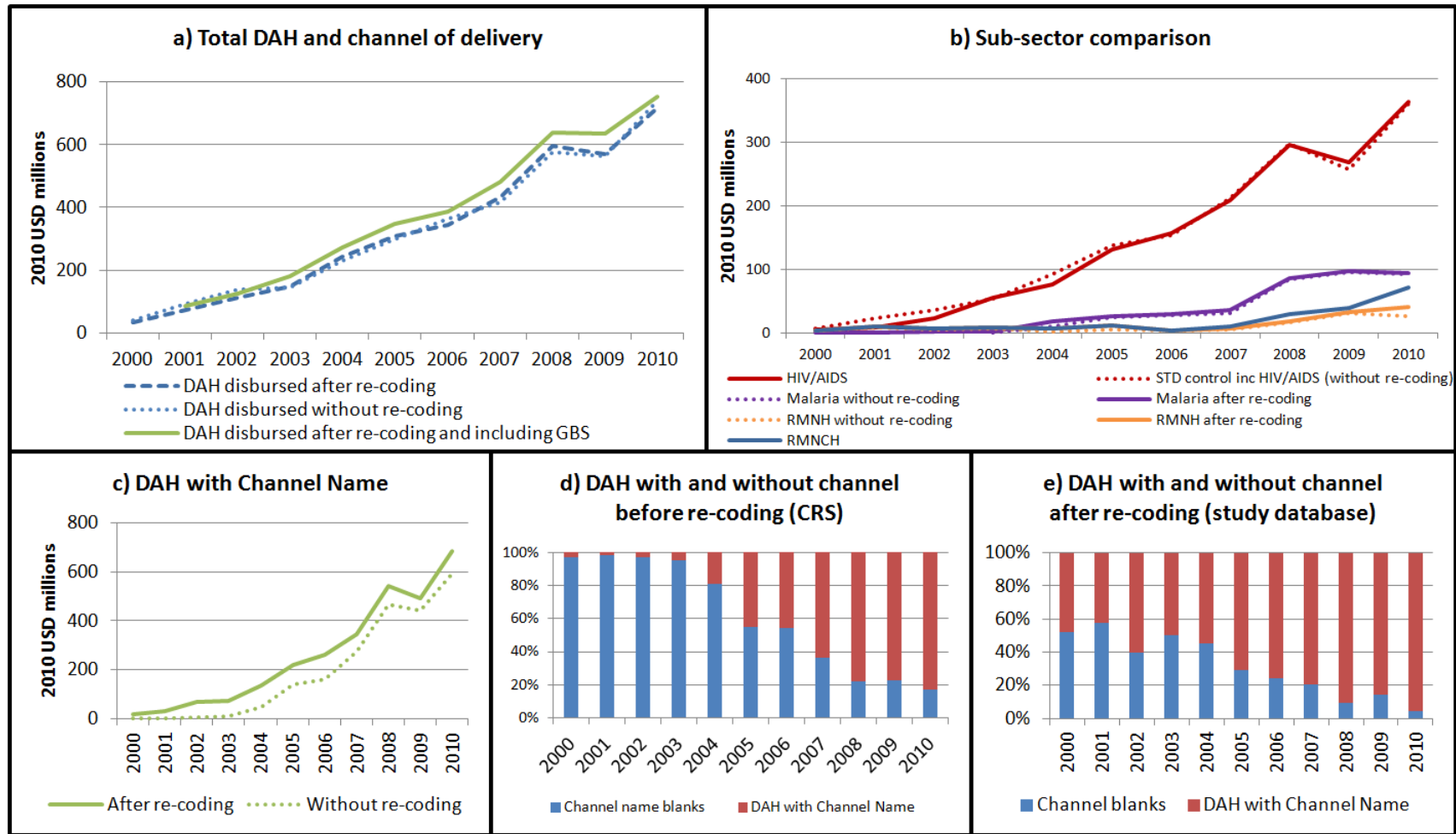


Figure 6.2 above does not include the proportion of GBS allocated to health in the channel name field, in order to show the amount of projects for which DAH channel was re-coded (as the channel for GBS is known). Table 6.1 below shows this to illustrate the proportions that had a channel name both including and excluding GBS. The proportion of all DAH projects of the CRS database that had a channel of delivery was less than 3 %, which stayed under 5 % until 2003, after which it steadily increased up to 83 % in 2010. The re-coded version of the database still shows large percentages of DAH without a channel of delivery (starting from in 2000 59 % if GBS is included); however, it is approximately half of that of the CRS database. This shows that the reporting of DPs to the CRS has become more detailed over time, with re-coding of the database adding a channel name for 12 % extra the projects in 2010 (compared to 45 % in 2000 excluding GBS).

Table 6.1: Proportion of projects with a channel code before and after re-coding

Year	Without re-coding		After re-coding	
	% projects that had a channel code (no GBS)	% projects that had a channel code (inc GBS)	% projects that had a channel code (no GBS)	% projects that had a channel code (inc GBS)
2000	2.9	23.6	47.8	58.9
2001	1.4	27.9	42.2	57.7
2002	2.7	23.0	60.2	68.5
2003	4.5	35.4	49.6	65.9
2004	19.2	32.4	54.6	62.1
2005	45.2	55.2	70.9	76.2
2006	45.9	55.8	75.6	80.1
2007	63.5	69.6	79.7	83.1
2008	77.8	79.8	90.9	91.8
2009	77.3	81.4	85.9	88.5
2010	82.7	84.5	95.5	96.0

No effort was made to re-code the data on domestic sources of health financing, primarily because the data represents the audited government figures and was not available at a highly disaggregated level.

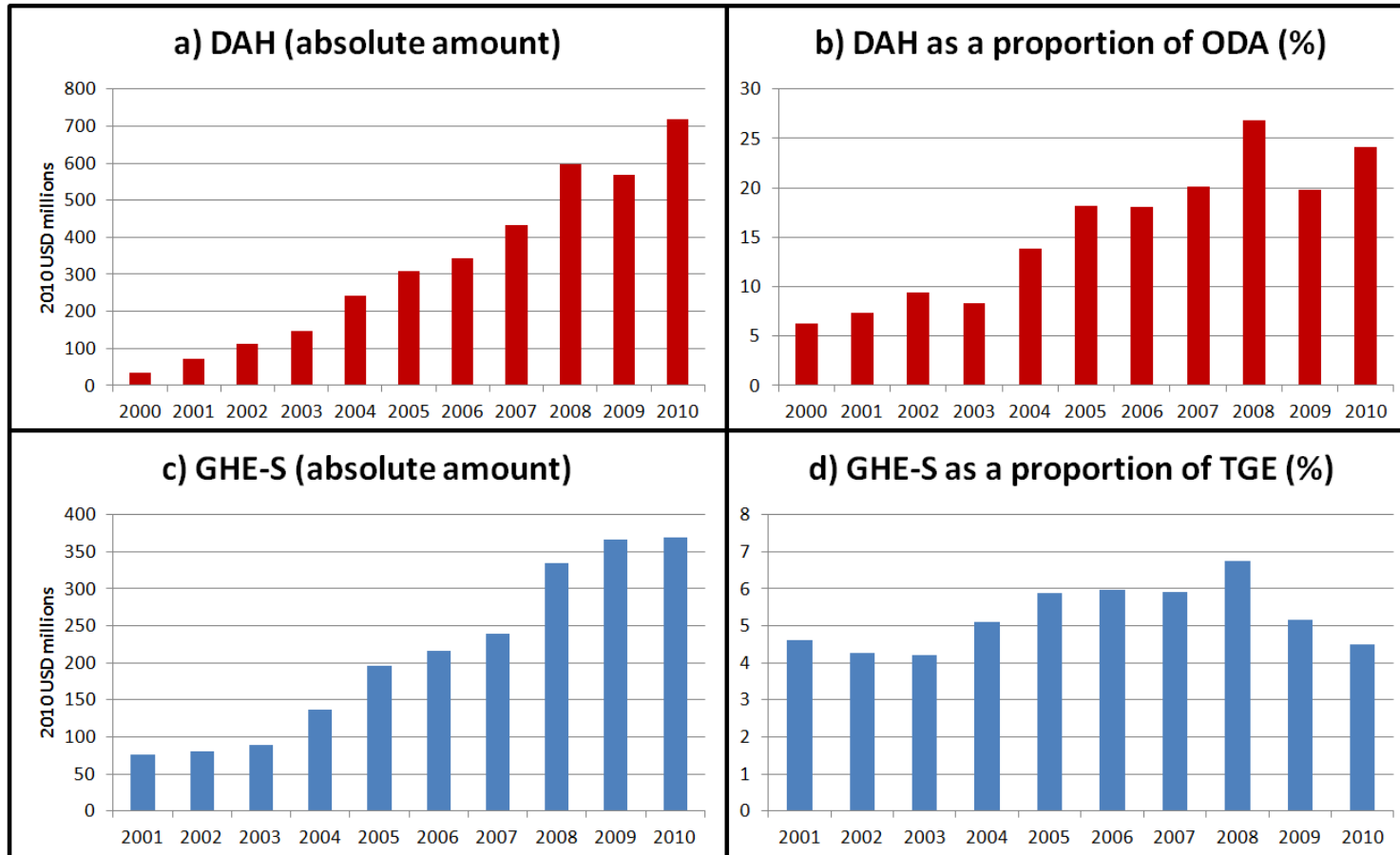
6.4 External and domestic health expenditure

The rest of this chapter describes health sector expenditure in Tanzania that resulted from analysing the database compiled and re-coded for DAH and data extracted from the budget speeches and PER reports for domestic expenditure on health.

A total 28,139 aid projects/transactions were delivered to Tanzania in the time period of 2000-2010. Of these, 5,603 were classified as belonging to the health sector. DAH made up an increasing proportion of total aid flows (Figure 6.3b). Both Official Development Assistance (ODA) and DAH have been rising in the time period of 2000-2010, with ODA increasing from \$816 million to almost \$3 billion, and DAH rising from \$34.5 million to \$718 million. However, the proportion of ODA made up by DAH has almost quadrupled from 6.2 % in 2000 to 24.1 % in 2010.

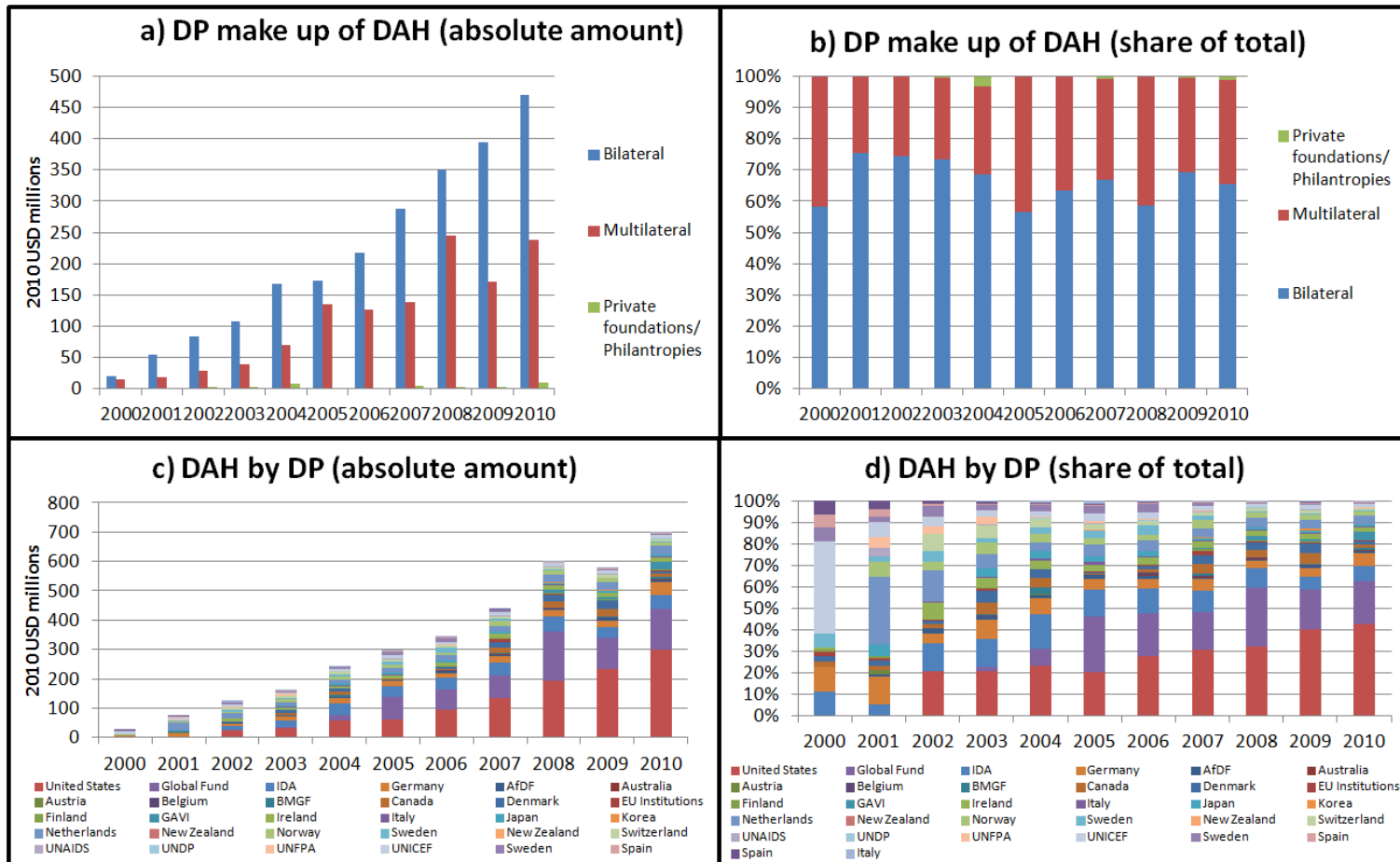
Government data were only available from 2001. They show a similar increasing trend both in total government expenditure and government expenditure on health as a source, with a noticeable increase since 2008. GHE-S increased from \$76 million in the year 2001 to \$370 million in 2010. However, TGE experienced a fivefold increase (from \$1.6 to \$8.2 billion). Therefore, despite the marked increases in GHE-S during the time period of study, the proportion of total government expenditure on health has fluctuated between 4-7%, which is well below the Abuja target of 15% (334). This is lower than the figures on the PER (where it fluctuates between 10-12%), although close to those of the NHA (6-7%). There are two reasons for the difference between the ratios found in this study and those of the PER. First, the GHE-S is lower than that reported in the PER, since the GBS portion allocated to health has been deducted from it (see Methodology section). Second, in this study, consistent with the budget speech, total government expenditure includes the Consolidated Fund Services (CFS, which is debt repayment), whereas this is excluded in the PER.

Figure 6.3: Comparison of Development Assistance for Health and Government Expenditure on Health as Source as absolute amounts and as a proportion of total Official Development Assistance and Total Government Expenditure respectively⁴³



⁴³ ODA does not include non-DAC DPs, whereas DAH does; therefore, DAH as a proportion of total ODA (graph Xb) will be slightly over estimated

Figure 6.4: DAH to Tanzania by source⁴⁴



⁴⁴ Private/philanthropies include the Bill and Melinda Gates Foundation and Bloomberg, but not expenditure from international NGOs

6.5 DAH by source

The rest of this chapter focuses on DAH in more detail, by analysing both its sources and allocation according to different priorities. DAH from all sources has increased. The top two DAH DPs to Tanzania are the United States (US) and the Global Fund. Despite having started out from similar levels in 2000, bi-lateral sources have consistently outweighed multi-laterals from 2001 (Figures 6.4a and 6.4b). Looking at the DP breakdown, this is explained by increases in funding from the US, which has been the dominant DP since 2006, and since 2007 has roughly made up 50 % of all DAH. The US is followed by a group of European DPs (Netherlands, Germany and Denmark), Canada, and Norway, Ireland and Switzerland (by size of DAH). The United Kingdom is not shown graphs 6.4c and 6.4d because, despite globally being the second largest provider of DAH (see Chapter 2), in Tanzania, during the time period of study, the United Kingdom moved out of the health sector and favoured General Budget Support (although it has since resumed providing DAH). Emerging bi-lateral DPs and providers of South-South co-operation were not found to contribute substantial amounts of DAH, although this may be a reflection of data availability on these DPs.

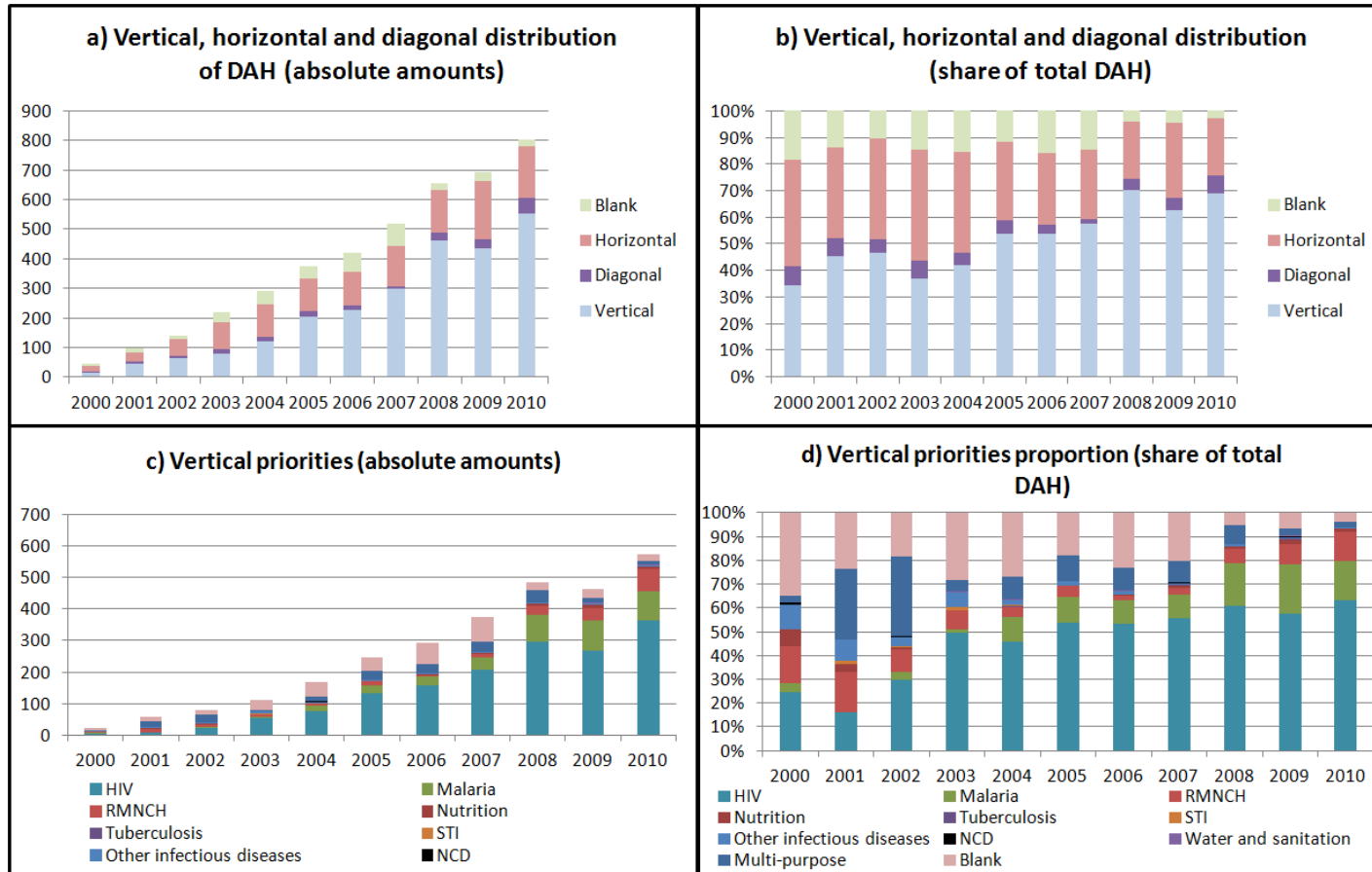
In terms of multi-lateral trends, up to 2005 the WB was the leading agency, but since then it has been overtaken by the Global Fund. UN agencies (dark blue bars in bottom right graph) represent a decreasing proportion of total DAH, under 20% in 2004, reducing to 10% in 2010, although DAH levels have stayed constant at about \$10 million per year. The level of funding from bi-lateral sources has shown a more constant upward trend, compared to multi-lateral funding, which follows a more uneven pattern.

6.6 DAH sub-sector distribution

This section describes the last part of the analysis of funding flows, which explores the sub-sector distribution of both domestic and external health funds. Figures 6.5a and 6.5b show

the trends in the amount of DAH being delivered vertically (targeting a single disease), horizontally (pooled funds and budget support) and diagonally (health systems interventions delivered as projects) in absolute amounts and as a proportion of total DAH respectively. Figures 6.5c and 6.5d show the different vertical priorities. Looking at the top half of the figure first, blue-shaded bars represent vertical funds, red-shaded ones horizontal funds and purple bars diagonal funds (green bars represent DAH flows that could not be coded). All forms of financing have increased in absolute terms. However, in relative terms only vertical priorities have increased, with horizontal programmes reducing their share of total DAH from 47 % to 28 % between 2000 and 2010, whereas vertical programmes have increased from 34 % of DAH flows in 2000 to about 69 % in 2010. This suggests that investment in health systems has received lower attention than vertical disease programmes. However, this needs to be interpreted with caution, as vertical projects may also target health system components and investments in health systems also benefit vertical programmes. Diagonal approaches (classified as those projects targeting health systems components rather than a particular disease/population group) made up 7% of all DAH in 2000, decreased between 2004 and 2007, before rising again to 7% in 2010. In absolute terms, however, they started at \$3.2 million in 2000 and increased exponentially to \$54 million.

Figure 6.5: Sub-sector distribution of DAH, by vertical (disease oriented), horizontal (health systems pooled) and diagonal (health systems project-based) distribution, and by vertical priorities, in absolute amounts and as a share of total DAH⁴⁵



⁴⁵ Blank represent projects for which the purpose could not be identified

Figures 6.5c and 6.5d show the distribution of vertical DAH by sector priority. Pink (blank) and dark blue (multi-purpose) bars represent projects that could not be allocated to the priorities selected. The amount of projects that could be coded improved over time, particularly after 2003. The data show there are marked differences between the different priorities. HIV/AIDS, malaria and RMNCH have received increasing amounts of funding; however, funds for water and sanitation⁴⁶, non-communicable diseases (NCD), Tuberculosis, Sexually Transmitted Infections (STIs), and other infectious diseases have remained low. HIV/AIDS received the most project funding, making up over 50% of all vertically distributed DAH from 2005. It is followed by malaria, which has received an increasing share of DAH since the year 2004, mainly as a result of the Global Fund and US bi-lateral funding (data not shown). The proportion of vertical DAH funding for RMNCH has increased, but this is mostly due to child health (data not shown), and still remains below 10 % of all DAH.

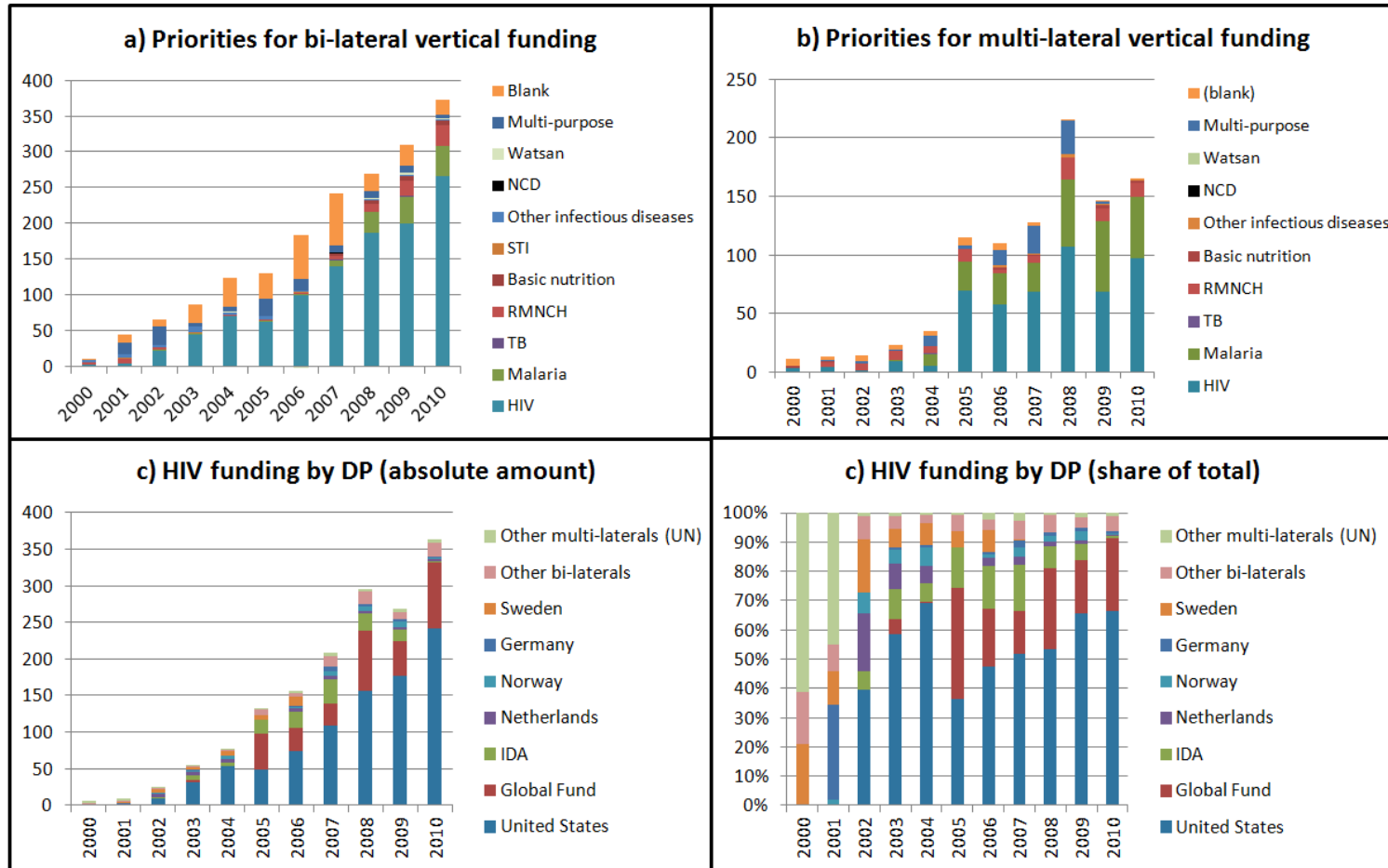
To examine vertical funding trends in more detail, Figure 6.6 below shows the distribution of vertical funds across more aggregated categories of DP type and disease priority. Both bi-lateral and multi-lateral DPs fund HIV/AIDS as their first priority (Figures 6.6a and 6.6b respectively). However, bi-laterals place more emphasis on health systems components than multi-laterals, whereas multi-laterals spend a bigger proportion of their funds on malaria than bi-laterals do. Figures 6.6c and 6.6d further break down DAH financing by showing the DPs financing HIV/AIDS. They show that the trends in HIV/AIDS are directly correlated with trends in DP composition, as the two DPs providing the highest amount of DAH (The Global Fund and the US) are also the top providers of HIV/AIDS funds. The share of these two DPs in HIV/AIDS DAH increases both in real terms (Figure 6.6c) and in relative terms, providing 90% of all HIV/AIDS funds between them in 2010 (Figure 6.6d). Funding for HIV/AIDS from other multi-laterals has remained relatively constant in real terms and

⁴⁶ This only includes water and sanitation projects that specifically targeted health

funds from other bi-laterals have shown increases, particularly from 2007 (data not shown).

The distribution of DAH by channel of delivery was also assessed and is reported in Chapter 8, as it is one of the indicators selected to assess the aid effectiveness agenda.

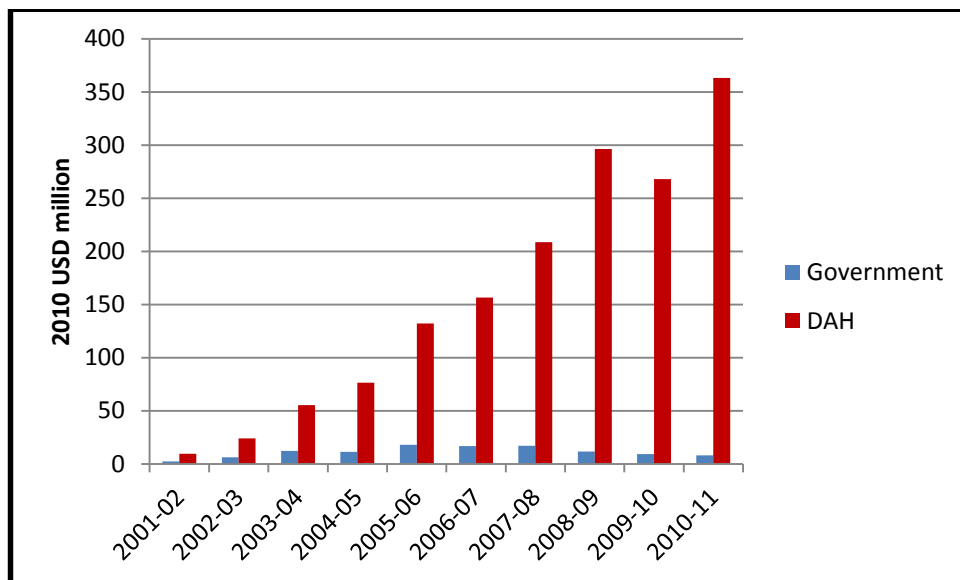
Figure 6.6: DAH vertical priorities by type of DP⁴⁷



⁴⁷ Blank represents projects for which the purpose could not be identified.

Finally, Figure 6.7 shows a comparison of the sub-sector distribution of DAH and domestic funds targeted to HIV/AIDS using data from the HIV/AIDS PER and the study database. HIV/AIDS funding trends show external expenditure rising exponentially and domestic expenditure initially increasing from \$2.3 million in 2001 to \$18 million in 2005 before falling to \$8 million in 2010. However, this may be an underestimate of the amount of funds spent by the government on HIV/AIDS, as the government accounting system is not structured around vertical programmes and government expenditure on health systems (such as human resources and medicine supply chains) would benefit HIV/AIDS. Nevertheless, HIV/AIDS funding is heavily DP-dependent.

Figure 6.7: HIV/AIDS funding comparison between domestic and external sources⁴⁸



Other sub-sector comparisons could not be made due to lack of data availability.

⁴⁸ Sources: Xa National Health Accounts data and Xb HIV/AIDS Public Expenditure Review for domestic expenditure and the study database for DAH

6.7 Discussion

This chapter has analysed health financing flows in Tanzania during the time period of 2000-2010. It has shown that health expenditure in Tanzania from all sources and through all channels has greatly increased between 2000 and 2010. Government expenditure on health has quadrupled in the time period, but has not managed to increase as fast as total government expenditure, and has not achieved the Abuja target of 15% of total government expenditure (334). In contrast, DAH has outpaced increases in ODA, making up over 20% of total ODA. This may indicate that the government does not prioritise health as much as DPs, but may also be a result of low absorption capacity for extra funds (335) or indeed may be a sign of fungibility (336). These possibilities are further explored in Chapters 8 and 9.

Although increasing DAH levels are encouraging in resource-poor settings such as Tanzania, there have been discussions in the literature regarding the sustainability of increases in DAH funding, particularly in the current global economic climate. The annual global DAH tracking conducted by the IHME suggests DAH is beginning to plateau (331), although a recent study by Stuckler et al. (2011) concludes previous economic recessions did not affect development assistance levels, so there is no precedent to assume DAH will decrease (unless it is driven by ideological shifts towards austerity) (129). This study found indications that DAH funding levels to Tanzania are beginning to plateau, supporting findings from the IHME. The impact of this trend will depend on government's expenditure on health (336), but it may call for increased efficiency of spending (337). One way to do this would be to allocate resources to where they are mostly needed. However, this does not just mean towards diseases with the highest burden, but also to where they can make the most impact and be most cost-effective.

Increases of DAH have taken place unevenly across different priorities. There has been an active debate in the literature regarding the relative merits of vertical and horizontal funds, with some arguing that they lead to coordination difficulties and only benefit the targeted services (109, 117) whilst other studies have shown the potential for positive interactions and synergies between these initiatives and health systems (338-339). This study found that although both types of funding had increased in real terms, in relative terms vertical funding has contributed an increasing share of all DAH, raising concerns about coordination of funds. Diagonal approaches, which have been presented as bridging the vertical-horizontal divide by investing in the health system through the use of project modalities, have also increased. There have been concerns about diagonal approaches being good in principle, but not being accompanied by an increase in funding (120). This study found that in absolute terms diagonal approaches saw an increase, although in relative terms they still make up a small proportion of DAH funds to Tanzania (fluctuating around 7%). This shift in aid modality may have an impact in terms of the achievability of aspects of the Paris Declaration such as alignment and harmonisation. This will be explored further in Chapter 8.

With regards to the sub-sector distribution of DAH, increases in DAH have also been uneven across different priorities. As part of their Global Burden of Disease project, the IHME have estimated the Disability Adjusted Life Years (DALYs) in Tanzania⁴⁹. These can give an indication of the distribution of DAH funding according to burden of disease. For instance, this study found that resources were largely skewed towards HIV/AIDS (making up about 50% of all vertical DAH). The IHME's Global Burden of Disease project found that HIV/AIDS contributed to an average of 4.7 million DALYs in 2010. In a cross-country regression, Boussalis and Peiffer found that need (defined as GDP per capita and HIV prevalence) was an important factor in distribution of HIV/AIDS bi-lateral funds (103). Whilst this may be the case when examining the global distribution of HIV/AIDS resources,

⁴⁹ <http://www.healthdata.org/search-gbd-data?s=Tanzania>

when analysed at the country level against other financial resources, the distribution looks rather skewed, compared to the prevalence of other diseases. The second biggest vertical priority is malaria, which is also targeted by the Global Fund and the US. DAH targeted to malaria has greatly increased in absolute and real terms, making up 17% of all vertically-delivered DAH in 2010. Given that the burden of malaria in 2010 was 3.2 million DALYs, it seems that malaria and HIV/AIDS funding is somewhat associated with disease burden relative to each other. The third vertical priority is RMNCH. The Countdown to 2015 project has been tracking resources for RMNCH from 2003, and, as was the case with HIV/AIDS funding, it found that distribution across countries was targeted towards countries with higher maternal and child mortality, particularly from 2005 (104). Once more, this is a cross-country distribution, rather than within a recipient country. According to IHME figures, maternal, neonatal, and nutritional disorders⁵⁰ accounted for 10 million DALYs in 2010. RMNCH made up 7.5% and other infectious diseases less than 1% of vertically-delivered DAH, and therefore DAH targeted at these conditions looks disproportionately lower than DAH targeted to HIV/AIDS and malaria.

In contrast to these three priorities, non-communicable diseases, water and sanitation interventions for health and other infectious diseases have received consistently low levels of DAH funding. These trends have also been observed at the global level, where a cross-country study found that per DALY DAH was up to 20 times higher for HIV/AIDS, malaria and tuberculosis than for non-communicable diseases (105), indicating that these conditions may be underfunded at the national level.

A recent study exploring HIV/AIDS funding in Honduras, Rwanda and Thailand found that the arrival of big initiatives targeting HIV/AIDS had displaced funding from other DPs (153). This was not found to be the case in Tanzania, where all DPs increased their funding for

⁵⁰ This definition may not completely match the definition of RMNCH used in this study

HIV/AIDS between 2000 and 2010. However, this chapter found that government level of financing for HIV is much lower than DP funding. This mismatching of domestic and DAH financing may be an indication of differing priorities or again of fungibility taking place. This will be explored in more detail in Chapter 8.

Finally, increases in DAH have been coupled with changes in the makeup of the agencies providing DAH during the 2000-2010 time period. At the start of the time period, bi-lateral and multi-lateral agencies made up similar proportions of funding. However, the rate of increase of bi-lateral agencies has outweighed that of multi-laterals, driven by drastic increases in US funding. New multi-lateral players, such as the Global Fund and GAVI have appeared in the time period of study, constituting an increasing share of DAH, whilst the share of funds contributed by UN agencies has been on the decline. These findings are consistent with global trends reported by the IHME (2, 331). Despite increasing discussions in the literature regarding emerging DPs and South-South cooperation (7, 9-10), this study found these DPs provided a very small proportion of DAH. This may have been because data on these DPs are harder to obtain, but a study has also recently highlighted that some of this cooperation (namely from China) does not qualify as Official Development Assistance (8).

There has been some discussion in the literature of the merits of different types of agencies, some ranking individual agencies based on their performance on a number of quality indicators (15, 340), others arguing that aid delivered through multi-laterals is more effective because of their incentive systems and lower political pressure (6), that multi-laterals are better at targeting their funds according to need (104) and provide more predictable disbursements (341), or that bi-lateral aid is more effective at reducing AIDS-related mortality (24). This chapter found an increasing number of DPs active in the Tanzanian health sector with differing priorities, resulting in the allocation of DAH being

more associated with the DP profile than the disease profile of the country. In particular, the prominence of the Global Fund and the US, which together made up over 60% of total DAH in 2010, and which both prioritise HIV/AIDS and malaria. In the context of Tanzania, it is therefore more important to assess the fragmentation of DAH and how the large number of DPs coordinate the increasing amount of funds and their priorities, than the merits of the composition of the different agencies. These are further explored in Chapter 8.

Three methodological findings arise from this research. First, values for the selected indicators varied according to the source used, although with the exception of AidData, the variation observed was not substantial. A consolidated country system for measuring health financing flows, both domestic and external, would ensure consistency and be more efficient. A study undertaken at the same time as this thesis compared commitments and disbursements from the OECD-CRS, IHME, AidData, the Global Health Expenditure and NHA databases for the Sub-Saharan African region (as a region and by country) (342). The authors found differences between the results obtained from the different sources, with the biggest differences observed when analysing a single country or DP agency (less so for regional and global analyses) (342). The authors recommend that NHA should be institutionalised and data on expenditures used for DAH analyses (rather than commitments or disbursements, which do not show the actual amounts spent), but acknowledged better reporting by DPs needs to happen at the country level for this to be possible (342).

The findings from this study somewhat contradict these recommendations, as the differences found between the different sources were not substantial. In Tanzania, some effort to harmonise data sources is being made through the PERs and NHA (which are already institutionalised). In addition, the recently-adopted Aid Management Platform⁵¹,

⁵¹ <http://amp.mof.go.tz/>

which was established by the Ministry of Finance to collate all development assistance flows quarterly, and to which all DPs are requested to report their aid disbursements, is an excellent way of consolidating DAH funds. The key may lie in integration between the PER and Aid Management Platform for external health flows (rather than having separate processes for collecting these data) and improving the consistency of the levels of data disaggregation of the PER. Given the annual nature of the PER, it can be used to influence decision-making in resource allocations. The NHA could then stay as a larger less frequent, more resource-intensive exercise, where important but less rapidly changing issues (such as out-of-pocket expenditures) can be monitored. In addition, it would be recommended that efforts to make the Aid Management Platform publically available are increased, so that independent assessments of development assistance can be undertaken.

Second, re-coding was not found to make a difference to categories that were already present in the CRS, but it was important to enable the creation of new categories, such as RMNCH and essential for classifying DAH by channel of delivery. Future analyses would be more accurate if DPs reported to the CRS consistently and accurately and if it allowed for multiple coding of projects (for instance, for malaria and maternal and child health, something that has already been called for (239)), although until DPs report more consistently and accurately, there is no guarantee that adding additional fields would result in an improvement. In addition, it may be more important to report DAH expenditure by levels of care than vertical projects. However, the data obtained in this study did not allow for this.

Despite there being no standard way of including GBS as part of health sector funds, this study found that it makes an important difference to the results obtained, not just in the total amount of DAH, but importantly also in the comparison of the sub-sector distribution of funds, particularly by increasing the proportion of DAH delivered through the

government and in the form of horizontal approaches. It has also helped to calculate the amount of government expenditure on health as a source. The method used here is different to that used by IHME studies of fungibility (158, 343-344), who calculate GHE-S by deducting DAH-G from all the government expenditure of health as an agent. We feel the method used in this chapter is more robust (if still crude and more resource-intensive), as it relies on GHE-S from the budget speech (which is government sanctioned) and then subtracts from it the proportion that would have been contributed by GBS.

The trends reported in this chapter need to be interpreted with caution, as several methodological difficulties were encountered and assumptions made when conducting this research. First, there is likely to be under-reporting of DAH, both at the sector and sub-sector level because despite the efforts to construct a comprehensive database, some DPs are not captured. Second, HIV/AIDS and malaria were not included as part of RMNCH, as the focus was on disease priorities rather than population groups. This means that the amount recoded as RMNCH is much lower than it may be in studies focusing on population groups (as it has been shown that HIV/AIDS makes up over half of reproductive health funds (255, 345)).

Third, re-coding and estimations were kept to a minimum and care was taken to be transparent about assumptions made and not to over-analyse the limited data (echoing Pitt et al.'s call for caution when making conclusions based on this type of data (239)). However, there are problems comparing project disbursements to health systems components with diseases, as there are overlaps and vertical disease projects contribute to the health system and investments in the health system benefit vertical programmes. Although this means the trends outlined here must be interpreted with caution, it is possible to conclude that DAH is heavily skewed towards HIV/AIDS funding. Forth, manual re-coding was only done by one person, so there is potential for bias in the allocation to

priorities. In addition, the method of estimating the proportion of GBS allocated to the health sector (as a proportion of government expenditure on health), although advised by local experts is hindered by the lack of counterfactual, and does not take into consideration the fact that the surge in funding provided by GBS may not be absorbed in equal amounts in all sectors, or that conditions for social spending may result in higher spending in health than would have otherwise have taken place. Finally, no analysis was possible of DAH distribution by health sector activities (human resources, prevention activities, policy, etc.), as there were not enough data available, which would have allowed for comparison of priorities against recommended benchmarks, such as 40% investment in capital (human and infrastructure) recommended by the High Level Taskforce on Innovative International Financing of Health Systems to improve absorption capacity (346).

In conclusion, this chapter has shown the importance of taking the perspective of a recipient country when tracking domestic and external health financing flows. This chapter has found that the increases in the amount of external resources the Tanzanian health sector has received may not be sustainable, resource allocation is skewed towards HIV/AIDS and that the aid architecture has become increasingly complex with an increase in the number and diversity of agencies. It is therefore important to coordinate DP agencies and have priority-setting dialogue with government to identify how best to allocate resources. Finally, some recommendations on how to improve availability and quality of data at the country level have been made.

7 DEVELOPMENT OF AN ASSESSMENT FRAMEWORK FOR THE GLOBAL AID EFFECTIVENESS AGENDA

This chapter addresses the third objective of the thesis. The aim is to develop a set of measurable indicators to assess the principles of aid effectiveness in the context of the Tanzanian health SWAP. The chapter starts with a brief description of the rationale for developing indicators to assess aid effectiveness as well as the criteria used to identify indicators in this study. This is followed by a description of the international and Tanzanian national declarations on aid effectiveness. The third section provides, for each principle, the definitions and indicators that have been used in global and national documents and in the literature, and proposes a set of indicators for use in this study. The chapter concludes with a discussion of the implications of the main findings.

7.1 Introduction

Differences in local interpretation of aid effectiveness principles have been shown to affect coordination efforts of aid resources within the Sector Wide Approach (SWAP) (347). This is in part driven by the importance of the context in which these principles are applied, but also results from the vague nature of the language used in international declarations of aid effectiveness. Moreover, the indicator frameworks used to assess progress towards aid effectiveness declarations has been criticised for being narrow in scope (90).

Given that this study uses the aid effectiveness agenda as a lens to assess the SWAP in Tanzania, it was important to develop a set of indicators that were comprehensive and relevant to the country context. This was done through document and literature review and in-depth interviews as described in pages 92-103 through three steps. First, a review how principles of aid effectiveness have been defined and assessed in international declarations of aid effectiveness and the literature was undertaken. Second, this study explored how these principles are defined in national policies and understood and

interpreted by local stakeholders. Third and based on the first two, a list of measurable indicators for use in Tanzania was developed.

When selecting the indicators to assess each principle the SMART criteria were used: indicators must be specific, measurable, assignable, realistic and time-related. In order to ensure indicators were realistic, a data scoping exercise was undertaken for each of the indicators identified from the document and literature search; only those for which enough data were available were included.

Box 2: Key messages of Chapter 7

- The global aid effectiveness agenda has evolved over time – basic principles have remained the same, but the way they are defined and measured, and the weight placed on them has changed.
- Definitions of aid effectiveness principles are often vague and have multiple dimensions.
- Although having broad non-specific definitions of aid effectiveness principles at the global level is not necessarily a bad thing, more specificity would facilitate measurement of progress.
- Indicators in the agenda do not always reflect the definition of the underlying principle, or only address one aspect of it. They are often based on processes and structures (technocratic).
- Lack of specificity of indicators and their inability to measure principles means the agenda is assessed through a narrow, technocratic focus.
- Definitions of aid effectiveness principles and indicators proposed for their measurement vary across the different sources reviewed – aid effectiveness policies (national and international), literature and between actors.
- Definitions and indicators of aid effectiveness principles are in part context specific and should be adapted to the context, interpreted locally and set with the input of national stakeholders.
- Both quantitative and qualitative indicators are needed to evaluate the global aid effectiveness agenda.

7.2 The global aid effectiveness agenda

Increases in the amount of development assistance and concerns regarding its effectiveness have resulted in the international community holding a number of high level forums aimed at improving the effectiveness of aid (Table 7.1). In 2002, during the Monterrey Consensus on Financing for Development, donor countries committed to mobilise financial resources and increase financial and technical cooperation for development. The international community then signed the Rome Declaration on Harmonization in 2003, and pledged to deliver development assistance following partner country priorities and using harmonised procedures. This was followed by the Joint Marrakech Memorandum on Managing for Results in 2004, where development banks agreed to orient development cooperation towards country results. The key forum to date, however, has been the Paris Declaration on Aid Effectiveness, held in 2005, where over 100 signatories agreed on five principles of aid effectiveness:

- Ownership
- Alignment
- Harmonisation
- Managing for results
- Mutual accountability

The Paris Declaration proposed a set of indicators to measure progress, with targets to be achieved by 2010. The Paris Declaration was followed by Accra Agenda for Action in 2008, which was aimed at accelerating progress towards the Paris Declaration principles, and as such did not have any measurable indicators or targets. The latest high level forum on aid effectiveness took place in Busan in 2011, where partners signed the Busan Partnership for Effective Development Cooperation. Following the signing of the Partnership, a global

monitoring framework consisting of 10 indicators with targets to be achieved by 2015 was agreed.

In addition, there has been one global, health sector-specific declaration – the International Health Partnership (IHP+) – which was signed in 2007, with the aim of applying the principles of the Paris Declaration to the health sector (189).

The five principles of the Paris Declaration are found in previous and subsequent declarations, and are therefore referred to as the five principles of aid effectiveness henceforth.

Table 7.1: International and Tanzanian policies aimed at enhancing the effectiveness of aid

Year	International declaration	Tanzanian national declaration
1997		Helleiner review's 18 "Agreed Notes"
2000	Monterrey Consensus on Financing for Development	
2002		Tanzanian Assistance Strategy (TAS) Health SWAP Code of Conduct
2003	Rome Declaration on Harmonization	Health Basket Fund Memorandum of Understanding
2004	Marrakesh Memorandum on Managing for Results	
2005	Paris Declaration on Aid Effectiveness	
2007	International Health Partnership	Joint Assistance Strategy for Tanzania (JAST) Health SWAP Code of Conduct
2008	Accra Agenda for Action	Health Basket Fund Memorandum of Understanding
2011	Busan Partnership for Effective Development Cooperation	

The Tanzanian aid landscape has also experienced major changes in the last two decades. Tanzania is a signatory of all the international declarations on aid effectiveness. In addition, it has its own aid policies. Since 1997 Tanzania has adopted three aid effectiveness frameworks: the Helleiner review's 18 "Agreed Notes", the Tanzania Assistance Strategy

(TAS) and the Joint Assistance Strategy for Tanzania (JAST). These echo international commitments towards aid effectiveness, and emphasise transparency, accountability, local ownership, coordination and harmonization (348-349).

7.3 Results

Results are presented following the five principles of the aid effectiveness agenda. Given that there is often a disconnect between how principles are defined and measured, definitions and indicators for measurement are presented separately. A set of dimensions was developed to classify the different definitions and indicators of each principle. Where appropriate, the definitions and indicators of each principle are reported by the different dimensions. At the end of each principle, a table is provided summarising the different definitions and indicators found according to the different dimensions of the principle, as well as the indicators selected for this study.

7.3.1 Ownership

The definition of ownership

This study found differences in how the different declarations, literature and national stakeholders interviewed defined and assessed ownership. Ownership is mentioned from the early declarations (Monterrey, Rome, Marrakech), often in conjunction with leadership. However, it was not until the Paris Declaration in 2005 that ownership was internationally recognised as a principle of aid effectiveness, later considered “the first priority” (Accra). Giving the recipient country ownership of the development process is often hailed as the major advantage of the SWAP approach (212), and both Tanzanian health SWAP and basket fund documents talk about the importance of increasing government ownership. Despite this, however, it is unclear *whose* ownership is discussed in these documents, or *of what*.

In terms of *whose* ownership, international declarations usually refer to the “partner country”, although in the JAST national ownership is defined in terms of government leadership of the development process (even if the role of non-state actors in development is acknowledged). The definition of “partner country” has also evolved, with initial declarations being very focused on the recipient government, but Accra, Busan and the TAS extending it to include Parliaments, local authorities and civil society. This broadening of the definition of “country” was echoed by some Development Partners (DPs), who viewed the increasing role civil society is playing as an essential part of “the system”.

“... that’s for me a strengthening of the system. That’s a great thing, and that’s the best development which happened in this country: the civil society has got stronger.” (DP)

When defining ownership of *what*, the Paris Declaration principle of ownership states that “*partner countries exercise effective leadership over their development policies, and strategies and co-ordinate development actions*”. This definition can be divided into two dimensions: leadership of development policies and coordination of development actions. The latter part of the definition has received the most attention in national and international declarations of aid effectiveness. It is encompassed in Busan (where it is called leadership of development partnerships), the JAST, which defines ownership as having a “*government planned and organised dialogue process (...) and domestic stakeholder involvement in managing the development process*”. Some studies in the literature also define ownership as the government having leadership of the development process (350-353). For the Tanzanian government representatives, ownership meant all of the above: having health and broader strategy documents and the capacity to coordinate

funds, negotiate and lead the dialogue. However, for most DPs the definition of ownership was restricted to the degree of government engagement in the SWAP dialogue⁵².

“If I was looking to answer that question, I would look and see actually how – within the last year or two years – how much the government owns or engages in that process” (DP)

Relatively little importance is given to the former part of the Paris Declaration’s definition of ownership (country leadership of development policies) in international declarations. In Busan it is toned down to development policies being tailored to country context and needs, and in Accra DPs agreed to change their conditionality rules to make them more consistent with country ownership. In contrast, for some non-government stakeholders this was the key definition of ownership, which they described as having the “upper hand” when deciding priorities of domestic and foreign resources. Similarly, a DP used the metaphor of giving the government ownership by putting it in the “driver’s seat”, although acknowledged this did not guarantee government ownership.

“... we talk a lot about ownership, government is in the driver seat, and then if we complain all the time about the driver and the driver's style of driving, I think that is very difficult then for the driver to really maintain the driver's seat responsibility.”
(DP)

Confusion as to what this meant in practice led to frustrations amongst national stakeholders, who felt that ownership was interpreted by DPs as not being involved in the “nitty gritty” technical level health sector management.

“At least it’s a misunderstood concept; if that is the way it is perceived. I have heard development partners maintain that they should not be technically involved in what (the government) are doing here because that would reduce ownership...” (Non-government)

⁵² The SWAP dialogue is made up of different structures where DPs, government and other stakeholders meet to plan and account for the use of health resources (see Chapter 5 for a description of these structures)

The definition of ownership as the recipient country leading development policies has also received much attention in the literature, although interpretations have ranged from giving the government control of external financing (351), letting the government set its priorities (354-355), in an inclusive process involving all major stakeholders (including DPs) (356), or having national policies that are supported by domestic and external resources (205). A related issue, which is receiving increasing attention in the literature, is the impact external financing has on domestic resource priorities. This is known as fungibility, and although largely absent from international declarations, some studies have explained fungibility as the result of differing priorities between governments and DPs (160, 162), a view supported by some DPs:

“It’s the government that makes the marginal decisions. So if (DPs) say we are going to provide an extra X hundred million dollars for health, the total amount of health is still up to the government.” (DP)

If fungibility is interpreted as the government having its own priorities and re-allocating its resources in response to foreign finance, then it is also a definition of ownership. There are different definitions of fungibility in the literature. These include general fungibility (aid intended for a general purpose is used for a different expenditure, for instance investment vs. consumption), categorical fungibility (aid is spent for a purpose other than what it was intended for) and fungibility as non-additionality (aid is allocated to the intended expenditure but government’s own resources are reallocated elsewhere) (357). The latter definition was used by national stakeholders in relation to ownership.

“... we’re shovelling money in and they’re shovelling money out.” (DP)

Finally, some definitions of ownership in national declarations overlapped with international declarations’ definition of alignment. For instance, the TAS asks DPs to adopt

the national expenditure framework and the JAST it includes national capacity development as part of ownership.

In summary, despite recognition of the importance of ownership, there was no consensus regarding its definition among the data sources reviewed in this study. Definitions can be classified as those which describe *whose* ownership and those which describe *what* should be owned. The notion of *whose* ownership has evolved and broadened over time to include government and non-state actors. Definitions of *what* should be owned by countries included development partnerships (favoured by national and international declarations) and development strategies (more prominent in the literature and amongst stakeholders interviewed).

Review of indicators

Despite the multiple dimensions of ownership mentioned in international declarations, the literature and by national stakeholders, the indicators proposed to measure the attainment of this principle have a narrow focus. A review of the ownership discourse concluded the Paris Declaration indicator for ownership is restrictive, quantitative and arbitrary (358). Given that ownership only became a principle of aid effectiveness in Paris, it is the first declaration to propose an indicator for it, which is whether countries have operational development strategies. This indicator was also used by some studies in the literature (355, 359-360). The Accra Agenda does not have indicators, and the indicator that is proposed to assess ownership by the Busan partnership is the extent of use of country results frameworks by co-operation providers. This shows that despite the changes in definitions for ownership over time, the indicators proposed to assess it have not changed, except for incorporating a results-based focus. Nationally, the TAS has two indicators: the degree of government leadership in developing policy priorities and strategic frameworks and the degree to which DP policies complement domestic capacity building efforts. In the JAST,

the principle of ownership is assessed through the use of the Paris Declaration indicators for alignment: the percentage of technical cooperation for capacity development through coordinated programmes, and having reliable procurement and public financial management systems in place. Other indicators for ownership found in the literature include the degree of control governments have over resources, both domestic and external, including setting priorities and managing DP funds (205, 351, 354-356, 361) and whether there is evidence of a coordination committee meeting regularly and if they are attended by different stakeholder groups (362).

Studies of fungibility⁵³ are often undertaken across countries to assess fungibility through the comparison of the amount of Development Assistance for Health (DAH) going through the government (DAH-G) and the amount of government expenditure on health as a source (GEH-S) (67). Fungibility has been studied at the country level in Vietnam by comparing observed health outcomes of discrete projects in different regions (69).

Ownership indicators selected

To develop a set of comprehensive and context-specific indicators that assess the aid effectiveness principle of ownership, a combination of the indicators found in national and international declarations as well as in the literature and stakeholder interviews was used. These indicators assess the different dimensions of the definition of ownership identified.

The indicators proposed to assess ownership are:

1. Existence of a health sector strategy and financial expenditure framework (international and national declarations and literature)
2. Stakeholder perceptions of *national* participation in the dialogue (interviews and literature)

⁵³ This is limited to the non-additionality definition of fungibility

3. Degree of *national* leadership in priority-setting of domestic and external resources (interviews and literature)
4. Trends in domestic and external health financing (fungibility) (interviews and literature):
 - a) Trends in total Government Expenditure on Health as a Source
 - b) Trends in Government Expenditure on Health as a proportion of Total Government Expenditure
 - c) Trends in total Development Assistance for Health delivered through the government
 - d) Trends in Development Assistance for Health as a proportion of total official development assistance and Total Government Expenditure

The first indicator selected was the Paris Declaration indicator. This is because it is the main indicator in international declarations, is commonly used to assess ownership in the literature (359-360) and it was mentioned by national stakeholders. However, both the literature and interviews showed that this indicator was too simplistic, so three further indicators are proposed. The second and third indicators assess national participation in and leadership of the dialogue respectively. Given that the inclusiveness of actors that count as *national* has increased in later declarations, and that stakeholder interviews revealed that non-government actors have played an increasingly important role in the dialogue over the timeline of the SWAP, the term *national* here includes government and non-government agencies involved in the health sector (such as the relevant ministries, Parliament and civil society). The second and third indicators are measured qualitatively through non-participant observation of dialogue meetings and in-depth interviews. The final set of indicators addresses fungibility. Fungibility is assessed by comparing trends in health financing from domestic and external sources. Availability and quality of data on national expenditures on health is limited (see Chapter 3); therefore, quantitative trends

are described and possible explanations for the trends were discussed during in-depth interviews. We compare trends in total domestic and external health expenditure and the relative shares each represent of total (domestic and external) expenditure to give an indication of how they change in relation to each other and as an overall priority to DPs and government.

Government ownership of technical assistance is an indicator of ownership in the TAS; however, it was not included here because of a lack of adequate data to track it.

Table 7.2: Definitions and indicators of the principle of Ownership⁵⁴

Dimension	Policy Documents		Literature		Interviews	Proposed indicators
	Definition	Indicators	Definition	Indicators	Definition	
Leadership of development partnerships	<ul style="list-style-type: none"> Strengthen government leadership of dialogue, including leading coordination of DPs (JAST, Accra, Paris, Busan) 	<ul style="list-style-type: none"> Degree of integration of resources into the strategic expenditure framework (TAS) 	<ul style="list-style-type: none"> DPs work with govt (351) 	<ul style="list-style-type: none"> Coordination mechanisms are institutionalised and led by the government (205, 361) Coordination committee meeting regularly with stakeholder participation (362) 	<ul style="list-style-type: none"> Government participation in the dialogue Capacity and exercise of leadership dialogue 	<ul style="list-style-type: none"> Stakeholder perceptions of national participation in the dialogue
Leadership of development policies and priorities	<ul style="list-style-type: none"> Countries determining and implementing their development policies (Paris, Accra, Busan, TAS) 	<ul style="list-style-type: none"> <u>Partners have operational development strategies</u> (Paris, IHP+) Extent of use of country results frameworks by co-operation providers (Busan) 	<ul style="list-style-type: none"> Giving govt control of money (351) Government sets its priorities and has control over finance and operations (354-355), in an inclusive process with major stakeholders, including DPs (356) 	<ul style="list-style-type: none"> <u>Partners have operational development strategies</u> (Paris) (359-360) Government has leadership of the development process (350-353), domestic and external resources (361), health programmes (363) 	<ul style="list-style-type: none"> Government being in the driving seat Degree of DP involvement in health sector management Fungibility 	<ul style="list-style-type: none"> Existence of a health sector strategy and financial expenditure framework Degree of national leadership in priority-setting of domestic and external resources

⁵⁴ Indicators that are repeated across different sources are underlined

Dimension	Policy Documents		Literature		Interviews	Proposed indicators
	Definition	Indicators	Definition	Indicators	Definition	
	<ul style="list-style-type: none"> • DPs change conditionality to make it more consistent with ownership (Accra) 	<ul style="list-style-type: none"> • Degree to which DP policies complement domestic capacity building efforts (TAS, Rome, JAST and IHP+) 	<ul style="list-style-type: none"> • Domestic and external resources support national policies (205) 	<ul style="list-style-type: none"> • Government leadership of the process of designing development strategies (364) • Partners have the capacity to implement development strategy (365) • Degree of control recipient governments are able to secure over implemented policy outcomes (366) • Fungibility: change in Government Health Expenditure as Source with increases in Development Assistance delivered through the government (38, 67) 		<ul style="list-style-type: none"> • Trends in total Government Expenditure on Health as a Source • Trends in Government Expenditure on Health as a proportion of Total Government Expenditure • Trends in total Development Assistance for Health delivered through the government

Dimension	Policy Documents		Literature		Interviews	Proposed indicators
	Definition	Indicators	Definition	Indicators	Definition	
						<ul style="list-style-type: none"> • Trends in Development Assistance for Health as a proportion of total official development assistance and Total Government Expenditure

7.3.2 Alignment

The definition of alignment

Like ownership, alignment was mentioned in early declarations but did not become a principle of aid effectiveness internationally until Paris in 2005. It was no longer a principle in Accra or Busan, although they both include commitments to alignment under their ownership principles. However, in the national sphere, alignment appears in documents pre-dating the Paris Declaration. Definitions of alignment found in the sources reviewed in this study can be classified into three dimensions: adherence to country development strategy, increased use of country public financial management and procurement systems and improvements in the quality of country systems.

The definition of adherence to country strategy was mostly uniform across the different sources. On the whole it meant respecting country's priorities as stated in their sector or national development plans (Accra, JAST, IHP+, Paris, (367-370)), a view also supported by some DPs:

"In our case we are aligned to the sector wide approach, our objectives, targets, indicators, they are taken from the (Health Sector Strategic Plan), the national reform agenda in the health sector, which is aligned to MKUKUTA⁵⁵." (DP)

Some international declarations go a step further by asking DPs to report their expenditure on national budgets (IHP+ and Paris), if they attach conditions to their aid, to do so drawing from the country's national strategy, and to link funding to a single framework (Paris).

All sources also agreed alignment meant using country systems, which are defined as public financial management (PFM) (Paris, Accra, Busan, (371-372)) and procurement systems (Paris, Accra, (372)). More specific definitions of alignment include: providing funds in the

⁵⁵ Poverty reduction strategy

form of general budget support and basket funds (SWAP code of conduct, JAST, TAS, Heillener, (368)); aligning to the government's budgetary cycles (JAST, (362, 367)); relying on country audits and financial reporting systems (SWAP code of conduct, Marrakech); improving predictability (Paris, Accra, JAST, TAS, (372)); and untying of aid (Paris, JAST, TAS, (372)). DPs also saw alignment as using the government systems, although some were unsure about how to do this in practice.

“So there's a variety of models of how – working with government and how that would work. So we're looking at that right now (...) about how we could make that engagement happen.” (DP)

The government also viewed alignment in terms of DPs delivering aid “on budget” (through the government financial management system) and following government priorities. They also referred to alignment of reporting to its processes of accountability for resource use, rather than DPs asking for separate reports.

The final dimension of alignment is improving the capacity of government systems, which is consistently referred to in international and national policies and in the SWAP code of conduct, often as a pre-condition of DPs using the government system. However, this was not a prominent feature emerging from interviews or the literature.

In summary, definitions of alignment are mostly consistent between the different sources reviewed in this study. However, despite alignment featuring strongly in the Paris Declaration, its relative importance in subsequent international declarations has declined.

Review of indicators

Indicators proposed by different sources are in line with the three dimensions of the definition outlined above. Alignment to national strategies is measured as the proportion of aid flows reported on national budgets (Paris, Busan, JAST, (372)) and the proportion of technical assistance that is coordinated (Paris, (372-373)). Use of country systems is

assessed as: the percentage of aid flows disbursed through country PFM and procurement systems (Paris, Busan, JAST, (362, 367-368, 372-377)); the number of Parallel Implementation Units (PIUs) (Paris, (372, 374)); the proportion of funds committed that are disbursed in a timely manner (Paris, TAS, JAST); and the proportion of aid that is untied (Paris, JAST). In addition, the JAST has three additional indicators: percent of projects/programmes not aligned to national and sector strategies and the number and percentage of projects which are only for piloting, emergency and large scale infrastructure (conditions acceptable to the government to disburse aid as projects). The capacity of country PFM and procurement systems has been measured using criteria developed by the World Bank (PFM) and the Organisation for Economic Co-operation and Development (OECD) (procurement) (Paris, Busan, TAS, JAST).

Alignment indicators selected

The indicators proposed in this study assess two of the dimensions of alignment: the use and strengthening of country systems. DP's alignment with country strategies was assessed as part of ownership, and is therefore not included here. Country systems for monitoring and accounting for results will be included in the related principle (managing for results). The definition of "country systems" adopted was public financial management and procurement systems, as it was the prevailing definition in the literature and the Paris Declaration, and was also used by stakeholders during interviews.

The indicators selected to assess alignment in this study are:

1. Trends in the percentage of DAH going through the government (DAH-G) (international declarations and literature).
2. Trends in the percentage of DAH-G that is in the form of budget support and basket fund (national declarations).

3. Stakeholder perceptions of the drivers of trends in channel and modality of DAH delivery (interviews).
4. Stakeholder perceptions of quality of country systems (interviews).

The first and second indicators assess the use of country systems quantitatively. This is done as the proportion of DAH that is disbursed through the government (indicator 1) and as the proportion of DAH disbursed through the government that is either budget support or pooled funds (indicator 2). The reason for the latter is to assess how DPs comply with national declarations of aid effectiveness. In addition, to understand why different funding modalities and channels were used, indicator 3 assesses stakeholder perceptions of the reasons behind changes in trends for indicators 1 and 2 since the establishment of the SWAP. The final indicator proposed assesses the quality of government systems. This will be measured qualitatively for two reasons. First, because the quality of country systems has already been assessed quantitatively in the evaluation of the Paris Declaration and, second, because assessment of stakeholder perceptions of quality is considered a precursor of aligning to the system in international declarations.

The tying and predictability of aid and number of PIUs were not included in the indicator framework. The tying of aid was excluded because the quality of the data available did not allow for assessment and non-participant observation and interviews revealed that, with the exception of technical assistance, this was no longer an issue of concern for the government stakeholders that took part in the study. Although predictability of aid and number of PIUs are used as indicators of alignment in international declarations and the literature, DAH data were not sufficiently complete to allow for these indicators to be measured.

Table 7.3: Definitions and indicators of the principle of Alignment

Dimension	Policy Documents		Literature		Interviews	Proposed indicators
	Definition	Indicators	Definition	Indicators	Definition	
Alignment to government strategy	DPs base their support on partner countries national strategies (Paris)			<ul style="list-style-type: none"> Alignment of funds with sector priorities (compared with health strategic plan) (368) or with PRSP (369) 		
Use of country system	Use of country financial management and procurement systems (Paris)	<ul style="list-style-type: none"> <u>% aid to government reported on national budget</u> (Paris, Busan, JAST, IHP+) % ODA disbursements using national financial reporting and auditing procedures (Paris, JAST) 	<ul style="list-style-type: none"> DPs use of partners' national development strategies as the framework of reference for programming country assistance (367) 	<ul style="list-style-type: none"> <u>Proportion of health aid reported on national budgets</u> (372) <u>Use of country procurement system</u> (Paris indicator) (373) <u>Use of recipients' PFM systems</u> (372-374) Trends in DAH funding mechanisms (368) <u>Number of PIUs</u> (372, 378) 	<ul style="list-style-type: none"> Working with the government Delivering funds using their system 	<ul style="list-style-type: none"> Trends in the percentage of DAH going through the government Trends in the percentage of DAH delivered through the government that is in the form of basket fund and budget support

Dimension	Policy Documents		Literature		Interviews	Proposed indicators
	Definition	Indicators	Definition	Indicators	Definition	
		<ul style="list-style-type: none"> • <u>% DPs and aid flows using partner PFM and procurement systems, which either adhere to good practices or have a reform programme</u> (Paris, Busan, JAST, IHP+) • <u>Number of Parallel Implementation Units (PIUs)</u> (Paris, JAST, IHP+) 	<ul style="list-style-type: none"> • Alignment to the budget cycle (362, 367) 			<ul style="list-style-type: none"> • Stakeholder perceptions of the drivers of trends in channel and modality of DAH delivery
Capacity of country system	Capacity building in line with national priorities (Paris, IHP+, Busan, SWAP, Helliener, TAS)	<ul style="list-style-type: none"> • Quality of PFM systems (World Bank's Country Policy and Institutional Analysis criteria) (Paris, Busan) • Quality of procurement systems (OECD-DAC criteria) (Paris, Busan) 		<ul style="list-style-type: none"> • Proportion of technical cooperation that is coordinated (372-373) 	<ul style="list-style-type: none"> • Capacity and quality of the country system 	<ul style="list-style-type: none"> • Stakeholder perceptions of quality of government systems

7.3.3 Harmonisation

The definition of harmonisation

Early declarations made a strong emphasis on harmonisation. Emphasis on harmonisation has however decreased post-Paris, with Busan and Accra replacing it with inclusive and effective development partnerships. Reference to harmonisation is often found in the literature within discussions of coordination. Coordination is seen as a pillar of the sector-wide approach (347), and has been defined as a way of managing inputs at the sector level, led by the government, with all DPs aligning to the national development strategy (205, 361, 379). Harmonisation is therefore one aspect of SWAP coordination, following from ownership, for DPs to work together. However, harmonisation itself can be viewed as a coordination mechanism. Indeed, the definitions of harmonisation reviewed in this study can be divided into two dimensions: coordination of DP processes and procedures, and fragmentation.

Harmonisation has been defined as DPs having common arrangements, including planning, funding, disbursement, monitoring, evaluating and reporting aid flows (Rome, Paris, IHP+, Helleiner, JAST (350, 356, 361, 376, 380-381)); procedures, such as field missions and country analytic work (Monterrey, Marrakech, Paris, JAST, with the goal of reducing transaction costs (382)); an effective division of labour (Paris, Accra, Busan, JAST, (381)), use of Programme Based Approaches (PBAs) (Paris, Busan, (351, 372)) and delegated cooperation (Busan). In addition, DPs have committed to changing their internal structures and incentives to achieve this (Rome, Paris). Other definitions found in the literature include the existence of DP meetings (376, 381, 383), having a strategic plan and consultative meetings (356, 376, 384) and pooling arrangements (376, 381). The latter two fall under the definitions of ownership and alignment adopted in this study respectively.

In Accra and Busan DPs also agreed to reduce fragmentation as part of their commitment to a harmonised approach. Fragmentation has also been used in the literature as a measure of effectiveness of DP harmonisation and coordination (54, 361), and was a matter of concern for DPs in Tanzania, some of whom saw it as an objective of the Paris Declaration.

“... that’s the point of Paris, right? It’s try to minimize [fragmentation], try to minimize transaction costs, try to improve coordination, and harmonization and alignment...” (DP)

Review of indicators

Of all the national and international declarations, only Paris, the Helleiner review and the JAST have proposed indicators to assess harmonisation. These include: the percentage of aid flows provided as a programme-based approach (defined as budget support, basket funding and projects delivered through a sector-wide approach) (Paris); the percentage of DP missions and country analytic work that are joint (Paris, JAST); and the number and frequency of coordination meetings between DPs and government (Helleiner, SWAP code of conduct (2007)). These indicators are not used in the literature, however. Studies in the literature assessed the efficacy of coordination systems according to whether they reduced duplication of services and decreased the number of conflicting policy signals (361), the existence of documentary evidence that stakeholders have attended preparatory meetings (362), reduced transaction costs (205), or through open-ended qualitative questions about existence of coordination mechanisms and how and whether they worked (385).

When asked about how the success of harmonisation procedures should be assessed, all stakeholder groups felt that the purpose of DP harmonisation mechanisms was to build a common front for DPs.

“... (DPs) are supposed to act as one group with one voice ... they would meet – the donors – before the official meeting with the government and others, to agree on their opposition regarding the agenda of the meeting” (Non-government)

There is no indicator for fragmentation in international declarations. The JAST has two fragmentation indicators (number of active DPs per sector and number of sectors for each DP) to assess division of labour. Fragmentation has also been assessed in the literature quantitatively by measuring either project counts (44-45) and sizes (44), number of DPs (375) or DP concentration through, for example, the Herfindahl index (40, 45, 386) or the OECD index (44, 387). The latter measures the proportion of DPs that account for less than 10% of DAH. Despite there being different indicators to assess fragmentation, there is no agreed cut off point beyond which fragmentation is considered harmful or excessive, and indeed some studies have shown too little fragmentation is also not desirable (particularly given DP volatility and uncertainty about levels of future funding) (12, 44).

In summary, harmonisation has been defined and measured along two dimensions: DP coordination, which was particularly highlighted in international declarations and national stakeholders, and fragmentation, which was the focus of the literature and national declarations of aid effectiveness. Although the definition of harmonisation has not evolved over time, its importance has declined from being the sole purpose of the Rome Declaration, to being incorporated under “inclusive development partnerships” in Busan.

Harmonisation indicators selected

Five indicators were selected to assess harmonisation; the first two assess the functionality of DP coordination mechanisms and the last three assess fragmentation. Given that the Paris evaluation already assessed coordination mechanisms quantitatively, and quantitative data were hard to obtain, qualitative indicators are proposed for DP coordination mechanisms to explore how they have worked in practice. A combination of indicators of

fragmentation was selected from the literature. The OECD fragmentation index was chosen over the Herfindahl index as the latter is used in cross-country regression studies, and the OECD index combined with the other three indicators provides enough accuracy to assess trends over time in a single country, single sector. Instead, it was felt that it was more important to assess the fragmentation indicators at the sector and sub-sector level by DP and sub-sector priority to provide a more in-depth analysis of the DPs or priority areas that were driving the fragmentation trends observed.

Therefore the indicators proposed to assess harmonisation are:

1. Stakeholder perceptions of functionality of common arrangements and procedures (division of labour, joint visits, planning and monitoring), including whether they improve the management of the sector and reduce fragmentation, and therefore transaction costs (national and international declarations and interviews)
2. Stakeholder perceptions of DPs' ability to have a common position (interviews)
3. Number of DPs (literature)
4. Proportion of DPs accounting for less than 10% of DAH (literature)
5. Number and average size of projects (literature)
6. Stakeholder perceptions of the drivers and impact of fragmentation (interviews and literature)

Table 7.4: Definitions and indicators of the principle of Harmonisation

Dimension	Policy Documents		Literature		Interviews	Proposed indicators
	Definition	Indicators	Definition	Indicators	Definition	
Coordination	<ul style="list-style-type: none"> • Common arrangements and procedures (Paris, JAST, IHP+) • Incentives for collaboration (Rome, Paris) • Delegated cooperation (Rome, Accra, Busan, JAST) • Processes harmonised with national calendar (JAST) • Inclusive partnerships involving new actors (Accra, Busan) 	<ul style="list-style-type: none"> • Coordinated operational procedures (Monterrey, Rome, Paris, Busan, TAS), planning (Paris), DP missions (Rome, Paris, TAS, JAST, SWAP Code of practice) • <u>Coordinated country analytic work – reviews, evaluations, accounting and reporting</u> (Rome, Marrakech, Paris, TAS, JAST, Accra, IHP+) 	<ul style="list-style-type: none"> • Coordination of aid activities to reduce transaction costs (382) • DP coordination of resources across developing countries (382) • Differentiate between coordination within sector, sector-wide, across sectors at national level and global-level (380) • Common budgeting and accounting procedures (350, 376) • Consultative meetings (376) • DP-DP meetings (376) 	<ul style="list-style-type: none"> • Existence of coordination structure that meets regularly and is attended by key stakeholder groups (362) • <u>Percentage of missions and analytic work that are joint</u> (372, 377) • Programme/project implementation through existing structures and mechanisms (362, 367) 	<ul style="list-style-type: none"> • Coordination meetings • Burden on government • Division of labour • Common front (“speaking in one voice”) 	<ul style="list-style-type: none"> • Stakeholder perception of functionality of common arrangements and procedures, including whether they improve the management of the sector and reduce fragmentation and lower transaction costs

Dimension	Policy Documents		Literature		Interviews	Proposed indicators
	Definition	Indicators	Definition	Indicators	Definition	
	<ul style="list-style-type: none"> • Division of labour (Paris, Accra, JAST, Busan) • Aid disbursed through PBAs (Paris, Busan) 	<ul style="list-style-type: none"> • Number and frequency of coordination meetings rationalised (Heillener) 	<ul style="list-style-type: none"> • Coordinated decision-making, oversight and M+E and service delivery (385) 	<ul style="list-style-type: none"> • Aid disbursed PBAs⁵⁶, including budget support and basket funding (372, 374-377) 		<ul style="list-style-type: none"> • Stakeholder perceptions of DPs' ability to have a common position
Fragmentation		<ul style="list-style-type: none"> • <u>Number of active DPs per sector</u> (JAST) • Number of sectors for each DP (JAST) 	<ul style="list-style-type: none"> • Proliferation of DPs and projects (40) • Concentration of DPs across sectors or countries (130) 	<ul style="list-style-type: none"> • Number of projects counts (44-45) • Size of projects (44) • <u>Number of DPs</u> (375) • Herfindahl index (40, 45, 386) • OECD fragmentation index (44, 387) 		<ul style="list-style-type: none"> • Number of DPs • Proportion of DPs accounting for less than 10% of DAH • Number and average size of projects • Stakeholder perceptions of the drivers and impact of fragmentation

⁵⁶ The definition of PBA varied across different studies

7.3.4 Managing for results

The definition of managing for results

Managing for results was a very important principle in early international declarations, and has regained importance since the Paris Declaration in 2005. Nationally, it was not a part of Tanzanian aid policies until the JAST (2007). Definitions of managing for results varied widely in the different sources reviewed as part of this study.

Managing for results is broadly defined as DPs and recipient countries having an approach to development based on achieving results. Managing for results is often used interchangeably with results-based management (388). However, in the literature a difference has sometimes been made, with results-based management involving results-specific information, capacities and results-specific objectives (389). As a result of tensions with ownership and predictability, results-based management has been toned down to “commitment to achieve results” rather than actually achieving them in the Paris Declaration (390).

Specifically, there have been different interpretations of what “managing” means, with definitions varying between achieving results (Marrakech), aligning programming, monitoring and evaluation activities to expected results (Marrakech, Paris, JAST), keeping results reporting simple, cost-effective and user-friendly (Marrakech) and using results information in decision-making (Marrakech, Paris, JAST and Swiss (2005) (389)). Articles mostly defined management for results as an approach focusing on achieving outputs and outcomes, rather than inputs (391) or policy conditionality (392). DPs sometimes referred to it as “*performance orientation of results*”, without elaborating further.

In addition, there are some disagreements as to what “results” means. The general definition used in the Paris and Marrakech agreements (also used by the OECD (388)) is

outputs, outcomes or impact. However, some studies have reported different agencies adopting different terms (393). In Busan, results were equated with eradicating poverty and reducing inequality, achieving sustainable development, and enhancing developing countries' capacities. Finding the right measure of results was an issue for some of the DPs interviewed:

"... it's easier to look at the big indicators. 'Ah, infant mortality has gone down' 'Ah, under five mortality has gone down. great great.' But we never asked ourselves with the money we inject we could've achieved a lot more" – DP

In addition, some DPs felt that there was increasing pressure to show outputs and outcomes.

"... you do get all of those questions about what has the basket accomplished? What are the outputs of the basket? What are the outcomes of the basket?" (DP)

Similarly, another DP reported that despite increased awareness among DPs and government "that more needs to be done in terms of performance orientation of financing", having performance indicators is not enough to manage for results. Government stakeholders did not have a specific definition for managing for results, but defined effective aid as that which achieves outputs (medications) and outcomes (saves lives), which reflects a results orientation.

This lack of agreement on what managing for results is was reported with concern in the literature, particularly regarding the ambiguity of definitions of terms (392-394), and problems of assigning causality as there are multiple DPs and exogenous factors that can affect outcomes in addition to aid itself (392-393, 395).

Review of indicators

The Marrakech Memorandum of Understanding had eleven indicators to assess management for results (see Table 7.5), assessing: the extent to which strategies and

budgets of governments, development agencies and civil society organisations are linked to results; the capacity to manage for results; harmonisation of monitoring and evaluation; and information availability and use. In contrast, the Paris Declaration and the Busan Partnership only have one indicator each. The Paris Declaration focuses on countries having “transparent and monitorable” performance assessment frameworks. This is taken further in Busan, which proposes that the use of these frameworks by DPs be assessed. These indicators are echoed in the literature, which focus on recipient countries having a results framework (396-398) that is unified and linked to a budget (399).

Out of the national declarations, only the JAST has indicators to measure management for results. JAST indicators focus on the proportion of funds budgeted and spent on the poverty reduction strategy (MKUKUTA), which would better fit earlier definitions of ownership. Although sharing and using information is part of the definition of managing for results in these declarations and the literature, Paris, Busan and JAST have no indicators for this. National level stakeholders also reported that despite increased emphasis on measuring results, there were no clear guidelines on how to act on the information collected

“So I mean all these together we have a lot of evidence, so in terms of accountability, now what do we do with that?” (DP)

Managing for results indicators selected

Three indicators are proposed to assess managing for results in this study. The first indicator assesses the existence and quality of a performance assessment framework. This is based on the indicators of the Paris Declaration and Busan Partnership (but also on those included in Marrakech and the literature), and would be the starting point for managing for results. However, the literature review and in-depth interviews revealed having a performance assessment framework in place is not enough to manage for results, the

information of the assessment of results needs to be made available in order to hold the government and DPs to account, but also to influence policy-making. The second and third indicators address these issues. Given the lack of clarity of what constitutes results outlined above, both outputs and outcomes were included (following the Paris Declaration and OECD definitions).

The indicators proposed to assess management for results are:

1. Existence of a unified, comprehensive and usable performance assessment framework with monitorable indicators that is used by DPs (international declarations)
2. Stakeholder perceptions of availability of quality information on results (outputs and outcomes) to assess health system performance (interviews)
3. Stakeholder perceptions of the use of results assessments in policy-making (interviews)

Table 7.5: Definitions and indicators of the principle of Managing for results

Dimension	Policy Documents		Literature		Interviews	Proposed indicators
	Definition	Indicators	Definition	Indicators	Definition	
Commitment to managing for results	<ul style="list-style-type: none"> • Focus national strategies and systems on country results (Marrakech) • Focus dialogue on results at all stages (Marrakech) • Align programmes and all activities to country results (Marrakech) • Focus on outcomes and impact and then identify inputs and activities (Marrakech) 	<ul style="list-style-type: none"> • Increased aid to strengthen country capacity to manage for results (Marrakech) • Development co-operation is focused on results that meet developing countries' priorities (Busan) • % national budget allocated and spent to MKUKUTA/MKUZA (JAST) 	<ul style="list-style-type: none"> • Increased focus on outputs and outcomes, rather than inputs (388, 392, 394, 400) • Programmes are aligned with objectives (398) • Evaluate by comparing against expected results (394) • Pay for performance (392, 394) • Commitment to achieve results rather than actually achieving them (390) 	<ul style="list-style-type: none"> • Increased emphasis on outputs and outcomes 		

Dimension	Policy Documents		Literature		Interviews	Proposed indicators
	Definition	Indicators	Definition	Indicators	Definition	
Performance assessment framework	<ul style="list-style-type: none"> • Use and support country’s results framework (IHP+, Busan, JAST) • Integrate aid monitoring into government processes and strengthening government capacity to manage this (JAST) • Establish baselines, identify targets and indicators upfront (Marrakech) 	<ul style="list-style-type: none"> • Annual poverty reduction strategy progress report provides more favourable assessment of results focus (Marrakech) • Number of M&E reports prepared by civil society watch groups (Marrakech) • Number of countries with an integrated assessment of capacity for results based approaches (Marrakech) • Number of annual budget reports incorporating results based monitoring and evaluation data (Marrakech) • Number of agencies introducing a results-based approach to cooperation programs (Marrakech) 	<ul style="list-style-type: none"> • Formulate outcomes, goals, targets, objectives (392, 394, 398, 400) • Need indicators for outcomes (394) 	<ul style="list-style-type: none"> • Have results framework (396-398) that is unified (399) • Prioritization within framework and strategic link to budget (399) 	<ul style="list-style-type: none"> • Contribution towards performance assessment framework • Definition of “result” 	<ul style="list-style-type: none"> • Existence of a unified, comprehensive and usable performance assessment framework with monitorable indicators that is used by DPs

Dimension	Policy Documents		Literature		Interviews	Proposed indicators
	Definition	Indicators	Definition	Indicators	Definition	
		<ul style="list-style-type: none"> • Share of country cooperation programs with explicit results framework by agency (Marrakech) • Number of countries that adopt harmonized results reporting mechanisms based on national M&E systems (Marrakech) • Number of countries with a fully costed, integrated statistical action plan (Marrakech) • Number of consultations conducted by each agency (Marrakech) • Performance Assessment Frameworks are results-oriented, transparent and monitorable (Paris) 				

Dimension	Policy Documents		Literature		Interviews	Proposed indicators
	Definition	Indicators	Definition	Indicators	Definition	
Availability and quality of data	<ul style="list-style-type: none"> • Improve information systems (Accra) • Information is shared in a transparent, timely, clear and accessible manner (JAST) • Disseminate good practice (Marrakech) 	<ul style="list-style-type: none"> • Number of agency performance assessment reports published (Marrakech) 	<ul style="list-style-type: none"> • Need performance data (baseline and after) (389-390, 394, 396-397, 400) 		<ul style="list-style-type: none"> • Use of results in policy-making 	<ul style="list-style-type: none"> • Stakeholder perceptions of availability of quality information on results (outputs and outcomes) to assess health system performance
Use of results in decision-making	<ul style="list-style-type: none"> • Use results in decision-making (Busan) 		<ul style="list-style-type: none"> • Report and use results (393-394, 396-397, 400) • Need capacity and incentives to act on information (389) 			<ul style="list-style-type: none"> • Stakeholder perceptions of the use of results assessments in policy-making

7.3.5 Mutual Accountability

The definition of accountability

Accountability is now a key principle of national and international declarations; however, it was not present in international declarations pre-Paris and was first mentioned nationally in the TAS (2002).

Accountability of development assistance has been widely researched in the literature, where accountability is described as comprising different dimensions: “*when*” or at what stage of the aid process (decision-making, implementation, monitoring and evaluation) (174); “*for what*”: inputs, activities, outputs, outcomes and impacts (401); “*to whom*”: governments, DPs, end-users, institutions (402-403); type of accountability: financial, performance or political (404); and “*how*” or through what mechanism (81).

These distinctions are present in national and international aid policies. In terms of “*when*”, the emphasis in international declarations tends to be on end-stage results and monitoring and evaluation; however, national-level stakeholders and policies focus on the DP-government dialogue, which serves for planning and accounting for results. The “*for what*” dimension was described in the managing for results section.

Interestingly, there has been a shift in the “*to whom*” dimension in national and international declarations. Up to Paris, international declarations have focused on DPs and recipient governments being mutually accountable for results and resource use. In Accra this was extended to DPs and recipient governments being accountable “*to each other and their citizens*”, and in Busan this is reaffirmed and taken further by also including organisations, constituents and stakeholders. The TAS focuses on accountability of the government, whereas the JAST focuses on mutual accountability between DPs and government (in line with Paris). DP-government mutual accountability is also the focus of a

study by Oliveira Cruz and McPake, who explored DP's ability to hold the Ugandan government to account through the use of the "*aid contract*" (405).

The final dimension is "*how*". International declarations have focused on having joint (DP-government) reviews (Paris, also in (175-176)). This was also supported in the JAST, which in addition requires independent reviews. In Tanzania, the core of health sector accountability took place through the dialogue, particularly in the Joint Annual Health Sector Review, where progress for the year was reviewed and milestones for the following year were established. Some DPs considered government participation in the SWAP dialogue was synonymous with accountability.

"Are they showing up to the meetings? Are they accountable to the process?" (DP)

Equally, some DPs also thought their participation in SWAP meetings ensured they were accountable to the government.

"... in the sector wide approach [...] we join the annual planning meetings at the regional level, we are part and contributor and discussant of the annual review to the overall SWAP structure and dialogue processes, so I think accountability is more or less through the whole dialogue structure" (DP)

National declarations and representatives from the GoT also viewed having the provision of reports on budget execution as a mechanism of accountability, as did a study in the literature (81). The literature also calls for mechanisms for holding those responsible to account (175, 406), although national-level stakeholders were not clear on what this would mean in practice.

Finally, national and international declarations, as well as some studies in the literature, also defined accountability in terms of transparency, both in terms of the decision-making process and the use of funds (170, 176-177).

Review of indicators

The indicators to assess accountability mostly focus on the “*how*”. The key indicator for accountability in international declarations was the existence of mutual assessment of progress (Busan, Paris and JAST). This can take the form of sector reviews, which have been assessed in terms of their completeness (inputs, activities, outputs and outcomes); degree of institutionalisation and promotion of reform towards achievement of the Paris Declaration; alignment with existing frameworks; and the degree of participation of governmental and non-governmental actors (407). In addition, in Tanzania assessment of progress also takes place through the annual JAST implementation and mid-term and final independent assessment reports (JAST, also agreed in the Health Basket Fund agreement) and audit reports from the Controller and Auditor General (TAS). Other indicators include a qualitative assessment of sector dialogue (JAST), the degree to which the GoT has created an appropriate national accountability system for public expenditure (TAS), the proportion of development assistance that has a good monitoring and evaluation framework (408) and the degree to which DPs are able to keep the government to account on its promises through the use of rewards and penalties (405).

Transparency has been assessed in aid effectiveness declarations according to whether all DPs have a common, open standard for electronic publication of timely, comprehensive and forward-looking information on development co-operation (Busan), the percentage of DPs providing timely quarterly reports to government (JAST), the proportion of non-state agencies that adhere to code of conduct on transparency and accountability (JAST) and the degree of transparency in reporting and accountability at both national and sectoral level (TAS). Transparency has also been assessed in the literature in relation to DPs by whether they report to aid databases (408-410), the quality of this reporting (408, 411) and whether DPs are members of the International Aid Transparency Initiative (408).

Accountability indicators selected

Some dimensions of the definition of accountability are included under other principles, for instance accountability for results (*for what*) is included in managing for results and participation in dialogue (*how*) is assessed as part of ownership. Given that the Paris Declaration and the JAST only focus on accountability between government and DPs, and that this was the only type of accountability mentioned by national stakeholders, indicators selected to assess accountability only focus on mutual accountability between DPs and the government, rather than to citizens of DP or recipient country.

The evaluation of the Paris Declaration used the existence of a mechanism for mutual performance review to assess accountability. This was in place in the Tanzanian health SWAP – the Joint Annual Health Sector Review. However, based on the literature review and stakeholder interviews, it was felt that this alone was not enough to assess accountability. Therefore, this study proposes to explore accountability along three indicators. The indicators selected are all qualitative, in an effort to be less prescriptive than for the other principles. This is because the notion of accountability is not only context specific but also dependent on the perspectives of the different stakeholders, and accountability was the principle local stakeholders found the hardest to define. The indicators proposed here can be explored through different qualitative methods including in-depth interviews, document review and non-participant observation.

The first indicator proposed is the ability of DPs to hold the government to account, as it is the focus of much of the literature. In addition, international declarations call for mutual accountability, which would also involve the government holding DPs to account. Therefore the second indicator is the ability of the government to hold DPs to account. Finally, given the importance of transparency in declarations of aid effectiveness, and particularly in the literature, this is proposed as the third indicator.

Therefore accountability in this study will be measured using three indicators:

1. Stakeholder perceptions of ability of DPs to hold the government accountable
(international and national declarations and literature)
2. Stakeholder perceptions of ability of the government to hold DPs accountable
(interviews)
3. Transparency in the use of resources of both DPs and the government
(international and national declarations and literature)

Table 7.6: Definitions and indicators of the principle of Mutual accountability

Dimension	Policy Documents		Literature		Interviews	Proposed indicators
	Definition	Indicators	Definition	Indicators	Definition	
To whom	<ul style="list-style-type: none"> • Accountability to beneficiaries, citizens, organisations, constituents and stakeholders (Busan) • Strengthen dialogue (JAST) • Independent monitoring group review progress of DPs and Govt (JAST) • Governments commit to involving all stakeholders to develop common vision for health sector (IHP+) 	<ul style="list-style-type: none"> • DPs and government jointly assess mutual progress (Paris, Busan, JAST, IHP+), holding each other accountable for mutually agreed results (Accra) • Government has created national accountability system for expenditure and receives clean audits from the Controller and Auditor General (TAS) 	<ul style="list-style-type: none"> • Inputs, activities and outputs, outcomes and impacts (401) • Accountability to DPs and end users (402) • Accountability to public and institutions (403) • Accountability to end users and governments (402) • Processes, institutions and information should be accessible to understand and monitor health matters (403) • Three types: financial, performance and political/democratic (404) • To whom and for what (412) 	<ul style="list-style-type: none"> • Share of ODA with good M+E framework (408) • Answerability (413) and controllability (406) 	<ul style="list-style-type: none"> • Government accountability to DPs • Accountability mechanisms 	<ul style="list-style-type: none"> • Stakeholder perceptions of ability of DPs to hold the government accountable • Stakeholder perceptions of ability of the government to hold DPs accountable

Dimension	Policy Documents		Literature		Interviews	Proposed indicators
	Definition	Indicators	Definition	Indicators	Definition	
	<ul style="list-style-type: none"> • DPs accountable for delivering funding and technical support they commit (IHP+) 		<ul style="list-style-type: none"> • Mechanisms: reports and disclosure statements, performance assessments and evaluations, participation, self-regulation and social audits – tools vs. process (81) • Three dimensions: upward-downward, internal-external and functional-strategic (81) 			
How	<p>Performance assessment framework is transparent (IHP+)</p>	<ul style="list-style-type: none"> • Provide reports on budget execution, PER, GBS annual review, MKUKUTA implementation and JAST progress (JAST) 	<ul style="list-style-type: none"> • Decision-making progress and use of funds (170, 176-177) 	<ul style="list-style-type: none"> • Ease of access to agency's staff information and costs via website and email (409-410) • Whether DPs report info to DAC and CRS or other database (408-410) 		<ul style="list-style-type: none"> • Transparency in the use of resources of both DPs and the government

Dimension	Policy Documents		Literature		Interviews	Proposed indicators
	Definition	Indicators	Definition	Indicators	Definition	
		<ul style="list-style-type: none"> • DPs report disbursements to govt and non-state actors quarterly and these share info on their activities and resources with their constituents and the Govt (JAST) • Greater transparency in the use of external and domestic resources (Accra, Paris, Accra, TAS), including establishing aid management systems (Busan). 		<ul style="list-style-type: none"> • Quality (completeness) of data available (408, 411) • Whether a DP is member of the International Aid Transparency Initiative (IATI) (408) • Decisions and actions taken openly and information available to assess that relevant procedures are followed (406) 		

7.4 Discussion

This study has developed a framework based on the principles of the global aid effectiveness agenda to evaluate the Tanzanian SWAP based on a synthesis of international and national data sources and stakeholder views in country. This is the first attempt to provide measurable and locally specific indicators for measuring the implementation of the global aid effectiveness agenda (some efforts have been made on individual principles (351)). The set of indicators proposed here include a combination of quantitative and qualitative measures, based on data availability at the country level and local and global appropriateness. Some of the proposed indicators are novel, such as the ability of DPs to form a common front to measure harmonisation (based on country-level interviews) and fungibility as an indicator of ownership (based on the literature and interviews).

This research found that the five principles that constitute the global aid effectiveness agenda (ownership, alignment, harmonisation, managing for results and accountability) have been a consistent feature of international and national documents for some time. However, the way they are defined, measured and the relative weight that is placed upon them has changed. The principles have evolved and show an increasing recognition of the role of non-state actors. For instance, ownership was initially focused on the recipient government and was later expanded to include civil society. Similarly, accountability was defined as being mutual between DPs and country recipients in the Paris Declaration, whereas in the Busan Partnership the notion of accountability was extended to citizens of donor and recipient countries. Moreover, the weight given to the individual principles has also changed. For instance, managing for results was initially very important with a whole declaration devoted to it, but lost weight during the Rome and Paris Declarations, which placed more emphasis on harmonisation and ownership, but is back to being a key principle in the approach to development outlined in Busan. Conversely, the principle of

harmonisation was key in the Rome Declaration, was still important in Paris, but subsequently decreased in importance. The decline of harmonisation has been associated with efforts to attract non-DAC DPs to discussions (382).

This chapter has found that the definitions used for each principle in international and national declarations are often vague and have multiple dimensions. This is particularly the case with the principle of ownership, but also with managing for results and accountability, which may be due to the fact that they are abstract concepts and are therefore hard to define and measure. Sometimes the definitions and indicators of principles overlap, particularly between those that assess ownership and alignment.

Despite the multi-dimensional nature of some of the principles, indicators often only focus on one aspect of the principle. For instance, ownership is defined as recipient countries having a development strategy and leading dialogue structures, yet the focus of the indicator used in international declarations is only on the first aspect of the definition. When assessing managing for results, the indicator used from the Paris Declaration onwards only measures whether there is a results framework in place or the extent to which it is used by DPs, and not whether information is available to evaluate results, and if anything is done with the results of the evaluations.

Further, indicators tend to focus on the technocratic aspect of the definition, such as having structures/processes in place rather than whether these structures lead to the attainment of the principles (for instance joint assessment of performance to assess mutual accountability). This is further compounded by the fact that indicators in international declarations are quantitative in nature, which restricts their evaluation to elements that can be measured in this way (191) (although the Paris Declaration evaluation employed a thematic qualitative study (414)). The proposed indicators in this chapter expand those in declarations by not just assessing whether a process is in place, but by exploring whether

the process takes place and is found by those involved in it to contribute to its related principle. These indicators are more difficult to assess routinely, but a start could be to add open-ended questions to interviews and surveys used to evaluate aid effectiveness principles.

This study also found that the definitions and indicators used to measure the principles of the agenda varied across the different data sources used (national and international aid effectiveness policies, the literature and in-depth interviews with Tanzanian stakeholders); although this varied between different principles. For instance, international declarations and the literature focused their measurement of harmonisation on whether DPs had common arrangements and procedures, whereas for national-level stakeholders harmonisation was dependent on the extent to which DPs could form a common front when meeting with the government. The indicators also varied between global and national aid effectiveness policies, despite the JAST being based on the Paris Declaration. For instance, the JAST and TAS have more detailed indicators of accountability mechanisms than the Paris Declaration. Further, the indicators of the TAS were not easily measurable, as they were vague in nature and read more like a wish list. This has changed in the JAST, showing improvement in the design of national aid effectiveness policies. Further, with the change in language from aid to development in the Busan Partnership, it will also become important to understand what development means in different contexts and for different stakeholders (191).

Differences found between the global and national level show that one size does not fit all when it comes to aid effectiveness, neither for how the principles are defined or measured. This was also found by Sundewall et al., who assessed how ownership and coordination were understood in Bangladesh, Uganda and Zambia, and concluded that definitions varied between different participants and contexts (351). This means that perhaps having non-

specific definitions and indicators at the global level may be a good thing, if they are then interpreted and assessed nationally through locally relevant definitions and indicators. However, in a separate study Sundewall et al. found that differences in local interpretations of ownership and coordination did result in problems when disagreements in health sector management arose (347). The global agenda would therefore benefit from being more specific in certain respects, for instance by defining who makes up “national” ownership, what “results” means (input, outcome, output or impact), or, given that accountability has been expanded since Accra to include citizens, it would be helpful to develop an indicator to measure this at the global level.

The analytical framework developed in this chapter has some important weaknesses. The purpose was to adapt indicator frameworks available to assess the five principles of aid effectiveness to the Tanzanian health sector, rather than to develop a multi-component replicable index of aid effectiveness. Nevertheless, the indicator framework proposed in this chapter has some major shortcomings. No weight has been given to the different principles, the dimensions or indicators within them; in addition, although modifying the weights given to different components has been used to assess the robustness of multi-dimensional indices (415), this was not done here. Chapter 3 describes the steps taken to ensure validity and reliability of the qualitative part of the study. However, this could have been taken further to improve the robustness of the framework by testing criterion and construct validity (416) and by re-testing the indicators to check if the same result is obtained to assess the reproducibility of the framework (417).

Despite these shortcomings, the indicators developed as part of this study could be used elsewhere, especially those derived from the literature and international declarations; the others could be tested in other settings. However, the advice would be to always try to develop indicators that capture contextual factors and are relevant to the local

stakeholders. This may not always be feasible, in which case when doing evaluations of aid effectiveness, researchers should include open-ended questions for interviews and employ an inductive analysis to allow for themes to emerge, although this would of course increase the cost of and expertise needed to conduct evaluations. Having selected a set of indicators, it is also important to apply them to a real-life context. This is done in the next chapter to evaluate the extent to which the health SWAP has achieved aid effectiveness principles in Tanzania.

8 HAS THE TANZANIAN HEALTH SECTOR-WIDE APPROACH ACHIEVED THE PARIS DECLARATION?

This chapter addresses the fourth objective of the thesis and aims to complement the SWAP literature by assessing whether the Tanzanian health SWAP has achieved the five principles of the aid effectiveness agenda, using the set of indicators reviewed in Chapter 7. The chapter starts with a brief overview of the current state of the literature on SWAPS. It then provides an outline of the analytical framework used to assess each of the principle of aid effectiveness. This is followed by the results of applying the framework to each principle. The chapter ends with a discussion of the reasons for the findings observed, including whether these principles remain achievable and desirable as a means to improve aid effectiveness.

8.1 Introduction

The literature review in Chapter 2 reported that concerns about the effectiveness of aid have led the international community to develop the aid effectiveness agenda and to adopt a new aid management mechanism – the Sector-Wide Approach (SWAP). There has been a wide recognition that the functioning of the SWAP is dependent on the policy, institutional and economic environment in which it is implemented (418). Evaluations of the sector-wide approach in the health sector have therefore normally adopted a case study approach, either of a single or multiple countries. These studies have found mixed results, with Development Partners (DPs) increasingly integrated into budget processes, joint reviews and procedures successfully established, but highlighting concerns regarding low DP accountability, government leadership and the management complexity of the SWAP (204-206).

Despite these evaluations, there are concerns in the literature that the health SWAP remains under-studied (38, 205). If the SWAP is viewed as a vehicle to achieve aid

effectiveness, then one way to evaluate its implementation would be by using the aid effectiveness agenda itself as a framework (213). There has only been one previous study that has empirically done this in the recently-established health SWAP of the Solomon Islands (207). The study found that there had only been modest adherence to the Pacific Islands principles of aid effectiveness (based in the Paris Declaration), and cautioned against an approach that is too focused on processes and inputs (207).

There is now a need to evaluate whether a more established SWAP has attained the aid effectiveness agenda principles and whether the concerns highlighted in the Solomon Islands have been overcome. This chapter does this by applying the analytical framework developed in Chapter 7, based on the literature, the global and Tanzanian aid effectiveness agenda and the interpretation of national stakeholders, to assess each of the five aid effectiveness principles. The specific objectives are to assess whether the SWAP has led to: increased country ownership; the alignment of Development Assistance for Health (DAH) with government systems; harmonisation of DPs; an approach based on management for results and mutual accountability between the government and DPs.

Box 3: Key messages of Chapter 8

- There have been mixed results in the attainment of the different principles.
 - All actors in the health sector work under a unified sector strategy, but this does not guarantee country ownership
 - Initial progress towards alignment and pooling of funds was observed, but there are indications this is now reversing
 - There have been significant efforts towards harmonising an increasingly fragmented and diverse DAH architecture, although it is uncertain whether this has reduced transaction costs.
 - Performance assessment frameworks have been adopted, but concerns regarding data quality and the use of evidence in policy-making may undermine managing for results.
 - There has been limited progress towards mutual accountability.
- Generally, the indicators of international declarations, which have a technocratic focus, showed better progress than the indicators developed as part of this study, where broader definitions and the context are incorporated.
- When applied at the country level, the agenda was found to include contradicting principles and be hindered by institutional factors, such as DP dependency on headquarters and government capacity; but the SWAP remains feasible and desirable.
- There is fatigue and commitment to the SWAP approach has been declining. This may be improved if SWAP structures become more streamlined and government leadership is strengthened.
- Findings from this chapter highlight the importance of studying the institutional factors that may help understand these results.

8.2 Assessment framework

The Tanzanian health SWAP is made up of the following structures:

- Policy and expenditure framework
- Common funding mechanisms
- DP harmonisation mechanisms
- Performance assessment framework
- Policy dialogue for budgeting and accounting for financial resources

The indicator framework developed in Chapter 7 to assess aid effectiveness principles was applied to assess each of these structures of the SWAP. Table 8.1 below summarises for each aid effectiveness principle, the indicators used, the relevant SWAP mechanisms, and which quantitative and qualitative methods were used to measure indicators.

Table 8.1: Framework used to assess the attainment of aid effectiveness principles

Principle	Indicator	SWAP mechanism studied	Qualitative methods	Quantitative methods
Ownership	Existence of a health sector strategy and financial expenditure framework	Policy and expenditure framework Policy dialogue	<ul style="list-style-type: none"> • Non-participant observation • Document review • In-depth interviews 	N/A
	Stakeholder perceptions of national participation in the dialogue	SWAP and Health Basket Fund policy dialogue	<ul style="list-style-type: none"> • Non-participant observation • Document review • In-depth interviews 	
	Degree of national leadership in priority-setting of domestic and external resources	Policy dialogue	<ul style="list-style-type: none"> • In-depth interviews 	
	Trends in domestic and external health financing (fungibility)	Funding mechanisms	<ul style="list-style-type: none"> • In-depth interviews 	Analysis of domestic and external health expenditure
Alignment	Trends in the percentage of DAH going through the government	Funding mechanisms	<ul style="list-style-type: none"> • Document review 	Analysis of DAH flows
	Trends in the percentage of DAH delivered through the government that is in the form of basket fund and budget support	Funding mechanisms	<ul style="list-style-type: none"> • Document review 	Analysis of DAH flows
	Stakeholder perceptions of the drivers of trends in channel and modality of DAH delivery	N/A	<ul style="list-style-type: none"> • Document review • In-depth interviews 	
	Stakeholder perceptions of quality of government systems	N/A	<ul style="list-style-type: none"> • Document review • In-depth interviews 	

Principle	Indicator	SWAP mechanism studied	Qualitative methods	Quantitative methods
Harmonisation	Number of DPs	Funding mechanisms		Analysis of DAH flows
	Proportion of DPs accounting for less than 10% of DAH	Funding mechanisms		Analysis of DAH flows
	Number and average size of projects	Funding mechanisms		Analysis of DAH flows
	Stakeholder perceptions of the drivers and impact of fragmentation		• In-depth interviews	
	Stakeholder perception of functionality of common arrangements and procedures, including whether they improve the management of the sector and reduce fragmentation and lower transaction costs	DP harmonisation mechanisms	• In-depth interviews • Non-participant observation • Document review	
	Stakeholder perceptions of DPs' ability to have a common position	DP harmonisation mechanisms	• In-depth interviews • Non-participant observation	
Managing for results	Existence of a unified, comprehensive and usable performance assessment framework with monitorable indicators that is used by DPs	Performance assessment framework	• Document review • In-depth interviews • Non-participant observation	N/A
	Stakeholder perceptions of availability of quality information on results (outputs and outcomes) to assess health system performance	Performance assessment framework	• Document review • Non-participant observation • In-depth interviews	N/A
	Stakeholder perceptions of the use of results assessments in policy-making	Performance assessment framework	• In-depth interviews	N/A

Principle	Indicator	SWAP mechanism studied	Qualitative methods	Quantitative methods
Mutual accountability	Stakeholder perceptions of ability of DPs to hold the government accountable	SWAP and Health Basket Fund policy dialogue	<ul style="list-style-type: none"> • Non-participant obs • In-depth interviews • Document review 	N/A
	Stakeholder perceptions of ability of the government to hold DPs accountable	SWAP and Health Basket Fund policy dialogue	<ul style="list-style-type: none"> • Non-participant obs • In-depth interviews • Document review 	N/A
	Transparency in the use of resources of both DPs and the government	SWAP and Health Basket Fund policy dialogue	<ul style="list-style-type: none"> • Non-participant obs • In-depth interviews • Document review 	N/A

8.3 Results

The rest of this chapter reports on the results of this, and is structured by each principle of the aid effectiveness agenda: ownership, alignment, harmonisation, management for results and mutual accountability. This is followed by a brief account of stakeholder views on the aid effectiveness agenda.

8.3.1 Ownership

The principle of ownership was assessed according to the existence of a health sector strategy and financial expenditure framework, national participation and leadership of the dialogue and fungibility.

Existence of a health sector strategy and financial expenditure framework

An essential component of the SWAP is having a single policy and expenditure framework. In Tanzania these are known as the Health Sector Strategic Plan (HSSP) and the Medium Term Expenditure Framework (MTEF) respectively (see Chapter 5 for a description). The first HSSP was adopted in 1999 (and is now in its third version) and the first MTEF in 1999/2000 (419). All DPs interviewed stated they adhere to the health sector strategic plan; however, it has 11 strategies and 6 cross-cutting themes, and so encompasses most priorities. The MTEF was reported to guide discussions and the budget, and was seen by both DPs and the government as a vehicle for guaranteeing country ownership.

“Everything is done within the context of the MTEF, so I think there definitely is that ownership.” (Anonymous)

Stakeholder perceptions of national participation in the dialogue

When discussing national participation in the SWAP dialogue two themes came up: who participated (government and non-government) and how engaged the government was. For some DPs the SWAP dialogue was successful because it was led by the government and

had participation from all national agencies active in the health sector, including civil society.

“... in Tanzania, frankly speaking, (the SWAP dialogue) works. We have the civil society, we have the private sector, the faith based, the donor agencies, the UN. I mean all the people around the table ... And the ministries are chairing. So this works.” (DP)

When asked about their participation in the dialogue, a member of civil society explained that the government was initially reluctant to involve them, but this had improved over time.

“In the beginning it was a bit tough (for civil society) to be accepted ... There were instances where email addresses for civil society organizations went missing in the mailing list and therefore, you learned of an event after it had happened, but nowadays it is not like that ...” (Non-government)

However, participation of other non-government groups (including the private sector and other civil society organisations) in the SWAP dialogue is still weak and has some way to go.

One of the main concerns expressed by DPs in interviews and coordination meetings was a decline in government engagement in the formal dialogue process in recent years, with technical and financial meetings often happening late. This affected the budget process and resulted in DP frustration and the use of less inclusive mechanisms for engaging with the government, such as the basket fund meetings, where only the government and DPs are present.

“... the SWAP has not happened that well. It's rarely happened on time, so rather we tend to use informal mechanisms...” (DP)

When asked about why there had been a decline in government participation, respondents alluded to the structure of the SWAP dialogue, which, although inclusive and logical, is burdensome and consumes substantial amounts of government and DP time, particularly in

preparing for and attending meetings. Every year there are two SWAP and two Basket Fund Committee (BFC) meetings, 12 meetings for each Technical Working Group (TWG) and sub-groups and four BFC audit sub-committee meetings.

“I think probably the government thinks that the DPs are too hands on. Part of that, I think is because the architecture around the TC-SWAP⁵⁷ is extremely onerous ... it sort of turns the government off working with the DPs, because it seems to be so complicated ... And I question whether all that administration is a good use of the ministry’s resources.” (Non-government)

However, the key barrier for government participation in the dialogue mentioned by most stakeholders was its limited capacity, which, together with the demanding structure of the SWAP, resulted in low attendance at meetings by government officials, which in turn led to DP frustration and fatigue.

“But the big issue, I think, is just capacity. You get a sense of government just being overwhelmed by expectations of donors and donors frustrated with the government not delivering and it becomes a vicious cycle.” (DP)

This was not a unanimous view, however. One DP believed that limited government engagement in the dialogue on certain issues was a result of a lack of political willingness to participate rather than a lack of capacity.

“... when so many donors are involved in these discussions that string along for years and years with hardly any progress, and people are wondering whether it’s maybe something to do with capacity. Rubbish, it has nothing to do with capacity; it’s a clear indication that there is no desire to take that thing forward” (DP)

Some DPs also believed the reason for government disengagement with the dialogue was that they did not perceive it to be contributing to the management of the health sector, but saw it rather as an imposition from DPs.

⁵⁷ TC-SWAP: Technical Committee of the SWAP

“... my big issue is (the dialogue) is donor driven. We push for it. We push for meetings, ... and it feels like the government is often just responding to our needs as opposed to the government having a dialogue in place to serve their purpose which should be the point...” (DP)

Moreover, this DP also felt that the government viewed the SWAP dialogue as *“something that is getting in their way or a nuisance to them”*, rather than a useful mechanism.

Degree of national leadership in priority-setting of domestic and external resources

This section explores national leadership in priority-setting within the main two government-DP dialogues: the SWAP and the Health Basket Fund (HBF) dialogue. By definition, the Technical Committee of the SWAP and the TWGs are led by the government. In-depth interviews with government representatives showed that they felt the government had ownership of its priority-setting process, as it first set its priorities and then looked for assistance. At the end of negotiations with the government as part of the Joint Annual Health Sector Review (JAHSR), DPs reported that most actors were successful in getting their priorities onto the agenda, which suggests that rather than a negotiation, the dialogue resulted in an expanded list of priorities.

“I mean, everybody just wanted to be at the table. That’s, I think, how it ended up with how many (milestones)? twenty? Thirty?” (DP)

Overall, respondents believed the dialogue was DP-driven; however, some DPs perceived it not to be the real forum for decision-making, with some important decisions being taken by the government behind closed doors.

“Well I think it’s something that’s more secret and in house, isn’t it? I don’t think they seek to make the decisions in committees with large numbers of donor personnel there trying to influence the discussion.” (DP)

The HBF dialogue was perceived to be of better quality. Early Tanzania SWAP documents show tensions between the priorities for the health basket fund between the government,

who wanted these resources to remain at the central level (and fund tertiary care) and DPs, who favoured the strengthening of local primary health care (310). This was also recounted by some of the DPs who had been in the country for a longer period of time.

“... the initial requests from – in terms of the basket fund was on tertiary care, and blood transfusion, and out-of-country medical treatment, and we said, ‘Hold on. We’re interested first and foremost in providing basic services to the population.’”

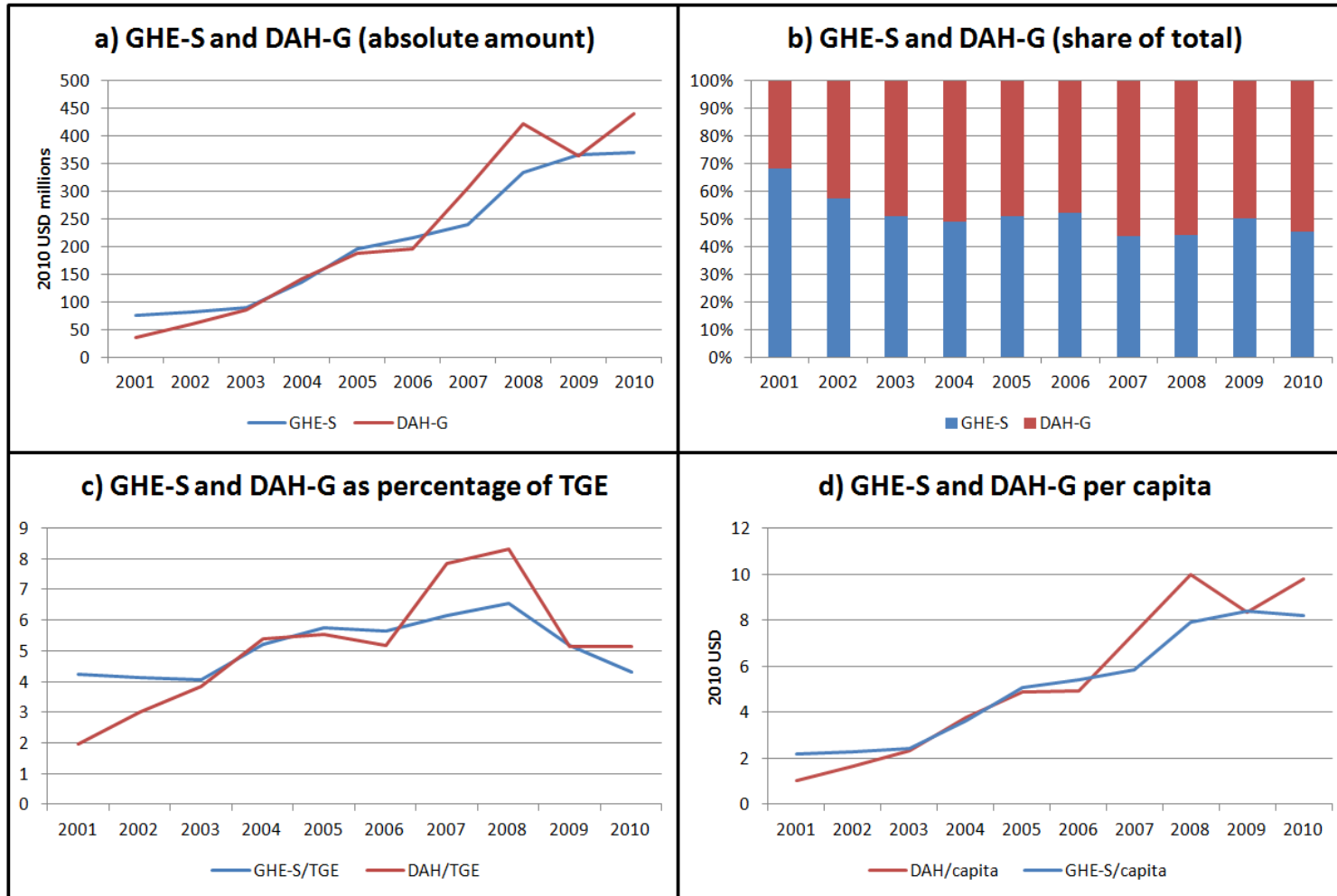
(DP)

The issue of de-centralisation was still under discussion during health basket negotiations. However, when describing the basket fund dialogue, both government and DP representatives currently involved in the dialogue reported being satisfied with the priority-setting process and the balance of power in negotiations, even when government and DPs had different priorities, with a basket DP describing that DPs *“compromise where we need to, and the government stands its ground if we’re being ridiculous”*.

Fungibility

Fungibility was assessed by exploring trends in health financing. Figure 8.1 below shows trends in health expenditure channelled through the government (as an agent), both domestic expenditure (Government Health Expenditure as a source (GHE-S)) and external funding (Development Assistance for Health delivered through the government (DAH-G)). These are shown as absolutes and as percentages of government expenditure on health (Figures 8.1a and 8.1b), as percentages of Total Government Expenditure (TGE) (Figure 8.1c) and as expenditure per capita (Figure 8.1d).

Figure 8.1: Trends in GHE-S and DAH-G financing in Tanzania in the time period of 2001-2010



Figures 8.1a and 8.1d show that both domestic and external sources of government expenditure on health have increased during the time period of observation. From the time period of 2001 to 2006 domestic expenditure was consistently higher than external expenditure; however, with the exception of 2009, between 2006 and 2010 there was a greater increase in DAH, which surpassed domestic expenditure. DAH-G represents a growing share of government expenditure on health increasing from 25% in 2001 to 50% or more from 2007 (Figure 8.1b). When examining GHE-S and DAH-G as a proportion of total government expenditure (Figure 8.1c), DAH-G increased steadily between 2001 and 2008, before decreasing again. Up to 2007 GHE-S represented a higher percentage of TGE, but since 2007 DAH-G has made up a higher proportion. Notably, in both cases the percentage has decreased since 2008 (probably due to increases in total government expenditure). These results therefore show that DAH-G has overall experienced higher rates of growth than GHE-S.

When asked about whether fungibility was taking place, DPs and non-government stakeholders believed it was happening because as a share of total government expenditure, government expenditure on health as a source had decreased.

“... (the government) share of the total (government expenditure) has been going down. The general response from finance is that in relatively good economic growth that the overall government budget is going up, therefore you’re getting a smaller share of a growing budget. Certainly that’s true, but that is not the idea. I mean the idea was the Abuja target.” (DP)

Equally, when asked about resource allocation at the health sub-sector level, DPs and other non-government actors believed fungibility was taking place, particularly with the basket fund and drug expenditures.

“All the time, of course. That’s how it is. All the money you provide to the health sector, I mean, the government takes it out in the other end.” (Non-government)

However, government stakeholders did not agree. They reported that domestic expenditure on health has increased steadily over the last few years. When probed, government respondents thought it was rational for the government to spend their money on things other than those funded by the health basket. This view was supported by some DPs, who acknowledged why the government may choose to reduce its share of health sector funding.

“So if it’s a zero sum game because you do have limited resources, if you have funds that are coming in, is it a poor choice then to switch your attention to fund the other thing? And if I’m playing devil’s advocate I would say that’s a smart thing to do...” (DP)

The reduction in domestic expenditure on health could also be interpreted as the government exercising ownership of its health budget and expenditure, by deciding how much to allocate to the different (sector and sub-sector) priorities and re-adjusting its expenditure accordingly following the commitment or disbursement of external funds.

8.3.2 Alignment

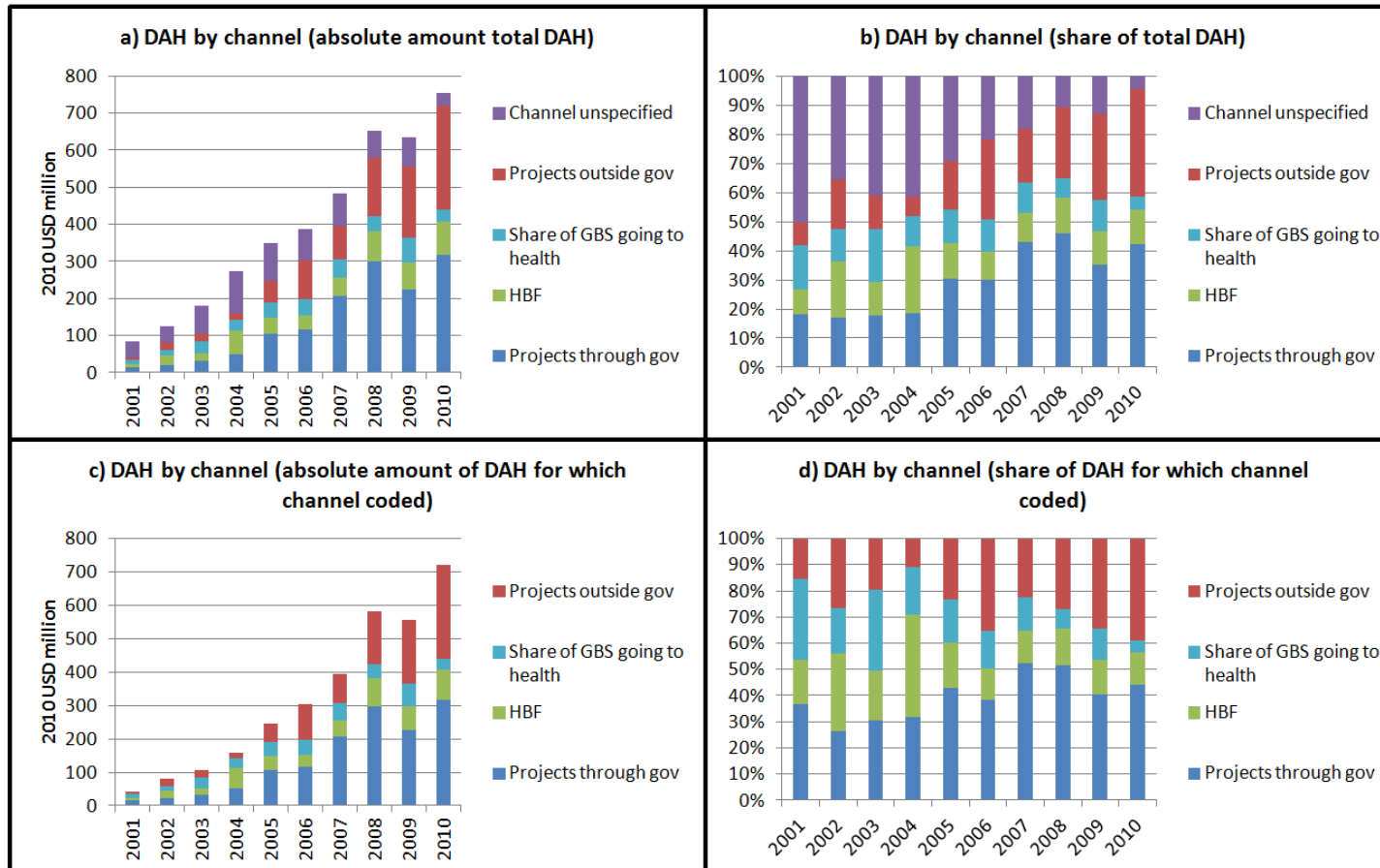
The principle of alignment was assessed by measuring the use of country systems and by exploring the capacity of the government system.

Use of country systems

Three indicators were used to assess the use of country systems: trends in percentage of DAH going through the government, trends in the proportion of DAH delivered through the government that is in the form of basket fund and budget support (pooled DAH) and stakeholder perceptions of the drivers of trends in channel and modality of DAH delivery. Figure 8.2 below shows trends in funding instruments through which DAH is delivered over the time period 2000-2010. The graphs show expenditure in real terms (8.2a and 8.2c) and as a proportion of total DAH (8.2b and 8.2d). Graphs 8.2a and 8.2b include DAH funds for

which the channel could not be coded (purple bars), whereas Graphs 8.2c and 8.2d only show trends in DAH channel for DAH disbursements for which the channel could be coded.

Figure 8.2: Funding modality used to deliver development assistance for health in the time period 2001-2010⁵⁸



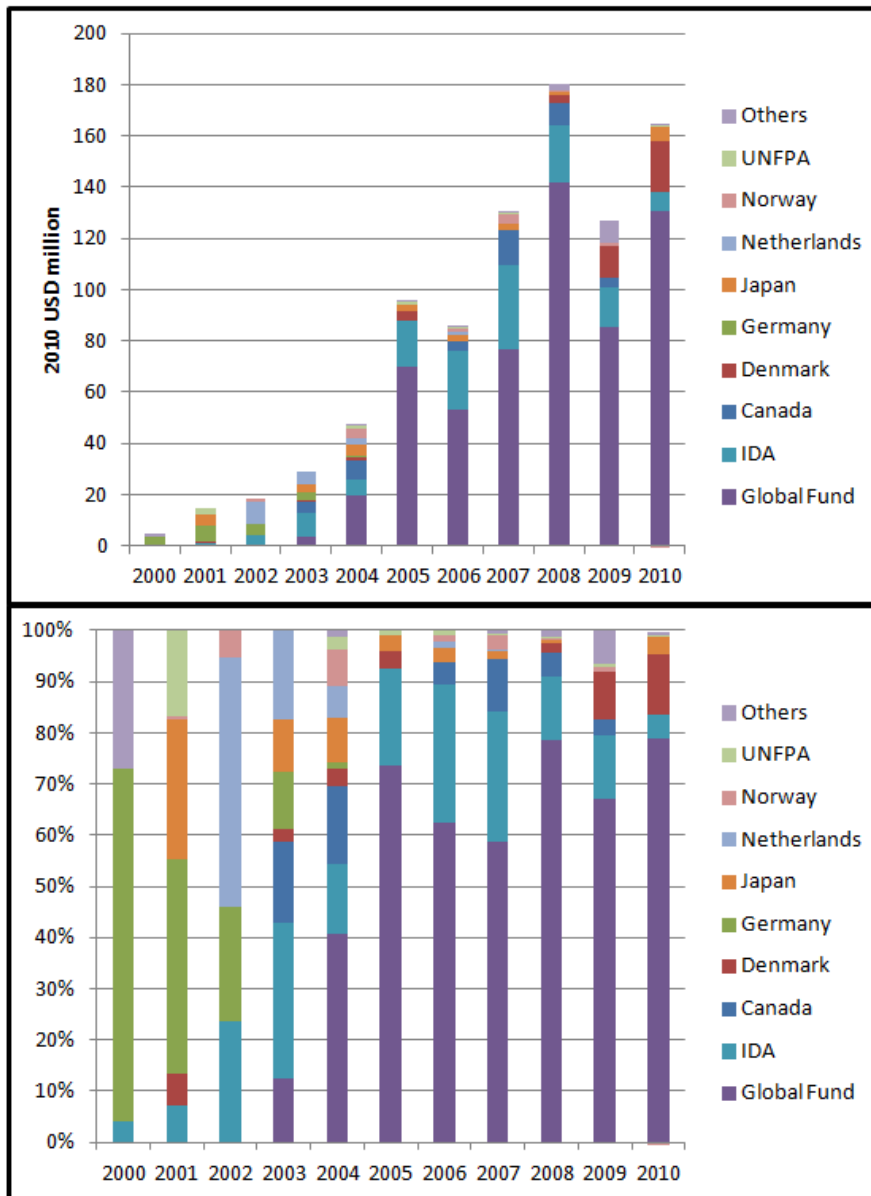
⁵⁸ HBF shows DAH funds delivered as health basket funding. Projects are discrete, earmarked interventions, which can either be delivered through the government or a parallel system. The share of GBS going to health was calculated in Chapter 6 based on the proportion of government expenditure that is spent on health.

Looking at the purple bars first, they show that the amount (and proportion) of DAH flows for which the channel could not be specified represent a larger share of total DAH between 2000-2004, making it difficult to draw firm conclusions for these years. Of the DAH that could be coded, the green (health basket), dark blue (projects through the government) and light-blue (proportion of General Budget Support (GBS) allocated to the health sector) bars represent the external funds going through the government system. Absolute amounts of these funds show an increasing trend, peaking in 2008 (Figures 8.2a and 8.2c). As a proportion of total DAH, funds channelled through the government fluctuated between 40-60% of total DAH (Figure 8.2b). However, as a proportion of DAH funds for which the channel could be coded, DAH channelled through the government represent 77% of the total in 2005 (previous years are too inaccurate); they decrease in 2006, before going up again in 2007. From 2007 to 2010 they represent a decreasing share of DAH, accounting for 61% in 2010 (Figure 8.2d).

Increases in funds channelled through government systems have mainly been in the form of project funding. Project funding is the dominant lending modality going from under 20% in 2000 to about 70% of all DAH in 2010 (both through and outside of the government) (Figure 8.2b). In contrast, basket funding and budget support fluctuated between 20-30% between 2001 and 2009, before decreasing to 16% in 2010 (Figure 8.2b). This decrease is even greater if DAH funds for which the channel of delivery could not be coded are not taken into account (Figure 8.2d). In real terms, however, the basket fund increased from \$7 million to \$90 million between 2001-2010 and GBS going to health went from an estimated \$13 million to \$67 million between 2001 and 2009, before decreasing again to \$34 million 2010 (this is a reflection of both GBS trends stabilising after 2005 and the share of TGE that is spent on health decreasing post 2008).

Figure 8.3 below explores channel of delivery further by showing the levels of DAH and percentage share channelled through the government by each DP. It shows most of DAH that is channelled through the government is provided by the Global Fund and the World Bank through its International Development Association (IDA), who together have made up 80-90% of DAH delivered through the government since 2005, followed by Canada and European DPs. The US was the biggest DP disbursing outside of the government, disbursing \$239 million in 2010, representing 68% of DAH funds channelled outside of the government (data not shown).

Figure 8.3: DAH channelled through the government by DP in real terms and as a proportion of total DAH



The table below explores DAH funds in more detail by describing trends in the proportion of DAH that is delivered through the government (including and excluding funds for which the channel could not be specified) and in pooled funds as a proportion of all DAH going through the government.

Table 8.2: Proportion of DAH that is delivered through the government and in pooled funds.

Year	A Proportion of DAH delivered through the government (DAH-G) (out of total DAH)	B Proportion of DAH delivered through the government (DAH-G) (out of DAH for which channel could be coded)	C Proportion of DAH-G that is pooled ⁵⁹
2001	42.0	84.4	56.5
2002	47.5	73.44	64.1
2003	47.4	80.6	62.4
2004	52.1	89.1	64.6
2005	54.3	76.5	44.0
2006	50.7	64.8	40.5
2007	63.5	77.6	32.4
2008	65.0	72.9	29.4
2009	57.3	65.7	38.3
2010	58.5	61.1	28.1

If DAH funds with channel blanks are taken into account (Column A), then the proportion of funds going through the government has increased from 42% to 59% of all DAH between 2001 and 2010. However, if only DAH for which a channel could be specified is taken into account (Column B), then the proportion of funds going through the government has decreased from over 84% to 61%. The proportion of funds that can be coded has increased substantially in later years, explaining why the two columns are more similar in these years. Whether the proportion going through the government has decreased or stayed constant would depend on where the coding was least accurate. The US makes up a large percentage of the funds that could not be coded, and US funds are not usually disbursed through the government (although sometimes they are through delegated cooperation). This would suggest that at least some of the non-coded projects are delivered outside the government, and therefore the proportion of DAH going through the government may have stayed constant. Finally, the proportion of DAH that was delivered to the government in the form of pooled funds (GBS to health and HBF) has steadily decreased from 57% in 2000 to 28% in 2010. In reality, we saw that both project and pooled funding modalities

⁵⁹ DAH-G includes projects that could be coded as projects delivered through the government, health basket fund and GBS going to health (therefore figures in Column C represent projects for which the channel was specified)

have experienced significant growth in absolute terms in the time period of 2001-2010 (Figure 8.2). However, despite DPs adopting GBS and HBF modalities in Tanzania, project funding still exceeds horizontal funding as a share of total DAH and in absolute terms.

Discussions on the choice of modalities during in-depth interviews shed some light on these trends. They revealed that new (pooled) modalities and alignment to country systems were first met with great enthusiasm and high expectations by DPs. As a consequence, DPs initially switched from project modalities with parallel systems to approaches that relied more on the government's public financial management and procurement systems. However, the trend has since been reversing back to projects. There are several reasons for this. First, DPs expected results from pooled funds very quickly.

"There was too much change of approach too sudden ... I think the failure has been always to throw away the existing old fashioned work modalities, collaboration modalities, because we find that something new should be there ... you can't throw away parallel systems from one day to the other." (Non-government)

Second, limited government capacity meant that projects had to continue. A DP who delivered DAH using both projects (through and outside the government) and basket funds reported that given the increasing amounts of DAH they were delivering, they had to find a balance between the basket and projects, which they did based on what they believed was the government's capacity to manage the increasing amounts of funds.

"... it's finding a balance between the government's capacity at any given time and working toward increasing the government's capacity, but balancing that with making sure that services that need to get delivered now get delivered." (DP)

Third, DPs were under increasing pressure to show results, which is easier to do through projects than investing in the health basket or institutional reform. A multi-lateral DP described this shift as countries needing to *"attribute (money) to results"*, particularly in *"such hard economic times they can't make a strong case to justify it"*.

Fourth, trends in funding modalities in the past decade, ranging from very earmarked to un-marked budget support (and back), have been attributed to peer pressure and the influence of international aid effectiveness declarations. A DP described it in this way:

“... when I arrived we were at the peak of joint assistance strategy to Tanzania, the so-called JAST. It was the aftermath of Paris, and we had Accra, and then we got Busan and there was a group of development partners who were very strongly advocating for GBS, with (DP X) moving out of even sector budget support⁶⁰ and all to GBS. And it was a very strong peer-pressure to go away from projects and even sector budget support. And everybody thought we had found the Holy Grail, but I think now the people are a little bit more critical and realise that it's not that easy. And now we see another move moving away from GBS, sector budget support and back to projects, and putting the flag...” (DP)

Finally, the switch from projects to pooled funds and budget support and working under a SWAP was associated with DPs losing some control of their funds in return for participating in the policy dialogue. However, disappointment with government participation in the policy dialogue was also seen to be contributing to the move back to projects by some DPs.

“I used to hate the vertical programs, because I thought they were capacity destroying and external and sort of anti-developmental, and I was in favour of providing financial support and having discussions about policy and things, ... there aren't really any policies, or there's not any willingness to have a discussion about them anyway. ... Then maybe it's not a good idea to just pour money into that.” (DP)

Central government respondents also confirmed that pooled modalities were in decline and project ones were again on the rise. However, they did not express a view about the decline. The government has stated its preference for budget support in the JAST, where it clearly details the specific conditions whereby aid can be delivered through project-based modalities (pilots, emergency funding and large infrastructure programmes). Further, local

⁶⁰ DAH to Tanzania has never been disbursed as sector budget support. It is assumed therefore that this respondent refers here to the basket fund

government respondents reported being “100% dependent” on the basket fund for undertaking supervisory visits and buying supplies.

Quality of country system

Broadly, DPs were concerned that the government lacked capacity to allocate and manage its financial resources, including the “ability to prioritize, or ability to disburse against, to even move the money”, particularly at the local level. Respondents from all institutions, not only DPs, felt that there had been insufficient efforts from the government and DPs to strengthen or reform health financial management and procurement systems, and this had limited the ability to align development assistance. For instance, a non-government stakeholder reported that they were still fighting “the same shortcomings that we were facing in the 90s”, including “severe delays and not being able to carry out the work we set out to do because we can’t get the money”.

However, government respondents felt some aspects of capacity had improved over the last few years, particularly the capacity of regional managers to coordinate activities and provide support to the local level.

Many DPs and some non-government respondents believed that rather than invest in capacity development, by delivering their funds through the system it would automatically improve, and now, disappointed with the lack of results they were moving away from channelling money through government systems.

“So everyone started with, ‘Okay, let’s put all of our money into the government systems and hope that it functions.’ I don’t think there was enough effort at the upfront ... into building the capacity of the government systems ... So I think after 8-10 years of that, people are realizing, ‘Well the system didn’t really deliver on us. We’re worried about corruption, we’re worried about accountability ... And we haven’t seen an evolution or a strengthening in the government systems.’ Whereas, we needed to invest in those things. ... And so we’re now kind of abandoning it...”
(DP)

Not all DPs were as pessimistic, however, with some recognising the problem and increasing their investment in the government systems to improve their capacity, and others, such as one DP interviewed, acknowledged that although lack of capacity led to *“a lot of issues in terms of financial management, procurement, monitoring evaluation”*, they still *“very much use country systems”* to disburse funds.

8.3.3 Harmonisation

The principle of harmonisation was assessed by analysing trends in fragmentation and exploring the success of DP coordination mechanisms.

Fragmentation

Fragmentation was assessed by calculating the number of DPs, the proportion of DPs that account for less than 10% of DAH, the number and average size of DP funded projects, and through in-depth interviews. Table 8.3 shows trends in the number of DPs present in the Tanzanian health sector, the number and size of projects, and the effect of the basket fund on these indicators.

Table 8.3: Trends in DAH fragmentation and impact of the health basket fund on these⁶¹

Year	A	B	C	D	E	F	G	H
	Total DAH (2010 USD million)	No of DPs in health sector	No and % of all DPs accounting for less than 10% of DAH	No of projects	% DAH could not allocate to a project	Average project size (USD 2010 million)	% decrease in proportion of DPs accounting for less than 10% of DAH with HBF	% increase in average size of project with HBF
2000	36.3	19	10 (52.6)	55	2.3	0.63	40.0	31.0
2001	96.3	22	16 (72.7)	88	37.5	0.81	56.3	11.0
2002	157.2	23	17 (73.9)	167	5.2	0.67	41.2	27.6
2003	175.5	26	22 (84.6)	108	44.9	1.37	50.0	16.1
2004	420.6	27	22 (81.5)	143	36.3	1.70	50.0	34.7
2005	319.1	26	20 (76.9)	117	19.6	2.63	35.0	16.1
2006	733.9	27	21 (77.8)	228	12.4	1.51	28.6	11.7
2007	669.8	28	25 (89.3)	311	6.2	1.39	36.0	12.6
2008	631.6	29	27 (93.1)	343	1.1	1.74	29.6	15.8
2009	548.7	29	27 (93.1)	384	0.6	1.48	29.6	14.8
2010	716.7	33	29 (87.9)	334	1.3	2.15	24.1	14.2

Table 8.3 shows that the number of DPs delivering DAH to Tanzania has increased from 19 in 2000 to 33 in 2010. The percentage of DPs accounting for less than 10% of DAH has also increased considerably (from 53-88%) meaning DAH has become more fragmented. The number of projects (Column D) has increased from 55 in 2000 to 334 in 2010. This by itself does not mean an increase in fragmentation as the overall amount of DAH has also experienced a big surge (Column A). Average project size is a better measure of fragmentation, as it accounts for increases in DAH. Average project size initially increased during the time period, meaning that DAH was becoming more concentrated, but between 2005 and 2009 this trend was reversed. Average project size increased again in 2010. The proportion of funds that could not be allocated to a project was particularly high for the

⁶¹ GBS is excluded from this because it is managed with the rest of government funds. Columns A-F include the basket fund

years 2001, 2003 and 2004 (Column E), meaning the number of projects would be underestimated for those years, and the average size of project over-estimated.

One could argue that one of the objectives of the basket is to reduce fragmentation levels, by decreasing the proportion of DPs accounting for less than 10% and increasing average project size. Columns G and H of Table 8.3 test this by showing the difference the basket fund has made to these measures of fragmentation. Including the basket fund in calculations resulted in a 40% decrease in the proportion of DPs accounting for less than 10% of DAH in 2000. However, the basket fund effect reduced over time, and only resulted in a decrease of about 20% in 2010. Similarly, the introduction of the basket increased the average size of projects by 31% in 2000, it fluctuated between 11% and 34% between 2001 and 2004, after which it decreased steadily until 2010, when it decreased project size by 14%. This shows that the basket has had some effect in decreasing fragmentation; however the effect has decreased over time (linked with the increase in project-based DAH over the time period). The basket did not make an important difference to the number of projects. This is because all DPs who participated in the basket also provided DAH through other modalities.

Overall, total DAH has increased, but it has also become more fragmented (despite some of this fragmentation being off-set by the introduction of the basket fund). To try and better understand the reason for increased fragmentation, we examined the number of projects and average project size by sub-sector priority and for each DP (Figure 8.4). Graphs 8.4a and 8.4b show the number and average size of projects by sub-sector distribution and graphs 8.4c and 8.4d by DP.

Until 2005 the number of projects was similar across sub-sector priorities, except for malaria, for which there were less than ten projects active per year prior to 2005 (and only increased to 22 by 2010). However, the number of HIV/AIDS projects (dark blue line)

increased from 6 in 2000 to 77 in 2010. The HIV/AIDS average project size also increased from \$0.95 million in 2000 to \$5 million in 2009 before decreasing again to \$4.7 million in 2010. The sub-sector priority with the second highest number of projects is diagonal health systems funding, with 70 projects in 2010. The average size of health systems projects also increased from \$0.5 million in 2000 to \$2 million in 2010. Similarly, the number of projects for RMNCH rose exponentially from 6 in 2000 to 59 in 2010; however, the average project size remained constant at around \$0.6 million during the same time period. Therefore although HIV/AIDS had the highest number of projects, it also had the biggest projects, whereas health systems projects were smaller (but also high). Conversely RMNCH had the lowest average project size, and was therefore the most fragmented. Malaria was the least fragmented priority, with the lower number of projects but also high average size (\$4.3 million in 2010). The un-coded projects also show high degree of fragmentation; however, it is not possible to say to which sub-sector priority they belong to (or indeed whether they come from one or multiple priorities).

In terms of DPs, most DPs had fewer than 15 projects active per year prior to 2006. From 2006 Germany, Canada, the US and Norway substantially increased the number of projects they fund. Conversely, with the exception of the US, these DPs do not fund the largest projects. The Global Fund and the World Bank (IDA) having the largest average project size (\$14.2 million and \$15.7 million respectively in 2010), followed by the US. This would suggest that bi-lateral DPs focusing on health systems funding are the most fragmented. Paradoxically, these DPs are also important contributors to the basket fund.

Stakeholders were aware of the high levels of fragmentation in the health sector. When discussing the reasons for fragmentation trends, DPs believed that health attracted DPs because it was viewed as an important sector to be involved in. For instance, a respondent described how a DP had left the health sector because *“they didn’t need a thirteenth donor*

in the health sector". However, this DP had now come back to the health sector because *"health's important, so you have to be involved"*.

In addition, DPs agreed that fragmentation levels had reduced with the SWAP approach, but this trend was now reversing.

"[fragmentation]'s gotten better but there are concerns that it's gone backwards and that it's going to start reversing the trend." (DP)

This indicates that fragmentation levels can also be explained by some of the issues raised by stakeholders under alignment, particularly with regard to trends in modalities and a move back to project funding.

In-depth interviews also revealed that DPs were worried about the level of fragmentation, and that it has had an impact on the quality of the dialogue.

"... there are so many activities and initiatives and implementing agencies that the dialogue often remains very general and at a higher level we are not able because of the multitude of actors to coordinate all activities very well yet." (DP)

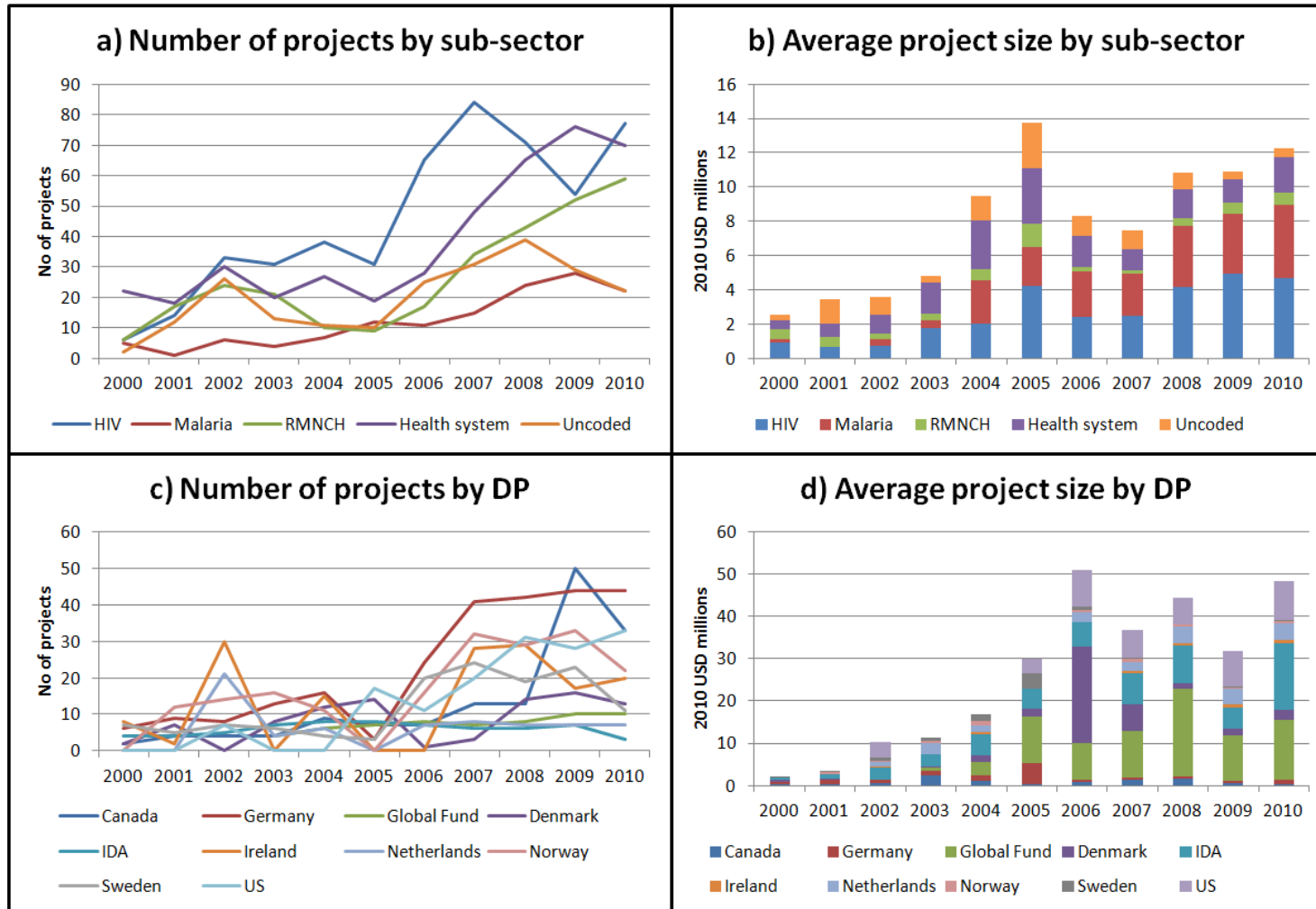
However, not everyone agreed fragmentation was necessarily bad. Some non-government actors did not think it was a big issue, and one DP actually thought fragmentation benefited the health sector dialogue because it helped get attention from the government.

"... there's a more active dialogue in health than there is in some other sectors I think, like education, ... perhaps because there's more donors, or perhaps there's more projects, or for whatever reason, there's a bit more substance in the discussions between donors and government in the health sector I think." (DP)

In summary, quantitative measures show fragmentation has increased, both as the number of DPs active in the health sector, the number and size of projects they fund. Results from in-depth interviews suggest health is viewed as an important sector to be involved in, and that although fragmentation levels hinder the dialogue and increase the need for coordination, they may also result in the government paying more attention to the health

sector. The next section explores the ability of the SWAP to coordinate all the actors and initiatives active in the health sector.

Figure 8.4: Number and average size of project by DP and sub-sector allocation



Common arrangements and procedures

A significant challenge for the SWAP is to coordinate such an amount of diverse DPs, initiatives and priorities. To address this, different DP coordination mechanisms have been set up. All DPs coordinate their activities through the Development Partner Group for Health (DPG-H), which is led by a Troika of three DPs who communicate with the government through regular meetings on behalf of the whole group. In addition, DPs providing DAH in the form of basket funds coordinate through the basket fund committee. Finally, DPs who provide DAH in the form of vertical projects coordinate through the use of delegated cooperation (providing DAH through other DPs to reduce burden on the government) and engage with the government through the SWAP Technical Working Groups.

The success of these forums was assessed according to the degree to which DPs had harmonised arrangements and procedures for planning and reporting for the use of DAH resources, the extent to which stakeholders perceived these had lowered the transaction costs of aid and the degree to which DPs have a common voice when meeting the government (next section). Arrangements and procedures here refer to: division of labour so that DPs are not doing similar work in the same region; increasing information-sharing among DPs; reducing or carrying out joint field missions; and relying on SWAP procedures, rather than their own evaluations, for reporting.

The evidence from in-depth interviews suggests that some aspects improved and others did not. Overall, DPs and government valued DP coordination forums, which were seen as harmonising planning, reporting and facilitating information sharing amongst DPs. The government felt that DPs had harmonised their reporting requirements, which was an improvement from previous years.

“... definitely I think (the DPG-H) is very good in terms of information sharing and coordination.” (Anonymous)

However, some DPs felt planning was only done at a superficial level, and there was need for more detailed planning at the national and district levels, with increasing information shared about what each DP was doing where, in order to avoid duplication of efforts on some priorities and neglecting others (thereby improving division of labour).

“... we don't have a clear overview, who is doing what. It's more the very broad, large categories that we talk about priorities not so much in terms of implementation or practical support. I'm sure if we would (look into who is working on what and where) we would see many clusters ... and other areas are fully neglected.” (DP)

Reporting was supposed to be harmonised under the SWAP, with DPs relying on joint reviews for assessment of their programmes and avoiding “backdoor” meetings with the government (313). Some DPs certainly did so, but government representatives reported that some DPs required separate reporting for their projects, which were very time-consuming for the government.

In terms of overall transaction costs, the view of most DPs was that coordination structures had increased rather than lowered transaction costs; although they still valued them as worthwhile exercises. In particular, DPs regarded coordination structures as successful in reducing DAH fragmentation,

“... the coordinating mechanisms that we have help to reduce fragmentation. We have development partners group, I think having the health basket also helps reduce fragmentation. If you had eleven partners each trying to spend their portion of \$100 million a year separately it would be a disaster.” (DP)

On the other hand, other DPs believed the SWAP has reduced the burden of development assistance, for instance by reducing the number of field missions, but suggested the parallel increase in funding makes it difficult to see the effect of the SWAP:

"I would like to see the counterfactual, ... the number of health missions might have stayed the same ... but the amount of donor funding probably has quadrupled, and you might have had 2000 missions by now per year if it wasn't for the SWAP." (DP)

When asked about how DP coordination could be improved, some DPs believed that the government would need to show stronger leadership and demand greater DP coordination. For instance, one DP felt that DPs would coordinate better if the government said:

"Development partners, I want one annual planning and this planning session I want to know what is your investment, on which activity, package, and where in the country are you doing this." (DP)

Nonetheless, most respondents thought problems with harmonisation of DAH were a result of DP agencies delivering DAH in the form of vertical, single disease projects, and increasing levels of fragmentation.

"... one thing, which has also undermined a little bit this Paris agenda is the fact that we had on the one hand the agencies playing by the harmonisation and alignment rules and we still had apart from that these huge resources coming in and distorting the system focusing on certain specific issues like HIV/AIDS, TB, malaria, immunisation..." (DP)

Another DP supported this view, and attributed the high burden of DAH in terms of field visits and reporting requirements to agencies providing vertical funds:

"... a lot of ... missions to the country (are) based on specific projects ... here in Tanzania the huge bulk of funding is coming from the Global Fund and from the PEPFAR, so I guess it depends very much what their standards are in terms of missions, reporting, monitoring, follow up and so on." (DP)

When interviewed, a representative of a DP agency that delivers DAH in the form of vertical programmes acknowledged the problems of having separate structures and being highly fragmented, but also defended their approach indicating that projects were discussed as

part of the SWAP technical working groups, thereby minimising the burden they caused on the government:

“... the discussion comes with a broader participation and development of the strategic plans for the sector, and then you may have some further discussion within the TWG to clarify ... it’s more of a management burden on us as well to run these other things.” (DP)

This suggests that although the number of projects has increased, SWAP structures have allowed for more efficient coordination.

In contrast, vertical agencies and programmes were seen as having undermined DP harmonisation by creating separate coordination and dialogue structures. For instance, the Global Fund has its own country coordinating mechanism (the Tanzania National Coordination Mechanism or TNCM⁶²) and there is a separate HIV/AIDS development partner group (DPG-AIDS⁶³) and dialogue with the government. A DP described the Global Fund’s coordinating mechanism as being *“very active and very functional but not so much integrated into the health sector dialogue”*.

The separate HIV/AIDS dialogue was created due to the initial multi-sectoral nature of the response to HIV/AIDS. However, despite most HIV/AIDS activities now falling within the health sector and representing a significant proportion of health sector funding, the HIV/AIDS dialogue has remained outside the health sector. Representatives from the Global Fund, DPG-AIDS and DGP-H do sit in each and update each other’s forums, but there is no coordination or agreement on policies between the different coordination or dialogue structures. Efforts to bring the two dialogues together have had some success in DP coordination mechanisms, but have been met with some government resistance.

⁶² The TNCM was established in 2002 and although members vary from year to year, it is made up of government departments, DPs, civil society and private sector agencies.

⁶³ DPG-AIDS was set up in 2000 and is made up of all DPs providing HIV/AIDS funds

“... because the government sees the Global Fund dialogue structure and says, ‘That’s enough. How much more do you really want us to talk about HIV and AIDS in the Global Fund?’” (DP)

In addition, integration is also hindered by the fact that the health and HIV/AIDS dialogues fall under different ministries. The HIV/AIDS dialogue is led by the Tanzania Commission for AIDS (TACAIDS), which falls under the Prime Minister’s Office, whereas the health dialogue is led by the Ministry of Health.

Agencies delivering funds through vertical programmes have reacted to criticisms and, faced with similar problems when working with the government and coordinating their resources as the other agencies, are now becoming more engaged with the health dialogue, something which led to a certain degree of frustration amongst DPs who had been involved in coordination structures for some time:

“I’m afraid it’s a little bit late... (vertical DPs) now come close because they are under pressure, they realise they face fiduciary risk and accountability issues, which are the same we face, and we have a lot of experience on that so suddenly they say ‘hey hey we’re interested to work with you’... ah! finally!” (DP)

This would suggest that although agencies, such as the Global Fund, look more integrated into the government system by delivering their funds through the government, they may actually place a higher burden on the government as they function outside of SWAP coordination mechanisms.

Speaking in “one voice”

Most respondents perceived the main objective of DP coordination mechanisms was to facilitate DPs having a common front when engaging with the government. Early SWAP documents describe tensions between DPs who adopted the basket fund and those who did not, as the former were seen as having more access to the government and could negotiate more than DPs that did not join the basket (310). Such tensions were not found

in this study. When describing DP coordination meetings, some respondents considered these mechanisms were successful at unifying DP's position despite their different and often conflicting priorities, with some DPs being directive, wanting to *"really drive a priority"*, and others preferring government to lead. A non-government respondent reported DPs having improved their ability to speak in one voice.

"(DPs) are quite good at working out a common line between them, we get spared a lot of that debate. Obviously they do have different views, but I think they are better at being, you know, speaking with one voice." (Non-government)

However, some DPs acknowledged having difficulties arriving at the common position, which they described as a reluctantly accepted position, rather than *"once voice"*. Further, a non-government attendee of SWAP dialogue meetings reported the common position easily disintegrated once DPs arrived at the meeting.

"... they are supposed to act as one group with one voice, but that has not usually been the case. Although they would meet, for example, before the official meeting with the government and others, ... during the meeting you will still see that they have not totally agreed with the position that has been proposed." (Non-government)

The majority of interviewees believed DPs still need to improve their ability to speak in one voice, as their failings on this resulted in DPs undermining each other in their dialogue with the government.

"On the face value you think they are together, they are talking the same language, but when it comes strictly to implementation of serious actions against the government, they are not together ... which means then the government is not forced to implement the actions..." (Non-government)

An example of this was noticed when undertaking interviews with local government stakeholders, who reported that the DPs had changed the rules so local government could not have training with DP funds disbursed *"on-budget"*, but DPs then separately conducted their own training workshops.

8.3.4 Management for results

Management for results was assessed according to the existence of a performance assessment framework, availability of quality information on results and the use of results assessments in policy-making.

Existence of a performance assessment framework

The Tanzanian health sector performance is reviewed annually through the health sector strategy performance assessment framework, the JAHSR milestones (in place since 1999), the national performance assessment framework and different ad-hoc performance appraisals, including Poverty and Human Development and Millennium Development Goals reports (in addition to individual DPs' requests for performance reports). As such, there is performance assessment, but no unified framework. In addition, the available frameworks have too many indicators for a feasible, good quality, annual review. For instance, this is seen in the assessment of the health sector strategy – the Health Sector Performance Profile Report, which has 46 indicators, only 5 of which were assessed in the 2009/10 report (420).

Availability of quality information on results to assess health system performance

Health information is collected through the Health Management Information System (HMIS). Despite investment in this system with external and domestic technical input, many respondents were worried about the quality of the information it produced.

“Like the performance reports, you question the sources from time to time and sometimes you know they make very precise statements that you know are based on not so precise data. So you have to take it with a grain of salt sometimes.” (DP)

DPs reported having access to results from the various assessment exercises; however, their availability to the wider public and on the internet was limited.

Use of results assessments in policy-making

There was some indication that evidence informed policy-making although this was not always the case. During the JAHSR the results from the assessment of the milestones were discussed and were observed to influence the setting of the milestones for the following year. On the other hand, as discussed above, both government and DPs also tried to influence the milestones during the dialogue, and the reasons for this were not perceived to be fully evidence-based.

“We all know that the government has responsibility and these difficulties about Paris agenda. But the donors have an equal responsibility because our decisions are not related to the evidence of what's going on in the countries.” (DP)

Instead, this DP described decisions as sometimes being driven by “*political reasons*”. In contrast, other DPs reported using evidence when deciding what programmes to invest in.

“... (we have tools) to look at where you're going to get impact and improvement in peoples' health versus your – what intervention, and then you can overlay that with costing as well.” (DP)

Therefore, although significant efforts have been undertaken to assess and monitor performance, these would benefit from becoming further unified and transparent, and if the results from these exercises had a stronger influence on decision-making.

8.3.5 Mutual Accountability

Ability of DPs to hold the government accountable

DPs believed the government was accountable to them by attending meetings, preparing quality and timely reports and if there were consequences when the government did not meet its obligations. DPs reported that government interest in SWAP accountability has been waning in the past year, which was a matter of concern discussed in DP coordination

meetings and in the interviews. For example, the government was not always ready for dialogue meetings, which resulted in delays.

“... the main issue is with the timing of the meetings. Meetings that are supposed to take place in February might not take place until April and that pushes back the entire process”. (DP)

In addition, audit reports were neither timely not entirely satisfactory, although they were considered to be “good enough” by most DPs.

“... you put in place your triggers for accountability and the government never meets them 100%, but you set your threshold ... We would like the government to be closer to the 100% of meeting their triggers, but ... we need to be realistic with our expectations.” (DP)

Despite all the accountability mechanisms, most respondents believed that nothing happened when the government did not fulfil its commitments, showing once more they are not always unified when communicating with government.

“... we send completely erratic messages to the government. On one hand we can say your management is not good enough, and then we give them more money.” (DP)

DPs felt they were more effective at holding the government to account when money was involved as they were able to either withhold funds or ask them to be returned. For instance, a basket DP reported that the government had to return some money to the basket “holding account” resulting from an unsatisfactory audit.

“There was an audit a couple of years ago where there were –it involved some civil works and some of the contracts were not procured correctly so the Ministry had to refund that money to the holding account of the basket fund.” (DP)

However, this appeared to be an extreme example, and DPs reported it was more common for funds to be delayed than to be returned. Nevertheless, this may help explain why the basket dialogue was perceived to be more effective than the overall SWAP dialogue.

Ability of the government to hold DPs accountable

Despite all the mechanisms for government accountability to DPs, there were no formal mechanisms for government to hold DPs to account. For instance, the Health Basket Fund Generic Document outlines procedures that should be taken in case of financial mismanagement by the different government agencies, but only states that “DPs disburse as early as possible in the (Tanzanian) fiscal year their total annual commitments”, without any indication of consequences for this not happening. Some respondents felt that DP accountability to the government happened just by DPs taking part in the JAHSR and the SWAP structure. There was no evidence of action being taken if DPs did not keep to their commitments.

DP and government transparency on the use of resources

Respondents felt that the JAHSR process was in itself very transparent, as they were invited to participate in meetings; further, the documents have been made publically available through the Development Partner Group website⁶⁴. However, there were concerns voiced by DPs and other non-government stakeholders about the government’s degree of transparency outside of this forum, with reports of government reluctance to share results or health expenditures.

“(The basket) follows the normal government system; it is as transparent that you can read it in the newspaper every day.” (Non-government)

This study found DPs were transparent in sharing data and plans with each other, the government and other stakeholders. However, DPs were much more transparent in the use of the basket than with vertical programmes (for instance, Chapter 6 shows that the PER does not capture all vertical flows).

⁶⁴ <http://www.tzdpg.or.tz/index.php?id=1203>

Both government and DPs are becoming increasingly transparent online. DPs, through the DPG-H website⁶⁵, share many documents relating to the functioning of the SWAP and the basket, and many report expenditure on their websites and to the OECD, although the amount and quality of information reported was variable amongst DPs and years. During the period of fieldwork (2011-2012) the government started publishing aggregated national and local health expenditures online⁶⁶, indicating that government transparency is also improving.

8.3.6 The aid effectiveness agenda

Stakeholders were asked about their views of the aid effectiveness agenda. Some respondents felt the agenda itself does not reflect country ownership. This has resulted in an imposition of “country ownership” on recipient countries, as DPs have pressure to show to their headquarters and taxpayers that they work with the government. In Tanzania, this was perceived to contribute to government fatigue, with the government seeing meetings as something needed more to sustain the SWAP partnership than to address the problems in the sector.

“Here we sort of desperately are trying to get country ownership and see the leadership to drive that but often we’re driving the –it doesn’t make any sense – but to some degree we’re driving the country ownership by saying, ‘This needs to be you guys doing this.’ And they’re like, ‘Well, can you do it for us?’ And we’re like, ‘Well, that’s not how it’s supposed to be.’” (DP)

When asked about the importance of international declarations, all sets of actors acknowledged the importance of the Paris Declaration, although very few had heard of Busan, and none mentioned the International Health Partnership. Since Tanzania is not a signatory of the International Health Partnership, it may be expected that it was not

⁶⁵ <http://hdptz.esealtd.com/index.php?id=6>

⁶⁶ <http://www.pmoralg.go.tz/>

mentioned in the interviews; however, the disengagement with Busan suggests a decline in the relevance of these international forums at the national level.

“To be honest, I don’t think people paid as much attention to Busan. I read the outcomes of Busan and I couldn’t even tell you what they accomplished.” (DP)

Moreover, some participants also questioned whether these principles can just be applied and then expect for aid to be more “effective”, or if it would be wiser to use them as goals.

“I think the reality is that we all in this country moved into Paris aid effectiveness agenda and put a whole lot of stock in the government of Tanzania to deliver for us on that. So everybody said, ‘Let’s put all our money into the government of Tanzania and use its systems and do everything that Paris tells us we should do’ Well, Paris should have been seen as more of an end game as opposed to a starting point.” (DP)

Overall, both DPs and government revealed signs of disengagement with the aid effectiveness agenda and sector-wide approach.

8.4 Discussion

The aim of this chapter was to assess if the Tanzanian health SWAP has contributed to the attainment of the five principles of the global aid effectiveness agenda: ownership, alignment, harmonisation, management for results and accountability. To do so, it used a set of indicators previously developed based on aid effectiveness declarations, the literature and the interpretations of national stakeholders of the five principles. This study has found mixed results, with the indicators of the global agenda, such as the existence of a health sector strategy and performance assessment framework, which have a technocratic focus, showing greater progress than those developed for this study, including having a common voice and government participation in the SWAP dialogue, which were based on the Tanzanian country context and the literature.

Ownership was assessed according to the existence of a national health strategy, national participation and leadership in the dialogue, and trends in external and domestic health financing. Results show that operational policy, expenditure and institutional frameworks have been successfully set up, in the form of the HSSP, the MTEF and the SWAP dialogue respectively, and therefore the indicator of the Paris Declaration has been met in the Tanzanian health sector (the evaluation of the Paris Declaration also found it had been met nationally (421)). This is no small achievement, given the number of different actors with different priorities present in the Tanzanian health sector, and has not been achieved in all SWAPs (for instance the Zambian health SWAP did not succeed in bringing all DPs under a common framework (211)).

However, this study found these frameworks are not a guarantee of country (or government) ownership. The findings suggest the dialogue was led by DPs, but also that it may not be the only forum for some critical decision-making. This is consistent with findings from the Bangladeshi health SWAP, where DPs were found to dominate the dialogue but had limited influence on the government strategy (422), from Ghana, where the government was found to formulate development strategies to please DPs, but did not actually change everyday politics (350), and from Malawi, where the budget process has been described as a “theatre that masks the real distribution and spending” (423). Further, in this study DPs were concerned that government participation in the SWAP dialogue has declined over time, something DPs perceived may have been because the government viewed the dialogue as a mechanism to suit DPs’ purposes rather than something in its interest. Therefore, in reality, setting up the SWAP dialogue may have had little influence on government ownership of its development strategy.

Government ownership of external resources was mixed. On one hand, there was a balance of power in negotiations with DPs in the basket (although this may depend on the aid modality used, as vertical programmes and projects are already defined by DPs and GBS

grants the government near full ownership). On the other hand, this study found indications of DAH fungibility taking place both at the health sector and sub-sector levels, which could ultimately be seen as a form of government ownership of the overall amounts the different priorities receive, if the government re-allocates its resources in response to external resources.

Chapter 7 reported DP confusion regarding the definition of ownership has resulted in uncertainty about the extent to which DPs should be technically involved in the management of the health sector, which is echoed by national aid strategies that emphasise the need for technical assistance to be demand-driven and a study by Goldberg, which suggests capacity building should itself be country owned (424). At the same time DPs have much to contribute to the development process, not just in the form of financial resources, but as technical assistance and partners in the policy-making process, and their lack of engagement in health sector management led to some frustrations in-country. This tension was also found in a multi-country evaluation of SWAPs, which found national ownership was not sufficient to achieve results and concludes that respecting national ownership and leadership does not mean agencies, such as the World Bank, cannot undertake technical assessments and provide advice (205). Despite successive international declarations advocating for government ownership, and it forming the basis of the SWAP approach, the key may be in finding the balance between ownership and partnership, where the government has more information about the country context and needs, but DP intervention may sometimes be allowed in areas where local competency may be lacking. However, a suitable way to achieve this balance remains to be found (425).

Alignment was assessed by exploring the extent of DP use of country systems, the proportion of funds that were pooled and the capacity of government systems. DPs pledged to align themselves to the government system and to disburse funds in the form of pooled modalities, and initially made some progress towards this. This progress is now

reversing, driven by DPs' pressure to show results quickly and concerns about absorption capacity. Further, disappointment with the quality of the policy dialogue resulted in a loss of enthusiasm for budget support and pooled funding mechanisms. These findings differ from a study in Vietnam, which found that DAH was mostly delivered through projects because there was no costed health financing plan (100), but are similar to a case study of DAH alignment to country systems in Uganda, which found that the proportion of pooled and on-budget funds had decreased in the last decade due to an increased focus on achieving short-term results, as opposed to longer-term investments in health infrastructure, human resources or institutional capacity building (37).

A trend of moving out of the government systems is of concern as it may hinder government's capacity to plan for and allocate resources. In addition, reverting back to projects is also worrying as they have been shown to hinder coordination mechanisms and increase transaction costs (137-138) (for instance, worries about "institutional destruction" due to proliferation of projects are mentioned as early as the 80s (426)).

There has also been disappointment from DPs in the lack of strengthening of government systems for public financial management and procurement, which is a reflection of lack of government capacity, low investment in health sector reform and the fact that it takes time to see results from reform. The key to improving both of these indicators may be in disbursing according to the government's absorptive capacity and investing in strengthening it. However, there is no agreed threshold for how to balance improving absorptive capacity with addressing population needs. There have been some attempts to determine the amount of development assistance that can be absorbed. For instance, a study comparing aid absorption capacity and Gross Domestic Product found that for Tanzania, the estimated Official Development Assistance/Gross Domestic Product threshold was 15.6% (335); however, the study did not specify the sectoral threshold. This

study found that DAH delivered through the government as a proportion of total government expenditure was above 5% in 2010 and the proportion of government expenditure on health that came from external sources was over 50%. Both of these proportions appear large. In addition, the Taskforce on Innovative International Financing for Health System recommended 40-48% of health system investment should be on capital expenditures to increase absorption capacity (346). Data constraints meant it was not possible to assess how much of health expenditure was allocated to capital investment in this study, but it is recommended that DPs and government aim towards this target.

The Taskforce on Innovative International Financing for Health System also cautions that high levels of DAH fragmentation can further decrease capacity by taking up government time (346). This study found the fragmentation of DAH has increased from a surge in project funding. Fragmentation has been found to be highest in democratic, poor countries and in social sectors (44), so high fragmentation could be expected from the Tanzanian health sector. Of particular concern are trends observed in the levels of fragmentation of RMNCH and diagonal (project-based) health systems projects, which raises concerns about the diagonal approach as a solution to the vertical versus horizontal DAH modality debate (118, 120). Fragmentation was also assessed in terms of the number of DPs and the proportion that account for 10% of DAH flows. Although fragmentation has been found to increase aid transaction costs (40), there may also be some advantages to having many different DP agencies may stop a single agency from pushing its own agenda and may help to depoliticise aid (6). The impact of fragmentation levels observed in this study is therefore dependent on how DPs' ability to coordinate through harmonisation mechanisms.

This study found that DP coordination structures have improved information-sharing amongst DPs and integrated reporting, although more needs to be done to improve

division of labour and eliminate DPs' requests for additional reporting. However, it is unclear whether the SWAP has reduced transaction costs and to what extent, as there is no counterfactual. The SWAP approach in itself is very onerous, resulting in many committees and dialogue forums and taking up a significant amount of time of both DPs and government. However, transaction costs associated with vertical approaches are very high and with a proliferation of projects, the burden of DAH in the absence of the SWAP is likely to have been substantial. Therefore, although some transaction costs may have been lowered, they still remain high. This is consistent with findings from Zambia (427), but not from Bangladesh, where the SWAP was found to have reduced transaction costs through a systemic change in DP-government relations, increased DP coordination and common reporting requirements of pooled DPS (422). There is therefore room for further reductions in transaction costs in the Tanzanian health sector if DP agencies funding projects become more integrated in SWAP processes to reduce parallel dialogues (although it looks unlikely that separate HIV/AIDS forums will change in the near future). However, some costs associated with disbursing and managing funds will always be incurred, and additional coordination will also incur some costs in terms of meetings.

Harmonisation efforts, although successful at increasing the sharing of information among DPs, have not resulted in fully harmonised procedures or DPs speaking in "one voice". This is partly due to a lack of government leadership and the vertical nature of some agencies, particularly those targeting HIV/AIDS. This finding is consistent with two studies that concluded that political constraints, including the contractual nature of coordination mechanisms and the plurality of policy images, hinder DP coordination (382, 428), and a case study in Uganda that found that different interests and motives of various actors undermined alignment and harmonisation of Global Health Initiatives (429). However, it is in contrast to a study of the SWAP in Zambia, which found that HIV/AIDS support was better integrated than other support at local level, although the share of resources

provided as programme-based support had not increased (54). This shows that the impact of vertical agencies on harmonisation efforts may be dependent on the context.

There has been progress towards measuring and managing for results, with improvements in the quantity of information available, although more needs to be done to improve quality, and enhance the transparency and use of information in decision-making. Previous evaluations of the SWAP approach have concluded that for the SWAP to work there needs to be a stronger link between resources and results, and stronger incentives are required for this to happen (205). However, there have also been concerns with an approach based on results, which can encourage a focus on quick-wins, incentivise an audit-type attitude of staff, and bias evaluations towards accountability to DPs rather than learning (39). These concerns were voiced in this study; particularly a focus on quick wins has run contrary to the use of government systems, pooled funds and longer term investments in the health system. However, the literature is yet to suggest a way to achieve this.

Finally, mutual accountability between government and DPs has not been achieved because there are no official processes to keep DPs accountable, and DPs were often unable to hold the government to its commitments because of their lack of unity and mechanisms to hold the government to account. This study found that transparency of both DPs and the government has improved in the last decade, which is promising, particularly since a recent literature review of DP-government relationships in HIV/AIDS programmes, concluded that the key constraint to better leadership is a lack of information on the results achieved with the aid disbursed (92).

In the end, this study found that government and some DP stakeholders are becoming fatigued with the SWAP approach. There was also a certain degree of disengagement with the global aid effectiveness agenda was detected, as most stakeholders referred to the Paris Declaration when discussing aid effectiveness but few had heard of Busan.

Furthermore, initial progress towards some of the principles, such as alignment to country systems, is now being reversed. There seems to be a cyclical pattern in aid practices, where every time an approach does not work (often in the short-term) it is abandoned. Limited institutional memory means that after a few years the same approaches are repeated. This study shows there are indications that DPs are moving towards the old project-based way of working, and even those contributing to the basket funds typically fund an array of projects in parallel, which is worrying given the reasons why they had moved from projects in the first place.

Ultimately, although the Tanzanian health SWAP has made better progress towards aid effectiveness principles than other countries (such as the Democratic Republic of Congo (91) and the Solomon Islands (207)), the aims of aid effectiveness declarations outlined in the assessment framework have not yet been fully achieved. It is useful to reflect on two questions at this point: first is the global aid effectiveness agenda feasible and desirable; and second, is the current approach conducive to achieving the aid effectiveness agenda?

In relation to the first question, this study found tensions arise between different principles when the agenda is implemented at the country level. For instance, increased emphasis on managing for results is resulting in DPs becoming less aligned to the government system. Similarly, enforcing conditionalities is part of achieving mutual accountability, but runs contrary to government ownership, and if DPs become more harmonised they may exert more power on the government and decrease its ownership. These findings are not unique to this study, tensions between ownership and results have been observed in projects funded by the Swedish International Development cooperation Agency in Tanzania, Zanzibar and Cambodia (430), and worries about ownership and conditionalities have resulted in the European Commission modifying their conditionalities from policies to outcomes (431). However, discussions on this have been limited and a practical solution is yet to be found.

Furthermore, the SWAP has a very complex structure and poses a high burden on the government, which lacks the capacity, leadership and willingness to effectively participate in the dialogue. In its current state, the SWAP may end up being counterproductive to achieving the aid effectiveness agenda. However, these concerns would not be addressed by going back to an approach based on projects, so the agenda is desirable, although current efforts have not so far not fully facilitated its attainment. In fact, some respondents perceived that the reason for this was not the SWAP structure, but that the approach and the aid effectiveness agenda had been imposed on the government by DPs, contrary to the implementation of the Paris Declaration in countries such as Colombia, where joining the agenda was a government decision to improve its ownership and leadership, a decision that was met with mixed feelings from DPs (187).

In relation to the second question, the SWAP has been successful in setting up structures and processes for coordination and dialogue for DPs and the government, such as national development and health strategies, a performance assessment framework and a joint annual health sector review. These are significant achievements, particularly given the amount of DPs active in the health sector, and satisfy the Paris Declaration principles for ownership, managing for results and mutual accountability (which may explain the positive reviews Tanzania has received in its evaluation of the Paris Declaration (421)). However, the health SWAP has fared less favourably in the indicators developed for this study, such as DPs ability to speak in one voice and to keep the government to its commitments, or the government's participation in the dialogue processes.

One way to make further progress towards the aid effectiveness agenda may be to strengthen the basket fund, as a funding and coordination mechanism. There are several reasons for this. First, this study found stakeholders believed there was a balance of power in negotiations of the basket (potentially balancing government ownership and DP

involvement). Second, the basket fund uses government systems, but the additional checks and balances required ensure government accountability, and may themselves improve the quality of the system (and may eventually set an example of how the government could account for its own resources). Third, the basket decreases fragmentation, whilst still allowing for a number of different DPs with different views, which may enrich the health sector dialogue. At the same time, DPs would be more harmonized, and if they disbursed a higher amount of DAH through the basket and decrease their contribution through project-based modalities, DPs may lower their burden on the government. Finally, local government authorities reported being highly dependent on the basket for running health services, which indicates it is having an impact. Intermediate outputs could be set for the basket to assess performance (such as the percentage of funds arriving at the district level or being allocated by the medical stores department), and allow to manage for results, without compromising alignment.

The findings from this chapter suggest enthusiasm for basket funds is waning, so the basket may need to improve. For instance, it needs to find ways for DPs to be accountable to the government and the wider population, and to allow for the participation of other participants of the SWAP (like civil society) in the basket fund dialogue. Strengthening the basket fund may not solve the debate about agencies primarily disbursing DAH through vertical funds and the separate HIV/AIDS dialogue, but a separate HIV/AIDS basket could be set up, which would help in harmonising HIV/AIDS funds and lower transaction costs.

Finally, there have been suggestions in the literature linking some of the findings of this chapter with political and instructional factors. For instance, this study found a lack of coordination among DPs may be a result of limited government leadership. This was also found in a study of the Bangladeshi health SWAP, where the author concluded that it was not in the government's interest that DPs become fully aligned, as the government can

have more control of the health sector if DPs continue to have separate dialogues (50). Two additional studies have also suggested that the incentives of DPs and the political economy of aid hinder DPs' ability to harmonise; for instance, due to collective action problems (38) and uncertainties of whether DAC DPs and those engaging in South-South cooperation actually have any incentive to harmonise under the aid effectiveness agenda (432). Previous studies have also highlighted the importance of exploring the incentives of high-level politicians to better understand accountability (433) and transparency (434) of aid. Lastly, a study of two World Bank-funded projects in Timor-Leste found that technical quality was not sufficient for aid effectiveness, and that the political economy of the country needs to be conducive to aid effectiveness (97). It is therefore important to study institutional factors in more detail, particularly the relationships and incentives of the actors involved in the SWAP, and how these can be modified to allow for the achievement of aid effectiveness principles. This is done in the next chapter.

9 STUDY OF AID RELATIONSHIPS IN THE TANZANIAN HEALTH SWAP

9.1 Introduction

This thesis has so far described the Tanzanian health SWAP both in terms of domestic and external health financing trends (Chapter 6) and dialogue structures (Chapter 5). It has then explored the definitions of the five principles of the aid effectiveness agenda (ownership, alignment, harmonisation, management for results and mutual accountability) and developed a set of indicators to assess its attainment in the Tanzanian health SWAP in Chapter 7. This set of indicators was subsequently applied to assess the extent to which the principles of the agenda have been achieved in Chapter 8. Results show that although the processes for the aid effectiveness agenda to be achieved were put in place, this did not fully result in the indicators being met. It also found the approach to achieve the agenda was too technocratic and that there were contradictions between the principles in practice, raising questions about the appropriateness of the agenda itself. Further, institutional and political factors not directly addressed by the agenda were found to hinder its achievement.

The aim of this chapter is to explore these institutional and political factors, particularly the extent to which aid relationships are contractual, and therefore the appropriateness of the aid effectiveness agenda, and how these factors have influenced the attainment of the agenda. In doing so this chapter addresses the fifth objective of the thesis: “to explain the achievement of the aid effectiveness agenda through an analysis of institutional factors and relationships between the actors present in the Tanzanian health SWAP using a political economy framework”. This chapter presents the results of the stakeholder analysis carried out through in-depth interviews, document review and non-participant observation (as

described in Chapter 3). Specifically, it describes the institutions, actors, processes and political context of aid relationships in Tanzania.

The results of the stakeholder analysis are interpreted through the theories outlined in the conceptual framework described in Chapter 4. Briefly, the framework explores the institutional factors explaining the degree of attainment of the aid effectiveness agenda by adopting a reformist approach to aid effectiveness, combining managerialistic and non-managerialistic perspectives (267, 274). From a managerialistic, Principal Agent (PA) perspective, the aid effectiveness agenda is framed as an approach to maximise efficiency by aligning incentives, increasing information sharing and lowering transaction costs. Information sharing and transaction costs were explored in Chapter 8. This chapter explores incentive alignment between the different actors present in the Tanzanian health SWAP. In particular, it explores the extent to which ownership and mutual accountability serve to align the incentives of Development Partners (DPs) and government and their working towards common goals. In addition, managing for results is expected to align the incentives between DPs, government and beneficiaries, whilst harmonisation would align incentives between the different DPs. From a non-managerialistic perspective, the framework explores the power dynamics between DPs and the government, and between the different government agencies. Finally, the framework studies how the political context in which DAH is delivered affects the attainment of the agenda.

The chapter uses this framework to firstly examine whether the relationship between DPs and the government is contractual (and therefore if the agenda is appropriate). Secondly it explores how institutional factors affect the attainment of the agenda principles. It finally steps back to examine the political context within which the agenda is played out.

Box 4: Key messages of Chapter 9

- DPs and government agencies have not managed to fully align their incentives; this hinders the attainment of the agenda, but also means it is needed.
- There are contractual elements to the DP-government relationship; however, other political and power factors are at play, which are not addressed by the current approach to aid effectiveness.
- A technocratic approach that does not involve an array of important actors has undermined the SWAP
- There is a need to incorporate both managerial and non-managerial approaches to development in order to attain the aid effectiveness agenda.

9.2 Results

The first step in analysing the institutional landscape of the Tanzanian health sector was to draw a map of all actors present in the sector and their interactions with each other (Appendix F). To understand this complex web of relationships, the multi-dimensional conceptual framework summarised above was used. The results are presented following the three objectives of the chapter:

1. To examine whether the relationship between DPs and the government is contractual (and therefore if the agenda is appropriate)
2. To explore how institutional factors affect the attainment of the agenda principles
3. To examine the political context within which the agenda is played out

9.2.1 Relationships

The first objective of this chapter is rooted in principle agent theory and seeks to assess the nature of the contractual relationships in development assistance for health. In doing so, this section aims to examine whether the aid effectiveness agenda may be appropriate as a vehicle to ensure that implicit or explicit contracts for development aid are organised in a

way to ensure they are likely to result in efficiency (in terms of reaching social welfare objectives). This section tackles this question by exploring key contractual dimensions in the relationships between DPs and the Government of Tanzania (GoT). Chapter 8 showed that the Government of Tanzania and DPs were not able to hold each other to account. The reasons for this are explored further in this section, first by establishing the nature of the “aid contract” and in particular exploring why DPs are not fully able to enforce it. The section then examines how power dynamics may also impact contractual relationships and enforcement and the role of actors involved in the Tanzanian health sector beyond those active in the dialogue in enforcing that contracts are in line with beneficiaries’ needs.

Accountability and the aid contract

There are different contracts guiding the relationship between DPs and the government in the Tanzanian health sector, including the SWAP Code of Conduct, the Health Basket Fund Memorandum of Understanding and the contracts for bi-lateral agreements signed between single DPs and the government. There may also be an implicit contract. However, whether the relationship between DPs and government is contractual would in part depend on whether DPs (as principals) can keep the government (as agent) to account.

Chapter 8 reported that respondents felt the only tool DPs had (as principals) to enforce the “aid contract” was to withdraw funds. However, the analysis reported in this chapter found DPs’ incentives were not conducive to this for different reasons. First, pressures to disburse funds at the DP level made them less inclined to withdraw funds if the contract was not respected, and hindered DPs’ coordination efforts (see below). Second, DP accountability lines to headquarters were stronger than to actors at the national level, which meant that the DPs were less united in enforcing the contract. Finally, respondents reported concerns about the potential impact of withdrawing funds; for instance, if DPs are disbursing funds using the government system, sanctions can cause delays or prevent the

government from keeping to its commitments. In addition, DPs feared they would punish the local population, which provides some explanation of why DPs may continue to provide funds even when the government is not complying.

“... strategically the government allocates donor money into very sensitive areas in the sector, for example, procurement of medicine. And then if this fund is delayed it means no medicine in the facilities, and therefore this could cause more damage, probably deaths, something ... no one wants.” (Non-government)

This is further complicated by Ministry of Health and Social Welfare (MoHSW) employees' seemingly indifference for how much money they receive or when they receive it, which is partly due to a lack of results-based performance assessment (see below). A non-government stakeholder described this as being a result of the fact that government employees' salary is independent of how much money the government receives from DPs, and therefore whether DPs withdraw funds does not influence them personally, *“it is more something secondary that it would be easier if (government employees) got the money in time”*.

Therefore, if DPs cannot always keep the government accountable, then it may suggest that the government has more power than would be expected from a PA model.

Power

When asked about DP-GoT power relations to form the content of contracts and support contractual enforcement, this research found a mixture of opinions. Chapter 8 reported there was a balance of power in the basket fund negotiations. However, this study found evidence that all three power dimensions highlighted in the conceptual framework: visible, hidden and invisible, in the behaviour of DP and government representatives. Visible power was observed during the budget negotiations in Chapter 8, where different actors fought to get their priorities onto the agenda in the form of annual milestones. An example of hidden power was reported by a DP when describing basket fund negotiations for the previous

year on the share of resources that would be allocated to the districts and the central government. In this case the GoT used its power by deciding the budget ceiling and guidance before involving the DPs, and thereby reducing the negotiation space.

“... at the time that (budget negotiations were) happening, the budget guidelines and the budget ceilings had already gone out to the districts, so increasing the amount to the districts was logistically difficult ... and would require the districts to go through the whole planning process over again, and absorb more money. The donors were a little upset that the government hadn’t had that dialogue ... in time for the proper budget ceilings to go up.” (DP)

The final dimension of power is invisible power, which involves social conditioning and ideology. This was clearer from the DP side, where ideological changes at their headquarters resulted in changes in aid management practices, such as the introduction of performance measures, something some stakeholders feared may result in changing the basket fund so results can be more easily attributed to it.

“... some of the performance stuff will come in and hopefully that will attract donors to it. The other part of it that may end up happening ... to bring in other donors like the US government ... is for it to be a little bit more earmarked.” (DP)

Therefore, the distribution of power in the government-DP relationship is complex, with both sides exercising power in different ways when negotiating resource allocation. This calls into question whether the GoT-DP is purely contractual, as the government is not as powerless as may be assumed by PA theory.

Additional actors

The focus of the main dialogue between DPs working in the health sector and the government happens through the MoHSW⁶⁷. However, there are several other government agencies involved in the health sector, who have key roles in the

⁶⁷ This refers to the health sector dialogue, and not the HIV/AIDS dialogue, where the MoHSW participates, but TACAIDS leads (see Chapter 8)

implementation of the contract, which did not participate in the health SWAP dialogue (or had weak representation), despite the fact that some of these agencies have formally signed the SWAP Code of Conduct and the Health Basket Fund Side agreement, so were officially included in the “aid contract”. These include the Ministry of Finance (MoF), the Prime Minister’s Office for Regional Administration and Local Government (PMO-RALG) and the President’s Office for Public Service Management (POPSM) at the central level, and Regional and Council health authorities (RHMT and CHMT respectively)⁶⁸.

Despite the wide variety of government actors operating in the health sector, and that funds flow from the MoF to the PMO-RALG, RHMT and CHMT, the MoHSW was seen as having the overall responsibility for the sector and as such the centre of domestic and external accountability and dialogue.

“... if money runs out at the local level, the minister will probably be wheeled in front of parliament and press, the minister of health and not the minister for PMO-RALG.” (Anonymous)

When DPs talked about “the government”, they also often just referred to the MoHSW. The PMO-RALG and the MoF, which are both based in Dodoma (the capital) rather than in Dar es Salaam, and are key players in financing and providing health services, were less engaged in the dialogue.

“... we always speak of the Ministry of Health, but the big minister in health is the PMO-RALG and those guys [...] implement all the health services from district down to the periphery. They have a huge responsibility and we hardly have exchanges with them [...] we just discuss with the technicians because they are here next door and because we like it” (DP)

There are signs that this is improving through greater engagement with other government bodies in recent years, with efforts to strengthen the participation of the PMO-RALG in the

⁶⁸ See Chapter 5 for a detailed description of the Tanzanian health sector actors, policies and budget mechanisms

health sector dialogue. Further, DPs who work at the GBS level have their own dialogue with the MoF, where some of the issues affecting the health sector, such as macroeconomic and wider political decisions, are discussed. However, respondents felt that the link between these two dialogues had eroded in recent years.

Outside the Tanzanian national context, there are global and national actors that influence the Tanzanian health SWAP dialogue. Very important amongst these are the ministries in charge of development cooperation of bi-lateral DPs, which are discussed in section 9.2.3. Other actors include national and international pressure groups, which, although very important, fall outside the scope of this paper.

This indicates that the design of the health sector dialogue that forms the core of the SWAP may be too narrow. DPs may be directing their power at the MoHSW, whereas important budgeting decisions are made at a higher level. Findings from this section therefore support the view that framing aid relationships as only taking place between two parties may be restrictive to understanding the aid effectiveness agenda.

9.2.2 Institutions

This section explores the macro-institutional incentives, structural factors and micro-institutional incentives of Development Partners and the Government of Tanzania, and explores how each of these affects the SWAP dialogue and the attainment of the aid effectiveness agenda.

DP

Macro-institutional incentives

When asked about DP motivations for giving aid (i.e. their utility function), a DP representative reported they were driven by humanitarian reasons, and that it was an *“international obligation that the better off, the well to do countries support the least*

developed countries". This would suggest that, at least in part, the incentives of DPs are aligned to those of the beneficiaries, which would encourage country ownership of the development strategy, as national actors would have more information about beneficiary need. However, there is a risk that this type of response may be subject to social desirability bias, where a respondent wishes to present his/herself in a positive light to the researcher (435).

Further, government and non-government respondents reported that DPs also gave aid to pursue their commercial and political interests,

"(DPs give aid) because they want to be in control [of] policy, in control of processes, in control in terms of economy because then, depending on how much aid you give, the more recognition you get." (Non-government)

Where political incentives are out of line with maximising health benefits, this may misalign DP and beneficiary incentives, depending on the content of the policy of interest. These non-health incentives may also hinder aspects of the aid effectiveness agenda, including the management for results (if the results expected from DPs and beneficiaries are different) and country ownership (in terms of ownership of beneficiaries if their interests are not aligned to DPs). Further, if different DP agencies are pursuing different political interests, this would deter harmonisation. However, DP incentives may be in line with those of the government, potentially fostering government ownership, and it may encourage DPs to disburse DAH through government systems, if they view this as increasing their power over the government.

Structural factors

DPs acknowledged that their centralised structure was a key issue. Despite calls for mutual accountability between DPs and the GoT, respondents felt that DPs' accountability to their head offices was stronger than their responsibility for actions on the ground. Priorities and

important decisions were seen as being dictated by headquarters; for instance, the decision by some DPs to pull back from the health basket (thus hindering the principle of alignment and explaining the results reported in section 8.3.2). This also shows that headquarters are more powerful than DP national offices. DPs reported that their headquarters and SWAP commitments pulled them in different directions, which had a negative impact on the dialogue, and affected DPs' abilities to align to the government systems.

"We had a change in the government ... they are interested that we are able to account for the (money) spent in development cooperation in our partner countries. So from the former focus on budget support and health basket ... we have a slight change of political approaches ... from the implementing agency perspective we pointed out the importance of the health basket for the sector wide approach in Tanzania ... But it was a political decision." (DP)

This may result in both lack of DP harmonisation and lack of DP accountability to the government (and therefore explain some of the results reported in Chapter 8), and had an impact on the dialogue, as it resulted in DPs going back on their commitments, something a bi-lateral DP acknowledged created tensions with the government, which requested *"development partners not to steer so much from the headquarters, to be much more present here"*.

Micro-institutional incentives

Individual DP employees reported, like their organisations, to be driven by humanitarian reasons. However, the institutional set up of DP agencies, particularly the way in which performance was assessed, resulted in a set of incentives that affected the way aid was delivered and implemented. DPs reported their performance was assessed as disbursement ratios.

"They look at things like disbursement ratios so if you have whatever 10 or 15 million that's sitting around for the better part of the year, headquarters is going to

say, 'What's going on here? Parliament voted this money so that it could be used, not so that it could sit in a bank somewhere.'" (DP)

This was viewed to affect aid relationships and the aid effectiveness agenda in two ways. First, a DP stated that it was common practice for DPs to add (often large) unspent funds to the basket fund at the end of the year, resulting from fears about having a reduced budget the subsequent year, if all funds were not spent. These funds (which may be as much as five million dollars) come without any justification or request from the government, are outside of the budget process, resulting in *"a whole lot of negotiation and then the money is not spent and the procurement drags"*. This means that money comes when it is there and not necessarily when needed. In theory, this may support the alignment to country systems, if DPs disburse more of the funds as pooled funds; however, it would also affect the predictability of aid, and government's ability to plan, thus disrupting the budget process. Second, a non-government stakeholder felt that since DPs' primary objective was to disburse funds, it may make it less likely that they would withhold funds from the government, thereby hindering their ability to hold the government accountable. This explains why in Chapter 8, respondents reported that DPs sent mixed messages to the government and criticised DPs for disbursing funds despite being unhappy with the government.

Respondents further felt that institutional incentives for career-strengthening discouraged DPs from reporting negative results to their headquarters, hindering problem-solving and learning, and resulted in incentives with unintended consequences for aid relationships, as it discouraged transparency and accountability between the DP national office in Tanzania and their headquarters.

"... any negative message home to headquarters is a burden on their shoulders ... you send good, positive messages back to your headquarters ... And if there's anything with a problem, you just reduce it because ... the one who is always

feeding positive things back to the headquarters will be the one with opportunity for career promotions.” (Non-government)

From the perspective of a PA relationship between the DP headquarters (principal) and the DP country office in Tanzania (agent), this can be understood as an incentive to abuse information asymmetry for country-based DPs, and bias reporting towards only positive outcomes.

Respondents from both the government and DPs reported a change in the skill set of DPs from the time the SWAP was introduced. Initially, DPs were very involved technically, but they gradually became more bureaucratic, administrative and diplomatic.

“It is that gradual shift of development partner position ... from being very much involved and very much working on (the government) side when we started the SWAP collaboration (to) people who have no knowledge about the sector ... they can be economists, or some generalist of a kind” (Non-government)

This had an impact in the dialogue and relationships with the government, and both government and DP interviewees reported the dialogue having become more formal and less constructive. However, not all respondents were in agreement on this. DPs discussed how to provide technical assistance to the government on proposal writing, and some DPs felt the dialogue was more constructive than in the past.

Another factor that influenced the quality of the dialogue was the short nature of postings. Most of the people who designed the dialogue mechanisms were no longer around. Relationships take time to build and many stakeholders felt that often, by the time DPs really understood the context and developed good working relationships, they moved on. This also shortened institutional memory, and resulted in DPs repeating things that had already been done.

“... it used to have stronger relations. But I think also some of it must be a function of time because as the sculpturers of the framework have moved on, then is there that absolute buy-in and belief in the structure with new people?” (DP)

GoT

Macro-institutional incentives

The mission of the MoHSW is to improve the health of the Tanzanian population (436). However, DPs expressed reservations about the government’s ability to act in the interest of beneficiaries, clearly viewing the political process as insufficient to ensure that the government acted in the interests of its beneficiaries. The Tanzanian government as a whole was viewed by some DPs as wanting to keep getting funded by DPs.

“They want to do enough to stay aided but that’s not very hard. They already do that so they don’t have to do anything else” (DP)

Given that Tanzania is a democratic country, one would assume the government would also be incentivised by winning elections. These incentives are not necessarily perverse. The government is an agent of both DPs and beneficiaries, so if DPs’ and beneficiaries’ interests are aligned then this should pose no conflict. However, willingness to accept external funding (and to achieve internationally agreed objectives) was perceived by some non-government respondents to be more important than what is best for the country. If this is the case, then differences between DPs and beneficiaries may decrease the effectiveness of aid, as the government accountability to DPs is stronger than to beneficiaries. Overall, actions of both DPs and the government were recognised by respondents to be motivated by more complex political agendas than the maximisation of the health of beneficiaries.

Structural factors

The hierarchical and bureaucratic structure of the MoHSW was also seen as important, and regarded by non-government stakeholders as deterring innovation.

“If we want to do something special, something to innovate the system, it’s almost impossible, because any small, small, small decision has to go the whole way to the very top of the organization, to have a signature, and come back. [...] it can take months.” (Non-government)

Further, a lack of communication and coordination between different departments of the MoHSW was viewed as affecting the dialogue because it hindered coordination of the different initiatives. The vertical and bureaucratic structure of the government also hinders innovation and may lower the capacity development of the government, resulting in DP frustration and hindering the quality of the government system and hence alignment.

Micro-institutional incentives

MoHSW employees also had a variety of incentives. They reported being motivated by improving health and their own performance targets, which were reviewed annually using the government’s Open Performance Review and Appraisal system (employees have annual targets, which are appraised by their line-managers). However, many non-government respondents believed performance was assessed and rewarded in less transparent ways. This was seen as resulting from the government’s remuneration system, where employees receive a fixed salary but are paid allowances and *per diems* for attending meetings, training courses and conducting supervisory visits and trips, which diverted them away from their daily tasks. The performance assessment and remuneration system was blamed for distorting incentives and resulting in employees being unproductive.

“... there's no incentive to perform. The allowance is not at all related to any performance or result. That's the biggest problem, which means if you are a director in the ministry, what you have to do is fight for having a slot in the budget to have a good training nationwide and that means that concretely you will travel for two months yourself to deliver the training with a few persons, so it's very good

for your position [...] and then you will also distribute allowances to those who come to training, which will reinforce your position.” (Anonymous)

As with DPs, the short-nature of postings of government employees was also perceived to affect aid relationships, some of whom DPs had spent considerable time building.

GoT micro-institutional incentives therefore hindered the attainment of managing for results, as the performance of neither government nor DP employees was assessed according to results. Overall, institutional factors were found to affect the attainment of the aid effectiveness agenda, by resulting in incentive misalignment and information asymmetries. However, this also means there is a need for the aid effectiveness agenda to tackle incentive problems.

9.2.3 Political context

This section outlines the political context within which aid relationships are played out, which influences but is not directly addressed by the aid effectiveness agenda. It primarily focuses on power within the GoT, but begins with a short section acknowledging and reinforcing the observation above concerning the balance of power between national and global DP offices.

DP Politics

Regardless of whether they were bi- or multi-lateral, respondents reported that development partners were subject to the political context their headquarters were in, particularly given the centralised nature of aid agencies. There is, however, a clear difference between the politics of multi- and bi-lateral agencies that needs to be noted. Multi-laterals are accountable to a multitude of funders/member states and may be considered by some as less susceptible to direct political influence – and short term political shock. Moreover, many of the multi-laterals include recipients of development

assistance within their governance structures. Bi-lateral agencies by their very nature are directly accountable politically to one government, and therefore subject to electoral pressures and internal politics of a specific constituency. Some DPs believed donor countries are facing a financial crisis and a broader ideological shift towards austerity, which had implications for the way aid is managed. For instance, it may be considered legitimate for a change of Minister of development political views to result in an agency to change approach in all countries, without taking into consideration the national context, relationships or prior commitments.

This is further complicated by the fact that some bi-lateral DPs are dependent on two different ministries, subject to their own (changing) ideologies, personalities and power dynamics.

“We have two ministries who are somehow linked to development cooperation and our major funding ministry is the ministry for economic cooperation and development, (which) is framing the policy and the policy is obviously linked to political parties and political environment.” – DP

This affects the implementation of the aid effectiveness agenda, as political factors may impact aid management practices, irrespective of national and international agreements.

GoT politics

As shown above, the health sector is made up of different government agencies. These are subject to relationships and politics between and within them. The MoHSW sits below the central ministries, but above the regional and council health authorities. This section will examine its relationship with both.

When negotiating the budget and deciding priorities, the MoHSW has to negotiate with the three central ministries, which have more power than itself (MoF, POPSM and PMO-RALG). The relationship between the MoHSW and the local level has been marked by a de-

centralisation programme known as “Decentralisation by Devolution” (308), which has been ongoing since 1994, when the government launched the Local Government Reforms Programme, and aims to provide more autonomy to the CHMT and RHMT. In particular, the reform aims to give Local Government Authorities (LGAs) responsibility for planning, budgeting and managing government services, including health services. The reform also changed the RHMTs, which became “facilitators” and part of the regional administration, rather than of the MoHSW. This reform was viewed by some as creating tensions between the MoHSW, who want to retain power, and the districts.

“The central government wants to do everything but the LGAs can do it on their own.” (Anonymous)

This has also resulted in tensions during the basket fund negotiations between DPs and MoHSW, when discussing resource allocation and the proportion of funds that would be spent at the central versus the local level.

“So as development partners kept pushing the government to put more money into the districts, the government pushed back and said, “We need money for drugs and medicines and that serves the districts well.” – DP

As a result of this power struggle, some respondents felt the local level was suffering as it has increased responsibilities, but the funds are still controlled centrally. However, this may falsely portray the CHMT as being the least powerful and having the most responsibility. In reality, due to poor public financial management, funds are often delayed, and typically arrive to the CHMT six months late. This means that for the second half of the year, the CHMT are spending funds in a different financial year than they had been planned for, and therefore have more discretion as to how to spend funds. The actual amounts spent would only be recorded by the Exchequer, but these are hard to access, reportedly even by some sections of the government. Despite the fact that de-centralisation meant it was harder to

monitor funds, DPs have favoured this approach and are in favour of providing more support to the local level.

“... what astonishes me is that the DPs seem to sort of just assume that (health being managed at the local level)’s a good thing so that more and more money gets paid out through PMO-RALG to the local level and I think there’s very little evidence of what that’s doing” (Anonymous)

This has implications for the implementation of the aid effectiveness agenda. First, ideology influences some of the decisions that are made, even at the cost of DPs having less information. Second, the importance of local government authorities has implications for the principles of ownership, alignment and accountability, particularly in specifying who owns development strategies, whose strategies DPs should adhere to and who should DPs hold accountable and be accountable to.

In addition, unforeseen political factors also have an impact on the dialogue. For instance, during the time of fieldwork Tanzania experienced a period of doctor strikes over salaries, which lasted for seven months and ended with 300 doctors dismissed (437). This drove the operations of the ministry to a halt, ended with a change in senior positions and had an impact on the government’s prioritisation of the health sector.

“I think the unfortunate thing is that we were starting to do better in the dialogue with the government and in the management of the health basket, but then the loss of all of the things that happened with the Ministry of Health and all that, six months or so, it’s been a bit of a setback. It’s delayed a lot of the dialogue.” (DP)

DP involvement in GoT politics

Despite this complex and diverse political structure and the myriad of actors present, DPs were criticised by some respondents for not being sufficiently involved in national politics. Some local stakeholders believed DPs were in a privileged position, with high access to policymakers and should therefore be involved in the management of the health sector, for

instance in influencing political decisions that local stakeholders found harder to engage in, such as the issue of *per diems* mentioned above.

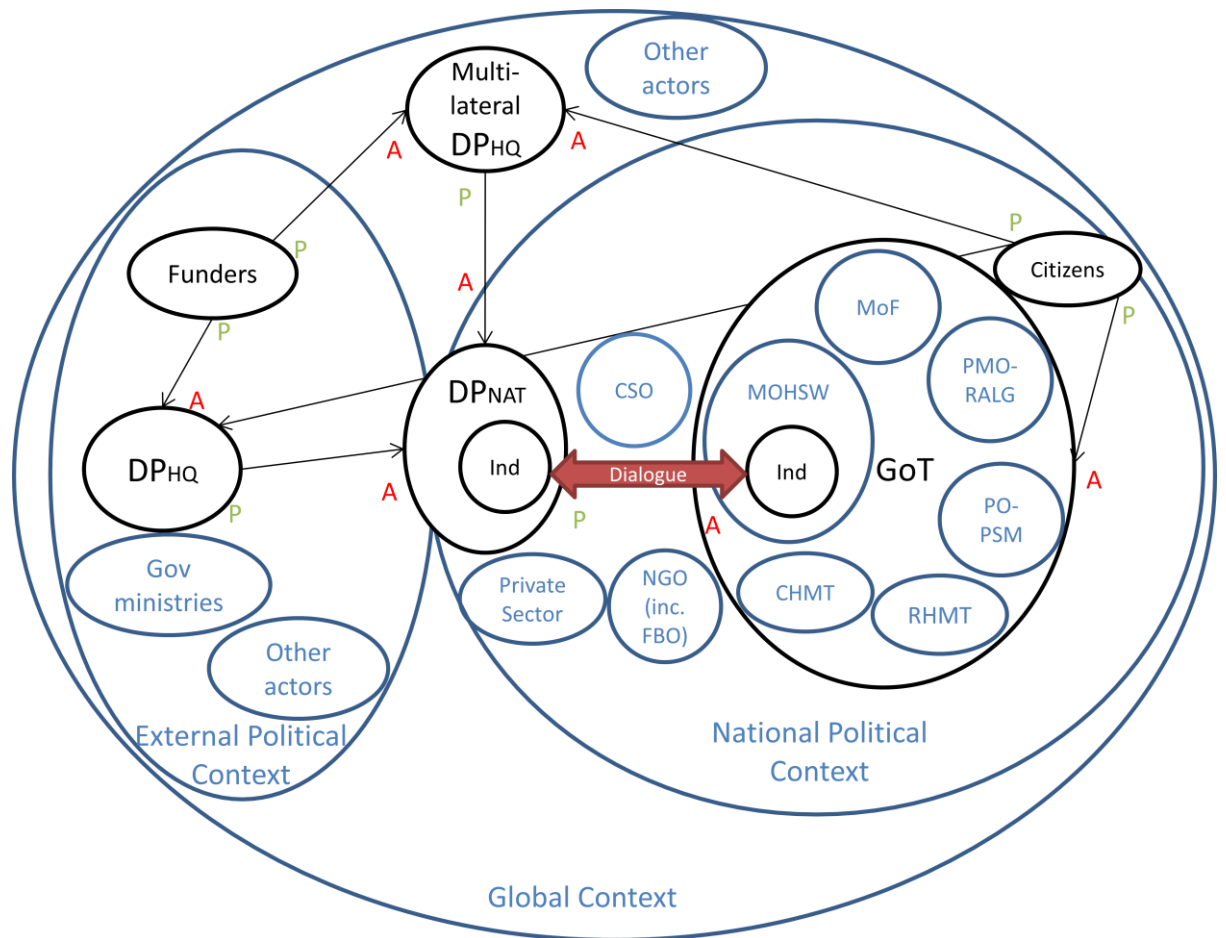
“... development partners ... have to acknowledge that they have a role being non-politicians here (and they should) put pressure on things that other state-funded groups have difficulties dealing with here. As a politician it’s very difficult to do something against that allowance culture ... everyone in the government will be against them from day one.” (Non-government)

DPs acknowledged this and recognised that they often either focused on administrative or very technical micro- issues, at the cost of engaging at the broader socio-political level. For instance, a bi-lateral DP reported the DPG-H had made significant progress at the technical level to develop a health financing strategy with the government, but now needed the political support for the necessary reforms to take place, with DPs working *“in the flow between political dialogue and technical dialogue and decision making”*, again reflecting that the approach to aid management may be too technocratic.

This lack of involvement however can be seen in another light, as other stakeholders criticised DPs for being too involved and for *“micro-managing”* the sector, which ran contrary to the achievement of the principle of country ownership. This shows that lack of precision in aid effectiveness declarations on *whose* ownership and *of what* has implications on the implementation of the agenda at the country level.

The results of this chapter therefore suggest that although there are contractual elements in the DP-GoT relationship, and indeed incentive misalignment within DP and GoT agencies are hindering progress towards aid effectiveness principles, the PA framework may be too simplistic to analyse aid relationships and the aid effectiveness agenda. Taking all the factors explored in this chapter into consideration, Figure 4.1 from the conceptual framework can be redrawn to reflect the context and all of the actors present in which aid relationships take place as shown in Figure 9.1 below.

Figure 9.1: Modified conceptual framework⁶⁹



9.3 Discussion

Earlier chapters examining the attainment of the aid effectiveness agenda at the country level in the Tanzanian health sector have shown that it is hampered by institutional and political factors. The aim of this chapter was to explore these factors, using a conceptual framework consisting of economic (principal-agent theory) and policy dimensions (power and politics). Specifically, this chapter has sought to address whether the agenda is

⁶⁹ Figures in black represent the actors involved in the Principal Agent framework shown in figure 4.1. Figures in blue represent all additional actors influencing the SWAP dialogue and the political context they are embedded in. DPHQ: Development Partner headquarters, DPNAT: Development Partner national (country) office, Ind: Individual employee, GoT: Government of Tanzania, NGO: Non-Government Organisation, MoF: Ministry of Finance, PMO-RALG: Prime Minister’s Office for Regional Administration and Local Government, PO-PSM: President’s Office for Public Service Management, RHMT: Regional Health Management Team, CHMT: Council Health Management Team

adequate to improving relationships between DPs and recipients, by exploring the existence of incentive misalignments and what additional power and political factors are present that are not currently addressed by the agenda.

Firstly using a PA perspective, the global aid effectiveness agenda has been framed as improving aid effectiveness by aligning incentives, improving information flows and lowering transaction costs. This study has found that both institutions and individuals involved have incentives beyond improving the health of the Tanzanian population, and that these incentives may be complex and not always aligned. This complexity may have a perverse influence on the achievement of the agenda by hindering DPs from holding the government to account and using a harmonised approach.

In addition, the lack of results-based performance assessment of DP and government employees could be interpreted to reflect the fact that the internal principals and agents within these institutions have not aligned their incentives to achieving results, which in turn means they have little incentive to manage for results. PA theory suggests that in contractual relationships where outcomes are not easily observable, there is an input bias in performance assessment of the agent by the principal (6). This was observed here, and has been documented in previous studies of the World Bank and of DPs in Uganda (179, 405). In addition, the broken feedback loop in aid chains, where those receiving the services (beneficiaries) are not the same as those paying for them (DPs), has been recognised as a hindrance to effective aid (6). In this study, the fact that the GoT is and agent and both DPs and beneficiaries share their role as principals means beneficiaries' power to hold the government to account may be diminished; they lack power for engagement in the dialogue. This may be improved if the role of beneficiaries as principals is strengthened. One way this can be achieved is by giving a more prominent role to civil society, as representatives of beneficiaries. However, much of the aid effectiveness agenda

focuses on the contractual relationships between DPs and national governments. The involvement of civil society in the dialogue in Tanzania has indeed increased, partly due to DPs' insistence (295), but it is not yet enough (this of course relies on the assumption that civil society can represent the interest of Tanzanian citizens). In addition, a study in Cambodia found that despite investing in civil society capacity, DPs actually sabotaged civil society reform by delivering aid in a fragmented project-based manner (438).

However, although PA is found to be relevant to study relationships within DP and government agencies, there are other factors, such as power and politics, not addressed by PA theory, which were found to have a potential role in both the achievement of social welfare, and the enactment of the aid effectiveness agenda in this study. For instance, Chapter 8 showed that DPs pledged to align themselves to the government system and initially made some progress towards this, although this is now reversing. On the one hand, this is driven by DPs' role as agents of their home populations, and the pressure they have to show results quickly. But on the other hand, DP headquarters are also subject to political and ideological influences, which have been shown here to influence the choice of funding modality.

This is also the case with harmonisation, where a lack of incentive alignment between the DP headquarters and the national office prevents DPs, as multiple principals, to coordinate, resulting in inefficiencies and hindering DP ability to hold the government accountable. This echoes findings from a similar study in the health and education sectors in Zambia, where Leiderer found collective action problems explained the lax adherence to aid effectiveness principles (38). However, in this study harmonisation was found to be further complicated by the political nature of decision-making, leading to power struggles amongst DPs; something also observed by Hyden in his study of power relations amongst DPs in Tanzania (295). In addition, this study found that tackling DP power struggles requires government

leadership, which it may not have an incentive to provide, given that by acting as one DP would have much more power (439).

Further, Chapter 8 showed DPs and GoT have not managed to keep each other accountable. This chapter found that this may be in part due to a lack of unity between DPs and the pressures they are under to disburse funds. It also means that by depicting the GoT as an agent, PA theory would assume it is powerless against DPs, however its dual agency of accountability towards its beneficiaries means that this is not the case. In addition, findings from this study suggest the government exerts its power in different ways (for instance, by excluding DPs from some negotiations). Furthermore, a number of government agencies are active in the health sector, resulting in no clear chain of accountability, and are not included in the PA framework. This suggests that either DPs do not have as much power as would be assumed, or they are either not using it or are directing it too narrowly at the MoHSW. For instance, issues of fungibility (Chapter 8) and allowances, which affect the health sector, should be addressed at the GBS dialogue. This would call for DPs to be more engaged in the national politics of Tanzania; however, individual incentives together with the hierarchical structure of DPs currently stop this from taking place. Further, this may also be difficult because DP involvement in country politics may go against the principle of ownership and respecting GoT sovereignty.

Apart from incentive alignment, the aid effectiveness agenda intended an increase in the availability of information. Chapter 8 reported that this was partially achieved through harmonisation efforts (which increased information sharing among DPs) and a shift towards managing for results (which improved the quantity of information available from the GoT, although more needs to be done to improve its quality). However, DPs did not fully understand the government public financial management and procurement systems, and found it hard to obtain certain information from the government. This is likely a

consequence of moving towards a government system, as DPs would naturally have less information than in vertical, project-based modalities (295). However, a lack of information is also a function of limited institutional memory, which results from short postings (295). DP rotation practices observed in this study therefore contribute to a lack of information. Furthermore, government hierarchical structures meant information-sharing was difficult between and within government agencies. Theories that regard information as power would explain why different players may not want to share information (298), but this also highlights the danger for DPs of being less involved technically, as they would decrease their knowledge of the sector and therefore their power. Despite the above and although more progress remains to be made, this study suggests the implementation of the aid effectiveness agenda has reduced information asymmetries.

The findings in this chapter are subject to two key methodological limitations. First, the institutional set up is unique to Tanzania, and therefore some of the findings are context-specific. However, it is hoped that key weaknesses described in the approach to development can be translated to other contexts that are facing similar issues and institutional setups. Second, analysis of power dynamics and the political context was used to complement weaknesses of PA theory, rather than an analysis its own right. Although some attempt was made to explore power beyond the visible dimension of power as decision-making, the design of the study and methods used did not allow for in-depth exploration of less explicit dimensions of power, such as Luke's second and third (power as non-decision making and thought control) dimensions of power (300). These dimensions of power are harder to measure and would involve understanding the spaces for engagement and the levels of power (local versus global) (440), but in doing so would provide a more complete picture of who and how determines what decisions are made. However, this is also a strength of the approach, as combining different disciplines allows for issues to be

explored from different lenses and eventually to propose better informed recommendations to improve the aid system.

Nevertheless, this chapter has also made some important contributions to the development literature. First, it has explored the applicability of the PA framework to evaluate aid relationships, and has found that whilst it is very useful for internal relationships within agencies, some of its assumptions do not hold for government-DP relationships. This is because PA theory misses some of the complexity of the context DP-government relationships take place and power dynamics in these relationships, which are neither simple nor static. To explore and unpack these in depth, it is useful to adopt theories and methods from the political sciences, such as power frameworks and stakeholder analyses. Second, the modified framework developed as part of this study can be applied to other sectors and contexts to evaluate the application of the aid effectiveness agenda or any other policy. Third, it has also shown a way of bridging across different disciplines arising from managerialistic and non-managerialistic approaches to development to analyse whether the institutional set up of the health SWAP in Tanzania is conducive to achieving the global aid effectiveness agenda.

In conclusion, although progress has been made towards decreasing information asymmetries, the aid effectiveness agenda has not been fully successful at aligning the incentives of the different actors active in the Tanzanian health SWAP. Therefore the agenda is relevant and needed, but the current technocratic approach may be insufficient to improve incentive misalignment. The results of this study suggest that to increase incentive alignment that would further the attainment of the aid effectiveness agenda, agencies involved in aid should undergo institutional reform. Furthermore, the agenda may not be sufficient, as it does not address important policy factors, such as the different government agencies involved, the different levels of government-DP dialogue and the

political context in which aid relationships are played out. In a study of the application of the Paris Declaration in Colombia, McGee also argued that development aid is a political rather than technical exercise and the application of the five principles of aid effectiveness increases complexity and encourages power games (187), and in Vietnam Dodd and Olive argued that aid reforms need to be understood as political, rather than merely technocratic efforts (100). This chapter would therefore recommend DPs explore ways to address the politics in which aid takes place, whilst still respecting country ownership.

10 DISCUSSION

The aim of this PhD project was to develop and apply methods to assess and explain the achievement of the global aid effectiveness agenda at the country level, using the Tanzanian health Sector Wide Approach (SWAP) as a case study. To fulfil this aim, the following objectives were undertaken:

1. To describe the history and the current structure of the Tanzanian health SWAP policy landscape
2. To analyse health financing flows (domestic and external) to Tanzania during the time period of 2000-2010
3. To develop a set of indicators to measure whether the implementation of the Tanzanian SWAP is consistent with the principles outlined in the global aid effectiveness agenda
4. To apply the indicators developed to assess the extent to which aid effectiveness principles have been achieved
5. To explain the achievement of the aid effectiveness agenda through an analysis of institutional factors and relationships between the actors present in the Tanzanian health SWAP using a political economy framework
6. To develop policy recommendations based on the findings for national policymakers implementing SWAPs, Development Partners (DPs) and researchers at the national and global level

This chapter addresses the final objective of the thesis. It first summarises the overall findings from this study. It then shows what this thesis has contributed to knowledge, before outlining the limitations of the research. The chapter concludes with policy and research recommendations based on the results of the thesis.

10.1 Summary of findings

The aid landscape of Tanzania is characteristic of the changes that have taken place globally in the last 15 years, with flows of Development Assistance for Health (DAH) increasing exponentially, new actors appearing (such as the Global Fund and GAVI), certain bi-laterals gaining importance (such as the United States (US)) whilst more traditional multi-lateral agencies (particularly the United Nations) representing a decreasing share of resources. The management of the Tanzanian health sector has experienced some important changes with the establishment of the sector wide approach in 1998, the health basket fund in 1999 and the adoption of national strategies of aid effectiveness as well as all international declarations of aid effectiveness between 2000 and 2010. The Tanzanian health SWAP therefore makes for an ideal case study to explore whether and how the global aid effectiveness agenda has been achieved at country level.

The Tanzanian health SWAP has a unified sector plan with a medium-term expenditure framework, common funding arrangements and DP harmonisation structures and a joint annual health sector review. This is consistent with the key elements of the SWAP approach (418, 441), and is supported by the aid effectiveness agenda, which advocates for an approach to delivering development assistance that is owned by the recipient country, who designs its own development strategy, to which all DPs adhere, working under a harmonised approach that is focused on managing for results, for which DPs and government are mutually accountable. This study used a mixed-methods approach to develop and apply a framework to analyse the Tanzanian health SWAP through the lens of the five principles of aid effectiveness: ownership, alignment, harmonisation, managing for results and mutual accountability. The rest of this section summarises the findings of this thesis, and is structured following the five principles of the agenda.

10.1.1 Ownership

Having a unified plan and expenditure framework is a core component of the Sector Wide Approach and is also the indicator for measuring country ownership in international declarations. All actors active in the Tanzanian health sector work under the Health Sector Strategic Plan (HSSP), which is linked to the medium-term expenditure framework; thereby meeting the country ownership principle in international declarations.

This study found ownership was the hardest principle to define and assess for three reasons. First, the definition of “country” has evolved, in the early years of SWAP being interpreted as the government, but later broadening to include participation of non-government actors in the dialogue. Second, the definition of government is unclear, with DPs mainly engaging with the Ministry of Health and Social Welfare (MoHSW), whilst other government agencies with more power over the health sector are not very active in the health dialogue, including the Prime Minister's Office Regional Administration and Local Government (PMO-RALG), the Ministry of Finance (MoF) and the President's Office Public Service Management (PO-PSM) at the central level, and the regional and council management teams at regional level and below. Further, despite the global aid effectiveness agenda assessing ownership based on the existence of a plan and expenditure framework, national interpretations of ownership went beyond this to include aspects such as the extent of national actor participation in the SWAP dialogue and the degree of government leadership in decision-making.

The extent to which the Government had ownership over the main priorities set in the plan was hard to assess, but this study findings suggest that there is still some way to go. The HSSP was very broad (encompassing 11 strategies and 6 cross-cutting themes). Furthermore, this study found that the extent of leadership, and thus ownership, of the government in the process of priority-setting and decision-making within the health

strategy and expenditure framework was mixed. Officially, priority-setting took place annually as part of the joint annual health sector review. This study found many stakeholders perceived this process as being DP-driven, echoing concerns in the literature over the influence of DPs on priority-setting in aid dependent countries (442). Moreover, in recent years the government's participation in the SWAP dialogue has decreased, something that was attributed both to a lack of government capacity and willingness to engage. Nevertheless, this study found that the SWAP dialogue was often not the real forum for decisions regarding budget allocations (likely decided by some actors not present in the dialogue with DPs, such as the MoF, PMO-RALG and POPSM). This was perceived by some to be an indication that the SWAP dialogue was more a requirement from DPs, than a government decision-making forum, something that has also been suggested in Malawi (423) and globally (191). The study also found some evidence that the government determined overall amount of funds going to the health sector and different sub-sector priorities by adjusting its own expenditure to the changing patterns of aid flows (fungibility).

Finally, this study found no mechanism has been put in place to encourage ownership of or direct accountability to the Tanzanian population (beyond accountability through their elected representatives). It is hoped that increased participation of civil society in the SWAP dialogue can improve this (although this would only be of use if the dialogue is the actual forum for setting priorities and if civil society are able to represent the interests of the Tanzanian population). This has been particularly encouraged in the Accra Agenda for Action, but also in the literature (183).

Institutional analysis provides some explanations for the results found. On the one hand, DPs were found to have a variety of motivations for providing DAH, including humanitarian reasons, but also to serve their own individual and institutional interests. Some of these

motivations may not be fully aligned with the interests of the government or beneficiaries, and therefore DPs may not have an incentive to grant them full ownership of the process. Government incentives were to stay funded and win elections. While both of these motivations may be considered to be in line with the interests of beneficiaries; the former may create a culture of aid dependency, which over time may not enhance ownership, and mean that governments may not act in the interest of the Tanzanian population, but act in the interest of DPs. This may suggest that DPs (as providers of development assistance) are in a more powerful position than the government (as recipient) (6), which would not be conducive to government ownership. However, this study found this is not fully the case in Tanzania, as the government also has ways of exercising its power, by excluding DPs from some negotiations (such as discussions of the budget ceilings) that happen away from the SWAP dialogue.

In conclusion, despite ownership being regarded as a key principle of aid effectiveness, the interpretations of country ownership varied between the global and national level, but also between different stakeholders. The Tanzanian health SWAP has been successful at setting up a forum for all actors to meet and jointly agree on priorities, which is a significant undertaking, given the amount and variety of actors present. However, the degree to which the SWAP has been able to address and balance the power of different actors remains limited, and the extent to which the beneficiaries' interests are represented unclear, with civil society having a limited voice. Ownership is also difficult to achieve because the interests of the different actors are not fully aligned. Further, there has been relatively little discussion on the desirability of the ownership principle, if it is interpreted as DPs not being technically involved, as DPs may also make valuable contributions to the development process. The key may be to achieve a balance between country ownership and partnership with development partners and other actors active in the health SWAP (425), as the

government has more information about the country context but DPs can contribute important technical competencies.

10.1.2 Alignment

The second component of the SWAP is for DPs to use common funding arrangements. This corresponds with the principle of alignment in the international aid effectiveness agenda, which goes further by urging DPs to use strengthened country systems, and in national aid policies, which specify that DPs should deliver DAH in the form of budget support and pooled funds. Definitions of alignment were quite consistent between the different sources reviewed in this study; the indicators developed to measure it focused on the degree of use of country systems, the quality of these and trends in the different funding modalities.

This study found that there has been a shift towards working with the government systems with the amount of funds delivered through government financial systems increasing from \$35 million to \$441 million; although as a proportion of total DAH, the amount of DAH delivered through the government stayed constant between 40 and 60%. One dimension of the SWAP approach (supported by the national aid effectiveness agenda) is for DPs to reduce their direct funding of vertical projects; and engage in supporting the government set priorities across the sector through a basket fund (443). However, although the amount of DAH channelled as budget support and basket funds increased, the main increase in the use of government systems was driven by the rise in vertical funding, making up to 70% of all DAH and about 40% of DAH delivered through the government by 2010.

Moreover, although early enthusiasm on the SWAP and the aid effectiveness agenda resulted in most agencies (although not all) shifting towards using government systems and delivering funds as budget support and basket funds, this trend is now beginning to reverse, with some DPs moving out of the basket fund and reverting back to projects.

Conversely, there are signs that some of those who did not initially move towards using the country system may do so now, even in the form of pooled funds, which means the health basket has been highly fluid with some DPs moving away from it whilst others are joining it. This fluidity of the commitment by DPs to using country systems raises questions regarding the desirability of DPs using the system, as it may impact government's ability to plan in the medium and long term.

Institutional factors go some way towards explaining these trends. First, there were concerns from some DPs regarding the quality of the government system, and a perception amongst most respondents that it had not improved sufficiently under the SWAP. This challenges the view that DPs can strengthen country systems by using them (378). Instead, DPs were criticised by non-government stakeholders for having moved to using government systems too quickly, without investing in institutional reform and capacity (something DPs themselves admitted). From the DP perspective, lack of system strengthening was also regarded as a reflection of a lack of willingness from the government to embark on a health sector reform. Worries about the absorption capacity of the government to manage DAH, particularly given the huge increases in DAH (from \$34.5 million in 2000 to \$718 million in 2010), have also resulted in DPs disbursing through Non-Government Organisations (NGOs). DP disbursement of funds through non-government channels may have some benefits in terms of civil society strengthening and increasing capacity; however, it has been previously shown to fragment the aid management system and may weaken government health systems by attracting workers from government into the NGO sector through higher salaries (88).

Second, some DPs felt that the amount of information sharing did not improve sufficiently after joining the government system. This could be expected to some extent, as by using the government system to deliver funds, DPs are relinquishing some control as to how

funds are used, yet some DPs also felt it was a result of the government being reluctant to share information with them. The lack of information sharing contributes to a lack of trust in the government aid management system, which means DPs still require checks and balances (basket) or vertical projects to maintain their accountability, rather than funding the government completely through general or sector budget support.

Third, the trend to channel more or less aid flows through pooled funds were reported to be a result of the pressures DPs are under to show results quickly and needs for visibility, in some cases highlighting that accountability towards their headquarters and constituencies may be stronger than to their commitments on the ground. The changing economic climate and political changes in DP home countries also affected the management of aid. For instance, the appointment of new development ministers was reported to result in ideological changes – such as not using pooled funds – being pursued globally, without taking into account recipient country contexts or previous commitments. This raises concerns about DPs using the government system to push their own political objectives rather than adapt approaches to the situation on the ground. In his 2008 discussion paper, Knoll argues that this has happened when delivering General Budget Support (GBS), where conditionality rules have been more influenced by Bretton Woods Institutions perspective on economic reform, rather than with recipient country-owned poverty reduction strategies, and that progress towards alignment and harmonisation was slower than DPs' need for visibility and improvements in public financial management systems and transparency (444).

Findings therefore show that initial enthusiasm with the SWAP approach corresponded with an increase in the delivery of DAH through government systems and in the form of pooled modalities. Unfortunately this progress is now reversing due to a perceived lack of capacity of the government systems and DP needs to retain control of how funds are spent

and to show the results achieved with them, partly driven by changes in the political and economic climate.

10.1.3 Harmonisation

In Tanzania, under the SWAP, development partners have set up coordination structures and mechanisms to improve DP harmonisation, including the Development Partner Group for Health, the basket fund committee and delegated cooperation. The principle of harmonisation was initially given the most importance in the global aid effectiveness agenda, but since the Paris Declaration this has decreased, in an effort to attract non-Development Assistance Committee DPs (382). This decline was not observed at the country-level in Tanzania, where DPs have become increasingly harmonised and harmonisation was perceived by many government and non-government stakeholders as a success of the SWAP.

The indicators developed to assess harmonisation in this study fell into two categories: the degree of fragmentation (based on the literature) and the success of coordination mechanisms at increasing information-sharing and reducing transaction costs (based on national and international declarations) and bringing DPs under a common position when negotiating with the government under the SWAP dialogue (based on respondents' interpretation of harmonisation).

This study found that information sharing amongst DPs has increased, but has remained superficial and has not resulted in fully harmonised planning and reporting procedures. Lack of counterfactual meant the effect of the SWAP on transaction costs could not be estimated; although results suggest transaction costs remain high. DPs have improved their ability to speak in "one voice" when interacting with the government, although more progress is needed as competing voices still undermine each other in the dialogue with the

government. Fragmentation has been shown to have increased during the time period of study (2000-2010) despite the introduction of pooled funding mechanisms and coordination efforts, with the number of DAH projects increasing from 55 in 2000 to 334 in 2010 and the number of DPs active in the health sector going from 19 to 33 during the same time period.

This study has found several institutional factors hampering DP harmonisation efforts. First, DP accountability lines, which are stronger towards their headquarters, have sometimes hindered them from fully aligning their incentives on the ground and adopting a common approach when negotiating with the government (particularly when disagreements arose between different DPs, who often had different ideas on how DAH should be managed). The basket fund committee meetings have had some success at bringing DPs together; however, not all DPs participate in this forum. Second, some DPs believed that if the government had stronger leadership and required them to work under a harmonised approach, harmonisation would improve; although the government may not have an incentive to do so, as it may make the DPs stronger (something previously found in the Bangladeshi health SWAP (439) and de-centralisation and governance policies in Indonesia (445)). Third, agencies delivering their funds through vertical projects, particularly those targeting HIV/AIDS were found to undermine DP harmonisation efforts, by having their own separate dialogue and coordination structures (field visits and reporting requirements), driving fragmentation. However, there are signs that they are becoming more integrated into SWAP coordination and dialogue structures.

Therefore, findings show that DPs on the ground have made impressive progress in coordinating their resources, adopting a common position and reducing (although not eliminating) parallel dialogues with the government. This is particularly needed given that increases in funding have come with increased levels of fragmentation. However,

harmonisation efforts were hampered by DP reliance on headquarters (particularly when there were differences in opinion or ideological shifts) and project-based vertical approaches, particularly those targeting HIV/AIDS.

10.1.4 Managing for results

The Tanzanian health SWAP has a performance assessment framework, thereby fulfilling international aid effectiveness declarations for managing for results. In addition, there has been a shift in management practices at DP head offices to achieving results. However, the indicators developed in this thesis to assess the extent of managing for results in the context of the Tanzanian health SWAP show a mixed picture. First, a review of the definitions of managing for results revealed disagreements regarding what “results” were. Despite most definitions encompassing outputs, outcomes or impact, the core of DP internal performance assessment was based on inputs in the form of disbursement ratios. This performance assessment practice was not conducive to managing for results, and hindered DPs from adopting a harmonised approach and holding the government accountable. Second, despite significant efforts to unify the performance assessment framework, government and DPs still face regular data requirements for parallel assessments of performance. Finally, although they certainly play a role in decision-making, results do not form the basis of the SWAP dialogue.

However, the shift to measure and manage for results has increased sharing of information, particularly amongst DPs, but also by the government, increasingly making information on health expenditure available online, carrying out assessments and making them public. Despite growth in the quantity of data that are available, this study found that poor data quality was the key constraint to holding DPs and the government to account. For instance, data on financial flows (inputs) were difficult to obtain directly from the government, so a combination of global and national publically available data sources was

used in this study. This sometimes resulted in different results for the same indicator (for instance, the amount of total DAH in 2009 varied from \$5.6 billion in the OECD Creditor Reporting System to \$6.8 billion in the National Health Accounts). There are hopes that data quality will improve with the setting up of the aid management platform for external resources by the government, but this needs to be made publically available. Data on outputs and outcomes are available from the Health Management and Information System (HMIS). However, these data were perceived by some of the stakeholders interviewed to be unreliable. Efforts to improve the availability and quality of data are ongoing. Furthermore, some indicators are difficult and costly to measure, particularly if needed on a regular basis.

Once more, institutional arrangements were found to undermine SWAP mechanisms for managing for results. DP and government internal performance assessment procedures were not results-driven and therefore not conducive to managing for results. DP performance was assessed primarily on inputs through the proportion of funds disbursed. Government performance assessment was harder to ascertain, but the remuneration system based on allowances and *per diems* for attending meetings and training workshops was not perceived to be linked to achieving results, as it rewarded government employees' attendance at meetings and training workshops at the cost of their daily tasks. Although activities rewarded by allowances were perceived as sometimes necessary, respondents felt the time spent on them was excessive compared to other activities that may have been more conducive to achieving results.

Managing for results has received increased emphasis in the global aid effectiveness agenda, which has led to some concerns, and also go some way in explaining the results found. First, there are worries that increased monitoring and evaluation are leading to a proliferation of indicators and disproportionate reporting requirements, without

understanding the causes of poor availability of health statistics or investing sufficiently in health information systems (446), also reflected in this study. This may explain the pressures DPs are under to measure and show results. Further, the emphasis on results has given rise to tensions with disbursement through horizontal (pooled) modalities, where results cannot be easily attributed to a single agency. Pressures to show results favour vertical projects, as they may be more effective in the short run, allow for visibility of results and for DPs to more easily take credit for achievements. This pressure to show results may therefore in part explain modality trends reported above. It is indisputable that DAH should achieve results and ultimately improve the health of the beneficiary population, and there have already been criticisms that DAH itself and its evaluations have been too process-driven, rather than based on outputs and outcomes. Results need to be achieved, and a push to accomplish them is needed; however, this is not synonymous with DPs' needs for quick results and visibility.

Therefore, although there has been some progress towards measuring results and making information available, this change in approach is still to be translated into institutional reform to align DP and government incentives to manage for results. Furthermore, there is a need for a more explicit definition of what managing for results means in practice and how it can be implemented without detriment to other aid effectiveness principles.

10.1.5 Mutual accountability

Mutual accountability takes place through the Joint Annual Health Sector Review, which is a DP-government joint assessment of mutual progress, and forms the core of the health SWAP dialogue. Despite being a comprehensive evaluation exercise, not all DPs rely on it exclusively, and some still require separate reports from the government as part of their vertical programmes. The indicators developed for this study assessed mutual accountability as the extent to which DPs and government held each other to account.

As with other principles, having a structure in place is no guarantee of mutual accountability taking place. When the government did not keep to its commitments DPs struggled to hold it to account. There were several reasons for this. First of all, DPs were not unified and undermined each other's efforts of holding the government to account. This again shows that DPs have not aligned their incentives, as meeting their own goals was more important than keeping the government to account, again stemming from DP accountability to their head offices. Second, respondents felt the only tool available for DPs to hold the government to account was to withdraw funds, which was difficult because of their performance assessment procedures were based on the proportion of funds spent, but also because of fears of punishing the local population. Third, the health sector in Tanzania has a diffuse nature, with different agencies at the central, sector, regional and district levels having different roles and responsibilities. Despite this, the MoHSW is the central focus for the sector's accountability. As a result, DPs are aiming their influence too narrowly. For instance, issues of allowances and fungibility should be dealt with at the level of the MoF, and the districts are accountable to the PMO-RALG; however, both MoF and PMO-RALG have little engagement with health sector DPs. Finally, for DPs to be able to hold the government to account they need to have power over the government. This study found power relations were complex, with the government also exercising power, for instance by excluding DPs from some negotiations or pre-agreeing the overall health sector budget before meeting with DPs. This also suggests framing the DP-government relationship as contractual may not be entirely accurate.

Under current SWAP arrangements there are no mechanisms for the government to hold DPs to account. This has previously been highlighted as an issue of concern (442), with studies emphasising a move to approaches that rely on government systems not being synonymous with DPs having less responsibility to account for the use of their financial resources (167).

Furthermore, the main line of accountability of government and DPs should be towards the beneficiaries. At present there is little way of accounting to beneficiaries, although the increased role of civil society may go some way to improve this (433). A study on Tanzania accountability mechanisms found that civil society (particularly the faith based sector) was well respected by the government, but more as a potential supplier of development projects for DPs' constituencies than to represent Tanzanian citizens (406), suggesting more needs to be done to strengthen civil society's capacity to represent citizens. In addition, DPs are in a difficult position, as they also need to be accountable to their funders, and there is a geo-political distance between funders and beneficiaries preventing funders from knowing the needs of beneficiaries and their satisfaction with the services they receive.

In conclusion, comprehensive regular accountability mechanisms have been put in place. However, they may not involve the right actors, both in terms of who is accountable (the MoHSW should not be the only government agency to be held accountable) and towards whom accountability is directed, as there is little accountability to the Tanzanian population. In addition, accountability mechanisms are not working as well as they could, as institutional factors and the government's own power hinder DPs from holding the government to account, and there are no mechanisms for the government to hold DPs to account.

10.1.6 Conclusion

The move towards a health Sector Wide Approach that adopts the five principles of aid effectiveness in Tanzania has been a huge effort on the part of all actors involved, which has seen commendable improvements in the way DAH is managed, bringing all actors together under a unified sector plan. This is no easy task given the variety of stakeholders

involved, their different motivations and the political context in which these relationships are played out.

Despite these achievements, actors have become fatigued with the process and disheartened at the slow pace of progress towards aid effectiveness and the management burden of new aid modalities. DPs informally compared working under the SWAP to being in an “*unhappy marriage*”. There is now a real danger of DPs moving back to old ways of working and reverting back to project-based approaches (after all, so far the history of development has followed cyclical patterns), and thus ending this marriage.

This thesis has contributed evidence to a fragmented literature on an issue that is so context-dependent that it can only be meaningfully evaluated through the use of case studies (either single or multi-country). In many ways the findings of this study support previous evaluations of the health Sector Wide Approach and the aid effectiveness agenda. For instance, an evaluation of the International Health Partnership found progress in national planning processes, mutual accountability and use of country systems, but little evidence of improvement of the quality of public financial management systems and of integration of performance assessment frameworks (189). Further, this study has shown that although international declarations and the introduction of the SWAP have led to a more coordinated delivery of DAH, despite over 10 years of literature and high level forums, DPs and governments are still grappling with the same issues of power that undermine DPs’ ability to harmonise found by Buse and Walt in the late 1990s (50, 383).

In contrast, this study found the approach adopted to achieve aid effectiveness in Tanzania (encouraged by the global aid effectiveness agenda) was essentially technocratic, based on setting up processes to achieve the five principles. However, all actors need to go further and reform their institutions to enable these processes to serve their real purpose of enhancing country ownership. For example, DPs should align with the government under a

harmonised approach that achieves results, for which all agencies are held accountable. Further, aid takes place in a heavily politicised environment, both globally and nationally at the level of donor and recipient countries. A technocratic approach was perhaps undertaken by the international community to avoid the politics of aid; however, in doing so it undermines itself, and indeed a study in Colombia has shown may even increase complexity and encourage power games (187). An approach that addresses the political context in which it is embedded is more likely to succeed.

Finally, SWAP structures need to be reformed, as currently they are too burdensome and the level of discussions is too superficial. This not only requires institutional reform, but a flexible, step-wise approach that is adapted to each recipient country. This echoes recommendations from previous studies, which found that in Mozambique incremental approaches (where DPs demands increased progressively as the system strengthened), DP willingness to take risks and adopting a long-term view were determined to be critical factors for the success of aid management mechanisms (381), and in Zambia where a study found the SWAP could improve by taking contextual factors into consideration (447).

It is unclear exactly what “working with the country” means in practice, in terms of how funds are disbursed, the degree of technical and political involvement, how results are measured and how DPs can be held to account, with sometimes contradictions between the different principles. There is a danger of applying “universalist” aid effectiveness principles to diverse contexts (187), and the uncertainties highlighted in this study can only be addressed at the country level through a flexible approach that encourages a certain degree of risk-taking and innovation, and is therefore sometimes allowed to fail.

10.2 Methodological findings and limitations

The literature review in Chapter 2 revealed methodological difficulties in assessing whether aid effectiveness principles are achieved, the reasons for this, or even in how to measure achievement. Some of these difficulties included data availability, lack of counterfactual and the importance of contextual factors. This study has been affected by these and other factors, but has also sought to make some inroads into improving the methodologies and data sources available to evaluate aid effectiveness. This section describes the methodological limitations and contributions of the approach used in this study, summarised in four categories: the case study approach, the study design, measurement of aid effectiveness and the theoretical framework. For each category, the contributions to the literature and limitations encountered are described.

10.2.1 Case study approach

Previous studies examining DAH effectiveness issue did so by means of quantitative analysis across multiple countries (19-21, 448) or very in-depth single-issue case studies in a single country (22, 53-54). This PhD has explored DAH from the perspective of a recipient country, but looking at the aid effectiveness agenda as a whole, rather than concentrating on a single aspect of it.

Taking the perspective of a recipient country has several advantages. First, cross-country health resource tracking studies are useful for holding DPs to account globally and identifying issues hindering the effectiveness of aid globally. A recipient country case study provides complementary information resulting from in-depth analysis of the distribution and management of resources at the country level, facilitating recipient countries holding DPs to account on commitments to principles of aid effectiveness and providing information to guide dialogue and priority-setting.

Methodologically, focusing on a single country has allowed for access and contrasting of different global and national data sources, thus providing a more complete and accurate picture of the health financing landscape of a country. Further, given the smaller size of the database, doing a single country study enabled manual review and coding of individual disbursements. This is a very labour intensive process that would not be feasible at the global level, but that allows for a more accurate description of results, as some categories have a high proportion of blank fields (for instance the channel of delivery field was empty for over 80% of projects up to 2003, gradually decreasing to 20% in 2010). In this thesis the channel of delivery and sub-sector distribution were manually re-coded for all health projects in the time period of 2000-2010 (manual re-coding allowed for the identification of the channel for about half of the empty cells), which is the first time this has been done in Tanzania and in so much detail (a study of DAH modalities in Uganda undertook some re-coding, but not in as much depth (37)). Studies of fragmentation often use data from the OECD without the necessary re-coding to distinguish between projects and single transactions (a DAH project can be delivered through several transactions, therefore not differentiating between the two may result in overestimating fragmentation levels) (44, 134), which has been done here. This is also one of the few studies to analyse DAH flows together with domestic expenditure, which allows for the analysis of the interaction between the two sources of financing, and the eventual repercussion of external funding on domestic resource allocation; however, this analysis is hindered by availability and quality of data (domestic resource flows are harder to obtain).

Second, the case study approach enabled an assessment of how globally agreed principles are understood and implemented at the country level and whether aid effectiveness principles are actually leading to better aid practices, as well as the identification of context-specific solutions that can be undertaken to tackle these problems. A country level assessment of coordination and ownership was also conducted in Uganda, Bangladesh and

Zambia (192); however, this is the first time such a study is conducted for all the principles of the aid effectiveness agenda.

Third, some issues, such as fungibility, are very context specific, but had previously only been studied through the use of quantitative multi-country analysis of trends (19, 64, 67, 72, 155, 158, 162, 357, 449). Such an approach has the advantage of being able to demonstrate statistical significance in relation to selected outcomes. However, there are worries about the quality of the data on which they are based (156) and they cannot shed light on how or why such trends emerge. This study has provided for the first time evidence on this issue from the country level, including reasons why fungibility takes place, the actors involved and suggesting ways it can be tackled.

By taking a historical perspective from the time the SWAP was introduced, this study has been able to map changes in actors and policies both at the national and international levels. For instance, trends in the use of basket funds and harmonisation mechanisms and the political reasons behind them have not been assessed previously. We have also shown that the principles of alignment and managing for results may undermine each other, as well as put forward proposals for institutional reform in order to align the incentives of DPs and governments to bridge contradictions between the two principles. However, this may also have been a weakness of the approach used in this study, as a historical overview was sometimes difficult to achieve in practice, as older documents were not always available, quantitative data before 2003 were difficult to obtain or of poor quality, and most of the relevant stakeholders had moved on (although it was possible to interview two DPs, one government and one non-government representatives that had worked in the Tanzanian health sector since the beginning of the SWAP).

Whilst conducting a single-country case study has the advantage of taking contextual factors into account; it has repercussions for the generalisability of the findings. This is

because the actors present in the SWAP relationships, the set up of the government and broader cultural norms are unique to Tanzania. It is hoped that the study findings nonetheless resonate among recipient countries with similar characteristics to Tanzania (heavily aid-dependent health sector and SWAP dialogue structures) and among other countries in the region that may have similar government structures and cultural norms. Further, this study has contributed to the theory on DP and government relationships, and therefore may contribute conceptually.

10.2.2 Measurement of aid effectiveness

This study has contributed to the framing of the global aid effectiveness agenda in three ways. First, the study used the aid effectiveness agenda as a framework to evaluate the SWAP (which to our knowledge is the first time it has been done empirically). Second, this thesis systematically assessed the evolution of the aid effectiveness agenda in terms of how the principles are defined, the weight given to them and how the indicators selected to assess them shape the approach to achieve the principles. This was done both through analysing the different high level declarations on aid effectiveness and the literature and interviews. Third, this study developed indicators for two key issues in the literature of aid effectiveness (fungibility and fragmentation) within the frame of the agenda, under the principles of ownership and harmonisation respectively.

Third, this study has developed a novel approach to assessing aid effectiveness in the health sector-wide approach by using a locally-adapted indicator framework of the global aid effectiveness agenda. This is innovative because the global aid effectiveness agenda has been predominantly assessed globally through quantitative measures. For instance, the Paris Evaluation evaluations at the global level only include quantitative indicators (185); although a thematic study of the Paris Declaration evaluation was undertaken (414), it remained focused on the global relationship between aid and development (414). At the

Tanzania level the Paris Declaration evaluation only includes a narrative provided by the government (421). By developing and applying qualitative indicators, this study has been able to provide a deeper interpretation of the issues affecting the implementation of the agenda, such as institutional factors or the degree of participation in dialogue structures, which would have been missed through the use of purely quantitative indicators. In addition, this study is innovative in being the first time some of the elements contributing to aid ineffectiveness (such as fungibility and fragmentation) have been explored as part of the aid effectiveness agenda and through the use of qualitative methods, as previous studies have all been quantitative. This has allowed a deeper understanding of whether and how different stakeholder groups perceive these two factors to hinder aid effectiveness and what could be done to improve the situation. Further, framing these two issues through the lens of the aid effectiveness agenda has allowed for a different understanding of them, for instance, when interpreted as part of country ownership, fungibility may look rational rather than the more commonly held view of something negative and detrimental to aid effectiveness. Finally, the principles of the global aid effectiveness agenda and the indicators developed to assess them lack clarity, are sometimes incomplete and are not applicable to all contexts. Therefore, by developing a country-specific assessment framework, this study has shown a way to apply the agenda in country.

However, there are several limitations to the approach taken to study aid effectiveness. First, this study did not assess the effect of DAH on health outputs or outcomes; it rather concentrated on the achievement of the agenda designed by the international community to help achieve these outcomes. This was an unanswered question worthy of investigation, and data constraints in many low income countries mean it is simply not possible to obtain annual outcome data. Furthermore, it would be very hard to attribute changes in DAH to changes in outcomes at the country level because of a lack of counterfactual and the

limited data available. However, a comparison between two different regions that receive different amounts of DAH, or that are favoured by different DPs, may have allowed for this.

Second, using an approach that focuses on the agenda as a whole required the use of quantitative and qualitative methods. Although this is necessary to conduct a comprehensive study of the implementation of the agenda as a whole, it inevitably results in forgoing the depth that could be achieved by focusing on one aspect of the agenda, for instance by conducting an ethnography of the government's ownership over the health SWAP dialogue. In addition, some elements of the agenda, such as managing for results, generated less discussion during the interviews and have therefore received less attention in this thesis than other issues, such as ownership and harmonisation.

Finally, the view of mutual accountability and ownership adopted in this study was narrow as it only included government and DPs, whereas the main accountability should be towards beneficiaries. This broader definition is included in Busan and would be important to explore more in further studies, as their perspectives are absent in this study.

10.2.3 Methodological approach

Although the methodological approach to assessing aid effectiveness was innovative, there were some limitations to the individual methodologies used in this study. This includes the quantitative and qualitative methods as well as the procedure used to integrate them.

The quantitative part of the study had several weaknesses. First, the overall amount of DAH has been underestimated because regional funds were not included. Second, despite manual re-coding, gaps remained in the database compiled for the study. These have been shown in the graphs, but may have altered the distribution of resources, although it is impossible to predict how. Further, accessing domestic health financing data was challenging. A combination of different data sources was used, and although careful

consideration was given to where data were obtained from, the different sources may have produced different results. Further, as only aggregate data were available for domestic health flows, it was not possible to check its accuracy or perform manual re-coding. Third, the amount of DAH delivered outside of the government is an underestimate as funds from international NGOs are not included. GBS funds were included in this analysis rather crudely (assuming that the amount allocated to health is equal to the proportion of total government expenditure on health), which may not be accurate, and may have resulted in an underestimate of how much DAH is delivered to the health sector if DPs attach strings to sectoral allocation of GBS. Fourth, it was not possible to fully disaggregate DAH funds into single disease and health systems, as single disease funds contribute to health systems functions and health systems funds benefit vertical disease programmes. Data constraints have meant that two indicators of the global aid effectiveness agenda (predictability and tying) were not included, which restricted the scope of the indicator framework. In addition, the fragmentation index may have been overestimated, as some DPs coordinate funds through delegated cooperation (by disbursing to another DP). Although these projects would still incur a transaction cost, it may not be incurred by the government, and would still be lower than if they were disbursing each project individually.

The qualitative part of the study also had some limitations. The most important limitation of the study is the under-representation of the Tanzanian voice. Several factors have contributed to this. First, when undertaking the interviews, many of the Tanzanian respondents did not allow the interview to be recorded. This may decrease the accuracy of the representation of their views, as I was relying on my notes, rather than transcriptions, and was not able to re-listen to the interview to contextualise the tone in which respondents spoke. Second, most of the GoT respondents did not give permission to be directly quoted. Efforts have been made to incorporate their views in the narrative (in line with their wishes), but their voice is largely absent in the form of quotes. In addition,

interviews were conducted in English, as all Tanzanian respondents readily spoke English, and to reduce the inaccuracies of having transcripts translated, or having a translator present whilst conducting the interviews. However, there may have been differences in the content of what was said in the interviews if respondents felt less comfortable speaking in English or if there were concepts they were not able to readily translate. It is hoped that attendance at meetings and informal conversations over the course of the fieldwork go some way to avoid misrepresenting their views. In addition to practical limitations to representing Tanzanian views, the interpretation of the results would have been biased by my cultural background and philosophical beliefs, which are different from those of a person of Tanzanian origin. Having stayed in the field for a year greatly facilitated my understanding of local culture and customs, but being foreign influenced both the information that was given to me and the way it was interpreted.

There are also some limitations to the sampling strategy used to identify interviewees. The inclusion criteria were for actors to be active in the health SWAP dialogue and I sampled to saturation (until no new themes arose). However, this research would have benefited from the views of actors present but not active in the dialogue; for instance, faith based organisations and the private sector, but also representatives from central ministries such as the MoF and POPSM (although access to the latter may have been difficult). Given that saturation was reached, it is hoped that the impact of this is minimal; however, it is not possible to predict what representatives of these groups would have contributed. It was not possible to interview one respondent, and therefore their views have been missed.

A similar concern arises from the document review, as some of the documents that were intended to be included in the review were not available; for instance a report carried out by the Controller and Auditor General on the allocation of resources by the Medical Stores Department could not be accessed in full, but only as a summary PowerPoint presentation.

Also, only the final version of the Milestones agreed for the Financial Year 2012-13 was available, but not the intermediary one that was subject to great discussion and prolonged negotiations. Finally, ethical restrictions have prevented the reporting of some of the content of the meetings observed, which would have added to the evidence on which this thesis is based.

There are also limitations to mixing different methods. Although care has been taken to be transparent about the reasons for using different methods and the method used to integrate them, the use of different methods inevitably means less depth was achieved with each of the methods. Further, some would argue against using quantitative and qualitative methods, as they come from fundamentally different positions (223) and may undermine the quality of qualitative methods. This is not the view taken here, however, as qualitative methods are viewed as having provided essential explanations to the quantitative trends observed, rather than being added as a complement to quantitative methods. Nevertheless, future evaluations of the aid effectiveness agenda and the SWAP would benefit from employing a mix of quantitative and qualitative methods. This may be more resource-intensive and may not always be feasible to do in depth, particularly at the global level; however, studies may benefit from including some open ended questions in quantitative questionnaires.

10.2.4 Conceptual approach

This study has contributed to the literature conceptually by exploring the relationships that underlie the “DAH system”. It has tested some of the hypotheses raised by previous studies empirically, and generated new evidence on how these relationships take place on the ground, which incentives are at play, how different stakeholders are accountable to each other and how stakeholders exert power over each other. It has used Principal Agent (PA) theory empirically for the first time to frame the aid effectiveness agenda, and it has

extend previous work on PA in Uganda (405) by conducting empirical research at country level of macro- and micro-institutional factors affecting the attainment of the agenda (applying the framework set out by Martens et al. (6)). By looking at the whole chain of aid relationships, this study has also been able to show the repercussions of incentives at one point in the chain, such as the impact the pressure DPs have to disburse has on the overall aid system. This study has found that the incentive structure generated by DAH in Tanzania is not fully geared towards the achievement of aid effectiveness principles, and therefore further institutional reform is needed to achieve the agenda.

In addition, this study found that PA theory was relevant to study aid relationships, especially in understanding micro-institutional factors that affect aid relationships (both DPs and GoT have hierarchical structures) and the degree of incentives alignment and information asymmetries. However, PA theory cannot alone describe or explain all the issues surrounding DP-GoT relationships, particularly because the DP-government relationship is not fully contractual and the government has more power than a straightforward PA relationship would depict. It is therefore important to emphasise the political part of political-economic framework. This has recently been called for in the development literature (450-451), but this study argues it is also essential in studies of the health sector.

Perhaps the most important theoretical contribution of this thesis is by going beyond the health and economic literature and adding two dimensions to the analytical framework of this thesis: a power dimension informed by Luke's three dimensions of power (300) and Gaventa's power framework (301); and a stakeholder analysis to explore the political context in which these relationships are played out, and thereby studying aid relationships beyond the aid contract. It is also the first time managerial (efficiency-based) and non-managerial (relationships) approaches are combined in a framework empirically at the

country level. Policy models have previously been used to evaluate the Paris Declaration (78) and coordination in Bangladesh (79); however, this study has examined power and the political context in which actors interact when disbursing and distributing DAH at the national and local level and combined it with economic theory, an approach that would be recommended for future studies of this kind, particularly because the implementation of the aid effectiveness agenda has been essentially technocratic in nature, and therefore following a managerialistic approach. However, this needs to be complemented with non-managerialistic approaches to find ways to engage in the political aspect of aid (rather than avoid it) and propose solutions to achieve institutional reform.

There are also some limitations to bringing together methodologies and theories from different disciplines, in this case health economics and health policy. Although each discipline contributes to analysing the relationships between the actors in this study and this thesis postulates they are complementary, they arise from different beliefs about how people behave. Economic theory is based on the assumption that people are rational, respond to incentives and act in ways that enhance their welfare. On the other hand, some of the works that have influenced the policy arms of the framework would argue that actors are driven by power and political interests. Moreover, one disadvantage of mixing the two disciplines in this study is the level of depth achieved in the analysis. In particular, this study was not originally designed to assess power, and therefore the analysis was mostly limited to dimensions of power that could be observed. A more in-depth analysis of power for instance, would have revealed more information on how and where and by whom resource allocation decisions are made.

10.3 Recommendations

The rest of this chapter provides recommendations for policymakers and researchers based on the findings from the thesis. Recommendations are classified into five themes: tracking health financing flows, the aid effectiveness agenda, the sector-side approach, institutional reform and further research.

10.3.1 Tracking health financing flows

This study can make some recommendations for future health financing tracking exercises, both for policymakers and researchers. First, it is recommended that this type of analysis be performed from the perspective of an aid-recipient country, both by researchers and practitioners, as this enhances ability to hold government and DPs to account at the country level, and provides valuable evidence for the priority-setting dialogue, taking into account resource availability and need. However, this must be accompanied by a real investment in this type of assessments at the country level, as currently most investment at the country level appears to be directed at measuring outputs and outcomes, whilst assessment of inputs is prioritised at the global level.

Second and specific to Tanzania, efforts to systematically and routinely collect data on health financing flows are commendable, but have led to three different processes (Public Expenditure Review (PER), National Health Accounts (NHA) and the Aid Management Platform (AMP)). It may be preferable to unify all three into one transparent system that periodically collates external and domestic health finance data, as this would improve efficiency. The first step to do this is to ensure DPs improve their reporting in country, as in Tanzania national databases were not as complete as global ones (particularly on DAH delivered as vertical programmes). For instance, DP technical assistance may be needed to ensure the AMP is accurate, up to date and transparent. The PER could then be used as the annual mechanism to track domestic and external expenditure (the latter could be

extracted directly from the AMP). As it is less resource-intensive, the PER can be performed in time to assist budget planning. Finally, the full NHA could be performed less regularly (every three to five years), given that it is more resource-intensive. This would compromise the ability of researchers to perform cross-country comparisons (as the NHA framework is standard, whereas that of the PER is country-specific), but would benefit country level planning and assessments. It is also important that expenditures are made publically available in a timely manner (and on the internet), to allow other stakeholders to undertake analyses of them, thereby increasing accountability. Furthermore, investments to strengthen the Tanzanian Health Management Information Systems should continue, to increase the availability of data on outputs and outcomes and thereby facilitate analysis linking these to inputs.

At the global level, the completeness of the OECD's Creditor Reporting System (CRS) has improved dramatically. This is to be commended. This study recommends further improvements continue to be made. First, by DPs improving their reporting practices, to ensure all DPs report consistently and accurately, leaving no empty fields. Second, as the database becomes more complete, some modifications to its structure could be considered. For instance, as Pitt et al have previously recommended (239), analysis of CRS data could be enhanced if the database allowed for multiple codes of different purposes; for instance, different population groups (child health) and conditions (malaria). It is possible that this may make the database very complex, particularly compared to other (non-health) sectors. To be more consistent with other sectors, the CRS database may also consider tracking DAH by level of care, perhaps including only a few key disease-specific or health system indicators, such as HIV/AIDS and human resources.

10.3.2 The aid effectiveness agenda

Several recommendations arise from the assessment of the aid effectiveness agenda. This study found there is a danger that international declarations are becoming less influential at the country level, so it is important to re-engage with national-level practitioners. Definitions of principles are sometimes vague and it is unclear how they should be adapted at the country level. Clarifying the meaning of some of the principles at the global level may therefore be of benefit. This is particularly the case for the principles of ownership and managing for results, which may benefit from clearer definitions of *whose* ownership the agenda refers to and precisely what *results* mean.

It is particularly important to have more clarity on the meaning of results, as a shift towards managing for results was found to hinder other principles, particularly alignment to country systems and the use of pooled mechanisms. There is a need to reconcile DP need for visibility and achieving quick demonstrable results, with achieving long term sustainable investment. One way to do this may be for intermediate outputs to be used (for instance drugs and medical supplies delivered through the basket, or even money flows through the government system). Having health systems-based indicators for success may suffice for DP accountability to their home populations, but may not be enough for accountability to some interest groups (such as those advocating for a single priority, such as HIV/AIDS or maternal health). Therefore a balance may need to be found between a few disease-specific indicators and broader health systems ones. Ultimately, this study does not aim to be prescriptive in the indicators that should be used to measure results, but calls for a more coherent set of indicators, adapted to the context of recipient countries, that may be compatible with non-project based modalities.

Conversely, the indicator framework developed to assess aid effectiveness principles is prescriptive, but also rather restrictive in the dimensions of the principles it focuses on.

Here, we support critics of a “universalist” approach to aid effectiveness (187), but suggest that broad principles of aid effectiveness may be good at the global level as a set of goals of best practice. However, the specific meaning of each principle and the indicators and targets to assess progress towards them should be defined at the country level. This has been done in Tanzania with some success, but the Tanzania Assistance Strategy (TAS) does not include measurable indicators and the Joint Assistance Strategy for Tanzania (JAST) indicators are almost identical to those included in the global agenda, so there is some room for making the principles and indicators more relevant to the local context.

This study found capacity was an important constraint to achieving aid effectiveness, particularly that of the Tanzanian government and non-government agencies, but also of development partners. It is therefore recommended that more emphasis on capacity is placed on future declarations of aid effectiveness, particularly linking leadership with capacity as part of the principle of ownership and further strengthening the emphasis on building the capacity of country systems in the principle of alignment.

Finally, an improvement of the Busan Partnership was the broad consultative process that preceded signing the declaration, where civil society organisations were particularly engaged. This is to be praised and further involvement of civil society is to be encouraged, at the global and national-level dialogues on aid effectiveness. Also, and most importantly, the presence and contribution of recipient countries in high level forums needs to continue to be strengthened, particularly given that there was a perception by some stakeholders that the aid effectiveness agenda had been imposed on the Government of Tanzania.

10.3.3 The sector-wide approach

This study found that overall the SWAP was a good vehicle for achieving the aid effectiveness agenda. The structure of the Tanzanian health SWAP (made up of the Technical Committee for high level decisions and Technical Working Groups (TWGs) for technical issues) is very logical. However, the way the SWAP has been implemented in the Tanzanian health sector has been too focused on bureaucratic processes, resulting in a high burden on both DPs and government. The SWAP structure needs to be streamlined to reduce the burden it has on both DPs and the government by having a more efficient allocation of tasks. For instance, the Technical Working Groups should be attended by the more technical people (already happening in some cases), which would deepen the level of the dialogue. As there are so many aid agencies involved in the SWAP, greater delegation of tasks between agencies should be encouraged, to reduce the number of people participating in the TWGs. In addition, some TWGs were reported to work better than others, which means there is scope for learning from the good-performers. In addition, DPs could strengthen their support with the health basket (and in some cases re-engage with it), as it was found to have a more productive and efficient dialogue. The decision to leave the basket was often political, and not based on the Tanzanian context. This study therefore recommends DPs reconsider their position with regards to basket funds.

Ultimately, given the high number of players active in the health SWAP, the most efficient way to reduce the burden of management structures may be to reduce the number of DPs. This is a very difficult decision politically, but one that has already been adopted by some DPs (who have become more concentrated across countries and/or sectors). Bi-lateral DPs could increase their delegation to multi-laterals; in addition, European DPs could rely on the European Union to assist them in organising their cooperation across countries and sectors (particularly if delegating to the European Union as a DP is difficult).

Further, the Tanzanian health SWAP would benefit from integration of the health and HIV/AIDS harmonisation and dialogue mechanisms. In particular, the Global Fund should become further integrated into health structures to avoid placing an additional/parallel burden on the government. This does not mean the HIV/AIDS dialogue should lose its multi-sectoral approach, but given that most HIV/AIDS interventions now fall within the remit of the health sector, greater coordination between the two structures would allow for more efficient management of funds. One way this could be achieved is the health sector-specific interventions, such as the provision of antiretrovirals, to be coordinated through the health SWAP structures, whilst prevention activities could still be coordinated at the multi-sectoral level.

Participation of civil society in the SWAP dialogue has improved and was found to play an important role in keeping the government accountable in Tanzania, but needs to be strengthened further. More investment is recommended to strengthen the number and capacity of civil society organisations, in order to expand on the essential role they already play in keeping the government accountable. There may be a danger in increasing the number of players (with their own interests) in the dialogue; however, in the Tanzanian context, this study found civil society was under-represented in dialogue structures. In addition, civil society groups should also be encouraged to be equally critical of the work of the DPs and to ensure they provide a fair representation of the voice of the Tanzanian population (for instance by the use bottom up accountability processes, such as score cards and surveys).

Finally, disappointment with the SWAP appears to be resulting in moving back to old ways of managing development assistance. This study found that generally all stakeholders felt the basket fund was the best delivery mechanism, so it would seem a shame to abandon it. Instead, a better way of building the capacity of systems and government employees

should be found. For instance, in his study of the Ministry of Health of the Republic of Tajikistan, Mirzoev suggests a set of short, medium and long-term measures that can be adopted to improve capacity, including improving knowledge and expertise of staff (short-term), recruitment of more qualified staff and wider involvement of civil society (mid-term) and a change in working culture (long-term) (452). This can also be applied to Tanzania; using a short, medium and long time frame is more likely to be conducive to long term reform, and also provides measurable outcomes to assess performance.

10.3.4 Institutional reform

This thesis found that institutional factors have hindered the achievement of aid effectiveness principles and have sometimes hampered SWAP structures. Although institutional reform is a long and difficult process, it is an essential one. The set of recommendations provided here start with the end goal that should ideally be achieved, but also attempt at outlining some initial steps needed to accomplish this goal.

First, it would be desirable for DP agencies to have a more decentralised structure, so country offices have more power to decide on priorities and funding instruments, can better harmonise with other DPs and keep to their agreements at the country level and therefore minimise susceptibility to political changes at their headquarters. This may be difficult to implement politically; however, it is in the DP's interest (altruistic and otherwise) that aid is effective, and this approach would help increase DP accountability to the recipient government. This would signify a significant change in aid management practices, and may need to be achieved gradually through a series of smaller actions. One step in the right direction would be to have internal consultations prior to important policy decisions (such as funding modalities) and give more weight to evidence and expert opinion. Different DP agencies do this to different degrees, and are not all so centralised. For instance, the UK Department for International Development (DFID) recently carried out

two reviews on its approach with the aim of influencing future strategies (453) (although it has still been criticised by the Independent Commission for Aid Impact for not doing enough to incorporate evidence into its approaches (454)). In contrast, other agencies that participated in our study felt frustrated by the political and centralised nature of decision-making.

Second, DPs should modify their internal performance appraisal system by decreasing the weight given to disbursement ratios and increasing accountability for results. This does not mean increasing the need for visibility or showing results, DPs (and their employees) should be assessed for improvements at the sector level if they engage in budget support and health basket funds. Better systems should be in place to measure inputs (financial flows disbursed and followed through the system), outputs (human resources, facilities, drugs and medical supplies), outcomes (such as health facility utilisation, health care deliveries) and impact (under five and maternal mortality). These are all in place in Tanzania (although as already highlighted can be strengthened), but only inputs are used for performance assessment of employees. Targets to measure the performance of DP employees could be developed with the input of national staff, and could include intermediary outputs, such as the amount of funds that reach the districts in a timely manner, or stock outs. In addition, the international community may need to adjust its expectations on what can be achieved with development assistance, and could make more realistic pledges, which may be easier to account for.

In addition, internal performance management of DP employees should be modified to facilitate reporting of negative results. This would involve relaxing incentives for career advancing and rewarding innovative behaviour that involves local institutions (government, but also research groups and civil society) in the design and evaluation of projects. Furthermore, DP agencies would benefit from enhanced institutional capacity, which could

be achieved by: DP employees having more technical training in the sector in which they work and having longer duration of posts (for instance, increasing the length of stay to five years); by having induction procedures for new staff that include training in political economy and the history of the country; and giving more responsibility to national staff, who are more likely to be permanent and have a better understanding of the cultural, political and historical context (although this needs to be balanced with brain drain fears). This would also give DPs a better understanding of the political situation in which they are working, and allow them to engage more productively with the government; for instance, by knowing who to engage with and what elements of the health system are highly-sensitive politically.

It is also necessary for the Tanzanian government to modify its internal performance assessment to make it more transparent and results-based. This would involve a reform of remuneration structures so all payments are made in the form of a monthly salary, rather than *per diems* (employees of course need to be repaid for the costs of travelling, etc. but this should be done to repay costs rather than for profit). This, again, is a highly politicised and difficult reform, but one where DPs and civil society should be involved (particularly as they pay the *per diems* (455)). A step in the right direction would be for DPs to adopt a common policy of not paying for (or reducing the amount of) allowances. Civil society could follow suit. This may be difficult at first, but in the long run it would send the right signal to the government. However, this would require DPs to be harmonised and for central offices to understand that in the short run it may cause some delays (and potentially reduce government attendance to trainings and meetings). This would also require for the continuum between health DPs and DPs working at the GBS and macro-economic level to be strengthened. The GBS dialogue should engage much more in political issues, such as allowances and funding for the different sectors (as it has access to government agencies

that make key decisions influencing the health sector). The health sector dialogue can then be more technical.

10.3.5 Further research

Aid effectiveness in general, and the institutions and relationships that make up the aid system in particular, are understudied. This may be a result of methodological difficulties in assessing these, but does not mean research in this area is not needed. There is a need for more creative ways of delivering and coordinating aid. In addition, academic research has much to contribute to the aid effectiveness debate, as it may be more impartial and could be carried out in more depth (for instance by looking at trends over time).

This thesis can be taken forward in different ways. First, more research is needed on how to further integrate political and economic elements of frameworks to analyse aid relationships. In addition, further research could use different political frameworks, such as frameworks of trust and relational theory, and economic frameworks, such as game theory. It would also be of great importance to adopt an approach based on complexity theory, given the dynamic nature of the many actors involved in aid relationships, something suggested by Ramalingam in his recent work (456-457).

The conceptual framework developed here could be applied to other settings, but also to different aid relationships. For instance, to study the relationships between international NGOs and recipient government and national NGOs. In addition, it is important to research relationships further upstream, as the incentives and political contexts of international interest groups, and actors in donor countries have an important influence on aid management practices.

From the perspective of a recipient country, more research is needed to identify ways to improve the participation of the population in the development dialogue. Further, it would

be interesting to undertake a comparative study of two countries, one good performer and one failing, or an aid darling and orphan, such as Rwanda and Burundi, to explore how the aid effectiveness agenda is implemented in different settings that have a similar culture.

Finally, at the global level, better methods and indicators are needed to evaluate the aid effectiveness agenda (and aid effectiveness). More research is needed to develop these globally and in recipient countries.

10.4 Final thought

After the considerable effort made to establish the sector-wider approach it would be a shame to move away from it, or the aid effectiveness principles it promotes. It would be more advisable to adopt a step-wise approach to achieving aid effectiveness ideals, including reforming the SWAP structures and the institutions involved.

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APPENDICES

Appendix A: Literature review Working Paper



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Working Paper No. 2012/69

Aid Effectiveness in the Health Sector

Melisa Martínez Álvarez and
Arnab Acharya*

August 2012

Abstract

This paper explores the current evidence underlying the debate on aid effectiveness, with a specific focus on the health sector. It summarizes the history of aid and outlines the methodological challenges encountered when assessing its effectiveness. The current evidence on ‘what works’ in the different aid modalities is outlined, highlighting examples of success. The review finds that resource allocation, lack of predictability of funds, fragmentation, fungibility and the system of relationships foreign aid generates all hinder its effectiveness. Furthermore, even when projects are successful, countries face constraints in scaling them up. The aid effectiveness debate is dynamic, however, and constantly influenced by new global policies and players. The paper ends with a discussion of the future of aid and how these new actors and policies are likely to shape the landscape of development co-operation.

Keywords: aid effectiveness, health, fungibility, harmonization

JEL classification: O10, O16, O19

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1 Introduction

There has been a long history of high-income countries providing development assistance to low- and middle-income countries (LMIC), most pledging to devote 0.7 per cent of their gross domestic product (GDP) for this purpose (Clemens and Moss 2005). Although most countries have not met their target, the amount of development assistance has risen exponentially over the past ten years. This, together with worries about the sustainability of increases in funding given the current economic climate, has resulted in widespread interest on the impact of development assistance, with a growing literature seeking to assess whether it has had any impact on growth and social development. As we shall see below, this literature shows mixed results, hindered by methodological difficulties and lack of data. The aim of this paper is to examine the current evidence regarding the effectiveness of aid in the health sector in order to shed some light on what the current state of knowledge is, and how the future of the aid effectiveness debate looks.

The history of development assistance has taken many turns, with infrastructure and ‘hard’ sectors being favoured in the earlier decades, and ‘softer’ social sectors preferred in the first decade of this century. The health sector has received particularly generous funding, having quintupled from US\$5.82 billion in 1990 to US\$27.73 billion in 2011 (Institute for Health Metrics and Evaluation 2011). The amount of development assistance for health (DAH) roughly remained at the 1995 level until 2000—the new millennium saw a surge in DAH. Secular upward trends occurred from 2002 to today (OECD-DAC data). The prominence of recognition of HIV/AIDS as a global problem resulted in a proportion of DAH going to HIV/AIDS, rising from being around 10 per cent of total amount DAH in 2000 to nearly 40 per cent by 2007 (see Figure 3). Table 1 shows historical trends in DAH from the early 1970s until the present day.

This increase in funds has been accompanied by a proliferation of actors who provide (governments, private foundations, individuals and the corporate sector), manage (bilateral agencies, inter-governmental agencies, global health partnerships, non-government organizations (NGOs), private foundations) or spend (DAH (multi-lateral agencies, the UN, global health partnerships, NGOs, private sector, and low- and middle-income governments and civil society organizations) (McCoy et al. 2009). This wide variety of actors deliver development assistance for health using different funding modalities, depending on the amount of earmarking they require and the extent to which they rely on government systems for planning, disbursement and monitoring of funds. These include project, programme aid, sector wide approaches and budget support, with projects having the most earmarking and budget support the least (Foster and Leavy 2001). See Section 2 for a discussion of aid modalities.

Concerns about the efficacy and effectiveness of development assistance are not new and have resulted in several international declarations endorsing ‘good practice’ principles aimed at improving aid effectiveness, including the Monterrey Consensus on Financing for Development in 2002, the Rome Declaration on Harmonization in 2003 and the Joint Marrakech Memorandum on Managing for Results.

Table 1: Development assistance for health flows (2009 constant US\$ millions)

Year	Africa (non-specified)	America (non-specified)	Asia (non-specified)	Europe	Far East Asia	Middle East	North & Central America	North of Sahara	Oceania	South & Central Asia	South America	South of Sahara	Unspecified	Grand Total
1973				19.49618124	99.09566662		0.224883675	86.45212557	7.31569032	19.27003169	212.8359661	157.1627558		601.853301
1974					88.82041736	0.218576842	94.21013857	6.833660202	11.58165584	67.76448141	85.1858849	232.3985212		587.0133364
1975					22.16357456	5.820907485	139.7931362		11.28823437	244.7256012	23.66324801	113.2291298	0.334288516	561.0181201
1976	0.185255234			0.797308746	82.94963823	1.46886642	272.6727707	45.28607588	17.09836561	65.56233124	67.40752577	127.7409597		681.1690975
1977				1.683612553	56.34726082	28.24052027	32.50201807	19.46373256	13.41630898	190.4349687	13.91713511	165.8500812		521.8556382
1978	0.64424937	2.407134489			304.9456878	9.619513637	106.8552672	70.69806449	14.05097418	166.6985811	117.3475973	172.9945688		966.2616383
1979				0.656009348	282.1369811	1.043703107	13.11640587	26.3156607	2.303883385	195.6303932	77.46865771	160.8694557		759.5411501
1980				0.220564825	215.0893301	5.96849822	130.8539787	129.5146723	1.133146624	418.8830741	65.0447117	170.4085443	0.831600417	1137.948121
1981	23.72775573	0.561410674	3.274241392		343.8508778	1.643417314	190.9883859	178.3422077	4.186935329	389.7997009	92.49871885	337.5526393	21.61191989	1588.038211
1982	36.70946899	1.016795121	1.972266023		295.4943745	33.45537484	149.9040715	92.35166283	2.143727253	275.4197726	166.534109	517.537324	9.907532937	1582.44648
1983	43.40458006	1.672416269	5.848357826	0.146689821	194.3253649	49.09825335	88.03043469	90.24167459	8.665171139	367.5543838	100.9937196	455.3169493	25.63260323	1430.930598
1984	38.30078099	0.341132947	10.4192989		369.7263166	70.06226917	93.04281003	25.40165552	12.46461285	613.1957146	135.8226601	383.6588151	31.12587668	1783.561943
1985	49.57091594	5.153573279	11.51282964		262.9445092	38.43715391	243.4221234	99.96144241	60.54215798	501.0997819	96.62394804	538.6044055	19.13791908	1927.01076
1986	45.61528242	19.74073163	16.43205202		150.028725	27.26953315	198.5645749	77.42756903	25.36959723	661.0881285	40.90386525	560.6046753	36.38635574	1859.43109
1987	86.25503584	5.131764224	9.130717893	12.70385789	253.7941038	26.28985006	266.6659099	84.85236219	14.57758588	450.9709619	69.96222605	699.6512452	45.28452494	2025.270146
1988	151.0943332	25.72323125	6.610118796	3.474178205	185.0122078	19.47655811	182.433026	189.7367565	20.81628327	467.192683	155.5220581	1018.128238	131.3011133	2556.520786
1989	118.1543848	11.22204105		0.175825347	236.477793	23.8114055	204.7960558	78.04519964	32.50218388	533.3964754	112.5014853	921.1126746	114.0111471	2386.206671
1990	61.05424184	6.900219148	5.760949909		318.6135082	17.84398583	180.7909335	31.85183698	37.21699946	775.1818979	130.0766592	887.208564	29.49459915	2481.994395
1991	116.1217346	2.864988749	7.468618557	0.691127457	317.9888423	64.10963183	192.4856672	74.53718663	75.4050643	681.0682667	175.0132787	1128.498768	63.52189442	2899.775069
1992	41.98112471	2.491130521	6.567949316	33.47311336	117.6393361	21.91256822	177.6068949	122.6479086	49.14549442	1109.875167	181.0898923	1176.568002	142.696812	3183.695393

1993	26.47668252		4.189576967	2.10677583	658.2643838	87.57190556	297.89413	148.9527058	44.30314551	552.0848201	199.9856795	1166.24185	253.0334743	3441.105129
1994	69.88280702	0.021327116	3.457786711	31.33195046	385.8234545	50.19230698	141.4072371	115.7409639	34.74439055	1029.741309	137.9220842	1088.202962	740.2835278	3828.752107
1995	39.70945512	2.347773389	1.076049237	40.21565817	446.9439108	80.54901454	238.8550051	130.1487862	8.391671703	406.932973	300.065659	1381.407387	845.0651599	3921.708503
1996	47.01138919	3.878246699	2.377169733	45.32448539	728.3707097	83.52769031	249.8788306	79.47585121	82.99346758	1162.385648	123.9831447	1174.461465	467.9699887	4251.638087
1997	94.10113241	41.94251181	54.23891852	55.28475789	329.7822297	54.89582616	279.8529643	59.83357953	55.81654336	1446.655852	255.1929963	1272.530341	567.6754737	4567.803126
1998	51.30337345	16.46345326	19.39075532	64.99931609	469.5838767	89.34071089	433.5516426	455.3025303	76.01717453	1561.667063	211.0861327	1622.407016	586.2108839	5657.323928
1999	91.36473544	13.97389845	30.21191096	129.5222975	571.3185059	97.21006292	332.88719	152.9182551	147.2913747	832.2528149	313.6423953	1734.016945	614.2476208	5060.858007
2000	122.2966317	21.8745737	29.56580329	228.2127936	570.3159148	145.1818712	214.0607453	202.8628406	205.909608	1314.157179	198.648662	2707.311943	596.4864843	6556.88505
2001	78.35436128	38.55702649	34.92323908	82.42543579	713.7963168	115.8466706	267.0792706	114.2183161	101.1764853	792.2695059	251.3471443	2881.298785	930.2545101	6401.547067
2002	73.00076346	28.75589583	68.58262614	112.7643773	818.5022685	249.643004	424.8545476	106.4480679	137.0596077	1025.274809	247.6124065	3147.858946	1508.263458	7948.620779
2003	125.7008984	16.60087488	36.9511949	186.7975106	982.366066	228.9164228	370.2401227	98.84183708	125.2296951	1397.21378	357.9395983	4041.083241	1776.675985	9744.557227
2004	803.0569352	522.0791525	336.3560142	4633.411447	11945.3586	13566.48616	4898.820409	4281.15107	1452.810176	17891.25914	4685.382864	34888.09703	15113.81615	115018.0851
2005	583.4397282	525.9642569	881.7921555	6627.64663	14399.36678	25924.44902	5587.403291	3479.319614	1307.561031	19338.03315	3933.329389	43478.56035	14559.71106	140626.5765
2006	48.90396041	19.46542205	19.08829623	199.6676687	1225.346277	447.7125212	466.2802792	217.8485907	155.3642153	3155.973204	257.3045151	6050.547723	3178.26001	15441.76268
2007	209.7076477	48.10007203	70.352063	183.9678724	1148.472301	299.8163644	438.818928	218.2165315	116.0177964	2799.027106	288.9828523	7570.435107	3333.847031	16725.76167
2008	122.6016923	49.29439215	82.00519215	285.6391601	1312.414283	369.8554684	478.4763388	243.1542854	206.0053196	2220.96943	312.7120835	8853.899668	3043.574955	17580.60227
2009	87.39993038	169.7937733	195.1448603	263.7147833	1502.733271	295.3387056	597.2671315	288.8558004	172.6528812	1807.676339	399.833272	9962.099381	4213.150444	19955.66057
2010	172.3375214	135.4383654	96.96826942	360.3804622	1333.468512	333.8217602	606.3909644	134.5220091	220.0949605	2276.666525	276.3407893	9364.452268	3974.507305	19285.38971

Source: based on OECD-CRS data.

The most important declaration so far has been the Paris Declaration on Aid Effectiveness in 2005, where donors, recipient countries and multilaterals agreed on five principles of ‘good practice’: ownership, alignment, harmonization, mutual accountability and results-based management. The mid-term evaluation found that although some progress was being made, it was not fast enough (OECD 2008b), which led to the signing of the Accra Agenda for Action in 2008, to accelerate progress towards ownership, inclusive partnerships and results. The deadline of the Paris Declaration is now up, and its evaluation found that overall the quality of aid has improved, but highlights lack of transparency and aid management burden as impeding progress. Importantly, it calls for more realistic expectations of the contribution of aid to development (Wood et al. 2011).

The Paris Declaration was followed by the Fourth High-Level Forum on Aid Effectiveness, which took place in Busan in November 2011. The principles for best practice agreed are not too dissimilar from previous declarations with partners committing to ownership of development priorities by developing countries, focus on results, inclusive development partnerships and transparency and accountability to each other. By the middle of 2012 a set of indicators will be developed to monitor progress towards these principles.

It is therefore important to assess what we know about the effectiveness of development assistance for health, successes, failures and what has worked in making aid more effective. After this introduction this paper will cover methodological challenges in assessing the effectiveness of development assistance for health, followed by a review of the current evidence on whether aid works. Section 3 will then outline the different aid modalities, examples of their successes and lessons learnt. This is followed by an overview of the factors hindering the effectiveness of DAH in Section 4. Section 5 will then highlight the issues associated with scaling up aid-funded health programmes. The paper will finish with a discussion summarizing key issues in the current debate on aid effectiveness and with a look at the future of development assistance for health, including new donors and partnerships, shifting donor priorities and the effect of the financial crisis on DAH.

2 Methodological challenges in assessing aid effectiveness

How can we study the impact of aid? One obvious way is to examine welfare benefits that can be attributed of aid funding to the recipient countries. In the early literature around growth and development, which emphasised rapid capital investment and emerged in the 1950s after many low- and middle-income countries gained independence, it was argued that aid would make up the shortfall in foreign reserves and domestic savings that many countries consistently faced (Chenery and Strout 1966). It was also recognized that there would be humanitarian aid. Further, the geopolitical landscape of the Cold War ensured that foreign aid would flow to poorer countries which would not have expressed developmental concerns (Bourguignon and Leipziger 2006; Bobba and Powell 2007) . Although aid sceptics voiced strong views, particularly the British economist P.T. Bauer in the 1970s, a strong body of literature only emerged nearly ten years after the Cold War when aid giving was expressly meant for raising the level of wellbeing in LMICs (see bibliography in (Rajan and Subramanian 2008). Controversies around aid effectiveness centred on bilateral aid; multi-lateral aid seemed to have generated very little controversy. For example, Headey (2007) argues that multilateral aid for 56 countries for years 1970-2001, which may have had less political intent, has had a positive effect. We did not find much of analysis that centred on

ineffectiveness of multi-lateral aid; we note below that responsiveness to, for example, concessionary loans seems to be positive.

In answering questions around aid effectiveness, the primary concern has been growth. Given the recent emphasis on development assistance for health and aid aimed specifically at particular development aims, questions around effectiveness of particular type of funding have also emerged. Concerns about the process of aid-giving have also been raised. A question around process involves domestic fiscal response to aid; another involves questions around modality of offering aid. The last two questions lead to qualitative issues around accountability. The issues can be summarized into three categories: (1) welfare implication of aid; (2) fiscal response to aid; and (3) modality of aid. In this section we examine some methodological issues that pertain to examining aid effectiveness, whether it be overall aid effectiveness or sector specific effectiveness.

2.1 Aid benefits

Questions as to whether aid benefits recipient countries or not is methodologically confounded by endogeneity problems, including reverse causality. This problem is beyond just being a methodological issue. In recent years we note the phenomenon of being a ‘donor darling’ when certain countries have, starting from a surge, a large number of donors along with large per capita development assistance. The surge follows the recipient country experiencing sudden economic upturn or a period of peaceful recovery from conflict. Cassen (Cassen 1986) noted the tendency for aid to follow well-performing countries. Although this may indicate that donor countries would like to see their aid work and claim credit for good performing countries, it also makes it difficult to measure the impact of aid. Thus, it is possible we will find that aid follows good performance while lack of aid follows bad performance. Further, if aid improves some type of performance around education, health or economic growth, we should not expect the impact to be completely instantaneous but to have a lagged effect. As Rajan and Subramanian (2005) put it we want to know: can aid take a country to its potential, a higher rate of consistent economic growth rate? This entails that longer horizons be examined whenever impact of aid is studied (Rajan and Subramanian 2005), which would necessitate longer run analysis. An important way of seeing if the potentials are met is to examine if aid affects intermediary factors such as human capital, health and investment, as has been done by Arndt et al. (2011).

What constitutes ‘longer run’ would be a natural and empirical question to ask. Should this be a time when the current aid recipient countries started receiving aid? If so, the post-independence period of 1960 to today should be the examination period. This may be an interesting period but the purpose and mode of aid giving has dramatically changed since the 1960s. In 1960 a developing country on average received aid from two countries, while the corresponding number was 28 in 2008 (Frot and Santiso 2008). Also in this period, many of the larger recipients were given aid for political reasons, thus it is common to single out countries such as Egypt (Rajan and Subramanian 2005) and adjust for countries where motivations for aid may be political and not socioeconomic development. This adjustment does not solve the problem of endogeneity, even in a panel data with fixed effect, as one might notice, for example, the problem of ‘aid darlings’ might arise and disappear within the period of analysis. The use of fixed country effect, structural model or generalized method of moments with instrumentation for aid giving to isolate the exogenous element of aid giving go some ways to correct for some of these problems. A host of instrumentations have been

used to find exclusion condition which cannot be related to economic performance (see (Rajan and Subramanian 2008; Hansen and Tarp 2000; Arndt et al. 2011), among others). Testing for exogeneity in time series, (Juselius et al. 2011) find aid is not usually exogenous. Most likely, the choice of the years included in the study will matter, as years since the Cold War may have had more economic interest attached to aid giving. One way of avoiding making a choice is to report on different divisions of 1960 to the present with some time effect. Another natural division is to report on impact of aid since the end of Cold War (Lu et al. 2010). The shorter period ignores the cumulative and the long-term effect of aid (Arndt et al. 2011).

Rajan and Subramaniam (2005) along with many others concluded that total development assistance did not result in higher growth rate, see (Doucouliagos and Paldam 2011). The opposite has also been shown. Arndt et al. (2011) show a positive impact on growth through a structural model where life-expectancy along with investment and education are intermediary factors through which aid affects growth. An interesting tact is to examine effectiveness at the country level as done by (Dollar and Easterly 1999), finding aid ineffectiveness in general, and Juselius et al. (2011), finding aid effectiveness in general. Few studies have measured the impact of development assistance on health. As something like DAH may lack apparent political motivations and be expressly aimed toward improving wellbeing, some authors have tried to measure the impact of developmental aid setting aside non-developmental aid such as military aid. Clemens et al. (2004) indicated that for the short run aid allocated to support budget and balance of payments commitments and infrastructure result in rising income. Similarly they speculate that aid promoting democracy, health and education will have a long-run impact on growth. Minoiu and Reddy (2010) show through Gaussian mixture model (GMM) estimation that when total is separated into developmental and non-developmental aid, non-developmental aid does not contribute to growth while developmental aid's contribution to growth is strong.

Examining the link between development assistance meant for the purpose of development goes some way toward seeing if DAH is effective. But it is not a direct method of measuring the impact. A question can be how much donor expenditure targeted as DAH contributes toward development. Mishra and Newhouse (2007) present some interesting discussions regarding inferring links between donor expenditure and developmental indicators. First, one might think lagged values of aid might be predictor of current development indicator along with country fixed effects; however, as indicated before, country fixed effects do not take account of country-specific factors that are time variant and may be related to health and DAH. Donors may respond to previous health system crises for example. Mishra and Newhouse estimate system GMM method for data from 1975 to 2004 to obtain a result that shows doubling health aid decreases infant mortality by 2 per cent in a subsequent five-year period. Obviously regression methods show marginal changes; thus a slightly ambitious interpretation the authors give is that DAH may have saved 170,000 lives at the costs of US\$76 million (\$432/life) (Mishra and Newhouse 2007). This is corroborated by Burnside and Dollar (1999), who find that for countries with effective public management, aid reduces infant mortality—they find that aid equivalent to 1 per cent of GDP reduces child mortality by 0.9 per cent. But on the other hand, Wilson (2011), using data from 96 high-mortality countries found that DAH has no effect on mortality and its effectiveness has not improved over time. Finally, the paper by Masanja et al. (2008) on Tanzania links drops of 24 per cent of child mortality with doubled expenditure on health, decentralization policies, the sector-wide approach (SWAP) and vertical programmes to prevent malaria and improve nutrition.

The discussions around relevant time periods for analysis draw attention to how aid was seen from the point of donors. After the Cold War donors tended to express concerns over specific developmental aims, for example improved health. A question one can raise is: how do recipients view aid when it is specifically designated for a particular sector? This issue revolves around how DAH would be seen by the recipient country. Recipient governments would see DAH simply as income, although they might constrain themselves to spending at least the DAH amount, and adjust their expenditure accordingly.

2.2 Fiscal spending and foreign aid

When isolating the impact of DAH it is often asked whether it is legitimate to expect that the recipient sees the budget provided for health or development is as solely for the purpose of additional amount of expenditure on health. Thus US\$100 million for health yields a health budget US\$100 million above what the recipient would have planned on spending. This is known as the issue of fungibility. If donors earmark aid by specifying it as DAH then they expect recipient public expenditure on health should rise by exactly that much from the level planned. It is, of course, very difficult to observe what was planned. We take up the measurability issue around fungibility.

Questions around fungibility stem from the literature known as the flypaper effect which is observed for public financing under fiscal federalism (Hines and Thaler 1995). Empirical findings indicate that money given to states in the USA by the federal government is actually spent rather than replacing state-level revenue. Of course, extra funding should result in some expenditure increase due to income effect, but the observation has been that funding induces expenditure beyond what would be predicted by income effect. The stickiness of the flypaper is perhaps what motivates earmarked funding in the international setting. Economic theory goes against the view that federal allocation earmarked for particular activities should be seen anything other than the regular income generated by the states, say, through income tax. As van de Walle and Mu (2007) point out economists would find fungibility as the norm. However, in international policy circles the expectation is for there to be no fungibility; the donor community would expect no decline in domestic expenditure when aid budget is increased for a particular sector. As any measure of fungibility requires that a counterfactual be known, a simpler question is, all things being equal, if a country receives US\$1 extra in health aid in comparison to another country, does that lead to US\$1 increase in public expenditure on health? The question is whether or not aid funding to government results in exactly the same amount of government expenditure. Feyzioglu et al. (1996) report that US\$1 increase in bilateral foreign aid induces much less than US\$1 rise in government expenditure; the corresponding increase seems to be much higher than induced by concessionary loans received from multi-lateral donors.

There is even the expectation of additionality; there should be some matching of increasing in domestic allocation as donor funding for a sector is increased (Brown et al. 2006). Conceptually, additionality may be easier to detect for a new programme, for example an HIV/AIDS programme, and this is where this concept has been emphasized. As donor countries put in more money, the same amount of money must be committed by the recipient from a point of zero funding. Fungibility is slightly different, as there is an expectation of some type of optimal behavior. It is easier to ask as stated before: does the total sectoral government expenditure, financed from resources made up of domestic revenue and foreign

aid targeted to the sector, increase exactly by the amount of targeted developmental aid?¹ Usually the test has been to detect whether or not the coefficient for the relation between the public domestic sectoral expenditure and earmarked funding is near to unity in some type of regression. The meaning of the coefficient is not exactly clear in welfare terms.

As noted above, foreign aid was often thought of in terms of filling a gap—perhaps one can think of development assistance as complimenting recipients’ domestic efforts. In this view one would note low levels of domestic expenditure on health, say, and this low level would be supplemented by donor funding earmarked for health to have a total amount not too much beyond the DAH. In recent years, the notion that fungibility should be prevented entails that country do not see DAH merely as an income for the overall budget; the expenditure on the earmarked sector would be beyond what would be predicted by income effect (van de Walle and Mu 2007).

In examining the relation between DAH and domestic expenditure the usual issues around endogeneity apply. As already stated, the empirical work is not exactly testing fungibility which embeds a counterfactual concept; however, we will use the word ‘fungibility’ below as shorthand. There is also a plethora of number of indicators used as dependent variables to reflect fiscal commitment, such as public expenditure per capita or public expenditure as a ratio of GDP.

2.3 Modality of aid-giving

The way in which aid is distributed may have different implications. Modalities can consist of giving direct aid within the budgetary process in the recipient country, carrying out specific projects through governmental channels, or directly funding projects through the private sector—private providers and NGOs to provide goods at subsidised rate. Discerning these channels from existing datasets has been difficult. Lu et al. (2010) suggest, using their own imputed data as to what might be funded through the non-governmental sector in the Organization for Economic Co-operation and Development (OECD) data on foreign assistance, that donor contribution through private means induces governments to increase their expenditure at a higher rate.

Another concern has been that aid is provided through multiple transfer instances and there are multiple donors for a single country as indicated above. Multiple events induce bureaucratic pressures. The presence of multiple donors induces unexpected impacts. Standard measures of concentration of donor activities using indices similar to the Herfindahl index of monopoly power indicates that fragmented aid giving is large (Acharya et al. 2006). The implications of fragmentation are debatable. Easterly (2002) claims donors can act as a de facto cartel in dictating what is done with the funding, hence the fact that the modality of funding dispersment does not matter. Knack and Rehman (2007) argue that it is unlikely a donor will internalize utilities of success and failure of other donors in a given country as the number of donors is large. There is diffused responsibility if the number of donors increases. Development assistance for health has become a favourite type of aid, as we note below. Thus the question of fragmentation is not inconsequential with regards to health. We also note below that multiple aid events, which may be more prevalent when non-government channels are used to deliver health, may impose a great deal of bureaucratic burden.

¹ Pack and Pack (1993); Boone (1996); Feyzioglu et al. (1998).

3 DAH modalities

Despite the methodological difficulties highlighted in Section 2, the literature assessing the effectiveness of aid, and DAI in particular, is growing. As outlined in the introduction, donors disburse funding using different modalities, depending on the degree of earmarking and trust in country systems. This section will summarize the current knowledge on the different aid modalities, and highlight successes and what can be learnt from them

3.1 Project aid

Project aid is the most earmarked type of aid. Projects are discrete interventions usually delivered through parallel systems, bypassing the government, where donors have control over the design, monitoring, disbursement and accountability procedures, and NGOs or the private sector are in charge of implementation (Foster and Leavy 2001). Projects are also sometimes delivered using government systems, where donors control the policy conditions and the sector in which the project is situated, but the funds are disbursed and accounted for using government systems. Projects have been criticised for lacking sustainability (Leader and Colenso 2005), having high transaction costs (Quartey 2005; NORAD 2008) and hindering partner country ownership (Marshall and Ofei-Aboagye 2004).

An analysis of projects financed by the World Bank throughout the years 1983-2009 (Denizer et al. 2011) found that the success of projects was correlated with overall country performance. In addition, it highlighted that the true impact of projects only becomes apparent over time and later evaluations tend to be less optimistic. This is particularly the case in the health sector, where the impact of interventions takes time to be seen. The evaluation found that some factors, such as high preparation costs and low country ownership, were associated with lower impact of projects. On the other hand, smaller size, good management and supervision were correlated with a higher impact of projects. However, the authors of the analysis (Denizer et al. 2011) do acknowledge that a significant proportion of the variation observed in project performance cannot be explained by these factors, highlighting the importance of the local context on project outcomes. A series of case studies conducted by the What Works Group at the Center for Global Development found that a World Bank funded project in China averted 30,000 cases of tuberculosis per year. The project's success was associated with high levels of political commitment at all levels of government and the use of creative incentives to both patients and providers (Levine 2004). Table 2 below summarizes other studies of successful projects.

Despite their criticism, projects can be effective in achieving their objectives. However, concerns regarding sustainability and weakening of country systems have driven the international community to favour programme-based approaches, such as SWAPs and budget support. This shift was at the heart of the Paris Declaration in 2005 and is still being pursued by many donors.

C Edwards, S Saha	From home to hospital, a continuum of care: making progress towards Millennium Development Goals 4 and 5 in rural Bangladesh	2011		Journal article	Integrated maternal and child health project	Bangladesh	Rural	Non-experimental		Proportion of mothers receiving antenatal care. Choosing a community skilled birth attendant. Having access to caesarean section. Having post-partum care	The study found that women living in the catchment area of the project have much better outcomes than the national average. The authors attribute this to the integrated system of care, providing a continuum of care between the hospital and the home, the provision of health worker training and community involvement. However, the study acknowledges that the model is very resource-intensive and would not be replicable by the government, hence being aid-dependent and potentially unsustainable.	http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2011
Buse, K., Ludi, E. & Vigneri, M.	Beyond the village : The transition from rural investments to national plans to reach the MDGs. Sustaining and scaling up the Millennium Villages	2008		Evaluation report	Millennium Village Project	Ethiopia, Ghana, Malawi, Uganda	Rural	Non-experimental		Distribution of long-lasting insecticide-treated bednets. Malaria treatment rates. Deliveries attended by trained health workers/birth attendants. Vitamin A supplements. Immunization. Deworming. Voluntary counselling and testing. Anti-retroviral therapy. Health services utilization	The villages taking part in the project have achieved huge gains in all of their health indicators, although some differences are observed across countries and indicators. The success of the project is linked to the concentration of resources at the community level and the priority given to lowcost, effective interventions. There are concerns, however, about the scalability of the project to the national level, as the budget is too limited to address upstream investments, rural-urban linkages and infrastructure and institutional constraints.	
Mize L. S., Harrison, M., Hoekman, N., Mercer, M. A. & Thompson, S	Health Alliance International: Improving maternal and newborn health in Timor Leste final evaluation report.	2008	2008	Project evaluation report	Child Survival Grant	Timor-Leste	Rural	Before-after study	7 districts	Proportion of women with children aged under two who received one or more antenatal visits. Last delivery was attended by a skilled birth attendant. Received at least two tetanus toxoid vaccine in their last pregnancy. Received Vitamin A supplement post-partum	The project met and exceeded its objectives. The evaluation attributes the success of the project to the technical ability of its staff and the investments made on their skills, accepting leadership from government, research and community consultations carried out before designing the project and the use of video and photographic materials for health promotion.	http://pdf.acm429.p

										Exclusively breastfed in the first months		
Hounton, S., Menten, J., Ouedraogo, M., Dubourg, D., Meda, N., Ronsmans, C., Byass, P. & De Browere, V.	Effects of a skilled care initiative on pregnancy-related mortality in rural Burkina Faso.	2009	2006	Journal article	Skilled Care Initiative	Burkina Faso	Rural	Quasi-experimental	2 districts	Pregnancy related mortality. Utilization of maternal health services	The study found that the Skilled Care Initiative project increased the number of babies delivered at health facilities (the aim of the project); however, it had no effect on pregnancy related mortality. The authors also found a low rate of caesarean sections, which they interpret to mean that substantial barriers still exist to service delivery, which may explain the lack of impact on health outcomes.	http://www.med/1857

Source: authors' illustration.

3.2 Programme-based approaches

Programme-based approaches (PBAs) are defined by the OECD as having the following characteristics:

1. being lead by the partner country;
2. having a single, comprehensive programme and budget framework;
3. donor co-ordination and harmonization of donor procedures for budgeting, management, procurement and reporting;
4. increased use of partner country systems (OECD 2008a).

They encompass basket funding, SWAPs, and budget support. They also include project aid that is delivered as part of a SWAP or pooled through a basket fund. Driven by the discontent with traditional project aid, donors committed to giving two-thirds of their aid in the form of PBAs by 2010 at the Paris Declaration on Aid Effectiveness in 2005. However, the mid-term evaluation found that the proportion of aid delivered as PBAs had only increased from 43 per cent in 2005 to 47 per cent in 2007 (OECD 2008a). The final evaluation of the Paris Declaration found that with a few exceptions, such as Uganda, there had been no rapid or linear move towards PBAs, with most of the evaluated countries and donors delivering aid using mixed modalities. In fact, it found a general reluctance on the part of the donors to move towards these approaches, mainly due to the slow pace of public reforms, which contributed to high fragmentation of aid. However, it also found that although PBAs require more effort than traditional project aid, they resulted in higher policy influence by the donors (for instance, in better targeting of expenditure on poorer communities), and better understanding of performance-based approaches by the partner governments, which lead the evaluators to reinforce the suitability of PBAs as the core target of the Paris Declaration, and to recommend it be included in further declarations and policy discussions (Wood et al. 2011). Examples of PBAs are shown in Table 3. SWAPs and budget support are discussed below.

Table 3: Programme-based approaches

Author(s)	Title	Year of publication	Year of study	Type of Publication	Type of policy intervention under analysis	Country/Region	Methodology used	Sample size	Outcome variables used	Main findings (and shortcomings)	web link (URL)
Chansa, C. Sundewall, J. McIntyre, D. Tomson, G. Forsberg, B. C.	Exploring SWAP contribution to the efficient allocation and use of resources in the health sector in Zambia.	2008	2005-2007	Journal article	SWAP	Zambia	Non-experimental, case study approach	26 stakeholders (21 in-depth interviews and one group interview)	Administrative, technical and allocative efficiency	The SWAP was not found to have achieved the expected improvements in efficiency. The authors attribute this to the partial implementation of the SWAP or the fact that it had not been embraced by all donors. Although they do not classify the SWAP approach as unsuccessful, the authors find it ineffective in its current form.	http://heapol.oxfam.org.uk/2008/04/23/2008-long
Buse, K.	Keeping a tight grip on the reins: donor control over aid co-ordination and management in Bangladesh	1999	1996 - 1997	Journal article	SWAP	Bangladesh	Non-experimental, case study	Discussions with 87 stakeholders and 22 semi-structured questionnaires	Effectiveness of aid co-ordination instruments	The study found that the SWAP did not succeed in allowing the government to play a leading role in aid management. This is in part due to donors not trusting country systems and in part because of the politics and power associated with aid co-ordination and particularly, with having a leading role.	http://heapol.oxfam.org.uk/2008/03/14/2008-full.pdf
Bowie, C. Mwase, T.	Assessing the use of an essential health package in a sector wide approach in Malawi.	2011	2008	Journal article	SWAP	Malawi	Cost-effectiveness analysis	55 Essential Health Package interventions	Technical efficiency, defined as 'the efficient delivery of health care to a population, through an analysis of the appropriateness of the EHP interventions and their coverage'	This study found that the SWAP invested in more cost-effective interventions than donor governments acting on their own. This leads the authors to conclude that the SWAP has resulted in an improvement in health service delivery at low cost.	http://www.healthsystems.com/2011/04/09-4.pdf

Lister, S., Carter, R. et al.	Joint Evaluation of General Budget Support 1994- 2004	2006	2005	Evaluation report	General budget support (GBS)	Burkina Faso, Malawi, Mozambique Nicaragua, Rwanda, Uganda, Vietnam	Non- experimental, case study approach	7 country case studies	GBS relevancy, efficiency and effectiveness in achieving a sustainable impact in poverty reduction and growth promotion.	Partnership GBS (PGBS) was found to improve harmonization, alignment and policy development on all countries reviewed, as well as having a positive influence on allocative and technical efficiency of public financial management in five of the countries. However, the study also found that unpredictability and volatility of PGBS were a problem.	http://www.oecd.org/dataoecd/79/1/215713679_1_1_1_1.00
Caputo, E., de Kemp, A & Lawson, A.	Assessing the impacts of budget support: Case studies in Mali, Tunisia and Zambia	2011	2010	Working paper	General and sector budget support	Mali, Tunisia and Zambia	Non- experimental, case study approach	Three country case studies	Extent to which budget support provides means for implementing national and sectoral priorities Efficiency and effectiveness of national priorities Sustainable outcomes and impacts on growth	They study found that budget support had resulted in better budget management, although its design, harmonization and alignment were not optimal. In addition, the authors found that budget support was associated with increased public expenditure on social services, which resulted in improvements in health. For instance, in Zambia increased health service provision was associated with a decrease in the incidence of tuberculosis, malaria, diarrhoea and maternal and child mortality. However, the study highlights concerns with respect to the quality of these services.	http://www.oecd.org/dataoecd/89/3/8934753.pdf
Visser-Valfrey, M. & Umarji, M. B.	Sector Budget Support in Practice Case Study Health Sector in Mozambique	2010	2008	Project report	Sector budget support	Mozambique	Non- experimental, case study approach	36 stakeholder interviews	Extent to which SBS has met the objectives of partner country and donors	The study found an increase in the number of donors engaging in sector budget support, better co-ordination and a positive influence on sector management, policy and monitoring and evaluation. However, it also found that more progress is needed in improving the budgeting process, systems for financing de-centralized services and technical assistance and capacity development.	http://www.odi.org/publications/6405.pdf

Source: authors' illustration.

3.3 Sector-wide approaches

Sector-wide approaches (SWAPs) arose in the mid 1990s as a result of the prevailing discontent with project aid (Harrold and associates 1995). Although there is no agreed definition of precisely what SWAPs involve, they are a co-ordination mechanism for donors working on the same sector that aims to improve donor co-ordination, government ownership and lower transaction costs of aid (Sundewall and Sahlin-Andersson 2006, Hutton and Tanner 2004). In essence, a SWAP represents a partnership between donors and the partner government, lead by the health ministry of the partner government (Hutton and Tanner 2004). The terms of this partnership are often agreed in advance, and vary between different countries (Sundewall and Sahlin-Andersson 2006). SWAPs are often associated with delivering aid as budget support, further supporting partner ownership and country systems.

Box 1: Health sector-wide approaches in practice: the cases of Zambia and Bangladesh

The sector wide approach was introduced in the Zambian health sector in 1993, with the aim of aligning and co-ordinating aid, as well as supporting the plans of the health ministry (ODI and Mokoro 2009). Chansa et al. (2008) carried out an evaluation of the Zambian SWAP in 2008 with the aim of assessing its contribution to efficiency, in the form of administrative, technical and allocative efficiency. The study found that the proportion of funds channelled through the SWAP made only modest increases during 1998-2005. In addition, the evaluation found that many donors were still operating outside the SWAP, with this trend increasing rather than moving towards a more harmonized approach. In terms of efficiency, the study found that the SWAP had resulted in small improvements in administrative efficiency, although transaction costs remained high, due to the amount and intensity of related meetings, which happened alongside meetings for donors operating outside of the SWAP—a fact probably enhanced by the arrival of global health initiatives in the time period of study. The authors of the evaluation found that both the funding to hospitals and the bed occupancy rate in these decreased since the introduction of the SWAP, resulting in a decrease in technical efficiency. Finally, the evaluation found small improvements in the allocative efficiency of the budget execution, particularly at the level of district funding. The results of this evaluation are disappointing, although the authors do not rule out the SWAP as a successful co-ordination model, they do conclude that the set up of the Zambian SWAP was not effective (Chansa et al. 2008).

The Bangladesh SWAP—known as the Health, Nutrition and Population Programme—started in 1998. It is often referred to as the biggest and oldest SWAP and has been the subject of a few evaluations. A study carried out by White (2007) found that the health SWAP in Bangladesh had succeeded in lowering transaction costs, and that the associated budget support had been a successful funding mechanism. However, the study also found that donors were still driving the policy process and that projects were too complex. Amongst the recommendations, White stressed the need for donors to adopt a more ‘hands-off’ approach, giving the government space to make their own decisions and restraining from criticism, whilst investing in its monitoring and accountability systems ((White 2007). Other studies of the Bangladeshi SWAP have found donors’ unwillingness to fully participate due to lack of trust in country systems (Buse 1999) and that despite of the clear contributions the SWAP has made towards donor alignment and predictability, and strengthening national health policy, the SWAP has failed to bring about organizational and governance reforms, government ownership, as well as stopping donors from developing parallel systems (Martinez 2008). However, the failure of the SWAP mechanism to fully achieve its intended results is not seen as a consequence of the inappropriateness of the SWAP model, but rather as a result of its implementation. The lack of success is seen as a consequence of the poor quality of the underlying health plans and monitoring systems, rather than on the SWAP itself (Martinez 2008).

Although the evidence on the impact of the sector wide approach mechanism on the health sector is mixed (Box 1), it is important to take into account that the SWAP mechanism involves a reform in the way aid is given and in the relationship between the donors and the government, which means it will take time for the impact to be seen (Hutton and Tanner 2004). In addition, the SWAP can be seen as a set of principles to give aid, but its implementation varies between the different countries, as the local political and cultural context have been found to influence the ‘shape’ of the SWAP in different countries, and hence its effectiveness (Sundewall and Sahlin-Andersson 2006).

3.4 Budget support

Budget support is a type of programme-based approach that is characterized by having little or no earmarking. There are two types of budget support: general budget and sector budget support. General budget support involves donors providing aid directly to the government’s budget, linked to a poverty reduction strategy. Success of budget support is dependent on the governance and policy environment of the partner country, with concerns regarding corruption and misuse of funds (Bourguignon and Sundberg 2007). During 2002-06 only 6.4 per cent of all aid was allocated as budget support (Piva P 2009), reflecting donors’ concerns and unwillingness to engage in this aid modality. However, the popularity of budget support is growing (Marshall and Ofei-Aboagye 2004), particularly amongst European donors. A study of general budget support in seven countries over 1994-2004 found positive results in all but two countries. It found that, overall, it was a relevant aid modality and that general budget support increased government ownership, accountability and capacity for public financial management. In addition, it enhanced the quality of aid by improving donor harmonization and alignment (Dom 2007). These findings have been corroborated in further studies (Carter and Lister 2007; Marshall and Ofei-Aboagye 2004; Leader and Colenso 2005).

Although donors do not select how the funds are distributed, negotiations of general budget support can increase budget allocation to the health sector. In addition, budget support can be delivered as sector budget support, where funds are earmarked to a particular sector, often the health and education sectors. A study of ten sectors in six African countries found that sector budget support had improved the efficiency of public resource use by supporting planning, budgeting, management and accountability processes. However, it found that although access to services had been greatly expanded, the quality and equity in the delivery of these services had not (Williamson and Dom 2010). Another study found sector budget support to lower transaction costs of aid programmes (Dom 2007)

3.5 Global health initiatives

Recent increases in the levels of development assistance for health have not only been associated with different funding modalities but with the arising of new donors and initiatives. Since the year 2000, there has been a proliferation in global health initiatives (GHI), which tend to focus on a single disease or group of diseases. Some of the more prominent GHIs include the Bill and Melinda Gates Foundation, the Global Fund for AIDS, Tuberculosis and Malaria, the GAVI Alliance in support of childhood

Box 2: Global Health Initiatives

Global Health Initiatives (GHIs) have been successful in bringing specific health problems into the global health agenda and in gathering large amounts of resources to tackle them. However, they have also been at the centre of criticisms for drawing resources away from broader health system issues and further complicating the aid architecture. Two large studies have been conducted to assess the interactions between GHIs and country health systems and the impact of GHIs on country co-ordination mechanisms.

The first of these studies, conducted by the Maximising Positive Synergies Collaborative Group at the World Health Organization, reviewed 221 existing reports and conducted 15 new studies to assess the interactions between GHIs and health systems. The study analysed these interactions in six different dimensions: health service delivery, health financing, governance, health workforce, health information systems and supply management systems.

The study found mixed results. In terms of health service delivery—defined as access, equity and coverage—the report found that while access to services targeted by GHIs increased, there was mixed evidence regarding access to other services. GHIs were accredited to have made some contribution to equity but not towards the causes of inequity or social determinants of health. In addition, whilst GHIs were found to improve quality by the provision of guidelines, there were also concerns that pressure on performance had compromised quality of services. With regards to health financing, it was found that GHIs resulted in an increase in funding, improved the availability of free services at the point of care (albeit not systematically) and contributed to improvements in predictability of aid funding. However, alignment with national priorities or the burden of disease was weak. GHIs were found to have an overall positive influence on health sector governance, by exposing weaknesses, improving accountability and productivity, and increasing capacity and community participation. Nevertheless, there were worries that the performance-based approach employed by GHIs may distort these indicators towards their specific targets. In terms of health information systems and supply management systems, GHIs have resulted in improvements in both, but only for their targeted diseases. In addition, they were also found to create parallel systems and, in the case of supply chains, to duplicate and displace local systems, resulting from a lack of co-ordination.

The study concludes that GHIs and country health systems are dynamic and inter-connected, and have positive and negative effects on each other, although policies to ensure the maximization of positive interactions are missing. The study recommends that the health systems strengthening agenda be given the same ambition and speed that characterises GHIs, to introduce health systems targets to existing GHIs, to improve alignment between GHIs and country health systems, for more data to be generated on costs and benefits of improving health systems, and for increases in funding for health systems in a predictable manner.

The second study, Spicer et al. (2010), examined the effects of three GHIs—the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), the President’s Emergency Plan for AIDS Relief (PEPFAR) and the World Bank’s Multi-country AIDS Programme (MAP)—on co-ordination in seven countries in Europe, Asia, Africa and South America. The study involved 379 in-depth interviews with stakeholders at the national and sub-national level. Overall, it was found that different contexts actually shared similar experiences. The study found that GHIs, particularly the Global Fund, had a positive effect on national level co-ordination and have achieved wide stakeholder participation, although participation from non-health government departments and civil society organizations (CSOs) remained weak. Country ownership, on the other hand, was found to be inhibited by weak decision-making power of co-ordination mechanisms, particularly at the sub-sector level. Although some improvements in ownership were observed over time, the study found that a lack of transparency and communication, competition for resources, and weak secretariat and managerial capabilities were impeding further progress.

A number of recommendations to improve the co-ordination and therefore the effectiveness of GHIs are made. These include improving secretariat capacity at national and regional level through financial and technical support, better positioning of co-ordination mechanisms within government to enhance their authority, increasing financial and training support to CSOs to improve their participation at the national and regional level, and better definitions of the roles of the members of national and sub-national co-ordination structures.

vaccination and the Stop TB Partnership. However, there are many others. Their increase in popularity (and funding) has sparked a debate between vertical, disease-focused programme and horizontal health system approaches.

Proponents for ‘vertical’ disease-focused programmes advocate that the urgency of tackling the spread of some diseases means specific programmes have to be designed and implemented for them (Biesma et al. 2009, World Health Organization Maximizing Positive Synergies Collaborative Group et al. 2009). On the other hand, broader health systems constraints have been identified as slowing down progress towards making improvements in these diseases, and in health more generally (Cavalli et al. 2010, Lieberman et al. 2009, Shiffman 2006b). There has been mixed evidence on the impact of vertical programmes on the health system, although it has been found that weak health systems are particularly vulnerable to the negative effects of GHIs (Cavalli et al. 2010).

The evidence on which this debate is based is scarce, with both sides using anecdotal evidence to make their case. However, some recent studies have shed some light on this. A multi-country review carried out by the World Health Organization’s Positive Synergies Collaborative Group (2009) found that although there were significant gaps in the data, there was potential for global health initiatives to positively interact and reinforce the health system. A seven-country study by Spicer et al. (2010) found that although GHIs (the Global Fund for AIDS, Tuberculosis and Malaria particularly) have had positive effects on co-ordination at the national level, they increased the complexity of the aid architecture, undermined alignment and lacked harmonization, especially at the sub-national level (Spicer et al. 2010). In contrast, Dodd and Lane (2010) found that global health partnerships have successfully innovated new approaches to raising and delivering funds and can provide longer-term funding, from which other donors should learn—more details on these can be found in Box 2.

A third ‘middle’ way has been put forward, known as the ‘diagonal’ approach. This approach consists of using single disease projects and programmes to address broader health systems issues, such as human resources, drug supply and financing (Frenk et al. 2003). However, there are warnings that unless accompanied by an increase in funding, this new approach will fail (Ooms et al. 2008). Examples of the diagonal approach include the Global Fund’s health systems strengthening programmes² and PEPFAR’s investments in human resources, supply chains and health systems infrastructure (Moore and Morrison 2007).

4 Factors affecting the effectiveness of DAH

4.1 Allocation of DAH

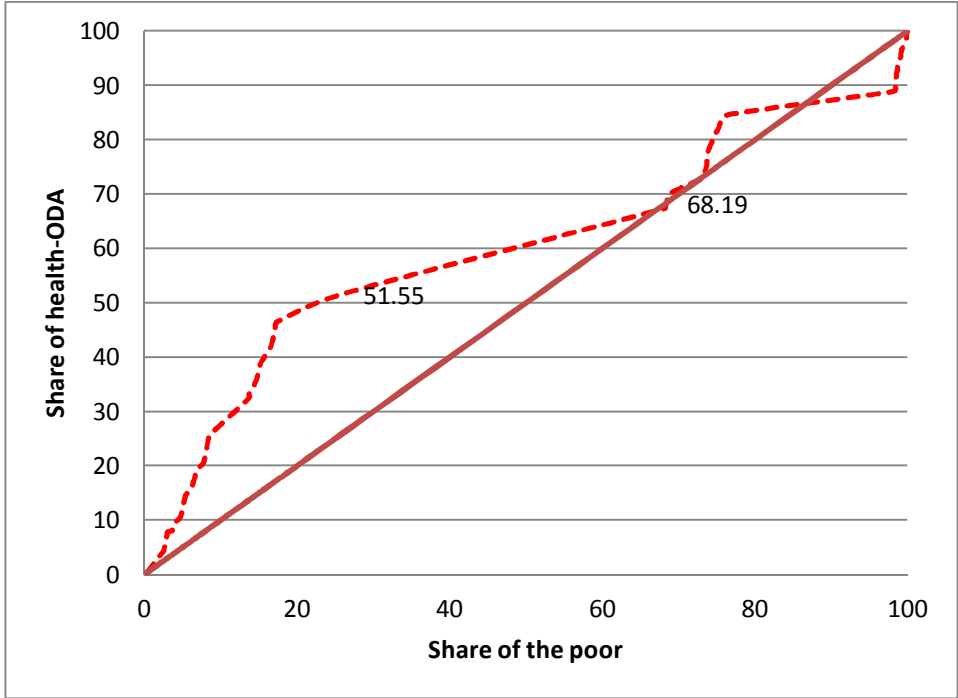
As outlined in the introduction, the amount of DAH disbursed has increased dramatically over the past ten years. However, this increase has been uneven both between countries and across different health priorities. The share of DAH allocated to sub-Saharan Africa (SSA) has increased steadily (albeit departing from low levels of investments in the sector, see Table 1) to account for 29 per cent of all DAH in 2008,

² Global Fund to fight AIDS, Tuberculosis and Malaria (2007).

making it the best-funded region in the world (Institute for Health Metrics and Evaluation 2010), which also reflects the severe deficits in health service provision in the region.

A cross-country analysis found no correlation between countries' GDP per capita and the amount of DAH they received, although this is improving (Ravishankar et al. 2009). This should not be taken as a measure of whether DAH has resulted in increased growth, but rather as an assessment of whether DAH is provided to countries that need it most. Some problems arise when contrasting total DAH with GDP per capita, as a few newly emerging middle-income countries—such as India, Pakistan and China—have large populations and receive large total amounts of foreign aid. India was actually the largest recipient of DAH in 2007; however the per capita DAH it received is actually low compared to almost all lower-income countries. Given that expressed motive for development assistance is to aid poor countries, DAH distribution is fairly consistent with this motive. Figure 1 shows the relation between the cumulative proportion of poor (defined as living under US\$1 a day) and the cumulative amount of health official development assistance (ODA) distributed for 56 countries, including India and China, but excluding countries with a population smaller than one million and for which DAH made up less than 1 per cent of their total government budget. These countries were ranked by per capita income, averaged over 1995-2006. For this sample of countries, the first 25 countries amounted to containing 26 per cent of the total poor while the amount of health ODA going to these countries amounted to 51.5 per cent of the total amount of aid in our sample. Of these countries 22 were in SSA, two in South Asia and one in Central Asia. The 26th country is India, home to 44 percent of the poor people in our sample. India received 17 per cent of the health ODA. At the point of India in Figure 1 the cumulative proportions are equalized.

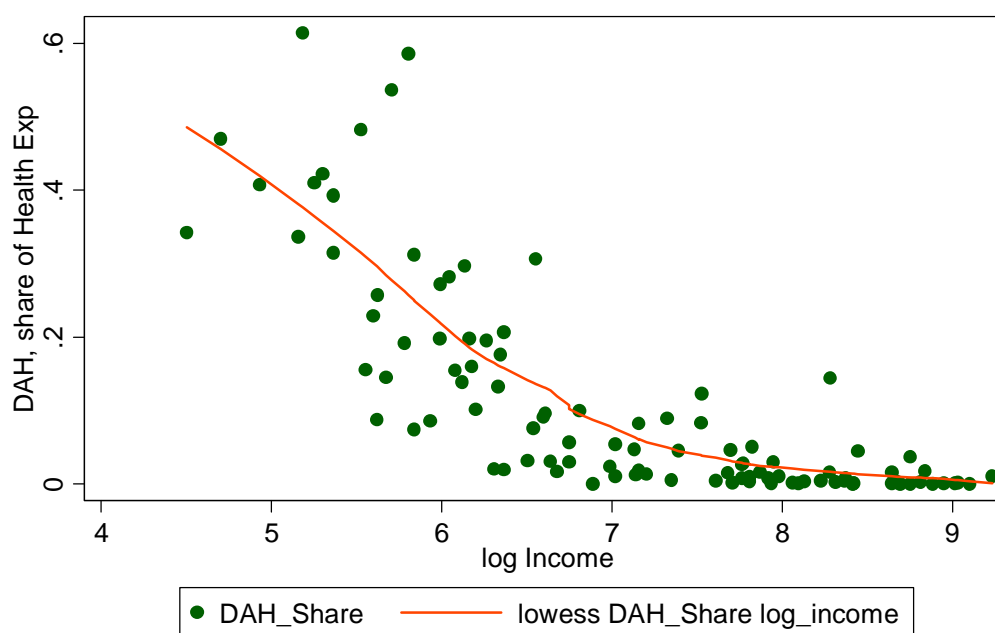
Figure 1: Cumulative distribution of health ODA in relation with the distribution of poor in 2006



Source: authors' illustration using OECD and World Bank poverty data from 2004-06.

Another indicator that may be important is the proportion of total health expenditure that DAH makes up; after all, DAH should make up the short-fall in health expenditure for poor countries. The evidence suggests that DAH measured as the amount going into a country makes up a larger share of total health expenditure for poor countries. Figure 2 depicts this relationship. Here we show that DAH is distributed in a pro-poor manner. In some countries DAH does nearly make up the entire public sector health budget. Although the political economic implications of this relationship are not clear, DAH makes up a large proportion of the health expenditure and budget for poor countries.

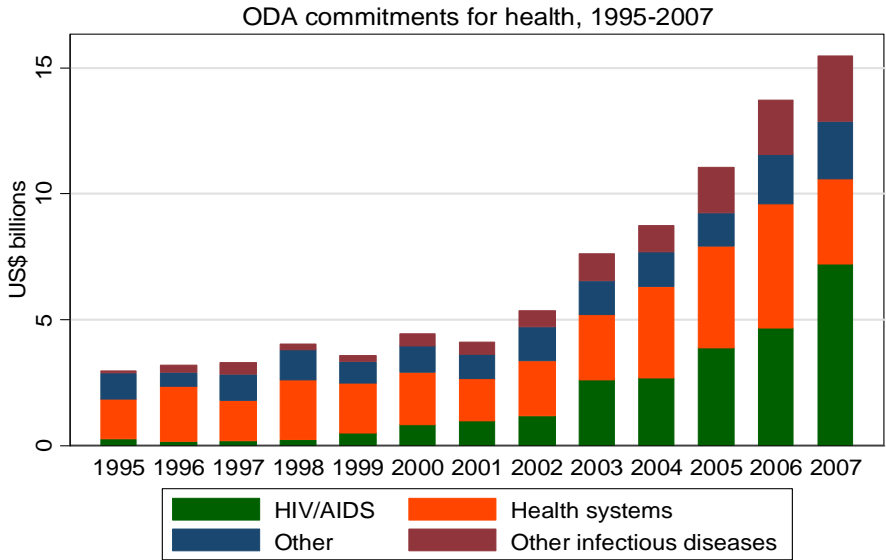
Figure 2: DAH as a share of total health expenditure and log income, average 2004-08



Source: authors' illustration using OECD and World Bank income data 2004-08.

Given the increase in earmarked project funding, one implication of the foreign source of health expenditure being large centres on whether the project funding meet the priorities within a country. The literature highlights some (but not full) correlations between countries' burden of disease and the level of funding they receive (Ravishankar et al. 2009; MacKellar 2005). For instance, Ravishankar et al. (ibid.) found that of the US\$13.8 billion DAH in 2007 for which project-level information was available, US\$4.9 billion was spent on HIV/AIDS, compared with US\$0.6 billion on tuberculosis, US\$0.7 billion on malaria, and US\$0.9 billion on health sector support. Another study found that non-communicable diseases received US\$0.78 per disability-adjusted life year (DALY) in 2007, compared to US\$23.9 per DALY attributable to HIV, tuberculosis, and malaria (Nugent 2010). Differences in funding are also observed amongst the goods and services that are funded; for instance, more funding is allocated to the procurement of drugs than to human resources or infrastructure (Juliet et al. 2009). Analysis of OECD Creditor Reporting System data shows the prominence of HIV funding, but also recent increases in broader health systems priorities:

Figure 3: Trends in priorities of development assistance for health (2009 constant US\$ billion commitments)



Source: Tandon (unpublished), compiled from OECD-DAC data, reproduced with permission from author.

If funding decisions are not fully based on disease burden, then what other factors are influencing donors’ choices? Discussions in the literature indicate that donors have non-altruistic motives. Countries may use DAH as a strategy within their foreign policy and security (Labonte and Gagnon 2010); for instance, to control infectious diseases that pose a threat to donors’ national security (Shiffman 2006a; Shiffman et al. 2002). In addition, there is some evidence that priorities are set to serve the interest of donor countries’ foreign policy and trade agenda (Feldbaum and Michaud 2010).

The current distribution of DAH affects its effectiveness in two ways. First, resources are not directed to where they are most needed, and hence are not achieving their potential impact. Second, the popularity of some countries and priorities means that donors and implementing agencies crowd around them, resulting in duplication and competition (see fragmentation below).

4.2 Predictability

By its very nature, DAH is discretionary spending for donors, and as such can be extremely unpredictable. Predictability is defined by the OECD as the provision of long-term indicative figures of aid flows, as well as the disbursement of committed funds in a timely manner (OECD 2008a). Donors often fail in both dimensions. A panel regression in 60 low-income countries for the time period 1990-2005 found that, on average, levels of annual aid disbursements and commitments differed greatly, particularly in SSA. It also found that this had only shown small improvements over time. Perhaps surprisingly, lack of predictability was found both as shortfalls and as excesses in the amounts of funds expected, with SSA countries more likely to receive excess disbursements (Celasun and Walliser 2008). This has been corroborated in single-country studies in Uganda (Orem et al. 2009) and Zambia (Sundewall et al. 2009). Other studies have found significant differences between countries (Strategic Partnership for Africa–Budget Support Working Group 2005), and that the poorest

countries are particularly affected by the unpredictability of DAH (Celasun and Walliser 2008).

Different reasons are found in the literature for the lack of predictability of aid flows. A survey of donors found that unmet policy conditions, donor administrative problems, recipient government delays in meeting conditions and political problems in the donor country all contributed to a lack of predictability (Strategic Partnership for Africa–Budget Support Working Group 2005). Celasun and Walliser (2008) found that 25 per cent of unpredictability was explained by recipient country stability and levels of aid disbursed. They blamed the rest on ‘fickle’ donor behaviour (Celasun and Walliser 2008). This lack of predictability has led to DAH only funding the developing budget in countries such as Tanzania, as recurrent costs need to be constant, and hence it is risky to have them depend on external assistance.

Lack of predictability can hinder aid effectiveness in several ways. First, it hinders recipient governments’ ability to plan their budgets (Orem et al. 2009). This is a particularly important problem in the health sector, as health systems development is a long-term process, where many costs are recurrent, resulting in governments being reluctant to scale up activities (Vassall and Martinez Alvarez 2011, Dodd and Lane 2010). Furthermore, budget aid that is larger than planned for may not be incorporated into the budget, and its expenditure will either be delayed or allocated to recurrent rather than investment spending. Second, lack of predictability has resulted in recipient ministries of finance being unwilling to allow long-term health spending commitments (Cavagnero et al. 2008), hence contributing to fungibility. Third, unpredictable aid undermines recipient governments’ budgets by forcing adjustments in expenditure and changes in original allocations during budget execution, hindering the achievement of government objectives, and disrupting the implementation of poverty reduction strategies (Celasun and Walliser 2006).

4.3 Fragmentation

As mentioned in Section 2, increased levels of development funding have resulted in the proliferation of the number of donors and the amount of projects and programmes they fund. This phenomenon is known as fragmentation. Fragmentation, which has been associated with decreased DAH effectiveness, affects countries differently (Frot and Santiso 2010). A study by Frot and Santiso (2010) found that poor and stable democratic countries, such as Tanzania, which had 1,601 aid projects in 2007, suffer most from fragmentation. The authors suggested that this was associated with donors preferring stronger institutions, which are found in these countries.

There are several reasons why fragmentation of DAH decreases its effectiveness. Acharya et al. (2006) classify these as direct and indirect costs. The direct (transaction) costs are a result of both the large number of donors, which require substantial amounts of senior officials’ time, and the amount of projects they fund, which incur a considerable managing and reporting burden for governmental authorities (Acharya et al. 2006). Indirect costs include aid agencies attracting public servants away from the government, thereby exacerbating staff shortages (Aldasoro et al. 2010); time and money spent by donors on technical assistance and training of local staff, which results in reduced worker productivity (Acharya et al. 2006; Mueller et al. 2011); governments finding it easier to protect their interests as donors can exert less pressure by acting

alone (Burnell 2002), but having to balance out many different interests; more difficult co-ordination resulting in duplication; and, lack of individual sense of responsibility (Knack and Rahman 2007).

4.4 Fungibility

The issue of fungibility is often hotly debated in discussions concerning the effectiveness of DAH. Methodological issues encountered when assessing fungibility were discussed in Section 2. Here, we outline the current views on the matter. Fungibility is the process by which the recipient government ‘offsets donor spending for a particular purpose by reducing its own expenditures on the same purpose ... therefore aid substitutes rather than supplements local spending’ (Foster and Leavy 2001). The existence of fungibility of development assistance has been documented extensively in the literature from as early as 1993 (Pack and Pack 1993, World Bank 1998). Fungibility can occur at the macroeconomic (Gottret and Schieber 2006), sector (Farang et al. 2009, Gottret and Schieber 2006, Lu et al. 2010) and subsector (Shiffman 2008, Gottret and Schieber 2006) level. Although the data available on health sector spending in low-income countries is often scarce and of bad quality, several studies have found that it is particularly affected by fungibility (Lancaster 1999). Estimates of the extent of fungibility in the health sector for every dollar spent vary from a decrease in US\$0.27-\$1.65 (Farang et al. 2009, Gottret and Schieber 2006, Lu et al. 2010) to a US\$1.50 increase (Mishra and Newhouse 2007). Much of these calculations in regards to DAH depend on methodologies used including how the dependent variable is constructed. Some attempt needs to be made in regards to critically survey this literature.

Merely documenting whether fungibility takes place is insufficient, it is more important to explore why it happens (Lahiri and Raimondos-Moller 2004; Ooms et al. 2010) and whether it is detrimental to DAH effectiveness. Some factors have been associated with increased fungibility, including low levels of recipient country income (Farang et al. 2009), fragmentation (Gottret and Schieber 2006), lack of predictability and the short-nature of DAH flows (Farang et al. 2009; Gottret and Schieber 2006), and lack of information (Halonon 2004). It is also important to explore why governments may choose to divert their spending from the health sector. It may be a government’s way of reallocating funding to other sectors, to anticipate the long-term unreliability of DAH, or to smooth DAH by spreading it across different years (Farang et al. 2009), a practice advised by the IMF (Stuckler et al. 2011).

Fungibility is often highlighted as a cause of aid ineffectiveness, as donor funds substitute rather than complement recipient governments’ budget for health, and some studies consider it synonymous with corruption (Lahiri and Raimondos-Moller 2004). However, fungibility has also been described as a rational and responsible response to DAH, resulting from donors’ and recipients’ differing priorities (Gottret and Schieber 2006; McGillivray and Morrissey 2000), where recipient governments reallocate the resources available to them according to their priorities (Waddington 2004). It may be seen as an indication that the recipient governments are aware of the DAH coming into the country, which may explain why funds channelled through NGOs do not result in fungibility (Sridhar and Woods 2010). In addition, some studies have concluded that fungibility has limited consequences (McGillivray and Morrissey 2000; Wagstaff 2011), that it is too narrow a concept to analyse aid effectiveness (Pettersson 2007), and that it may distract from the real issues (McGillivray and Morrissey 2000).

4.5 DAH relationships

In Section 2 we mentioned that the process of giving aid is in itself often a subject of study. Here we outline the current thinking on these issues. It is first important to acknowledge that DAH ineffectiveness is not just the responsibility of a particular actor or agency, but of the system of relationships that it generates. A variety of actors are involved in the delivery and use of DAH. These actors form dynamic and interactive relationships, which are shaped by differing underlying incentives, motivations, and information and power asymmetries and often result in lack of accountability (Eyben 2006, Holvoet and Renard 2007, Gibson et al. 2005, Alonso 2004). This section will explore the notions of accountability, incentives and information and power asymmetries that characterise DAH relationships.

Accountability is understood as the ‘means by which individuals and organizations are held responsible for their actions’ (Edwards and Hulme 1996). It is considered vital to the effectiveness of DAH, and has been repeatedly called for in the various declarations and commitments to aid effectiveness (Organisation for Economic and Development 2008, Balabanova et al. 2010). Accountability should happen at all stages of the aid process, from decision-making, through implementation, monitoring, and evaluation (Kapur and Whittle 2010). There are four components to a well-functioning accountability system: a clear statement of goals (ODA 1993), transparency of decision-making and use of funds (Ebrahim 2005; Ebrahim 2010, World Bank 2006), an appraisal process with published results (Ebrahim 2010; ODA 1993), and mechanisms for holding those responsible to account (ODA 1993).

In theory, beneficiaries should hold donors and implementing agencies to account, and donors and implementing agencies should be mutually accountable to one other for the distribution and outcomes of DAH. However, accountability should not be regarded as a linear process, as the many actors involved interact to form a complex web of relationships (Ebrahim 2005; Eyben 2006).

Repeated calls for mutual accountability between donors and recipient governments have proven difficult to implement in practice. Several reasons have been put forward in the literature for this. First, the DAH system faces the problem of being a ‘global public good’, where every country can benefit from improved health indicators and development in general (Alonso 2004), which may result in donors eluding individual responsibilities, as the rewards will be shared amongst all donors. Second, donors’ main accountability line is to their funders—the taxpayers (Haan 2009), and they therefore feel less responsibility towards the recipient government for their actions. Donor incentives are also often skewed towards spending of funds rather than achieving results, a trend known as the ‘money-moving syndrome’ (Monkam 2008b), which hinders accountability to beneficiaries. Third, accountability lines within donors mean that country offices are accountable to their headquarters, rather than the recipient government. Given the different motivations for giving DAH, country offices may be forced to follow the ‘official line’, even if that means bypassing mechanisms of country ownership, harmonization and alignment. Long project cycles and short-term posts in donor offices have also been blamed for hindering accountability (Monkam 2008a).

Lack of trust in recipients’ accountability mechanisms has resulted in donors either setting up parallel systems, which further undermine the government (Buse 1999),

attaching conditions on how assistance is managed and accounted for, which limits its predictability and country ownership, or attempting to improve governments' systems through technical assistance, which has been blamed for wasting resources on international consultants or luring government employees away from their jobs for training purposes with per diems or salary top-ups (Mueller et al. 2011).

Recipient governments and those implementing DAH funded services may not be fully accountable to their beneficiaries due to a phenomenon known as the 'broken feedback loop', whereby the people paying for the services are different to those receiving them (Easterly 2008). This is slowly changing, however, largely due to the advocacy efforts of increasingly stronger CSOs, both in donor and recipient countries.

Accountability is also hindered by power inequality between donors and recipients (Eyben 2006), as donors have control over resources, and can withdraw them at any point if they feel the recipient governments are not adhering to the conditions attached to the DAH (Ebrahim 2003). In contrast, there is no mechanism for sanctioning donors if they default on their commitments (Eyben 2006). Having said this, donors also face the Samaritan's dilemma, which arises when the cost of enforcing conditionality (i.e. withdrawing DAH) is higher than the cost of the conditions not being met (Gibson et al. 2005).

5 Scalability of aid-supported health care programmes

The aid influx into some countries, particularly to African and some of smaller South East Asian countries has increased the overall public expenditure on health dramatically. Consequently, scaling up of public activities around health has been observed for many of these countries.

However, several barriers, both financial and non financial, have been encountered when trying to scale up aid-funded health programmes (Hanson et al. 2003). A review by Mangham and Hanson (2010) highlighted absorption capacity and health system needs as key constraints to scaling up health interventions. Concerns regarding absorption capacity arise due to micro- and macro-economic constraints countries face in using additional aid resources effectively. There are worries regarding the effect increased development assistance may have on the partner governments' ability to plan, manage, and budget these resources, and their impact on service delivery (De Renzio 2005, 2007; International Monetary Fund 2007). There are also concerns about diminishing returns of increased aid, although studies have shown that these levels of funding have not yet been reached (Bourguignon and Sundberg 2006; Feeny and McGillivray 2011). Non-financial barriers to scaling up aid-funded health programmes can be encompassed as health system needs. These include the capacity of health workers and the appropriate policy and institutional framework that need to be in place for additional assistance to be used effectively (Mangham and Hanson 2010).

Two further concerns are quality and equity (Mangham and Hanson 2010). There are worries that scaling up health services will decrease the quality of those services, particularly if health systems needs for the scale up are not in place. For this to be prevented, it is important that additional expenditure on health infrastructure is accompanied by increased recurrent spending to support the additional health sector

supply. There is some evidence that this is happening, with the Global Fund funding the construction of facilities, training health care personnel as well as improving the availability of medicines (Yu et al. 2008; Schwartlander et al. 2006). Moreover, there may exist a trade off between efficiency and equity when scaling up health programmes. This is because it would take more resources to reach the poorest populations, as they are often hardest to reach, and therefore scale ups that aim to reach as many people as possible may not reach in these populations (Mangham and Hanson 2010). This has been found to be the case in two studies evaluating the affordable medicines facility for malaria initiative and the evaluation of the ‘3 by 5 Initiative’ by the WHO.³ In both cases they found that although the interventions had achieved wider coverage, this tended to be focused on the upper quintiles, with the poorer populations still experiencing the most acute shortages of medicines (Battistella Nemes et al. 2006; Cohen et al. 2010).

Work undertaken by Hanson et al. (2003) identified five levels at which the above constraints can operate, and to which interventions to address them should be aimed. The first is at the level of the community and household, where the key constraints are lack of demand and use of interventions. The second is at the level of health services delivery, which includes health systems issues, such as the quantity and quality of human resources, availability of drugs and medical supplies, etc. The third level of constraints is at the level of health sector policy and strategic management, where constraints include lack of adequate policies and incentives and over-reliance on donor funding. The final level includes public policies cutting across sectors and environmental and contextual characteristics, such as governance and the overall policy framework.

Despite all of the above, many examples can be found in the literature of successful scale up interventions (see Table 4 for a summary of these). A study of the scale up of an adolescent and sexual health programme in Tanzania was reported to achieve high coverage. The authors associate the success of the scale up with the structured nature of the process. However, they express concerns regarding the quality of the programmes and the need for increased supervision (Renju et al. 2011). In a set of case studies carried out by Medlin et al. (2006), the authors found that country ownership, strong leadership and management, and realistic financing were all associated with effective scale up of programmes. Similarly, three case studies conducted as part of the commission of macroeconomics and health in Chad, India, and Tanzania highlight the importance of addressing demand and supply issues by engaging with the community to integrate their needs and perceptions, and managing human resources and health infrastructure (Wyss K et al. 2003). They also highlight the need for clear objectives and information systems for monitoring progress, strong evidence-based technical design and innovative approaches to address constraints at the policy and management level (Rao Seshadri 2003), and the importance of sequencing and addressing policy and infrastructure constraints, often outside the health ministry (Munishi 2003).

³ WHO (2009); <http://www.who.int/3by5/en/>.

Table 4: Summary of successful scale-up interventions

Title and authors	Study summary
Steketee, R. W. and T. P. Eisele (2009). 'Is the scale up of malaria intervention coverage also achieving equity?' <u>PLoS One</u> 4 (12): e8409.	Review of Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and Malaria Indicator Surveys in African malaria-endemic countries in the time period of 2006-2008. The study found great variation between levels of coverage of insecticide-treated mosquito nets (ITNs), treatment rates and intermittent preventive treatment (IPTp). Furthermore, the authors found that 52 per cent of the countries studied had an equitable distribution of ITNs, 30 per cent of treatment coverage and IPTp in pregnant women was higher in urban and richer households. This study shows that equitable scale up of malaria programmes is possible, although only two countries achieved equity in all three areas, with distribution of mosquito nets achieving higher coverage levels. The study found that countries with higher coverage did not necessarily achieve higher levels of equity. Furthermore, they conclude that two factors are associated with higher equity: the policies and delivery strategy, and the quality of delivery systems available.
Wolkon, A., J. L. Vanden Eng, et al. (2010). 'Rapid scale-up of long-lasting insecticide-treated bed nets through integration into the national immunization program during child health week in Togo 2004'. <u>Am J Trop Med Hyg</u> 83 (5): 1014-1019	This study analyses the coverage of a campaign to scale up ownership of ITNs by integrating ITN delivery with the vaccination campaign in six regions of Togo. The authors conducted community-based cross-sectional surveys one and nine months after the campaign to assess coverage, equity and use of ITNs. The study found that the intervention achieved high levels of coverage and equity, even nine months post-campaign. Despite high levels of coverage, however, the study found low levels of use of ITNs. The authors of this study conclude that integrated campaigns are an effective way to scale up coverage, and therefore recommend this strategy to other countries. In addition, they reinforce the message that distributing ITNs free of cost was key in achieving high coverage.
Cohen, J. M., O. Sabot, et al. (2010). 'A pharmacy too far? Equity and spatial distribution of outcomes in the delivery of subsidized artemisinin-based combination therapies through private drug shops'. <u>BMC Health Serv Res</u> 10 Suppl 1: S6.	This study assesses the effectiveness of a pilot subsidy for artemisinin-based combination therapies (ACTs) used for malaria treatment in two districts of Tanzania. The study consisted of a baseline and four follow up surveys in the form of exit interviews over a period of 15 months. The results from the study indicate that although sales of ACTs increased substantially, there were significant geographical variations with shops closer to towns, main roads and accessed by individuals of higher socioeconomic status experiencing higher stocking and sales of ACTs. The study concludes that additional efforts are needed to achieve equity as this subsidy is scaled up across different countries.
Scott, V. E., M. Chopra, et al. (2005). 'How equitable is the scaling up of HIV service provision in South Africa?' <u>S Afr Med J</u> 95 (2): 109-113.	This study reports on the findings of a cross-sectional descriptive study on the availability and use of HIV programmes, as well as management and support structures, in three districts of South Africa. The findings from the study reveal inequalities in service delivery between the richer, urban site and the poorer rural ones. The study concludes that the scale up of HIV services is exacerbating inequalities in service delivery and calls for policy makers to take into consideration equity issues as these may lower the effectiveness of interventions.
Renju, J. R., A. B. A. Bahati, et al. (2011). 'Scaling up adolescent sexual and reproductive health interventions through existing government systems? A detailed process evaluation of a school-based intervention in Mwanza Region in the Northwest of Tanzania'. <u>Journal of Adolescent Health</u> 48 (1): 79-86	This study reports on the scale up of a school-based reproductive and sexual health programme in Tanzania. The study found that the 10-fold scale up achieved a high coverage, which the authors attribute to the structured nature of the process. However, the authors express worries that this may have come at the cost of quality of the intervention. The study recommends higher levels of supervision and incentives to improve on this.
Improving the Health of Populations: Lessons of Experience (Medlin, C. A., M. Chowdhury, et al. 2006).	This series of 17 case studies found that country ownership, strong leadership and management, and realistic financing were all associated with effective scale up of programmes.
Wyss K, Moto DD, et al. (2003). 'Constraints to scaling up health	This paper reports on an assessment of the barriers to scaling up health interventions in Chad. It highlights the importance of

related interventions: the case of Chad, Central Africa'. <u>Journal of International Development</u> 15 (1): 87-100.	addressing demand and supply issues by engaging with the community to integrate their needs and perceptions, and managing human resources and health infrastructure.
Rao, S. S. (2003). 'Constraints to scaling up health programmes: a comparative study of two Indian states'. <u>Journal of International Development</u> 15 (1): 101-114.	This study analyses the constraints phased by two Indian states when scaling up health interventions. It finds that in order to be successfully scaled up, programmes need clear objectives and information systems for monitoring progress, strong evidence-based technical design and innovative approaches to address constraints at the policy and management level.
Schneider, H., D. Coetzee, et al. (2010). 'Differences in antiretroviral scale up in three South African provinces: the role of implementation management'. <u>BMC Health Serv Res</u> 10 Suppl 1: S4.	This study compares the operational and strategic management of the antiretroviral therapy (ART) scale up in three provincial governments in South Africa, which had achieved different levels of coverage. The findings of the study reveal that although similar approaches were adopted for chronic disease care amongst the three provinces, differences were observed on political and managerial leadership, programme design, monitoring and evaluation systems and the nature and extent of external support and partnerships. The paper concludes by highlighting the importance of the managerial process for successful scale up of programmes.
Abuya, T., A. Amin, et al. (2010). 'Importance of strategic management in the implementation of private medicine retailer programmes: case studies from three districts in Kenya'. <u>BMC Health Serv Res</u> 10 Suppl 1: S7	This paper compares the scale up processes of private medicine retailers in three districts in Kenya. It found that technical support and sufficient resources were essential for successful scale up, although not enough. The paper found that an effective strategy for managing relationships and strong and transparent management systems are also needed.
Seymour, J. (2004) Controlling tuberculosis in China. Millions Saved: Proven Successes in Global Health. <u>What Works Working Group</u> . M. Kinder. Washington, DC, Centre for Global Development.	This study was part of a series of case studies demonstrating successful health programmes. It reports on the scale up of tuberculosis Direct Observed Treatment services from 0 to 90 per cent in five years. The author credits the success of the scale up with political commitment and the use of creative incentives.

Source: authors' illustration.

6 Discussion

This paper has provided a brief history of aid, and of the literature on aid effectiveness. In doing so it has highlighted the inherent methodological difficulties found when trying to ascertain the impact of aid on development and growth broadly and the health sector specifically. The key impediments to effective development assistance for health are summarized, including allocation of resources, donor fragmentation, fungibility of funding and issues associated with the process of giving aid such as accountability, power and information asymmetries. The different aid modalities, their success stories and failures are also summarized. In particular, the shift from project aid to programme-based approaches is discussed, and the implications and constraints of scaling up successful projects reviewed.

One thing that has become clear when looking at success stories in economic development over the last 50 years, is that the development process required thorough diagnosis of local contexts, which was followed up by eclectic policy prescriptions, where conflicting theories were at work even within one single country (Rodrik 2010). Whilst the overall 'best practice' principles endorsed at international fora on aid effectiveness are noble and have generally been found to improve the quality of development assistance (Working Party on Aid Effectiveness 2009), they are very

general, often unrealistic and need to be adapted to the local context. In addition, the international community has not managed to abide by them, although efforts seem to be moving in the right direction. Therefore transferability of ‘best practice’ is hard, particularly given that successful projects and programmes tend to be those that adapt best to the local circumstances and where there is real ownership by the local partners.

It cannot, however, be denied that low-income countries do share some common characteristics, and that opportunities for cross-country learning abound. This does not necessarily have to take place by directly trying to replicate success stories, but by taking into account what worked under what circumstances. In that sense, new and emerging donors engaging in South to South co-operation can provide significantly valuable expertise, some of them being aid recipients until recently themselves (or still receiving aid). With that in mind, a new form of co-operation, known as triangular co-operation, has emerged, where traditional donors—belonging to the Development Assistance Committee (DAC) of the OECD—provide assistance to support southern donors’ programmes, given their technical advantage. An example of this is Germany’s support for Brazilian HIV programmes across Latin America (Working Party on Aid Effectiveness 2009). Table 5 shows some further examples of triangular co-operation.

Table 5: Examples of triangular co-operation in the health sector

DAC donor	Emerging donor	Recipient country	Project/Programme description
Canada	Brazil	Haiti	Haitian National Vaccination Programme strengthening
Japan	Brazil	Angola	Development of human resources for health in Josina Machel Hospital
Japan	Brazil	Madagascar	Child health services improvement programme
UK	Brazil	Peru	HIV control
US	Brazil	São Tomé and Príncipe	Malaria control and prevention
Italy	Tunisia	Niger	Training of health workers
Japan	Mexico	Nicaragua	Integrated management of plagues
Japan	Sri Lanka	Various African countries	Hospital management

Source: adapted from <http://www.oecd.org/dataoecd/62/54/44652734.pdf>.

Few studies evaluating aid practices by new and emerging donors can be found in the literature. However, so far the evidence indicates that there are no significant differences between new and old donors in their distribution and practices, except that new donors do not appear to be influenced by the level of corruption of the recipient country when making decisions about aid allocation (Dreher et al. 2011). Emerging donors have been praised for bringing extra funds, but there are concerns about increasing fragmentation, their high levels of tied aid, a lack of engagement in dialogue with partner countries and an unwillingness to harmonize with other donors (Working

Party on Aid Effectiveness 2009). Other characteristics of non-DAC donors are that they provide more flexible assistance, and mainly engage in project assistance and technical co-operation (Working Party on Aid Effectiveness 2009).

The international community has begun to acknowledge the importance of new donors, and of south to south co-operation, and has made efforts to include them into the high-level fora on aid effectiveness. However, new donors did not adopt the Busan Partnership, but agreed to use its commitments and principles as reference for South-South co-operation on a 'voluntary basis' instead. Although many see their engagement in the forum as progress, there is clearly some way to go before they are fully integrated.

As a last word, worries that the increasing levels of DAH seen over the past ten years will not be sustainable have contributed to increased attention to the effectiveness of aid. They have also resulted in donors taking a closer look at how they spend their finances and more pressure to be accountable to their funders (taxpayer, other donors) to show 'results'. This has led to an increased emphasis on results and performance-based financing. There is also anecdotal evidence that some prominent donors are moving away from programme-based approaches, due to frustrations about the lack of progress and the increasing need to show results, which are harder to see in modalities such as budget support. Given the lack of clear evidence, and the difficulties in establishing whether DAH is effective, there is a danger that the international community keeps moving to different approaches due to external pressures without stopping to evaluate what has worked or failed and why. In addition, the results based agenda is problematic given the short window of analysis used. As discussed in Section 2, health as development is a long-term process, the results of which may take years to fully show.

In conclusion, the international community is increasingly recognising that aid can only play a limited role in the improvement of health, and the principal drivers of progress are domestic, including public policies, governance and institutions, education levels and the absence of conflict (Working Party on Aid Effectiveness 2009). It is therefore important to have adequate expectations of how much can be achieved with development assistance.

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Appendix B: Interview topic guide

This topic guide is shown here as a sample. The interviews will not necessarily cover all the topics or follow the order of the topic guide, as it will be adapted to each participant.

1. Introduction

The information sheet of the consent form will be discussed and any questions answered.

The participant will then sign the consent form and choose the anonymity option preferred.

2. Ice-breaker

- What does your job involve?
- What does your organisation do?

3. DAH effectiveness and best practice

- In your view, what counts as effective aid?
- Do you think aid has become more effective in the past ten years? Why/why not?
How?
- What do you think are the key factors affecting the effectiveness of DAH?
- In your view, does international 'best practice' (Paris) lead to more effective aid?
Has this been the case in Tanzania? Why?

4. DAH disbursement in Tanzania

Brief discussion of findings from quantitative element. Results will be discussed and explanations will be sought for the patterns observed.

Distribution

- I can see that DAH priorities have changed over time (explain how), what do you think has driven these changes?
 - o Prompt – what has led to increases/decreases in DAH?

- Explore different health priorities – HIV and other
- Do you think the situation has improved or got worse? Why?

Aid modalities

- Have aid modalities changed over the past ten years? How?
 - Explain what aid modalities means, give examples
- Has this had an impact? What impact? Do you think the situation has improved/worsened? Why?

Fragmentation

- Do you think aid has become more or less fragmented over the last 10 years? Why do you think that is?
- Do you think this has had an impact on the government or the effectiveness of aid? How?

Harmonization and alignment

- Do you think donors work under a harmonized approach? If so which ones? Are there mechanisms for promoting harmonization? Which ones? Which are most important/effective?
 - Prompt: Does the SWAP mean donors are more harmonized?
- Do you feel that donors have become more aligned? If so which ones? Are there mechanisms for promoting harmonization? Which ones? Which are most important/effective?
 - Prompt: Do you feel the Paris Declaration principle has resulted in donors being more aligned with country systems?
- Has H&A changed over the past ten years? How?
- Do you think donors should be harmonized? Why/why not?

- Do you think donors should be aligned? Why/why not?
- How would you describe the donor-government relationship?
 - o Who initiates the relationship?
 - o Who decides how much funding there is going to be?
 - o Who decides what will get funded?
- Is it different between the different donors/modalities? If so how?
- How would you describe the donors' relationships with each other?
- Could you describe the relationship the donors have with their headquarters? To what extent are priorities decided at HQ or country office level?

Predictability and macroeconomic considerations

- Is predictability of DAH a problem? If so how?
- Has this changed over the past ten years? How?
- Do you feel DAH has impacted on macroeconomic forces? Please describe.
 - o Prompts: exchange rate, monetary and fiscal policy, general inflation
- Do you feel DAH budget may increase price of health in the private sector?
- Does the government have any mechanisms for dealing with these? Are these mechanisms effective?

Ownership

- What does 'country ownership' mean to you? (prompt about 'whose' ownership)
- Do you think there is strong country ownership in Tanzania? How is this demonstrated? How this changed over time? How/why?
- Could you describe to me how the poverty reduction strategy (MKUKUTA) was developed?
- Do you think it is appropriate?

- How would you describe the involvement of the government and the donors in this?
- How would you describe the extent to which the government manages DAH (accounting, M+E, etc)? Has this changed over the last 10 years? How?
- Do different donors respect the principle of country ownership differently? How do they do this?

Fungibility

- Do you think DAH has influenced government budgets and expenditure in the health sector? Prompt – have government health priorities changed as a result of DAH? How?
- How about at the sub-sector level?
- Why do you think the above has happened?
- How would you value this influence? Why?

5. Incentives

- What are the objectives of your organisation?
- Why does your organisation give aid? What about other donors?
 - o Government: why do you think donors give aid?
- What are your personal objectives for your job?
- How is your performance in your job assessed? (if senior, how do you assess performance of the people in your team?) Prompt – how are promotions assess/decided?

6. Accountability

- Are there accountability mechanisms used by donors and government? Which are most important?

- Do you feel that the government and donors are able to hold each other to account? Why/why not? If yes, how does this happen?
- Are there any mechanisms of accountability to the people of Tanzania?
- Could you describe the monitoring and evaluation mechanisms of the aid modalities of your organisation? Prompt- frequency, what gets reported, to whom it gets reported
- What happens if a report is negative?
- Could you describe the monitoring and evaluation mechanisms of government (such as public expenditure review)? Prompt - frequency, what gets reported, to whom it gets reported
- What happens if a report is negative?
- Has accountability changed over the past ten years? How -
- Is there transparency on financial flows from the donors and within the government? Has this changed over the past ten years?
- How would you describe the JAHSR?
 - o Prompt: who participates? Is it useful? Is it a transparent process? Do you feel it influences policy? To what extent? What other elements influence policy?

Final question

- Is there anyone you recommend I should interview?

Appendix C: Coding tree

1. Ownership
 - 1.1. Ownership in Tanzania
 - 1.2. Definition
 - 1.3. Leadership
 - 1.4. Capacity
 - 1.5. Government lead
 - 1.6. Fungibility
 - 1.7. Other
2. Accountability
 - 2.1. Accountability lines – to whom? (all actors including parliamentary commission)
 - 2.2. Processes (reporting, PER, JAHSR, MSD audits, CAG)
 - 2.3. Accountability for what?
 - 2.4. Corruption
 - 2.5. Consequences/enforcing conditionality
 - 2.6. Transparency
 - 2.7. Modalities
 - 2.8. DP responsibilities
 - 2.9. Gov responsibilities
 - 2.10. Cost effective / Value for money
 - 2.11. Other
3. Harmonisation
 - 3.1. DP speaking in one voice
 - 3.2. Fragmentation
 - 3.3. Coordination
 - 3.4. Participation
 - 3.5. Development Partner Group
 - 3.6. Vertical agencies
 - 3.7. Delegated cooperation
 - 3.8. Burden on government
 - 3.9. Other
4. Aid effectiveness / results
 - 4.1. International declarations
 - 4.2. Effective aid
 - 4.3. Management for results
 - 4.4. Causality
 - 4.5. Other
5. Alignment
 - 5.1. Joint Assistance Strategy for Tanzania
 - 5.2. Government systems
 - 5.3. Parallel systems
 - 5.4. System strengthening
 - 5.5. Procurement
 - 5.6. Public financial management
 - 5.7. Health sector reform

- 5.8. Governance
- 5.9. Gov top-down structure
- 5.10. Other
- 6. Priorities
 - 6.1. HIV funding
 - 6.2. DP priorities
 - 6.3. DP home politics/HQ
 - 6.4. Government priorities
 - 6.5. DP influence
 - 6.6. Basket Fund
 - 6.7. Maternal and child health
 - 6.8. Drugs
 - 6.9. Human Resources
 - 6.10. Primary Health Care
 - 6.11. Other
- 7. Incentives
 - 7.1. Organisation roles
 - 7.2. Individual roles
 - 7.3. Allowances
 - 7.4. DP incentives
 - 7.5. Government incentives
 - 7.6. Risk-taking
 - 7.7. Impact of DP sanctions
 - 7.8. Performance management/assessment
 - 7.9. Other
- 8. Modalities
 - 8.1. Trends
 - 8.2. Speed of change
 - 8.3. Vertical
 - 8.4. GBS
 - 8.5. BF
 - 8.6. Off-budget aid
 - 8.7. Earmarking/control
 - 8.8. Technical Assistance
 - 8.9. "pulling out"
 - 8.10. Aid dependency
 - 8.11. Future/sustainability
 - 8.12. Other
- 9. Policy dialogue
 - 9.1. SWAP
 - 9.2. Technical Working Groups
 - 9.3. Non-government
 - 9.4. Side of the table / sitting at the table
 - 9.5. Short postings
 - 9.6. DP skills (technical vs. admin/diplomat)

- 9.7. DP participation/involvement (inc. Nitty Gritty)
- 9.8. Donor fatigue
- 9.9. Government fatigue
- 9.10. Unrealistic expectations
- 9.11. Regularity of meetings
- 9.12. Central vs. sector dialogue
- 9.13. Political willingness
- 9.14. BFC dialogue
- 9.15. Power
- 9.16. Information
- 9.17. Vertical dialogue

Other

Appendix D: Example of development of categories from themes

A : 1.1 Ownership in Tanzania		Elements/Dimensions	Categories/Classes
1 : No 15	<p>1. The CAG was not given a mandate for their health audits by the DPs</p> <p>2. Tz have good ownership, more than DPs think. If they really wanted to do PER, Planrep and health performance profile report, they have the capacity. It is because they are forced to do things</p>	<p>CAG has ownership. There is ownership but no willingness</p>	<p>Ownership by government level. Political willingness</p>
2 : No 16	<p>Everything is done within the MTEF, so there is ownership. They still try to influence, but ultimately it is a sovereign government so if they want to do things he doesn't like they just don't fund it.</p>	<p>MTEF guarantees ownership. DPs try to influence. Tz can choose what it does and DPs choose whether to fund it</p>	<p>MTEF. DPs level of influence</p>
3 : No 17 + 18	<p>1. They talk about ownership and the government being in the driver seat, but if they constantly complain about their style of driving, it is hard for the government to maintain responsibility*.</p> <p>2. It is difficult to operate within the government frame where their allowances for travel are higher than they are allowed to pay.</p>	<p>DPs drive ownership. Difficulties to maintain ownership with allowances</p>	<p>Ownership driven by DPs. DPs level of influence</p>
5 : No 20	<p>Ownership and engagement in the process has been declining, you can assess it by actions rather than words.</p>	<p>Ownership is declining</p>	<p>Trends in ownership</p>
6 : No 20 post interview notes	<p>The PER is funded by USAID through Abt although lead by MoHSW, they draw up plan and then ask donors.</p>	<p>Government has ownership of PER</p>	<p>Ownership by government process/accountability</p>

7 : No 21	DPs are driving ownership by telling the country what to do. It is a capacity issue.*	DPs drive ownership. Capacity	Onwership driven by DPs. Capacity
8 : No 1	<ol style="list-style-type: none"> 1. The JAST allows DPs to participate but discussion should be in line with govenment priorities and procedures 2. There is country ownership 3. The MoHSW determines the priorities and then looks for assistance. The DPs need to comply with priorities. 	<p>DP participation and government ownership defined by the JAST</p> <p>Opinion on degree of ownership</p> <p>Government has ownership because it decides on its priorities</p>	<p>JAST</p> <p>Degree of ownership</p> <p>Priorities</p>
9 : No 2	With the basket fund it is 50:50	BF ownership	Different modalities
11 : No 4	<ol style="list-style-type: none"> 1. There is an international shift towards increased ownership, but it is a misunderstood concept, whereby DPs believe they should not be involved technically. 2. Transparency and accountability requirements are more important than ownership. 3. Ownership can mean lack of involvement with the nitty-gritty, and therefore less information, which hinders the relationship and looks arrogant.* 4. It's a dream to think you can influence a sovereign country through a policy dialogue, if they want to give money to Tz it should be on its own terms, that's their ownership. 5. He is surprised tha the DPs do not take the initiative on the JAHSR, unhappy that it is because of ownership 	<p>Ownership vs. Technical involvement and initiative on joint processes</p> <p>Transparency and accountability more important than ownerships</p> <p>Tz has ownership</p>	<p>TA</p> <p>Importance of ownership</p> <p>Degree of ownership</p>

<p>13 : No 11</p>	<p>LGAs develop their own mission and vision, DPs can then come in and fund areas in line with their strategic plan, but don't tell them what they should fund. At the local level if there is a disagreement of what to do with foreign funds, either the government agrees with the DPs or they don't get the funding</p>	<p>LGAs decide their own priorities and DPs then come in and fund DPs have their priorities, and if the government does not like them they do not get the funds</p>	<p>Priorities Level of government</p>
<p>20 : No 22</p> <p>Occupation = Non-government</p>	<p>Sometimes the DPs have ownership, others it is the government, depending on the issue and the timing. The position of the government is predictable whereas the DP's isn't.</p>	<p>Depending on the issue sometimes it is the DPs others the government that has ownership</p>	<p>Degree of ownership</p>

* good quote



A study of Development Assistance for Health. The case of Tanzania

Information Sheet

Background

Tanzania has been a major recipient of Development Assistance for Health (DAH) over the last ten years, making up over 60% of the health sector budget. At the same time, Tanzania has experienced some health improvements, although the extent to which DAH has contributed to these is uncertain. This research aims to assess the effectiveness of DAH in Tanzania for the time period of 2000-2010.

Objectives and Methods

The objectives of this research are first of all to determine whether DAH given to Tanzania is being disbursed according to international 'best practice', and then, to evaluate whether this has resulted in an efficient allocation of resources in the health sector, and the factors contributing to this. In order to do this, this project will require secondary data analysis on health financing and expenditure, as well as semi-structured interviews with stakeholders, including government officials, donors and employees of non-government organisations.

Participation

You have been approached because we believe you may be able to contribute to our understanding of the process by which DAH is disbursed and distributed in Tanzania. By taking part in this study, participants are not putting themselves at any risk. Participants will gain from this study by having a chance to contribute to the improvement of the delivery of development assistance for health in Tanzania. Participation in this project will entail taking part in a semi-structured interview. Participation is completely voluntary, and should you agree to take part you may

withdraw at any time without giving a reason. Withdrawal will not have any negative impact on the participant. Should you like to participate, we would like to record the interview and have it transcribed to aid our analysis. However, you are free to indicate that you would prefer the interview not to be recorded, in which case the interviewer will take hand-written notes during the course of the interview.

Confidentiality

Where participants are happy for us to identify them, we will do so in any reports and academic papers that we publish. However, if you prefer to remain anonymous, we would ensure that your identity is anonymised. Should you wish us to, we will ensure that you will not be identified from any other information, such as the organisation that employs you, or your position within it. If you prefer not to be quoted at all, even anonymously, we will, with your permission, use information you provide us with to inform the analysis without specific citation or anonymous reference. I (Melisa Martínez Álvarez) will be the only person that will have access to the interview material. Where interviews are transcribed by a professional transcriber, the transcriber will be bound by a confidentiality agreement. All interview recordings will be destroyed at the end of the project.

Please note that we intend to publish our results, and may quote from interviews, so please consider whether you would like to remain anonymous, and the degree of anonymity you would prefer. You may discuss these issues at the interview, when any questions you may have will be answered your wishes can be clarified and.

Further Information

If you have any questions of require further information, please contact Melisa Martínez Álvarez at the address below:

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Aid effectiveness in Tanzania: Has Development Assistance for Health resulted in an efficient allocation of resources in Tanzania?

Consent Form for Interview Respondents

Investigator's name and contact details

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To be completed by the participant

1. I have read the information sheet for this study and I have understood what will be required of me if I take part in it
2. My questions regarding this study have been answered by the researcher
3. I understand that I may withdraw from this study at any time without giving any reason
4. I agree to take part in this study
5. Do you give permission for the interview to be recorded

- a. Yes []
- b. No []

6. Please read the following options carefully and tick ONE:

- a. I agree that material from this interview may be quoted and that these quotations may be attributed to me []
- b. I agree that material from this interview may be quoted but I would like my name to be anonymised, although you may mention my organisation and my position within it []
- c. I agree that material from this interview may be quoted but I would like my name and my position within my organisation to be anonymised, although you may mention my organisation []
- d. I agree that material from this interview may be quoted but I would like my name, my position and my organisation to be anonymised; however, you may refer me to “a donor”, “a Ministry X official”, “a representative from an NGO/SCO”, etc []

(if other please state.....)

- e. I agree that material form this interview may be quoted but I would like my name to be anonymised as well as any information that can be used to identify me, including my organisation and my position within it []
- f. I do not agree that the material from my interview may be quoted, but the researchers can use information from my interview to inform their analyses []

Name

Signed

Date

