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Changes in the International Context of Health Cooperation

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List of Abbreviations

CIDA	Canadian International Development Agency
CMH	Commission on Macroeconomics and Health
CSR	Corporate Social Responsibility
DAC	Development Assistance Committee
DANIDA	Danish International Development Agency
DFID	UK Department for International Development
DT	Development Today
EC	European Commission
EU	European Union
FDI	Foreign Direct Investment
GAVI	Global Alliance for Vaccines and Immunizations
GFATM	Global Fund to Fight Aids, Tuberculosis, and Malaria
GDP	Gross Domestic Product
GNI	Gross National Income
GNP	Gross National Product
HIPC	Heavily Indebted Poor Country
IMF	International Monetary Fund
IPPF	International Plan Parenthood Federation
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organisation
NHA	National Health Account
Norad	Norwegian Agency for Development Cooperation
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
PIU	Project Implementation Unit
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper

PSD	Private Sector Development
Sida	Swedish International Development Cooperation Agency
SRHR	Sexual and Reproductive Health and Rights
SWAp	Sector Wide Approach
TB	Tuberculosis
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	The United Nations Children's Fund
USAID	US Agency for International Development
USD	United States Dollar
WB	World Bank
WHO	World Health Organization

Executive Summary

Over the last decade there have been several trends and changes in the general aid environment, and in health-related patterns and ideologies, which have had implications for development assistance to the health sector. Sida plans to undertake an evaluation of its support to the health sector and, as a starting point, ECON has been commissioned to undertake the present study with the purpose of describing such trends and changes and to attempt to assess their relative importance for Sida. Hence, the study's aim is to provide the subsequent evaluation with a suitable and adequate focus.

The point of departure in identifying and selecting trends and changes for in-depth examination was a list of general issues suggested by Sida. Based on material gathered, interviews in Stockholm, Oslo, London and Geneva, and the experience and knowledge of the consultants, additions and deletions were made to this list. All trends and changes have been described and, in some cases, tentative ideas on ways that the eventual evaluation could examine Sida's response have been outlined. In assessing the relative importance of the different trends and changes for Sida, we used the interview results as a basis for our conclusions. We employed a simple scoring system to the interviews which allowed us to develop an indicative ranking of the different trends and changes. The result was that the Swedish interviewees emphasised the importance of: 'Ideological shifts'; 'Establishment of new disease specific global actors', and; 'A move towards budget support'. The international interviewees, however, primarily mentioned 'Strengthening of health systems' followed by the 'Establishment of new disease specific global actors' and 'A move towards budget support.'

Background

The multitude of problems, actors and activities which make up the context in which Sida's health support operates is subject to processes of transformation and evolution. Over the years, the international aid environment has changed dramatically, and the emergence of a new aid paradigm from 1999 and onwards has to a large extent focused on strengthening the leadership role of the recipient government and to increase local ownership. For example, as pointed out in the Terms of Reference (ToR) there have been changes in the guidelines and policies for the health sector as a whole, changes in the view of health as a tool for economic development, and changes in specific fields – most notably HIV/AIDS.

Sida plans to undertake an evaluation of its support in the health sector, with a particular focus on how the organisation has responded to changes in goals, context, and methods of working. The purpose of the present assignment is thus to outline the main trends and changes in the context in which Sida operates in order to help define the scope and the issues to be treated in the subsequent evaluation. Furthermore, the present study shall also attempt to assess the relative importance of these trends and changes for Sida.

Main directions of enquiry and method

Based on our understanding of the assignment, the following problem statement has guided us:

> *What are the key changes to the international context within which Sida's health cooperation has been carried out during the period 1995–2004 (with a focus on the last five years)?*

We commenced the process of identifying and selecting the key trends and changes by reviewing general issues suggested by Sida in the ToR. Material for the assignment has primarily been gathered in Sweden and from the Internet (previous studies and evaluations performed by Sida, organisations in the United

Nations (UN) system, other donors and similar actors in the sector), and from interviews in Stockholm, Oslo, London and Geneva. The steps taken in the identification and selection process were:

- A critical review of the various trends based on our (i.e. the consultants') experience working in the development field over the past ten years and in the development health field over the past five years.
- Inclusion of relevant topics that we have seen on the agendas of major multilateral and bilateral organizations over the past few years, based on our knowledge of the research and consultancy opportunities at such organisations.
- Comparison of the list to the current agendas and "hot topics"[1] on the web sites of a number of major donors and international organizations, notably the Organisation for Economic Cooperation and Development-Development Assistance Committee (OECD-DAC), World Health Organization (WHO), the British Department for International Development (DFID), and the Norwegian Agency for Development Cooperation (Norad).
- Examination of choice of issues covered in the (very few) papers we were able to find that provided overviews of the most important changes and trends in health and development assistance.
- Examination of the changes/trends that OECD-DAC mentioned as having influenced development financing trends in available past versions its annual report on development financing.
- Adjustments to the list based on interviews we conducted with the various health and development experts.[2]

In addition to the identification and selection of trends and changes, the present assignment also has the additional purpose of attempting to assess their relative importance for Sida. We used the interview results to arrive at a scoring of the various trends and changes and thereafter weighted the scores according to the number of interviewees. Hence, we arrived at an indicative ranking of the different trends and changes.

Conclusions

Based on the methods described above, we identified and selected a number of trends and changes for in-depth review. They are presented in Table A.

It is not possible to conclude that there is any common denominator between the trends and changes identified apart from the fact that they all have effects on development assistance to the health sector. However, it is our view that 'Changes in health related patterns and ideologies' are such that trigger a response or responses by actors, and that trends and changes in health related patterns and ideologies are such that cannot be attributed to strategic interaction between different parties but related to the environment or context in which actors exist. Therefore we have chosen to group the trends/changes identified into two broad categories; 'Changes in health related patterns and ideologies' and 'Actors' response to trends and changes' as is shown by Table A.

However, within the broad category 'Actors' response to trends and changes' many of the transformations are interlinked. For example, SWAPs and 'A move towards budget support' are interlinked and some argue that SWAPs constitute a step on the road to budget support. Another example is the relationship between SWAPs and the establishment of disease-specific global actors, i.e., how well new actors integrate with national priorities and SWAPs, and how the new actors' affect national health systems (see e.g. sections 4.2.2 and 4.3.1).

Table A: Trends and changes that have been reviewed

Changes in health related patterns and ideologies	Increased heterogeneity within recipient countries
	New epidemiological challenges
	Pharmaceutical developments
	Ideological shifts (SRHR & HIV/AIDS)
Actors' response to trends/changes	
Trends and changes in donor cooperation	Increased emphasis on harmonisation and alignment
	Emergence of horizontal approaches (strengthening of health systems, SWAps, and PRSPs)
	Emergence of vertical approaches (new disease specific global actors, "3 by 5", private-public partnerships)
	Changes concerning the availability of funding
	"Three ones"
Trends/changes in development/health assistance thinking	Increased emphasis on the link between poverty reduction and health support
	A move towards budget support

It is also our view that a better understanding of the trends and changes in donor cooperation might help Sida in strategic choices, e.g. to decide whether it would be more efficient to attack certain problems bilaterally or multilaterally.

In addition, it is our view that interpretations of the trends and changes in development and health assistance thinking are more subjective than the other transformations identified and hence will be more difficult to handle in a subsequent evaluation as they critically depend on Sida's philosophy. In other words, it will be difficult (in the follow-up project) to state objectively whether Sida "got it right" or not.

Based on interviews, we attempted to assess the relative importance of these trends and changes for Sida (i.e. those listed in Table A) and by applying a simple scoring method we arrived at an indicative ranking of trends/changes (see Section 5 for a more detailed description and Table B for the resulting top trends/changes). The conclusions, based on the indicative ranking, were that the three most important trends/changes as emphasised by the *Swedish* interviewees were: Ideological shifts (HIV/AIDS & SRHR); the emergence of vertical approaches (of which establishment of new disease specific global actors was the most important trend/change); and a move towards budget support. Among the *international* interviewees, the three most important trends/changes were: Emergence of horizontal approaches (of which strengthening of health systems was the most important trend/change); emergence of vertical approaches (of which establishment of new disease specific global actors was the most important trend/change); and a move towards budget support.

Table B: Top trends and changes

Trend/change	Ranking – Swedish interviewees	Ranking – International Interviewees
Ideological shifts (SRHR & HIV/AIDS)	1	4
Emergence of vertical approaches (new disease specific global actors, "3 by 5", private-public partnerships)	1	2
A move towards budget support	3	3
Emergence of horizontal approaches (strengthening of health systems, SWAps, and PRSPs)	4	1

1 Introduction

During the period 1995 to 2004 a number of trends and changes occurred in the international development field that were of potential relevance for the present study. Usually a trend is defined as a general direction in which something tends to move, or a general tendency to change. An actual change, on the other hand, is an event that occurs when something passes from one state or phase to another.[3] Using these broad definitions we can identify a few general trends in development assistance that have implications for the health sector. Examples include a move towards budget support, the enhanced stress on harmonization and sector wide approaches (SWAps), and an increased emphasis on the link between poverty reduction and health support. Some of these trends can be regarded as trends in donor cooperation and some can be regarded as trends in development assistance thinking.

More directly related to health, there are global trends and changes in disease burden that have implications for development assistance to the health sector, such as the increased heterogeneity within recipient countries. Even though world health is improving, not all aspects of world health are going in the "right" direction in all countries. In all countries, we are increasingly witnessing people with good health status living side by side with people with bad health.

At some point, trends result in actual changes. Examples include international commitments to a set of common development goals, agreement on the Millennium Development Goals; new national policies and guidelines for development assistance; the establishment of new disease specific global actors; new ways of organising support, and; changes in the availability of funding.

All of these trends and changes have implications for how an individual country organises its support to the health sector of recipient countries, and how effective that support is in terms of meeting specified goals and targets.

Sida plans to undertake an evaluation of its support in the health sector, with a particular focus on how the organisation has responded to changes in goals, context and methods of working. To that effect, the purpose of the present assignment is to outline the main trends and changes in the context in which Sida operates to help define the scope and the issues to be treated in the subsequent evaluation**.** Hence, the present assignment is descriptive regarding trends and changes, and aimed at providing a summary of the various transformations that have taken place. Based on our understanding of the assignment, we have therefore proposed the question to guide us:

> *What are the key changes to the international context within which Sida's health cooperation has been carried out during the period 1995–2004 (with a focus on the last five years)?*

In addition to the descriptive part of the assignment, the study also aims to assess the relative importance of these trends and changes for Sida. As the Terms of Reference (ToR) state "…the goal of the present study is to provide the subsequent evaluation with a suitable and adequate focus. Accordingly, the primary outcome should ideally be an outline of major trends and changes in the sector, along with their estimated importance for Swedish interventions in the field. The eventual evaluation may then juxtapose such an outline (combined with an overview of internal changes and processes) with Sida's actions in the sector as indicated by policies, composition of projects, methods of work, etc."

The remaining chapters are organised as follows. Chapter 2 describes how the various trends and changes have been identified. Chapter 3 presents broad trends and changes in patterns and health related ideologies; Chapter 4 commences with an overview of actors' response to trends and changes followed by a

presentation of these responses. Chapter 5 presents a tentative assessment of the relative importance of the trends and changes for Sida. Finally, Chapter 6 presents the conclusions of the study.

The ToR for the present assignment do not refer to the design of the methodology of the evaluation. Nevertheless, based on our knowledge of the various changes and trends, we have provided some initial practical suggestions on ways that the subsequent evaluation could examine Sida's response to a number of the changes and trends. These are provided as an "extra" at the end of the thematic presentation for the relevant individual changes and trends under the heading "Why it could be relevant". It should be emphasized that these are merely initial "brainstorming" ideas for the eventual evaluators and should not be taken as formal suggestions developed according to a consistent set of criteria.

2 Identification of trends and changes

The primary outcome from the present assignment should, according to the ToR, be an outline of major trends and changes that have affected the health sector, along with their estimated importance for Swedish interventions in the field. Hence, the first important task is to identify such trends and changes, with the relevant period to be studied being 1995–2004 (with a particular focus on the last five years).

As mentioned in the ToR, the trends and changes to be studied can be either changes in the context in which Sida's health cooperation operates (e.g. increased use of sector wide approaches) or trends and changes specific to the health sector (e.g. the establishment of the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM)). In addition, some trends and changes are the result of interactions between different actors whereas others cannot be attributed to such interaction.

2.1 Process of identification

In selecting the changes and trends to examine in depth, ECON took as a starting point the list of general issues provided as examples by Sida in the ToR. We then made additions and deletions to this list based on a number of considerations. The identification and selection was based on gathered material, interviews and the experiences and knowledge of the consultants and did not involve a formal scoring system. The different steps are briefly described below followed by a description of how we decided to organise the trends and changes that were identified.

- First, we critically looked at the various trends based on our own experience work in the development field over the past ten years and in the development health field over the past five years.
- Somewhat related to this, we took into consideration the topics that we had seen on the agendas of the major multilateral and bilateral organizations over the past few years. This was primarily based on our close tracking of research and consultancy opportunities with relevant organisations.
- We also compared the list to the current agendas and "hot topics" on the web sites of a number of major donors and international organizations, notably the Organisation for Economic Cooperation and Development-Development Assistance Committee (OECD-DAC), World Health Organization (WHO), UK Department for International Development (DFID) and the Norwegian Agency for Development Cooperation (Norad).
- We examined the choice of issues covered in the (very few) papers we were able to find that provided overviews of the most important changes/trends in health and development assistance (In particular those carried out by the Swiss Agency for Development and Cooperation, and DANIDA).
- Similarly, for a more general overview of important development topics, we noted the changes/trends that OECD-DAC have mentioned as having influenced development financing trends in its annual reports on development financing.
- Finally, we also adjusted the list based on the interviews that we conducted with a number of health and development experts. In particular, we presented our revised draft list to interviewees and asked them to both comment on which ones they thought were most important, as well as to suggest other important ones they felt should be added to the list.[4]

2.2 Organisation and selection of trends and changes

We first reviewed the list of general issues provided in the ToR:[5]

- Health problems and challenges (for instance, new epidemics, remedies).
- Aid modalities (e.g. harmonisation, budget support).
- Interactions between donors and developing countries (e.g. enhanced partnership, conditionality, efforts to increase local ownership).
- International actors (for instance, the establishment of the GFATM)
- Goals (e.g. Millennium Development Goals (MDG:s), "3 by 5")
- Interaction with other areas of development cooperation (e.g. the increased stress on the link between poverty reduction and health support).
- Availability of funding.
- Any other issue or area that may appear in the overview.

However, as the ToR had also mentioned different types of trends and changes (as described above) we decided to first sort these under separate headings based on their general characteristics. This implied separating some of the general issues listed above. For example, based on our view of aid modalities we decided to split harmonisation and budget support as they have different characteristics and therefore also different impacts on the health sector. In addition, we decided to distinguish between goals related to general development, e.g. MDG:s, and goals more directly aimed at the health sector, e.g. "3 by 5". The resulting initial list of trends and changes is presented below.

Trends and changes in health problems and technology. These are trends/changes that cannot be attributed to strategic interaction between different parties.

- New epidemics
- New remedies

Trends and changes in donor cooperation: These are trends/changes that we believe may assist Sida in the decision as to whether it would be more effective to attack certain problems bilaterally or multilaterally, or to channel their multilateral aid via certain institutions.

- Harmonisation
- Establishment of new disease specific global actors, e.g., GFATM, Global Alliance for Vaccines and Immunizations (GAVI), Gates Foundation
- MDG:S
- "3 by 5"
- Availability of funding

In addition, we added the increased use of sector-wide approaches (SWAPS) even though it was not in the initial list of general issues, but simply mentioned in the ToR as a broader trend in development cooperation. We concur with the view that there has indeed been a change in the view of SWAPS and we thus decided that it was important to include it on the list.

Trends and changes in development and health assistance thinking: These are transformations that stem from research about the delivery of bilateral or multilateral aid. As such they are more subjective than those above and hence will be more difficult to handle in a subsequent evaluation, as they critically depend on Sida's philosophy. In other words, it will be difficult to state objectively whether Sida "got it right" or not.

- Budget support
- Interactions between donors and developing countries (e.g. conditionality)
- Interaction with other areas of development cooperation (e.g. increased stress on link between poverty reduction and health support)

In addition to the above list, we have, in projects and in the public debate, come across other potentially relevant areas in which changes have occurred during the relevant time period. Some issues that have appeared quite repeatedly are: Management of aid for results/output-based approach; debate on the form that aid takes, e.g., grants, loans or other; and increased emphasis on private sector delivery of services. Hence, we decided to also include these trends and changes in our initial list.

After this first step of identifying trends/changes we commenced Internet searches and a literature review. The material gathered was primarily collected in Sweden and from the Internet. The literature review focused on previous studies and evaluations performed by Sida, organisations in the UN system, other donors and similar actors in the sector, as outlined in the ToR.

Following these reviews, some changes to the list of identified trends and changes were made. We found that two of the trends and changes (management of aid for results/output-based approach and the debate on the form that aid take, e.g., grants, loans or other) did not appear to be especially relevant for the health sector, as few documents referred to them and none of the interviewees considered them to have a significant impact on the health sector.

On the other hand, Sexual and Reproductive Health and Rights (SRHR) emerged as an important issue, as it has been affected by ideological shifts during the relevant time period. In addition, the Swedish interviewees emphasised the importance of SRHR, while the international interviewees emphasised HIV/AIDS to a larger extent (see also Section 5). Our searches and review also suggested that additionality is an area that have been subject to debate over several years and that has received renewed attention by the emergence of new disease-specific global actors. Conditionality, however, does not appear to have been the focus of either a similar debate or a renewed attention over the relevant time period. Hence, we decided to include additionality and exclude conditionality from the list of trends and changes. However, the interviews revealed that despite being subject to debate, additionality seems to be an issue that is rarely considered in actual negotiations.[6]

During our searches and review we also came across several references to the effects of EU enlargement (specifically Eastern European countries). Hence we first considered including these as a separate trend or change, but after more careful scrutiny it became evident that most of these references were linked to the issue of HIV/AIDS and SRHR and the fact that many of the new EU member countries have a large Catholic majority. According to the interviewees, it is largely the Catholic influence in these countries that have a negative effect on the possibility to reach agreements regarding HIV/AIDS and/or SRHR at the EU level. Therefore, we decided not to have EU expansion as a separate trend or change. In addition, we came across several references to the "Three Ones" initiative which was launched in 2004 as a completely new way of organising and coordination national AIDS responses. Because it is one of the most recent changes that have occurred, we decided to include it in our list of trends and changes.

The coherence agenda is something that has been widely discussed in Sweden and elsewhere, and we thus first considered incorporating it as a separate trend, as it represents a new way of viewing development assistance. However, we found few documents or references to this issue by other donors and actors in the health sector. We therefore decided to not include it in the list.

During the interviews, it was also mentioned that development assistance to the health sector has changed in other ways over the years. For example, health projects (e.g. building hospitals) were popular in the 1950s and 1960s. But these concrete health projects were subsequently sidelined, due to the view that other investments should take priority, from which better health outcomes would follow. One of the biggest shifts in the last decade, however, has been the appreciation that i) investing in health should be a priority and ii) international research on quantifying the impact of the disease burden on growth and development has been important. Moreover, it is sometimes mentioned that there has been a change in the health status within countries, and that the heterogeneity of recipient countries has increased.

In addition, we found that it was indeed possible to categorise the trends/changes in several different ways. For example, in many cases, the interviewees, literature and Internet documents referred categorised trends and changes as either horizontal or vertical. For example, horizontal approaches are focusing on improvements in public health services and attacking the basic cause of poverty while vertical approaches are targeting specific diseases and conditions.[7] Such definitions tend to cut across the headings we originally chose for the initial list of trends and changes.

Approaches that are considered as examples of horizontal approaches include:[8]

- Strengthening of health systems.
- Poverty Reduction Strategy Papers (PRSP:s).
- Follow-up on Commission on Macroeconomics and Health (CMH).

Approaches that are considered as examples of vertical approaches include:[9]

- Global Alliance for Vaccines and Immunizations (GAVI)
- Global Fund to Fight Aids, Tuberculosis, and Malaria (GFATM)
- The "3 by 5" initiative
- Public-Private Partnerships
- Roll Back Malaria
- Stop TB

Hence, we decided to further amend the list of trends and changes based on these findings, and to add strengthening of health systems, PRSP:s, and Public-Private Partnerships to the list of trends/changes.

We decided that the work performed by Commission on Macroeconomics and Health (CMH) could be covered under the "increased emphasis on the link between poverty and health support", and that the disease specific initiatives could be covered under "Establishment of new disease specific global actors". However, because the CMH has had impacts on several of the listed trends and changes, CMH issues will appear in different sections below.

Finally, we attempted to consolidate our findings into a sensible framework. However, there are many interlinked relationships which made it difficult to identify such a framework. For example, the MDG:s have triggered the launch of new approaches such as the "3 by 5" initiative while at the same time representing

an example of a new form of donor cooperation. Regarding the MDG:s, the interviewees also made it clear that the very commitment to these goals has triggered several developments, such as new vertical initiatives. Hence, we decided not to list "commitment to MDG:s" as a separate trend or change in the thematic presentation but to leave it for discussion wherever it was relevant under the other headings.

However, when reviewing the list we found that one way of organising the trends/changes was in terms of changes in health-related patterns and ideologies, and in terms of how different actors have responded to these changes. Such a list is presented in Table C.

Table C: List of trends/changes

Changes in health related patterns and ideologies	Increased heterogeneity within countries
	New epidemiological challenges
	Pharmaceutical developments
	Ideological shifts (SRHR & HIV/AIDS)
Actors' response to trends/changes	
Trends/changes in donor cooperation	Increased emphasis on harmonisation and alignment
	Emergence of horizontal approaches (strengthening of health systems, SWAps, and PRSPs)
	Emergence of vertical approaches (new disease specific global actors, "3 by 5", private-public partnerships)
	Changes in the availability of funding
	"Three Ones"
Trends/changes in development/health assistance thinking	Increased emphasis on the link between poverty reduction and health support
	A move towards budget support
	Additionality

The list in Table C is of course a simplified presentation, as these trends and changes are interrelated, wherefore the causal relationships between them can be difficult to disentangle.

3 Trends and changes in health-related patterns and ideologies

3.1 Increased heterogeneity within countries

An important trend that has taken place in health patterns is the increasing heterogeneity within countries. Even though the global population is getting healthier, differences in health status within countries are increasing. People with good health status are living side by side with people who are becoming increasingly marginalized with regard to health (Cooperation for Health Development, 1995; Marshall, 2004; Interview with Rosling). Additionally, the poor health of the poor continues to take its toll on the economy of many countries but increasingly has to compete for resources with health problems and priorities related to wealth, e.g. cardiovascular diseases and obesity, which creates a "double burden" of disease (Cooperation for Health Development, 1995; Marshall, 2004). Despite the increasing heterogeneity within countries, symptoms of failing health systems and suggested remedies are similar across countries, though. The "new" challenge is to match the aid modality to changing country circumstances, but for this to be successful capacity building and good governance is needed.[10]

Why it could be relevant

The increased heterogeneity within recipient countries could have an effect on how effective development assistance will be in achieving health goals both in terms of contributing to scarce resources and in terms of having effects on indicators. For example, the increased heterogeneity will place existing health systems under stress, and competition for resources might affect the effectiveness of aid to health. Hence, it might be worthwhile to consider new ways of administrating aid to the health sector in order to ensure effectiveness.

In many instances the success of aid to the health sector is measured by improvements in health outcomes, which in turn are measured by a number of indicators. However, these indicators might be affected by the heterogeneity. For example, morbidity figures are affected by both wealth related and poverty related diseases. Hence it could be difficult to obtain a true picture of how successful a certain programme is. As a result, indicators used to measure the success of aid to health programs may need to be revised to account for the increased heterogenity. For example, an evaluation could look at how well current indicators are able to track the objectives of current programmes and suggest improvements.

3.2 New diseases, remedies and epidemiological challenges

In addition, new epidemiological challenges have emerged during the last decade, for example, in the case of a resurgence of diseases that were considered under control such as cholera and measles. We have also seen the emergence of truly new epidemics, such as SARS and the Bird flu. In addition various fever related diseases such as the Marburg virus, Ebola, and Lassa fever continue to appear in sudden and unexpected outbreaks.

Furthermore, there have been new developments in diseases previously believed to be eradicated. For example, smallpox is a disease that historically killed two-three million people annually and scarred perhaps ten times that number. Following an eleven-year WHO-programme the disease was thought to have been eradicated, and routine immunisation ceased as well. However, this now implies that virtually nobody less than 30 years of age has immunity to smallpox and as a result "...smallpox is a potentially powerful weapon of biological warfare. In the United States this threat is perceived as so realistic that they have stockpiled 300 million doses of the vaccine just in case!" (Nossal, 2004)

However, research gives hope and, even though 2005 is outside the scope of the present assignment, it is worth noting that Swedish and international researchers have made a breakthrough regarding the genetic code of important parasitic diseases like Chagas' disease, Leichmania, and African sleeping sickness. These developments could contribute to pharmaceutical developments that would save many thousands of lives. In addition, a Swedish malaria vaccine has been developed and will be tested during 2005.

However, in many cases, a major obstacle is the lack of interest from private pharmaceutical companies, which do not consider developing countries as important markets.[11] One reason behind the lack of interest is that many companies face market barriers including high research and development costs, coupled with a relatively short patent life. Hence, a major concern is how to recapture high investment costs if the intended market is weak? However, there are exceptions, and one example is in the case of river blindness – a disease that is largely limited to Africa. River blindness destroys the eyes of the infected person. As it is spread by a fly that breeds in fast-flowing river water, farmers cultivating fertile riverside land are at particular risk. Fortunately, it was discovered that a drug that protects against heartworm in dogs also serves as an effective protection against river blindness. The pharmaceutical company that produced this drug actually donated more than 400 million doses which have resulted in a remarkable change of the situation. Originally, it was estimated that 120 million people were at risk and 18 million persons were infected. However, the donation, combined with a joint World Bank and WHO control programme, has resulted in twelve million children having been born without risk of disease and blindness. In addition, 25 million hectares of fertile riverside land have been resettled with agricultural production sufficient to feed 17 million people each year (information from Nossal, 2004).

Why it could be relevant

When it comes to new epidemiological challenges and new pharmaceutical developments, these are issues that have not been explicitly mentioned during the interviews but still appear in the debate and the literature. Related to an evaluation of development assistance to the health sector, it could be of interest to evaluate the impact of assistance directed to research and pharmaceutical developments as well as epidemiological emergencies and challenges in comparison to assistance going to other types of programmes. Such information would be helpful with regards to strategic decisions on how to provide assistance to the health sector in the future.

Especially important for developments in the area of HIV/AIDS, and sexual and reproductive health and rights (SRHR) are the ideological shifts that have occurred, particularly since the Bush administration took office. The anti-abortion stance of the US government and the Catholic Church hinders development, as condoms are "banned", despite being one of the single most important tools for reducing the spread of HIV/AIDS. Within the EU, the new members Malta and Poland work actively against the promotion of condoms, which has made the intra-EU work on HIV/AIDS more difficult. Among our neighbour countries, the Norwegian Christian-democratic government has been quite careful when it comes to issues related to sexuality and has not at all been at the forefront when it comes to SRHR.[12]

3.3 Sexual and Reproductive Health and Rights

Generally speaking the area of SRHR received more attention immediately following the Cairo 1994 conference. However, the Cairo Consensus of 1994 has been undermined by the increased anti-abortion stance of the US government, which had previously been the biggest contributor to the reproductive health agenda. This has served to take much of the attention away from the reproductive health issue. In particular, the US has tried to keep reproductive health off the list of MDG:S, despite lobbying by the DFID for its inclusion. Even though SRHR is not explicitly mentioned in the MDG:S, there is an implicit connection between maternal health and SRHR, as 13 percent of maternity-related deaths can be connected with

abortions. Accordingly, the stance of the US on the issue did have a negative effect but many countries have, de facto, liberalised their abortion legislation.[13]

Sida has been a leader and innovator in the field of SRHR since the 1960s. The major change within the area during the last ten is the increased attention it has received following the Cairo 1994 conference. After this conference, Sweden formulated its strategy within both the SRHR area and the field of health systems in general. Sida thereby moved away from vertical programs within the area of health. In fact, Sida followed the general trend within health-related development cooperation, as "likeminded" countries underwent similar changes and also focused more on SRHR and sector approaches, as well as harmonisation. SRHR is an area where Sida is considered to have significant expertise and an important agenda-setting role. For more information, a useful source is the previous evaluation; Sida's Work Related to Sexual and Reproductive Health and Rights 1994–2003.[14]

In addition, the increase in importance of the HIV/AIDS agenda, with its increasing focus on treatment, has taken attention away from reproductive health, as has EU enlargement to countries such as Malta and Poland – although their membership came only at the end of the period in question.[15]

Why it could be relevant

SRHR is recognized as an important but difficult area of health cooperation, even though the interview results suggest that a larger emphasis is placed on this theme by Swedish interviewees compared to the international interviewees. Given that SRHR issues are likely to be affected by several trends and changes it could be useful to evaluate:

- Efficiency of SWAps for reaching SRHR objectives – maybe other channels should be utilised
- How have SRHR been treated in recipient countries PRSP:s – is their treatment in line with Sida policies?
- Have SRHR issues been crowded out by the MDG:s?
- How is progress in this area evaluated and monitored?
- What goals and outcomes have been reached?
- Given that there is resistance to some parts of the SRHR concept (e.g. abortion) it might be useful to evaluate the way these issues have been brought forward as a package.

3.4 HIV/AIDS

HIV/AIDS was, for many years, an "unknown" disease. However, its discovery and the frightening rise in the resulting disease burden and associated deaths sparked a number of initiatives to combat the disease. The issue of HIV/AIDS has gradually been given more weight in international development cooperation. Currently, HIV is not only a health-related issue but also connected to development issues in general as well as to security. (The latter might be one reason for the increased interest in the issue from the US during the last five years.) In sum, HIV/AIDS has developed from being a problem in the US and Europe that primarily related to the health of men, to a global problem that affects both men and women.

The current HIV projections do not look bright; it is estimated that we will see a doubling of the number of infected persons by 2010, with particularly significant increases in Asia, Eastern Europe and Latin America. The "3 by 5" initiative, i.e. reaching three million people with antiretrovirals by 2005, will be difficult to attain since there are currently only 700 000 people on medication. According to Hjelmåker, the major reason for this is inadequate health systems in general. Hjelmåker also points to a number of particularly unfavourable circumstances:[16]

- Difficulties in absorbing large increases in HIV/AIDS-related aid (the absorptive capacity of recipients countries is low[17]).
- Medicine with antiretroviral effect is not a panacea (these medicines do not affect the root cause of HIV/AIDS).
- Accordingly, preventive measures are necessary.

New remedies, i.e., antiretrovirals, have been developed and the number of new cases has decreased – at least in some parts of the world. However, antiretrovirals have also resulted in less fear of the disease and a less cautious behaviour. The result has been a rising number of disease cases in a number of countries. However, in many of the poor countries, the problems are in many cases related to poverty itself, for example:

- Limited access to antiretrovirals because of low incomes;
- Low productivity of people affected by the disease which aggravates poverty;
- Too few people of working age which leads to sustenance of poverty;
- Orphans with low schooling productivity and hence low income earning potential;
- Reduced population and absence of the sufficient number of civil servants necessary to manage a country;
- Insufficient number of health workers which leads to increased stress on the health system;
- Depreciation of social capital and destabilisation.

There is an additional aspect that relates to the capacity of health systems and that has been raised during interviews. By setting up parallel or separate clinics and systems to deal with HIV/AIDS instead of handling it within general health systems, donors are in danger of repeating the same mistakes that were made in the area of family planning. (The Cairo consensus was to treat reproductive health as part of primary health care.) According to Steven Sinding, among others, it would have made more sense to integrate HIV/AIDS with sexual and reproductive health issues.

In addition, several interviewees have mentioned the significant negative impact that the Bush administration has had on the fight against HIV/AIDS, especially through its unwillingness to promote the use of condoms. Similarly, the Catholic church, through its reluctance to acknowledge condoms as a useful weapon to fight HIV/AIDS, is also a problem when global agreements are to be reached. Moreover, many countries wish to include promotion of and distribution of free condoms in programmes aimed at combating the spread of HIV/AIDS but such measures are frequently opposed by countries where the Catholic church has a strong standing.

Why it could be relevant

Given the changes that have taken place, it is our conclusion that the question of how Sweden designs its activities, and disburses and implements aid to combat HIV/AIDS would be important topics in an evaluation. For example:

- How has Swedish aid to HIV/AIDS developed in terms of amount of money disbursed over the years? Have these changes resulted in any changes in the Swedish development cooperation organisation?
- What channels have been used for disbursements? If there has been a change – what has caused it (i.e. are some channels considered more efficient than others)?

- Have the same countries been targeted the whole time? Has there been a change and if so, why?
- Has funding for HIV/AIDS-related activities crowded out funding for other health-related activities?
- Is there a monitoring and evaluation system in place that provides adequate information on the successes and failures of undertaken activities?

4 Actors' responses to trends and changes

Overview

Perhaps one of the most important events that have occurred on the international development arena during the last decade was the commitment to a set of common goals. The process started in 1996 when members of the OECD committed themselves to a partnership with developing countries and with countries in transition. Key targets from the United Nations (UN) summits – the International Development Targets – were to be used to measure the success of this partnership (Mundy et al., 2002). The ideas pertaining to partnerships and targets were taken further and, at the UN Millennium Summit in September 2000, the Millennium Declaration was adopted and the International Development Goals were reframed as the Millennium Development Goals (MDG:S). The eight MDG:S that all 191 UN member countries have pledged to meet by 2015 are:

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. *Improve maternal health*
6. *Combat HIV/AIDS, malaria and other diseases*
7. Ensure environmental sustainability
8. Develop a global partnership for development

For the health sector, these goals emphasize the importance of health for attaining economic development and reducing poverty, as three of the eight goals are directly related to health and the other five indirectly related to health.

The link between poverty reduction and health support was even more firmly established with the 2001 publication of *Macroeconomics and Health: Investing in Health for Economic Development*, the final report of the WHO's Commission on Macroeconomics and Health (CMH). One of the main conclusions of the report is that increasing the access of the world's poor to essential health services is the single most important action for reducing poverty and achieving economic development – but for this to happen a concerted, global strategy is essential (CMH, 2001) This emphasises the responsibilities of developed countries – as does the eighth MDG:. Indeed, it is made clear that the developed world has a responsibility that goes beyond merely increasing aid and improving coordination and alignment to country policies. The MDG:S urge developed countries to consider how their policies in areas traditionally kept outside the realm of development policy influence the situation of the world's poorest (e.g., the international framework for trade and investment, debt restructuring, coherence of national policies).

During the 1990s there were major shifts in the thinking regarding how development cooperation is best performed. The new paradigm emphasised strengthening the leadership role of the recipient government, including, but not only, moving towards budget support, harmonization and alignment, and sector wide approaches (SWAPS). Most donors have gone along with this, with the notable exceptions of the US and Japan, both of which continue to favour project-based approaches.

In addition, many of the persons interviewed for this study have emphasized the insufficient attention to sector-wide capacity building and strengthening of health systems. Sector-wide capacity building is acknowledged to be extremely challenging, and it is difficult to secure and sustain capacity improvements. Moreover, much capacity building work is poorly targeted and counterproductive as training can draw key health staff away from service provision. During the interviews it was mentioned that in extreme cases, health staff spend over 60 percent of their working time in (often poor quality and inefficient) training and other administrative work.[18] In addition, challenges related to human resource can have a destabilizing effect on countries' health systems, but this has only recently been acknowledged. First, there is a trend toward migration of health workers to more developed countries, such as the UK and Canada, and to a significant degree South Africa. Second, and perhaps more important, health workers are generally underpaid in developing countries (especially compared to what they could be earning elsewhere) and often do not receive payment on time.

These trends and changes in "thinking" have implied some real changes of importance to the health sector. For example, availability of funding and development assistance to the health sector has been rising in real terms as a proportion of official development assistance (ODA).

The period 1995–2004 has seen "swings" in the attitudes towards both horizontal and vertical approaches to reaching the MDG:s. In addition to what has already been mentioned, there was a growing dissatisfaction with donor driven vertical programmes during the 1990s, e.g. in the primary health care sector, as they were said to duplicate implementation arrangements, and were criticised for their lack of attention to sustainability and country capacity building (Mundy et al., 2002; Global Forum for Health Research, 2004). As a result of such dissatisfaction, new policies for health sector development were formulated with a new focus on cost efficiency, and the concept of the essential services package (ESP) was developed. As part of this, a new general focus on integrated support for improving health policies and promoting health sector reforms emerged (Mundy et al., 2002)

From 1994 (International Conference on Population and Development in Cairo) the control of communicable diseases, reproductive health and improved maternal and child health have been public health priorities. However, as the communicable disease burden has been getting worse, dissatisfaction with integrated programmes, including sector wide approaches, has resulted in targeted programs again being put on the agenda while new disease-oriented and target-driven global funds have started to emerge, such as Roll Back Malaria and Stop TB (Mundy et al., 2002; Cooperation for Health Development, 1995).

Since then a new generation of vertical global programmes have emerged on the scene, including the Global Alliance for Vaccines and Immunisation (GAVI) and the GFATM. Even though donors are generally positive, there are concerns that the high levels of short-term funding for these global initiatives may disrupt priorities and reforms that have been carefully negotiated between government and partners at national level (Global Forum for Health research, 2004).

Thematic presentation

The thematic presentation follows the same format as in the inception report, i.e., a brief introduction to the topic is followed by a short description of why we find it potentially relevant.

4.1 Harmonisation and alignment

The concept of "harmonisation" refers to recent efforts by donors to coordinate their activities with each other. Alignment refers to coordination with the priorities and procedures of aid recipient countries. The two are often discussed together as part of the "harmonisation agenda" or "aid effectiveness agenda".

The main goals of harmonisation and alignment are to increase recipient country ownership and to avoid proliferation of different architectures for delivering and monitoring aid, which can increase transaction costs and multiply the management burden on recipient countries.

The "harmonisation agenda" received international prominence at the 2002 Monterrey Conference on Development Financing to mobilise additional "innovative" sources to meet the MDG:s. Attention increased significantly at the High-Level Forum on Harmonisation, held in February 2003 in Rome. Representatives of over 23 multilateral agencies and 24 bilateral donors (including Sweden), and 28 recipient ("partner") countries attended the meeting in Rome. This was followed by a High Level Forum (HLF) in Paris in 2005.

The Rome Forum received crucial background input, including "Good Practice" guidelines, from the OECD-DAC Working Party on Aid Effectiveness and Donor Practices which had been set up in May 2003 after the Monterrey conference. The six papers on good practices produced so far cover the following topics: Framework for donor cooperation, Country analytic work and preparation of projects and programs, Measuring performance in public financial management, Reporting and monitoring, Financial reporting and auditing, and Delegated cooperation.

The Rome Declaration on Harmonisation of 25 February 2003 committed participants to a number of activities, notably:

- Ensuring that development assistance is delivered according to partner countries' priorities, including via PRS:s where they exist;
- Strengthening partner countries' abilities to develop appropriate priorities and procedures; and
- Reviewing and identifying ways to amend donors' own policies, procedures and practices in order to facilitate harmonisation.

Specific measures suggested to donors to increase harmonisation noted in the Rome Declaration include the following:

- Reducing the number of donor missions, reviews and required reports;
- Simplifying and harmonising required documentation with other donors;
- Streamlining conditions and harmonising them with other donors;
- Adapting harmonisation efforts to the country context, including by giving local staff (e.g., in embassies) more authority and flexibility; and
- Creating incentives within bilateral donors' own structures to encourage harmonization.

Since the Rome meeting, the harmonisation agenda has been broadened into what increasingly might be called the "aid effectiveness" agenda, which includes management for results.

Related to the health sector, the ongoing work in the WHO and World Bank includes working with countries to address issues regarding the harmonisation of health partners, through identifying institutional mechanisms to advance co-ordination, joint policy work and pooling of funds. At a global level, both WHO and the World Bank are working with, and tracking the activities of, other institutions working to increase harmonisation and aid effectiveness, such as UNAIDS' work with regard to the harmonisation of AIDS funding.[19]

However, while it may be possible to measure progress towards harmonisation, measuring its benefits seems to be more problematic. According to Kaori Miyamoto of the DAC Secretariat, the effect of har-

monisation on aid efficiency and health outcomes is so far largely theoretical and not actually based on actual evidence. So far, the limited experience with harmonisation has not produced any measurable improvements.[20]

Although the harmonisation agenda covers all types of aid, one of the targets is to increase the amount of funding through programme-based approaches such as SWAps and budget support. It is generally recognised that such aid modalities "have in-built harmonisation characteristics which make their adoption particularly advantageous for promoting harmonisation" (ODI, 2001, p. 5).

An important point of caution that we have heard regarding harmonisation is the danger that some of the most effective and progressive bilateral agencies risk "harmonising themselves out of business", e.g., by relying increasingly on budget support and "silent partnerships" with other donors, while withdrawing their needed sectoral expertise.[21] In addition, negotiations and compromises to reach agreements could result in certain issues that are important for a specific donor not being prioritized.[22]

Why it could be relevant

The harmonisation agenda represents a high-level commitment by donors (including Sweden) to ensure that their own institutions contribute to harmonisation, and to work with others to increase coordination, e.g., via the DAC Working Party on Aid Effectiveness.

In relation to the difficulties mentioned above for obtaining measurable improvements in indicators from harmonisation efforts, it could be useful for the subsequent evaluation to look into how Sida is measuring performance in relation to the health sector. Related to this, a discussion could be presented as to the appropriateness of the current performance measurements and how to obtain better empirical evidence.

In addition, an evaluation could look at how successful Sweden has been in promoting its own prioritised issues in processes of harmonisation. On a more general basis, the evaluation could also review the extent to which Sweden has followed up on good practices developed by the DAC Working Party on Aid Effectiveness, including the DAC requirement for donors to prepare (and carry out) a harmonisation action plan. As part of this, and to put Sida's response into context, it could examine the peer reviews DAC has undertaken for a number of other donor countries.

4.2 Emergence of horizontal approaches

"… there are two apparently conflicting approaches to which countries should give careful consideration. … The first, generally known as the 'horizontal approach', seeks to tackle the over-all health problems on a wide front and on a long-term basis through the creation of a system of permanent institutions commonly known as 'general health services'."[23]

4.2.1 Strengthening of health systems

"The way health systems are designed, managed and financed affects people's lives and livelihoods. The difference between a well-performing health system and one that is failing can be measured in death, disability, impoverishment, humiliation, and despair" (Gro Harlem Brundtland, WHO 2000).

In many countries, the health system is undermined by a lack of financial resources, but even more importantly, by a lack of systems to effectively manage the people, medicines, money, and information that contribute to improved health outcomes. This is true for all developing countries, but the problems are particularly prevalent in fragile and post-conflict states, where services are hampered by political instability, economic uncertainty, grave security concerns, or even natural disasters.[24] Hence, "health

systems strengthening, within the context of broader health sector reform, includes policy development and implementation, efficient financing mechanisms, increased information on health expenditures and costs, improved quality of health service delivery, surveillance and reporting of disease impact within communities, and implementation of sustainable health information systems" (Kolyada, 2004).

The Alliance for Health Policy and Systems Research (2004) define a health system as something that "encompasses all the organizations, institutions and resources that are devoted to producing health actions whose primary intent is to improve health. The four vital functions of health systems have been defined as:

- Service provision: encompassing both formal and informal service providers, whether public or private, and also service organization both at the level of service delivery and higher up the chain of management;
- Resource generation*:* encompassing key inputs such as human resources, physical capital, and drugs and medical supplies;
- Financing*:* the volume and sources of financial resources available for the health system, together with the mechanisms for pooling resources and transferring them to service providers;
- Stewardship*:* the role of oversight of the health system which falls to the government, and encompasses defining the vision and direction of health policy, exerting influence through regulation, and collecting and using key data."[25]

In addition to the above, it is important to add accountability structures between the different levels of the health system (fiscal, administrative, service providers), which affects the delivery of all services and thereby their outcomes.

It is increasingly recognized that stronger health systems are needed to deliver health care interventions at the scale necessary to achieve and sustain health-related MDG:s.[26] For example, in the past few years there has been an increasing awareness of two major human resource problems among health workers in developing countries. First, there is a trend toward migration of health workers to jobs in more developed countries, such as the UK and Canada, and to an important degree South Africa. Second, and perhaps more importantly, health workers are generally underpaid in developing countries (especially compared to what they could be earning elsewhere) and often do not receive payment on time. So far, few donors have done much to address these problems.[27] Similarly, according to Steven Sinding, there has been an increased emphasis on strengthening health systems, especially after the CMH report, but in reality, most donors only pay lip service to this idea and have done little concrete to improve recipients' health services. At the same time, there has been a rise in health-specific, vertical global initiatives.

In addition, one of the working groups of the CMH noted that while a lack of funding is often the ultimate constraint, it cannot be assumed that progress is assured if money becomes available. "Without a health system that can use money well, spending will not merely be inefficient – it maybe useless, or conceivably counterproductive" (Alliance for Health Policy and Systems Research, 2004, p.1). In addition, the increased recognition of the importance of health systems is also evident in the recently increased willingness of two of the largest global health initiatives, the GFATM, and GAVI, to allow increasing shares of their contributions to be used for investments in health systems strengthening (see also Section 4.3.1).

Why it could be relevant

As mentioned above, without a functioning and coherent health system, little will be accomplished by increased funding. Hence, all aspects of countries' health systems will have to be considered in order to

achieve health and poverty targets. Because the overall health system is of such importance, an evaluation of how Swedish aid to the health sector has contributed to strengthening of health systems would be useful, and some questions could be:

- Has development assistance been targeted at specific parts of a country's health system or strengthening of the overall health system?
- Is there a difference in focus on tangible targets (e.g. training of a certain number of medical staff) and intangible targets like the strengthening of accountability structures with the health system?
- Is there a difference in focus between development assistance channelled through multilateral actors, as opposed to bilateral relationships?

4.2.2 Sector Wide Approaches

The concept of Sector-wide approaches (SWAPs) was first articulated at a 1997 meeting of the Inter-Agency Group, an informal alliance of donors meeting under the World Health Organisation (Lavergne and Alba, 2003). Although SWAPs now exist in a wide range of sectors, they have been particularly present in the health sector.

A commonly quoted definition of SWAPs is an arrangement where "all significant funding for the sector supports a single sector policy and expenditure programme, under government leadership, adopting common approaches across the sector and progressing towards relying on [recipient] Government procedures for all funds" (Foster, 2000).

Based on this definition, a SWAP generally consists of the following core elements:

- "All significant funding agencies support a shared, sector wide policy and strategy."
- "A medium term expenditure framework or budget which supports this policy"
- "Government leadership in a sustained partnership."
- "Shared processes and approaches for implementing and managing the sector strategy and work programme, including reviewing sectoral performance against jointly agreed milestones and targets."
- "Commitment to move to greater reliance on Government financial management and accountability systems" (Walford, 2003)

Not all arrangements considered to be SWAPs are likely to have all of the features listed above, but it is generally agreed that they should be moving toward them.[28]

In practice, the degree to which donors' financial flows for the sector are coordinated (e.g., placed in one "basket" account) and/or sent via the (sector) budget varies considerably.

The actual SWAP is usually preceded by a preparation period of a few years during which the recipient government and donors work together to define the sector strategy and strengthen institutions for implementing it.

The SWAP approach appears to be increasingly common in the health sector, but has had to adjust to a number of other trends in aid delivery. For example, the rise of Poverty Reduction Strategies (PRS:S) has increased the emphasis on cross-sectoral approaches. In this context, as long SWAPs are coordinated with the PRS and with SWAPs in other sectors, they can be seen as a useful mechanism for delivering the PRS (ODI, 2001). On the other hand, some have placed emphasis on the importance that PRSP:S take more account of SWAPs and other sectoral strategy processes, since the analysis behind sectoral strategies is

often more rigorous (Walford, 2002). Incorporating the new global health initiatives, such as GAVI and the GFATM, has also complicated the goal of coordinating all or most donor sectoral funding under a SWAp (see also page 35).

Some donors, such as Canadian CIDA, prefer to speak in terms of programme-based approaches, of which they consider SWAps a subset and early example. Programme-based approaches share most features of SWAps, but are not necessarily sector-wide, nor limited to a particular sector, nor even limited to support for public sector actors (Lavergne and Alba, 2003).

Although SWAps often include pooling donor funds, few actually pass through the general or sectoral budget. Related to this, the OECD notes that SWAps have been slow to integrate with government systems for disbursement, monitoring, audit, and reporting, etc. (OECD-DAC, 2001).

The relationship between SWAps and the move towards general budget support also raises concerns about the possibility of maintaining sector policy dialogue – associated with SWAps – while de-linking it from sector funding (Norad, 2004).

There is some controversy as to whether SWAps are simply a stage on the road to budget support.[29] However, few countries are likely to move to complete budget support in the immediate future. This means that SWAps are not likely to disappear anytime soon. Given the draft target in the 2005 Paris Declaration on harmonisation for donors to provide at least 25 percent of aid through programme-based approaches by 2010, it is likely that SWAps may even increase in importance.

DFID, the Netherlands, Norad and the World Bank are donors that are active in health SWAps, while Sida, along with DANIDA, Development Cooperation Ireland, UNICEF, WHO, EU, and UNFPA are considered as "supportive" of such arrangements. Spain, Italy and France are rated as the donors who are least involved in health SWAp mechanisms (Jeffreys and Walford, 2003, p. 5). A 2003 review commissioned by Sida notes that health SWAps "beyond the stage of discussions" so far exist in the following 11 countries: Ghana, Tanzania, Mozambique, Senegal, Bangladesh, Zambia, Mali, Uganda, Burkina Faso, Cambodia, and Malawi.[30]

Why it could be relevant

SWAps represent an important initiative in aid coordination, effectiveness and recipient ownership. Continuing to supply a significant amount of aid in the health sector according to bilateral priorities while the government and other major donors are implementing a SWAp may undermine coordination and attempts to build recipient-country ownership. But it has also been noted that one of Sida's priority areas, SRHR, might actually suffer by the use of SWAps since governments do not always prioritize the delivery of these services.[31]

The evaluation could examine the extent of Sida's participation in health SWAps in countries where such programmes exist, e.g., in terms of coordinating Sida's goals with those of the SWAp, actively assisting the government and other donors to set up the SWAp, and delivering a significant percentage of Sida aid to the sector via the SWAp (after it has become clear that requisite institutions and mechanisms are in place).

4.2.3 Poverty Reduction Strategy Papers

The World Bank and the IMF initiated the Poverty Reduction Strategy (PRS) process in 1999 as a new way to develop country-owned, cross-sectoral strategies for poverty reduction and to focus government and donor priorities on the MDG:s.

Under the PRS process, a recipient government produces a Poverty Reduction Strategy Paper (PRSP). The PRS process is supposed to be country-driven, focused on outcomes that benefit the poor, cross-sectoral (in

recognition of the multidimensional nature of poverty), and involve the coordinated participation of domestic stakeholders and external donors (IMF, 2005). As of mid-2004, some 37 countries had produced full PRSP:s, and a similar number had produced Intermediate PRSP:s (I-PRSP:s).

PRSP:s usually follow a standard structure, beginning with an overview and analysis of the causes and features of poverty in the country, followed by an examination of specific issues by sector, an outline of proposed macroeconomic and sectoral strategies, a budget, and mechanisms to monitor progress (Dodd et al., 2004, p. 3).

Until 2005, joint approval of a PRSP by the World Bank and IMF was a prerequisite for receiving IMF and World Bank concessional lending and debt relief under the Heavily Indebted Poor Countries (HIPC) initiative. This may have led to a number of rushed PRSP:s, as well as strong incentives for such papers to reflect World Bank and IMF policy orthodoxies, thus perhaps somewhat undermining country ownership in practice (EURODAD, 2001, p. 6). Some observers also note that World Bank staff has sometimes played an important role in drafting PRSP:s (ibid, p. 7, and Dodd et al., p. 2).

PRSP:s have generally been promoted as a mechanism for aid coordination among donors, since they are supposed to define the recipient government's goals and spending priorities across sectors. The Nordic donors in particular appear to have been particularly concerned that their bilateral programmes should be consistent with PRSP priorities (Dodd et al., 2004, p. 2).

In practice, however, coordination of bilateral programmes with the PRSP may not be very difficult, since goals and priorities expressed in the latter document are often stated in very general terms. As Walford notes, the health section in most PRSP:s is "short, typically up to one page", which means that "statements tend to be fairly broad" (Walford, 2002, p. 15). She goes on to comment that, "Since the papers are so unspecific, they do not clearly establish priorities or force hard decisions over what will remain undone" (ibid, p. 19).

A joint report by the IMF and the World Bank noted that some PRSP:s include donor programs and projects "already in the pipeline[, which] could suggest that priorities are being driven by the supply of specific donor financing rather than deriving from newly articulated national policy agendas (IMF, 2005, p. 9)

In most cases, SWAPs, where they exist, may provide more practical guidance than PRSP:s do with respect to recipient governments' sectoral priorities. While some observers have pointed out the need for SWAPs and other mechanisms to adjust to the PRSP process, others have called for PRSP:s to better take into account existing sectoral strategies and processes. For example, Walford notes that, "[t]he development of health policies usually takes place over a longer time scale and with a depth of analysis and breadth of debate and consultation that is not allowed for in the PRSP process (for example in the development phase of a sector wide approach…)" (Walford, 2002, p. 16).

Although Walford recognises that PRSP:s are often "somewhat limited in scope and content", she suggests that internal and external stakeholders, including bilateral donors, should "engage with the process at an early stage" (Walford, 2002, p. 20). As some bilateral donors apparently have found, however, this may not always be easy. A report by EURODAD notes that "bilateral donors have felt that the influence of the IFIs in the process … has been such that even their own input is marginal … Donors were said to be nervous of the very small opportunity for input into the PRSP, the Bank being the main vehicle for any external assistance" for the writing of the document (EURODAD, 2003, p. 7).

Why it could be relevant

The PRSP process represents an important attempt to coordinate the expenditures of recipient governments and donors around a common set of priorities tailored to the needs of each country. Such priorities are furthermore usually based on an agreed set of international targets, the MDG:s.

The evaluation could examine in each country where a PRSP (or I-PRSP) exists whether the components of Sida's health-sector assistance to that country reflects PRSP priorities. However, this may not be a very rigorous test, since PRSP health priorities are often stated in very general terms.

The evaluation could also include discussions with Sida staff about attempts to participate in the PRS process in various countries. However, judging Sida by its participation in this process could be problematic, since World Bank dominance reportedly has been a barrier to participation by other donors.

4.3 Emergence of vertical approaches

"The second, or 'vertical approach', calls for solution of a given health problem by means of single-purpose machinery. For the latter type of programme the term 'mass campaign' has become widely accepted."[32]

4.3.1 Establishment of new disease specific global actors

The late 1990s saw the foundation of a number of global health initiatives, the most notable of which have been the GAVI (founded in 1999) and the GFATM (founded in 2001). Others include Stop TB, Roll Back Malaria, the Polio Eradication Initiative, the Tobacco Free Initiative and the Micronutrient Initiative, all founded in the years following 1996. Altogether there may be 50–75 global health initiatives. Most of them cover a single, often neglected, tropical disease, although a large number have focussed on HIV/AIDS. Many of the global initiatives were inspired by the work leading up to the agreement on the MDG:s. To some extent, this kind of global initiatives can be seen as a high-level political response to demonstrate commitment to such international agreed targets (HLSP, 2005).

Even though they are most common in the health sector, global initiatives have also emerged in other sectors, notably in environment, agriculture and education. Common features of such initiatives include: Benefits aimed at more than one region; establishment of a new organisation (though sometimes hosted by an existing one); partnerships that involve several organisations (usually including the private sector); and the development of new products or services (HLSP, 2005).

An important factor leading to the rise of global initiatives in the health sector in the late 1990s was the increasing burden of disease in developing countries, especially related to HIV/AIDS. This was coupled with a realisation that current funding to deal with many of these diseases had been inadequate. Global initiatives were seen as a way to mobilise and target commitment and funding, including funding from new sources such as the private sector (Bennet and Fairbank, 2003).

To a certain extent the rise of global initiatives also came about due to a "loss in confidence in the effectiveness of traditional aid delivery models" (HLSP 2005), as well as in existing multilateral institutions.[33] In this respect, global initiatives can be seen as a return to the use of "vertical" programmes, somewhat along the lines of those promulgated in the 1970s to address smallpox and other issues (Forsberg, 2001).

Successes

The 2000 Noordwijk ministerial conference noted that global initiatives such as GAVI had so far proven valuable for bringing various organisations and actors together around a set of agreed priority outcomes (Forsberg, 2001).

According to Caines, key successes of the global initiatives have included the mobilisation of funding, raising the profile of particular diseases while making progress in their eradication, and achieving price reductions for certain drugs and commodities. Caines further points out that most initiatives generally have been welcomed by recipient countries, and "most current and planned interventions funded by [global health initiatives] are potentially highly cost-effective" (Caines, 2004, p. 4).

Druce and Harmer note that many initiatives have enhanced efforts to establish norms and standardisation in treatment protocols, and have had some successes involving the private sector and civil society in delivering treatments, especially with respect to TB (Druce and Harmer, 2004).

Furthermore, a report by the HLSP institute points out that a number of global health initiatives are clearly "pro-poor", since they target diseases that mostly affect the poorest countries. For example, GAVI has targeted the poorest 75 countries, while poorer countries receive some 70 percent of Global Fund grants (HLSP, 2005).

Criticisms

Nevertheless, the global initiatives have received some criticism, particularly due to their "vertical" nature.

Effects on national health systems

The biggest concern about the new global initiatives has been the effect they may have on national health systems in recipient countries. A number of observers have speculated that the system-wide effects of the Global Fund and other initiatives – positive and negative, intended and unintended – are likely to be significant, given the relatively large amount of money involved in some grants compared to the health budgets of the recipients (Bennet and Fairbank, 2003; PHRplus 2005).

In order for the new initiatives to be sustainable, national health systems will eventually have to be in a position to take over relevant eradication programmes. The immediate problem is that the capacity of existing health systems in many developing countries is not sufficiently developed to be able to assume the many programmes and services sponsored by the new global initiatives.[34] While the most sustainable way forward would arguably be to strengthen national health systems, in practice this has sometimes conflicted with attempts to meet the global initiatives' short-term, global targets in an efficient manner. As Forsberg points out, the real challenge to a global initiative is when it "may have to sacrifice short-term goals for the sake of longer-term sector development goals." Unfortunately, in this situation it has "often been tempting to seek a 'short cut'" (Forsberg 2001, pp. 24, 26). In such cases, global health initiatives may end up contributing to effects similar to those for which traditional project aid has been criticised, e.g., undermining national institutions through the creation of parallel channels of delivery, reporting, monitoring and evaluation. Moreover, these effects could be compounded by the proliferation of such initiatives, each with its own parallel structures, whose combined effects eventually could overwhelm national health authorities (Caines, 2004; Druce and Harmer, 2004).

On the other hand, the urgency of particular epidemics, such as AIDS, may be a strong argument for bypassing local structures. For example, Lennarth Hjelmåker, who is a member of the board for GFATM, points out that in dealing with AIDS we cannot always wait for the aid harmonisation agenda process to fall into place (*DT*, 1 December 2004).

Concern about the effects of global initiatives on national health systems has existed almost since they were founded. For example, even as the Global Fund was being set up, a number of NGO:s, including Oxfam, demanded that it should also focus on strengthening national health systems (*DT* 5 June 2001). Similarly, Norwegian State Secretary for international development, Hilde Frafjord Johnson, expressed concerns shortly after the formation of GAVI that the new initiative may not place enough emphasis on addressing this issue (*DT*, 10 June 2001). Finland has also been vocally critical of the global initiative approach, preferring to "strengthen public health care systems as a whole, rather than concentrating on treating particular diseases" (*DT* 17 November 2004).[35]

At least a few global initiatives appear to have recognised the need to build up existing national health systems. For example, the fifth element of Roll Back Malaria's six basic programme elements calls for

efforts to be "implemented in a way which contributes to sustainable and effective health care systems." Despite lip service paid to the issue by some global initiatives, however, Forsberg points out that such global initiatives generally have not emphasised "active participation" in building health systems in practice. Instead, focus has usually been on what health systems can do for the global initiatives rather than the other way around (Forsberg, 2001, p. 24, 26).

Nevertheless, Forsberg and others admit that the global initiatives are increasingly taking critics' demands seriously. For example, Gijs Elzinga of the Dutch Institute for Public Health points out that the Global Fund's fifth call for proposals specifically encourages projects designed to strengthen health systems, and that GAVI is now using "substantial percentages" of its budget for strengthening basic immunisation service delivery. Nevertheless, Elzinga cautions that the vertical focus of the global initiatives, "rooted in their very constitutions", limits their possibility to finance general services" (*DT*, 21 March 2005). Caines similarly draws attention to possible limits in the ability of global initiatives to strengthen health systems, pointing out that their vertical nature prevents them from having "a whole system view of the health systems they work in, and in general rely on" (Caines 2004, p. 5).

Integration with national priorities and SWAps

There has also been criticism that global health initiatives have not been well integrated with national health priorities in general, and SWAps in particular.[36]

As noted by Druce and Harmer, "almost every commentary suggests that disease-specific partnerships must consider the opportunities provided by health sector development strategies and the new aid instruments such as PRSP:s and SWAps" (Druce and Harmer, 2004). Caines suggest that, whenever possible, global health initiatives should "pursue strategies or harmonisation and integration both with national systems and with each other (e.g., by providing funding through SWAps or basket funding where available, by harmonising systems for budgeting, accounting, monitoring, procurement and audit, and by integrating programmes with similar modalities)" (Caines, 2004, p. 5).

In principle, there does not seem to be major reasons why global initiatives could not be better integrated with national health priorities and SWAps in the future, especially not as most initiatives allow countries to propose their own projects for funding (HLSP, 2005). The problem may be that, in practice, countries are obliged to tailor their requests to the type of projects that they believe the global initiatives are most likely to approve.

The 2002 ministerial symposium held during the first meeting of GAVI partners agreed that for global initiatives such as GAVI to be successfully integrated into SWAps, certain conditions should be met, e.g., respect for national planning an implementation processes, appreciation of shortages in human and financial resources, and response to the need for "core" financial support to health systems (Forsberg, 2001).

Accordingly, Forsberg points out that global initiatives are not only a possible threat to SWAps but also an opportunity to provide part of their substance (ibid). Similarly, Druce and Harmer note that arrangements for managing Global Fund monies through SWAps are emerging, and these could "offer a way forward" (Druce and Harmer, 2004, p. 7). It has also been suggested that the global initiatives could reduce emphasis on global targets in order to allow for more flexible priority setting in individual countries (Forsberg, 2001). Finally, it should be noted that the Aid Effectiveness working party of the DAC is considering organising a sub-group to deal with the coordination problems posed by global initiatives.[37]

However, not all agree with the criticism against vertical initiatives and, during the interviews, the complementarities of 'vertical' programmes and 'horizontal' sector-wide approaches have been emphasised. For example, the process of enhancing immunization capacity (a basic health service) can be used as a

diagnostic for broader reforms. Since strengthening or enhancing immunization capacity requires actions at several different levels within a sector, such actions can provide insights into the challenges and opportunities associated with broader sector-wide reform.[38]

Non-traditional donors

Agreement at the Monterrey Conference inspired several global initiatives, such as GAVI and the GFATM, to focus on obtaining funding from foundations and the private sector (*DT* 31 Dec. 2003).

Some NGO:s, researchers and donors have expressed concern about the possible growing role of private funds in global initiatives, pointing for example to the effective veto held by the Gates Foundation over GAVI Board decisions (*DT* 5 June 2001).[39] However, global initiatives are perhaps even more often criticised for not raising enough money from private sources – apart from the Gates Foundation, which has been practically the only significant private contributor to both the GFATM and GAVI.

Early GAVI documents reportedly indicated that the alliance had originally expected funds from private sources other than the Gates Foundation to be around USD 50 million in 2000, rising to about USD 75 million per year by 2004. In reality, other private donors committed only about USD 5 million by mid-2004, or less than one per cent of the total budget if contributions from the Gates Foundation are excluded (*DT*, 14 May 2004). A small amount of additional GAVI funding has also come from pharmaceutical firms (HLSP, 2005).

The Gates Foundation is also the only significant private contributor to the Global Fund, providing some 4.7 per cent of the total budget, while grants from other private sources have amounted to less than 0.1 per cent. As *Development Today* comments, "this cannot even match the performance of small NGO:s" (*DT*, 2 November 2004).

Governments have stepped in to make up for some of the money originally expected from the private sector: Traditional bilateral donors now fund about 50 percent of GAVI (with 50 percent coming from Gates) and about 95 percent of the GFATM. According to some critics, this has led to a situation where, instead of bringing new money for fighting targeted diseases, global initiatives now compete for funds with "other UN agencies, aid institutions, and, not least, with requests from recipient governments" (*DT*, 2 November 2004). However, according to Jon Liden, former Director of External Relations at the GFATM, concerns about such competition may have been an issue in the past, but no longer should be, since "we make it possible for [them] to implement their projects by providing [them with] extra money" (ibid).

Why it could be relevant

The new initiatives represent important new vehicles for donor cooperation. Moreover, their size leads to the possibility that they will have significant unintended impacts on national health systems, governments and other donor programmes. The evaluation could for example look at the extent to which Sida:

- Has evaluated the tradeoffs of contributing to such initiatives.
- Has tried to constructively influence the direction of such initiatives, given the potentially large impact that such initiatives could have.
- Has been consistent in its arguments regarding global initiatives (for example, it appears that Sida has been more supportive of the GFATM than of GAVI).
- Whether there is a consistency between Sida's support to global initiatives and other channels used by the organisation?

4.3.2 "3 by 5"

The "3 by 5" initiative is a global target set by WHO and UNAIDS for providing antiretroviral treatment to three million people in developing countries by the end of 2005. The initiative is accompanied by a detailed strategy, measurable national targets, and calls for significant coordination among donors, and one of the key elements of the "3 by 5" initiative is strengthening of health systems (see also Section 4.2.1). The funding gap (over current commitments) for meeting the target was estimated at USD 5.5 billion.[40]

Currently an external evaluation of the "3 by 5" initiative has been agreed upon by the WHO and the major donor to the initiative, CIDA.[41]

Why it could be relevant

The provision of antiretrovirals helps prolong and improve lives, which is particularly important in the absence of a cure or vaccine. (At the beginning of 2003 fewer than eight per cent of those who required treatment in poor countries were getting it.) Coordination among all major donors is necessary in order to meet the ambitious targets. However, in view of the current evaluation it would be worthwhile for Sida to await the results of this exercise.

4.3.3 New public–private partnerships/private sector development

The term "public–private partnerships" covers a wide range of projects which include some sort of collaboration between the private and the public sector. These partnerships involve a diversity of arrangements that vary with regard to participants, legal status, governance, management, policy setting prerogatives, participants, contribution, and operational roles. Accordingly, it is difficult to find any exact definition of "public-private partnership". Generally speaking, it could either be when governments and inter-governmental agencies interface with the for-profit private sector to provide resources, or when they co-operate with the non-profit private sector for technical expertise or outreach. Similarly, partnership in the health sector can be set up for various purposes, e.g. research, developing a product, improving access to health-care products, to create global coordination mechanism, strengthening health services, public advocacy and education, regulation and quality assurance, and so on (Nishtar, 2004).

A number of initiatives and forums have been established to promote and facilitate public-private partnerships for global health research. Between 1995 and 2003, at least 70 public-private partnerships for health were created in response to the recognition that neither sector alone could deliver solutions to health problems (Global Forum for Health Research, 2004). In the 1990s, the Commission on Health Research for Development and the WHO Ad Hoc Committee on Health Research concluded that the central problem in health research was the so-called "10/90 gap". The "10/90 gap" refers to the situation that only ten per cent of the global expenditure on health research and development is spent on the health conditions that represent 90 percent of the global burden of ill-health. Accordingly, the Ad Hoc Committee report warned that the world community would face four critical health problems in the decades to come:

- Childhood infectious diseases and poor maternal and prenatal health;
- New and re-emerging microbes;
- Increase in non-communicable diseases, injuries and violence;
- Inequity and inefficiency in the delivery of health services.

One of the key recommendations to help correct the "10/90 gap" was the creation of the Global Forum for Health Research.[42] Established in Geneva in 1998, the Forum works closely with the World Health

Organization to "…help correct the 10/90 gap by focusing research efforts on diseases representing the heaviest burden on the world's health and facilitating collaboration between partners in both the public and private sectors". (Global Forum for Health Research, 2002, p. 25) The Forum is itself a public-private partnerships in the area of health research, and it receives financial support from the Rockefeller Foundation, the World Bank, the World Health Organization and the governments of Canada, Denmark, the Netherlands, Norway, Sweden, and Switzerland.

In addition, there has, over the last years, been an increased focus on private sector involvement, as well as private sector led solutions in development cooperation (the document "DAC Orientations for Development Co-operation in Support of Private Sector Development", was published in 1995 and focused on policies and programmes required for the private sector to promote economic growth in developing countries). In addition, there has been a re-focus of the issues and there is now a "new" private sector development (PSD) agenda. Whereas the "old" PSD agenda focused on providing support to private sector enterprises that were considered important for the livelihoods of the poor, the new PSD agenda demonstrates the recognition that it is market outcomes that may be more or less pro-poor, and hence focuses on institutions and policies that influence market outcomes.[43]

Barbara Turner has mentioned that during the 1970s and 1980s about 70 per cent of all assistance flows were government-to-government ODA.[44] Now about 80 per cent of such transfers from the US is from the private sector. This includes foreign direct investments (FDI), philanthropy, NGO projects and remittances. One explanation for the rise in the flow has been a policy of matching NGO fundraising in the private sector with government grants. Given the size of such flows, donor governments should be looking at how they can help direct them in order for them to become more efficient. For example, USAID has been working under contract with some US oil companies to carry out some of their corporate social responsibility (CSR) projects.[45]

On the other hand, private sector aid flows to global health initiatives have been somewhat disappointing as they have come mainly come from the Gates Foundation (see above). The global initiatives themselves seem to have been too lax in soliciting such private support.

Why it could be relevant

Given the increased emphasis and funding available from private sector sources it could be valuable to assess whether such funds result in pro-poor outcomes. If they do result in pro-poor outcomes this will both have positive effects on health and development and also be in line with the Swedish policy for global development. In addition, it could be useful to evaluate if and how the increase in private sector funding has affected the way in which "traditional" aid is being disbursed – both in terms of sectoral support and in terms of amounts. For example, is private funding crowding out traditional aid in certain sectors and if it is, would that be a good or a bad thing? If private sector funding is more effective than traditional aid in certain areas, then donors should find complementary ways of giving aid so as to maximise the overall positive effect for the recipient country.

4.4 Changes in the availability of funding

4.4.1 Trends in overall aid

Overall ODA from DAC members and major multilateral organisations fell sharply at the beginning of the 1990s, apparently in response to the end of the cold war, as well as reduced need for aid in some economies in Asia and Latin America. High fiscal deficits in some donor countries also preceded the decline. From the mid- to late 1990s, aid as a percentage of donors' collective GNI was at an all time low: about 0.22 per cent (OECD 2003).

The declining trend in overall aid was reversed in 2001–2002, with a 7.2 per cent real increase in 2002. This was the largest single-year increase in commitments in the history of the DAC. The OECD attributes this recent rise to two main factors.

- First, the terrorist attacks on the US appear to have led to a substantial increase in aid from the US on the grounds of national security.
- Second, the Monterrey conference in March 2002 led to new commitments by many donor countries to increase the quantity – as well as the "quality" – of aid (OECD, 2003, p. 30).

Even so however, commitments were still "well below the comparable levels of the early 1990s" (OECD, 2003, p. 21). Moreover, it should be kept in mind that commitments are not the same as disbursements.

There was a trend over the period 1996–2001 for overall ODA to be concentrated in recipient countries with "sound policies", e.g., as defined by the World Bank's Country Policy and Institutional Assessment (CPIA) set of indicators. For example, aid to countries in the CPIA's top two quintiles rose from 63 per cent to 68 per cent of the total, while the proportion going to those in the lowest two quintiles dropped from 21 per cent to 16 per cent. Still, this did not seem to change the percentage (around 65 per cent) of aid going to low-income and the least developed countries over the period (OECD, 2003, p. 17–18).

4.4.2 Trends in aid to health

According to a paper prepared for a meeting of the CMH, aid to health in the 1990s maintained "a relatively steady level at a time when total ODA plummeted" (Michaud 2003, p. 11). The paper attributes the relative increase in health aid to a "new understanding of the importance of health as a major determinant of economic growth", as well as the MDG targets related to health (Michaud, 2003, p. 1). Similarly, according to the OECD, "perhaps because some of the clearest of the MDG:s relate to health and education outcomes, there has been some tendency to downplay [aid to] other parts of the economy" (OECD, 2003, p. 25–26).

Total development assistance to health from "major selected sources" (DAC bilateral donors plus major multilaterals) increased from an annual average of USD 6.4 billion during the period 1997–1999 to some USD 8.1 billion in 2002. Much of this increase was due to new committed funds from both public and private sources to the GFATM (Michaud, 2003). In comparison, total bilateral ODA for health increased from USD 2.2 billion in 1990 to USD 2.9 billion in 2000.[46] However, these figures mask a slight decrease from the peak of USD three billion in 1995 (Michaud, 2003, pp. 1–2).[47] Nevertheless, at Monterrey, donors of all types made pledges amounting to a potential increase in annual assistance to health by USD twelve billion by 2006 (HLF, 2003, p. 5), i.e., an increase of about 150 per cent.

As can be seen in Table D, the US was the largest donor to health during period 1996–1998, both in terms of absolute amounts (USD 733 million) and the percentage of its aid going to health (17 per cent). The second largest donor in absolute terms was Japan but the percentage of Japanese aid going to health is among the lowest – only two per cent. Sweden is in between Denmark and Norway with USD 83 million and eight per cent of its aid going to health.

Table D: Aid to health 1996–98

	USD million	Per cent of donor total
Denmark	90	10
Germany	163	5
Japan	242	2
Netherlands	140	7
Norway	42	6
Sweden	83	8
UK	214	10
USA	733	17

Source: OECD (2000), p. 12.

UN agencies increased health funding from USD 1.6 billion in 1997 to about two billion by 2003 (Michaud 2003, p. 5). The Bill and Melinda Gates Foundation, established 1994, gave an annual average of USD 460 million to health during period 1997–1999, increasing to about USD 600 million per year by 2002 (Michaud, 2003, p. 62).

About 14 per cent of health aid for selected major sources went to HIV/AIDS and about three per cent each to malaria and tuberculosis during the late 1990s (Michaud 2003, p. 7). Most major donors also substantially increased funding for HIV/AIDS, particularly in Sub-Saharan Africa, between the period 1997–99 and 2002. For example, USAID increased such aid globally from USD 91.3 million to USD 300.5 million. Similarly, the World Bank's International Development Association more than doubled its budget for AIDS from USD 144.4 million to USD 314.6 million during this period (Michaud, 2003, pp. 5–6).

4.4.3 Meeting the MDGs

As the OECD-DAC pointed out in its 2003 report, "many analyses of the cost of faster progress towards the MDG:s, including not least the costs of the HIV/AIDS pandemic, suggest a need for yet further increases" in development assistance for health (OECD, 2003, p. 23). Michaud similarly notes that, "[r]ecent increases […], although encouraging, fall short of meeting real needs" (Michaud, 2003, p. 11). And a high-level forum on the Health MDG:s organised by WHO and World Bank in January 2004 called progress in meeting health MDG:s "too slow, particularly in low-income countries" (HLF, 2004, p. 1).

Many point out that an increase in aid will not be enough on its own and that institutional and policy changes on the part of both donors and recipients will also be necessary. Nevertheless, the report from the high level forum notes that, "even allowing for greater efficiency of resource use, there remains a significant gap in resource availability if the health MDG:s are to be achieved" (HLF, 2003, p. 2).

The CMH, chaired by Jeffrey Sachs, estimated that meeting the MDG:s for health would require total annual spending by donors and developing country governments, to rise by about USD 57 billion by 2007 and USD 94 billion by 2015 (CMH, 2001, pp. 11–13). The CHM notes that such aid flows will need to be phased in over time and sustained for about 20 years. It also cautions that such increases should be additional, in order to not undermine achievement of other goals that are likely to have an indirect effect on the health MDG:s, e.g., via improvements to education, sanitation and water supply. Low- and middle-income countries would also have to increase their domestic budget for health by about one percent of GNP by 2007 and by two percent of GNP by 2015 (CMH, 2001, pp. 12 and 18). While pledges at the Monterrey conference have

increased donor commitments substantially, these still fall far below the required amounts suggested by CMH. More worryingly, there appears to be little evidence of major increases in developing country expenditures on health (HLF, 2003, p. 4).

Most strategies for increasing aid to health concentrate on two sources: the potential non-traditional donors (such as the private sector) and the donor governments (that have yet to provide 0.7 percent of GDP in development assistance) (HLF, 2003, p. 8). Regarding non-traditional donors, money from the Gates Foundation has made a significant contribution. However, there is some concern that this foundation may have been a unique phenomenon, since so far this aid does not appear to have succeeded in catalysing significant donations from other private sources.

Countries with good policy environments are likely to attract most aid and are also likely to be able to use it most efficiently. However, as Steven Sinding points out, the countries with the best policies are often those in least need of aid. Reconciling this paradox will be difficult.[48]

Although most sources agree that not enough aid is being allocated to health, understanding and tracking the actual resource flows has proven problematic for a number of reasons. For example, DAC statistics show commitments and not actual disbursements, and recipient countries' budget information on health expenditures is often incomplete and compiled according to general budgetary categories (e.g., capital and current expenditures) rather than health-related categories. Although National Health Accounts (NHA:s) provide an internationally accepted methodology for measuring all health expenditures in a country (including spending by the government as well as by private actors and donors) most developing countries do not regularly maintain such accounts, but typically compile them as a one-off exercise. A Global Health Resource Tracking Working Group, chaired by the OECD-DAC, was set up in July 2004 to address problems related to tracking resources for meeting the health MDG:s. It is expected to deliver a report in mid-2005 (HLF, 2004, pp. 5–6).

Why it could be relevant

In spite of the economic austerity program undertaken during the mid- and late 1990s, Sweden has remained among the DAC member countries that has devoted the largest share of its GNP to ODA. As part of the austerity measures, the Swedish parliament replaced its previous target for ODA allocations of one per cent of GNP, with a floor of 0.7 per cent. Consequently, Sweden's ODA/GNP ratio fell from a peak of 1.03 per cent in 1992 to 0.70 per cent in 1999. Since then, it has risen to 0.74 per cent of the estimated 2002 GNI and to approximately 0.87 per cent of GNI in 2004.

As a percentage of total Swedish development cooperation, development assistance for health has increased from nine percent in 2001 to 10.5 per cent in 2003. In addition, the share of Sida disbursements to health from its Department for Social Development, and directly from the Swedish embassies has increased from 58 per cent in 2001 to 65 per cent in 2003.

The subsequent evaluation could look at how Sida has responded to changes in international aid flows – for example, if reductions and increases by other donors for certain areas have triggered similar changes in Sida's funding. In addition, the evaluation could examine to what extent Sida is providing health support through other institutions such as the Pan-American Health Organisation. The evaluation could also compare trends in Sida's overall and health-specific aid to those of the DAC aggregate or to those of selected bilateral donors. Another alternative could be to examine the extent to which Sida has followed the general recommendation of the CMH to increase donor assistance for health by 0.1 per cent of GNP. In addition, it could be useful to evaluate the continuity and regularity of aid disbursements, as such factors have effects on outcomes and recipient country planning, for instance.

4.5 "Three Ones"

In April 2004, a new initiative for organising donors and recipients activities in the field of HIV/AIDS was launched and agreed upon.[49] The initiative is called the "Three Ones" and includes three core principles: (i) one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; (ii) one national AIDS coordinating authority, with a broad based multi-sector mandate; and (iii) one agreed country-level monitoring and evaluation system. The principles were identified through a preparatory process at global and country levels, initiated by UNAIDS in cooperation with the World Bank and the GFATM. Overall, the aim of the new initiative is to better coordinate the scaling-up of national AIDS responses and to deal with the risk of duplication, overlap and fragmentation of the response, particularly where the capacity to co-ordinate is weak.[50]

The agreement confirms and supports the role for UNAIDS at the country level as a facilitator and mediator between stakeholders in country-led processes for following up on these commitments. For example, following-up would include tracking country-level progress in implementing the "Three Ones", and helping integrate an assessment of the efficacy of coordination arrangements and the application of the "Three Ones" into existing national reports.[51] In 2005, a new global task team was formed, with the mission to make the three ones work better.

Why it could be relevant

These three principles are not new, but bringing them together in this manner to focus on improving global responses to HIV/AIDS is significant, as it has clear implications for aid strategy and aid allocation. Furthermore, Sweden is party to the agreement on the "Three Ones". This implies a commitment to aligning Sida's with the agreed national HIV/AIDS action framework, via the national AIDS coordinating authority, and using the agreed country-level monitoring and evaluation system. It is, however, conceivable that this may cause tensions, e.g., where the agreed national strategy neglects or understates aspects of HIV/AIDS prevention and treatment often emphasised by Sida (e.g., SRHR). A related issue is the extent to which this model can and will be applied to other health issues (e.g., Malaria, TB) and to the building of capacity in routine health services in general.

4.6 Poverty reduction and health support

Over the years there has been an increased emphasis on the link between poverty reduction and health support.[52] There is no consensus on this issue, however. While some argue that focusing on health is the most important way to achieve economic development, others claim that other infrastructure investments are more cost-efficient. Either way, the causal relationship between poverty and health is not clear. What is clear, is that poverty leads to deteriorated health through various channels. For example, poor people are not able to afford neither preventive nor curative health care, nor are they able to afford good housing, nutritious food, or quality schooling. In turn, bad health reduces labour and schooling productivity and further reduces income, which perpetuates poverty. Conversely, good health increases labour and schooling productivity, which increases income and enables households to acquire better food and health care (e.g., Behrman and Deolalikar, 1988; Bhargava, 2000; Currie, 2000; Jensen & Richter, 2001). In addition, education enhances the ability of the individual to access health services provided by the state.

In May 1999, WHO and DFID organised a meeting called "World Health Opportunity: Developing Health, Reducing Poverty". This lead to the the establishment of the CMH, which had as its goal to consider health from a macro-economic perspective, in January 2000 (see the webpage of the CMH: www.cmhealth.org).

The CMH came up with surprising cost-benefit analyses related to health and poverty. For the poorest countries, the most essential interventions concerned infections and nutritional deficiencies and it was

estimated that the cost of such essential interventions would be approximately USD 34 per person per year. In addition, it was estimated that these costs could be met with additional donor support of USD 30 billion per year (representing one per cent of the global health budget and 0.1 per cent of global GDP), and that these essential investments would save eight million lives per year. In addition, the CMH calculated the direct economic benefit of such improved health would be USD 186 billion per year, representing a six-fold payback on the investment made(Nossal, 2004).

As for the related connection between health, education and poverty, several studies confirm that better-educated people have lower rates of infection, and a study of 15- to 19-year-olds in Zambia found a marked decline in HIV-prevalence rates among those with a medium to high levels of education, but an increase among those with lower educational levels. Accordingly, during the 1990s the HIV-infection rate among women in Zambia fell by almost half among educated women, but there was little decline for women without any formal schooling (Nanda, 2000). In addition, the education of women is found to have a greater effect on children's health and schooling than the education of men. It also has significant effects on contraceptive behaviour and fertility, which are important both for achieving a lower rate of population growth and for reducing the incidence of HIV/AIDS.

Why it could be relevant

In 2003, Sweden changed its development assistance policy from a structure with six sub-goals to a single new global development policy objective which translated into the following objective "...to help create conditions that will enable poor people to improve their lives". (Sida, 2005 p. 5) From this perspective, health improvement is, besides being a goal in itself, seen as a key to economic and social development and thereby to reduce poverty. In that respect there are several useful questions that could be considered in an evaluation, for example:

- There is a considerable time lag before the effects of improved health are translated into reduced poverty. Hence it could be useful to evaluate for how long each recipient country has received aid to the health sector and if there has been a consistency in the objectives and targets of such aid.
- Does it matter if funds are disbursed as budget support, through targeted initiatives in e.g. the HIV/AIDS field, or through other institutions including ones in the private sector? Similarly, does it matter if funds are directed at institutional structures of health systems, infrastructure, or capacity building? The reason for looking into this would be that effects on health and eventually poverty reduction may depend on how funds are disbursed.
- Is there a monitoring and evaluation mechanism that helps ensuring that resources target the poor?
- In how many of the largest recipients of aid to the health sector has poverty declined and by how much? Preferably the result should be presented for different poverty measures (as there is no universally accepted definition of poverty it can be informative to present results for different poverty measures).

4.7 A move towards budget support

As opposed to project support, programme support implies that donors and partner countries cooperate on joint programmes with one common strategy. Such cooperation is long-term and, in contrast to project support, many donors can contribute to the same programme. Programme support can take the form of either budget support or sector support (e.g. Cordella and Dell'Arricia, 2001; Sida's own web page).

Budget support involves providing financial assistance directly to the budget of recipient countries. According to most experts that we talked to, it began to emerge as a serious aid modality in the late 1990s

as disenchantment grew with traditional project-based assistance. It can take the form of general (also called "direct") budget support or sector budget support. It is sometimes referred to as "poverty reduction budget support" when it is associated with supporting a PRSP or equivalent processes.

One of the main arguments for budget support is that traditional project-based support tend to create parallel systems for project management and accountability outside government. In turn, this undermines government systems by focusing attention and resources to these parallel structures. For example, project implementation units (PIU:S) often attract the best local experts, thus taking them away from the government, which is usually not able to offer similar salary levels.

Since project aid is usually located outside the government's budget structure, it creates few incentives for donors to ensure that the government's systems are working properly. Moreover, accountability structures that bypass recipient government systems, including parliamentary review, also may undermine the accountability of governments to their people.[53] Conversely, budget support creates an incentive for donors to focus on improving the government's own management systems. Eventually, this should also increase expenditures made from the government's own resources.

Moreover, dealing with different management and accountability structures for different projects, each with its own procedures, also places significant demands on the limited capacity of recipient country governments. Elimination of such duplication should free up not only the attention of recipient government staff, but donor money as well. It is also thought that budget support should lead to more efficient allocation of resources, since disbursements can be made according to the priorities of the recipient country and not according to the multiple and sometimes conflicting priorities of various donors.[54]

The main reservations expressed by donors about whether to engage in budget support usually concern the extent to which the recipient government's stated spending priorities are in line with those of the donor, e.g., that such policies are really "pro-poor", and that the government allocates funds according to its stated priorities, while managing money efficiently.

Regarding the first concern, donors generally have used the PRSP process to ensure that recipient government policies are "pro-poor". In fact, the advent of PRSP:S has probably been an important facilitating factor in the rise of budget support.

Addressing the second concern typically involves evaluating a country's public expenditure management system. The international finance institutions and others have developed a number of tools that can be used for such assessments, such as the World Bank's Financial Accountability Assessments and the tools developed by the UN Programme for Accountability and Transparency. A number of donors have also produced policy papers on assessing institutional risks, e.g., DFID's "Managing Fiduciary Risk when Providing Direct Budget Support" (DFID, 2002). Similarly, the Public Expenditure and Financial Secretariat has produced a study that reviews the instruments used by the World Bank, International Monetary Fund, European Commission, DFID and others to assess financial accountability systems, with the goal of harmonising such efforts among donors (PEFA, 2003).

DFID notes that the decision to use budget support should depend on a careful assessment of country circumstances, "including political and institutional analysis […] and the nature of our relationship with the partner country" (DFID, 2004, p. 11). In addition, some note that the donor should also evaluate the costs and benefits of budget support against other types of aid. It should also be kept in mind that some goals may be better accomplished through projects, e.g., funding strategic changes in the institutional environment, policy experiments, projects to demonstrate alternatives, transfer skills, help the non-state sector, or to pave the way for future budget support (DFID, 2004; HLF, 2003). Thus, within a particular donor's portfolio in a particular country we should expect to see a variety of aid types for the foreseeable future.

Some observers predict inevitable disenchantment among donors with budget support in coming years, for example if fiduciary problems prove greater than originally expected. According to Steven Sinding, eventual disappointment with budget support could conceivably cause the pendulum to swing back to greater emphasis on project-based aid sometime in the next three to seven years.

Sinding also points out that the great paradox in the general trend toward putting the recipient in the "driver's seat" is that those countries that are most capable of sitting there are generally those that are least in need of assistance.[55] It is becoming increasingly clear that some countries simply may not be interested in budget support, for example the US, Japan and UN agencies that are all continuing to employ a project approach (e.g. Norad, 2004).[56]

A slightly different objection comes from Stewart Tyson who wonders whether some of the most forward-thinking bilateral donors – which also tend to provide the best expertise – could end up "harmonising themselves out of business" by focusing too much on budget support, leaving the field work to other, perhaps less capable donors.[57]

Sinding echoes this thought by observing that some "progressive" bilateral donors appear "too eager to simply write cheques", when this may be better left to multilaterals. In terms of comparative advantage, Sinding points out that the multilaterals are good at providing finance – including budget support – performing analytical work, developing strategic plans, and building infrastructure. But they are less good at technical assistance, institution building and training personnel to run infrastructure. These, he says, are generally the comparative advantage of the bilaterals, on which they should perhaps focus, while leaving budget support to the World Bank.[58]

A related concern of some donors has been whether moving to general budget support would still allow for sufficient policy dialogue with recipient governments on priority sectors, such as health. For example, Norway has examined the practicalities of "de-linking" sector dialogue discussions (e.g., those associated with SWAPs) from the provision of sector-based funding. It found that few donors have experience from such a de-linking even though it is a highly debated topic in most agencies. Furthermore, one could anticipate a substantive move in this direction by many donors in the coming years, as EC, Sweden and other like-minded donors are "struggling" with the same issues and appear to be eager to discuss challenges and options with other development partners (Norad, 2004).

Related to this, DFID is looking at a "graduated response" system, under which certain elements of general budget support would be subject to the achievement of quantifiable targets in key sectors. Such sector-specific triggers for budget support have already been used by the World Bank, for instance (Norad, 2004).

For some donors an apparent public relations-related disincentive to provide general budget support has been that such aid does not yet seem to be adequately accounted for in OECD Development Assistance Committee (DAC) statistics. In particular, such statistics can appear to show donors cutting back on aid to priority social sectors such as health and education, when in fact they are continuing to provide aid to such sectors via the recipient country's own budget mechanisms. For this reason some have suggested introducing "poverty oriented budget support" as a new line in DAC statistics. An alternative suggestion has been for budget support to be counted as support to all sectors supported by the recipient country's budget on a pro-rata basis (Norad, 2004).

In a somewhat similar fashion, some countries have practiced "notional" earmarking of budget support by stating that general budget support is intended to support a specific programme. For example, DFID often used to "link" its general budget support to reimbursing outlays towards teachers' salaries. This apparently allowed such money to be counted against specific sectors in DAC statistics. However, there is

some recognition that earmarking, notional or otherwise, goes against the spirit of general budget support. Both DFID and the EC are now moving away from notional earmarking, although the Netherlands apparently continues this practice.

It is too early to tell whether budget support will be able to deliver on all of its supposed advantages.[59] In any case, few of these are likely to be automatic (DFID, 2004, p. 1). As with most other aid modalities, the full expected effects may only come via harmonisation among donors, notably regarding objectives, management mechanisms and criteria for providing and cutting off such support. The DAC has been working with donors to harmonise mechanisms and criteria related to budget support in its Working Group on Donor practices. However, the subject may also require more thought on the division of labour between bilaterals and between bilaterals and multilaterals based on comparative advantages.

Why it could be relevant

Sweden has moved from strict donor-driven project aid with a large technical assistance component in the 1960s to today's sector support and budget aid, which intends to be fully integrated in the recipient economy. In addition, Swedish aid has gone from using detailed directives on the project level only, to a conditionality on the macroeconomic level that include policies regarding democratisation and human rights (Danielson and Wohlgemuth, 2003). Likewise, the Swedish budget support has evolved from a relatively short-term support for macroeconomic stabilization toward long-term support for poverty mitigation with a focus on partial support to the partner country's budget. Hence, Sweden has followed the general trend by moving towards budget support in its development assistance.

Programme support purports to address many of the adverse side-effects of traditional project-based aid. While it is generally only practical in countries with advanced institutions for planning, budgeting, monitoring, auditing and reporting, it calls for technical assistance to strengthen such institutions in other countries – or at least avoiding to undermine existing government institutions. Given its cross-sectoral nature, examination of this topic may not be relevant for an evaluation limited to the health sector. But still, the lack of holistic approach has been seen as one of the problems with traditional, project-based aid provision.

The evaluation could look at the extent to which Sida has developed a policy on budget support and if the organisation has attempted to build up and rely more on existing recipient government institutions in carrying out projects. It could also look at the extent to which Sida has been able to effectively provide sector-specific expertise even when its financial support goes through the budget. Additional questions could include the following:

- If the move towards budget support has resulted in better health outcomes in the relevant countries (i.e., the countries where a change has occurred)?
- Has the move towards budget support and the importance of the recipient country's governance structure affected the set of countries receive health support from Sweden?
- Does Sida's policy on budget support include clear conditions or "hurdles" for its introduction and for its withdrawal?
- Does Sida provide technical assistance to governments to enable them to better qualify for budget support?
- To what extent has Sida engaged in efforts to harmonise conditions and processes for budget support with other donors, e.g., via DAC, or through mechanisms in particular countries?

4.8 Additionality

Additionality refers to the principle of ensuring that donor funding does not supplant, and is instead additional to, existing expenditure and funds coming from other sources. The concept of additionality is often used with reference to the need for ensuring that aid programmes and projects do not discourage or displace private sector investment.

Additionality is one of the guiding precepts for the creation of the GFATM and is also a feature of contemporary debates on debt relief. While there is generally broad agreement on the need to ensure that donor spending in the health sector is additional, it has proven enormously challenging to monitor additionality, both at the donor level and within national financial systems. There are a number of examples of such intents, however, such as the National AIDS Account Reporting that is being used to track the additionality of GFATM grants (World Bank OED, 2002; UNAIDS, 2004)

Why it could be relevant

The issue of additionality has been a feature of the debate in international development assistance for many years. In the health sector, it has attracted renewed attention in recent years due to substantial amounts of funding available through 'vertical' programs (e.g., GAVI and GFATM). Sida and others has expressed a concern that: this funding may displace existing expenditure, and that such funds may displace and/or destabilise sector-wide health care system expenditure (see e.g. Norad, 2004)

The principle of additionality raises several questions regarding the modalities of Sida's support to the health sector:

- Does Sida have a reliable basis for monitoring the additionality of the support it provides in the health sector?
- What priority should be given to monitoring the additionality of Sida's support in the health sector?
- If improving the monitoring of additionality is a priority, how can country- and health sector-level monitoring systems be enhanced without placing an undue burden on recipient countries?

5 Relative importance of trends and changes for Sida

In addition to the description of trends and changes that have affected development assistance to the health sector, an additional purpose of the present study is to attempt to assess their relative importance for Sida.

As the present assignment is a preparatory study aimed at guiding a subsequent evaluation, the interpretation of 'relative importance' for Sida is quite important. The ToR mentions that "…the overall purpose of the eventual evaluation will be to assess how Sida has reacted to such changes (along with internal factors such as new guidelines and regulations, changed internal patterns of work, etc.). In addition, the ToR states that "…the consultants are asked to make an informed judgement as to the trends' potential importance for Swedish development cooperation in the sector. Such an assessment should be based on interviews, material gathered from other actors in the field, and the authors' own judgement."

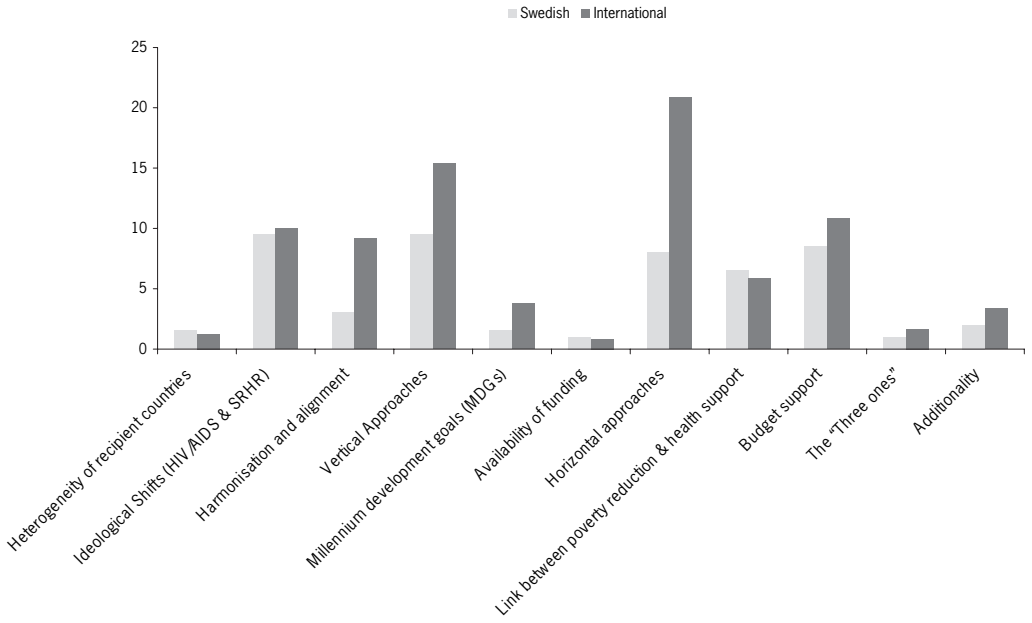
Before describing the various steps taken to assess relative importance, we would like to indicate some of the difficulties involved in making such an assessment. The limited time available has restricted the amount of material collected and reviewed and, in addition, the interviewees themselves add an element of subjectivity. Furthermore, the interviewees have emphasised the difficulties in ranking these trends and changes in order of importance, and some even thought it was an impossible task. We have, as described below, used a simple scoring method to arrive at some indicative rankings, but due to the problems involved in making such an assessment, the results obtained must be interpreted with caution (as is the case with all scoring and ranking exercises).

Through the identification and selection of trends and changes for in-depth review (see section two above), a first preliminary assessment of importance for Sida was made. The subsequent step to determine the relative importance of these trends and changes was based on information from the interviews. In that regard, we thought that it would be informative to compare responses from Swedish and international interviewees in order to see if the Swedes emphasise the same trends and changes as international interviewees do. We made a first-cut scoring of trends and changes depending how each of them was treated in the interview:

- 1.5 if very important
- 1 if considered important
- 0 if *not* mentioned or if specifically mentioned as unimportant.

Thereafter, the scores were added up and weighted by the number of Swedish and international interviewees respectively. Hence, we ended up with a indicative score of the importance of each trend and change. The result is presented in Figure A.

Figure A: Relative importance of trends/changes



Note: The scores were weighted by the number of Swedish and international interviewees respectively to ensure that the number of interviewees would not affect the result. No statistical tests have been performed on the results. Trends and changes that were not mentioned in any interview have been omitted from the table.

We also added the scores for the different horizontal and vertical approaches respectively in order to get a combined horizontal and a combined vertical score.

From the figure, it appears that the Swedish interviewees to a larger extent than their international counterparts emphasise the importance of increased heterogeneity of recipient countries, availability of funding and the link between poverty reduction and health support. As for ideological shifts (HIV/AIDS and SRHR) a breakdown[60] revealed that the Swedes put relatively more emphasis on SRHR than on HIV/AIDS even though the difference was small. The international interviewees put relatively more emphasis on HIV/AIDS than on SRHR and the difference was quite large.

Based on these indicative scores, the three most important trends and changes as emphasised by the Swedish interviewees were: Ideological shifts (HIV/AIDS and SRHR); vertical approaches (of which establishment of new disease specific global actors was the most important trend and change); and budget support.

Among the international interviewees, the three most important trends and changes were horizontal approaches (of which the strengthening of health systems was the most important one), vertical approaches (of which establishment of new disease-specific global actors was the most important), and budget support.

Table E presents the indicative ranking of relative importance of trends and changes based on the weighted scores from the interviews.

Table E: Indicative ranking of relative importance trends/changes based on scores from interviews (1 = most important)

		Swedish interviewees	International interviewees
Changes in health related patterns ideologies	Increased heterogeneity within recipient countries	7	10
	New epidemiological challenges	11	12
	Pharmaceutical developments	11	12
	Ideological shifts (SRHR and HIV/AIDS)	1	4
Actors' response to trends/ changes			
Trends/changes in donor cooperation	Increased emphasis on harmonisation and alignment	5	5
	Emergence of horizontal approaches (strengthening of health systems, SWAps, and PRSPs)	3	1
	Emergence of vertical approaches (new disease specific global actors, "3 by 5", private-public partnerships)	1	2
	Changes in the availability of funding	9	11
	"Three Ones"	10	9
Trends/changes in development/health assistance thinking	Increased emphasis on the link between poverty reduction and health support	4	6
	A move towards budget support	2	3
	Additionality	6	8

6 Conclusions

Sida plans to undertake an evaluation of its support to the health sector, which will take as its point of departure the changes and transformations that have occurred in the context of international development cooperation over the last decade. To that effect, ECON was commissioned to undertake a preparatory study with the purpose of describing trends and changes, and attempt assess their relative importance for Sida.

The process of identifying and selecting trends and changes for in-depth examination took as its starting point the list of general issues suggested by Sida. Based on written material gathered, interviews in Stockholm, Oslo, London and Geneva, and the experiences and knowledge of the consultants, additions and deletions were made to this list. The resulting list of trends and changes for in-depth review is presented in Table F.

Table F: Trends/changes selected for in-depth review

Changes in health related patterns and ideologies	Increased heterogeneity within recipient countries
	New epidemiological challenges
	Pharmaceutical developments
	Ideological shifts (SRHR and HIV/AIDS)
Actors' response to changes health related patterns and ideologies	
Donor cooperation	Increased emphasis on harmonisation and alignment
	Emergence of horizontal approaches (strengthening of health systems, SWAps, and PRSPs)
	Emergence of vertical approaches (new disease specific global actors, "3 by 5", private-public partnerships)
	Changes in the availability of funding
	"Three Ones"
Development/health assistance thinking	Increased emphasis on the link between poverty reduction and health support
	A move towards budget support
	Additionality

All these trends and changes have been thoroughly described. In some cases, tentative ideas as to how the eventual review could examine Sida's response have been outlined. (However, it was not in the ToR for the present assignment to design the methodology of the subsequent evaluation, wherefore these ideas should not be taken as formal suggestions developed according to a consistent set of criteria.)

For assessing the relative importance of the trends and changes for Sida, we used the interview results. We employed a simple scoring system to the interviews, where each trend/change was given a score of:

- 1.5 if very important
- 1 if considered important
- 0 if *not* mentioned or if specifically thought to be unimportant.

This system provided us with total scores for the various trends and changes and these scores were then weighted by the number of Swedish and international interviewees to allow for comparisons. This allowed us to develop an indicative ranking of the different trends/changes and the results from this exercise for the four most important trends and changes are presented in Table G.

Table G: Top trends and changes

Trend/change	Ranking by Swedish interviewees	Ranking by international interviewees
Ideological shifts (SRHR and HIV/AIDS)	1	4
Emergence of vertical approaches (new disease specific global actors, "3 by 5", private-public partnerships)	1	2
A move towards budget support	3	3
Emergence of horizontal approaches (strengthening of health systems, SWAps, and PRSPs)	4	1

Note: SRHR = Sexual and Reproductive Health and Rights, SWAps = Sector Wide Approaches, PRSPs = Poverty Reduction Strategy Papers.

These results must be interpreted with some caution as there are several difficulties involved in making these types of assessments. For example, it is never possible to fully collect and review all possible documentation and the interviewees themselves add an obvious element of subjectivity. Despite these caveats, an indicative ranking, like the present, can provide a useful basis for the subsequent evaluation.

Endnotes

1 "Hot topic" is the conventional denomination for key issues that international organisations/ and institutions are currently working on.

2 See Annex 2 for a list of people interviewed.

3 [http://www.thefreedictionary.com/trend] and [http://www.thefreedictionary.com/change]

4 For a list of people interviewed, see Annex 2.

5 See ToR, page 2.

6 Interviews with Fife, Walford, and Evans.

7 Global Forum for Health Research (2004)

8 Ibid.

9 Ibid.

10 Interview with Godal.

11 As evidenced by the "10/90" gap for instance (see section 4.3.3). See also The Economist (1999, 2001a and 2001b).

12 Interviews with Fife, Hjelmåker, Molin, Larsson.

13 Interview with Larsson.

14 [http://www.sida.se/Sida/jsp/polopoly.jsp?d=1265&a=26598]

15 Interviews with Tyson, Hjelmåker, Molin, Larsson.

16 Interview with Lennarth Hjelmåker who is the Swedish Ambassador for HIV/AIDS issues and a member of the board of the GFATM.

17 A country's ability to effectively absorb more resources depends on the particular needs of the country, the strength of government institutions, the activities that the additional resources finance, coordination with other programs and so forth. Unfortunately, there are no clear guidelines for how much aid any one country can effectively absorb. Estimates for the cut-off point at which additional aid no longer "helps" varies between 4 and 50 per cent of GDP, depending on which studies are referred to, as noted by Birdsall (2002).

18 Interviews with Stenson, Godal. However, the interviewees failed to identify these extreme cases.

19 [http://www.who.int/hdp/en/hlfworkplan_dec_2004.pdf]

20 Interview with Miyamato.

21 Interviews with Tyson and Sinding.

22 Interview with Molin.

23 Mills (2005), p.315.

24 [http://www.msh.org]

25 Alliance for Health Policy and Systems Reasearch (2004), p. 1.

26 Tanner (2005), and interviews with Båge, Molin, Sinding, Tyson, Fife and Walt.

27 Interview with Walford.

28 Sida's criteria for SWAPs seem to be consistent with the widely-accepted definition presented above. (See Walford, 2003, p. 9 for a comparison of criteria across different organisations.)

29 Interview with Tyson.

30 This review was prepared for a Sida-sponsored seminar on SWAPs held in San Francisco on 19 June 2003.

31 Interview with Molin.

32 Mills (2005), p. 315.

33 Interview with Walt.

34 Interview with Hjelmåker.

35 Anders Nordström, while at Sida and later at WHO, has been a major critic of the global health initiatives in this regard, noting in 2002 that the re-emphasis of the "vertical" approach under GAVI had set the approach on immunisation back 15 years (see for example DT 4 Feb 2002).

36 Interview with Rosling, Stenson, and Godal.

37 Interview with Miyamoto.

38 Interview with Stenson.

39 Interview with Dans.

40 [http://www.who.int/3by5/about/initiative/en/index.html]

41 [http://www.who.int/hiv/3by5evaluationteam/en/. The final evaluation report is expected to be ready by the end of March 2006. The evaluation team has consisted of the six members: Jean Beaudoin (Canada), Shaun Conway (South Africa), George Kivumbi (Uganda), Maria Ines Nemes (Brazil), Anne Skjelmerud (Norway), and Ulrich Vogel (Germany, team leader).

42 [http://www.globalforumhealth.org]

43 Interview with Dans.

44 Interview with Turner.

45 Interviews with Turner and Dans.

46 Including population-related health, which was a separate category until 1995.

47 DAC statistics on health only cover activities which have health as main purpose. They do not cover assistance delivered within multi-sector programmes, or aid to sectors that may have direct or indirect effects on health, e.g., water and sanitation and education and budget support. Medical assistance as part of disaster relief is also excluded.

48 Interview with Sinding.

49 The countries that were present at the meeting were: Australia, Belgium, Brazil, Canada, Côte d'Ivoire, Denmark, Finland, France, India, Ireland, Italy, Japan, Luxembourg, Malawi, Netherlands, Norway, South Africa, Sweden, United Kingdom of Great Britain and Northern Ireland, United States of America. The following organisations participated: UNAIDS Secretariat, United Nations Development Programme (UNDP), World Health Organization (WHO), World Bank, Organisation for Economic Co-operation and Development, Development Co-operation Directorate (OECD/DAC), International Council of AIDS Service Organizations (ICASO), Global Network of People Living with HIV/AIDS (GNP+).

50 [http://www.who.int/3by5/newsitem9/en/index.html].

51 [http://siteresources.worldbank.org/CSO/Resources/Strategic_Policy_Workshop_on_AIDS_English_summary.pdf]

52 Interviews with Molin, Akuffo, Båge, Sinding, Tyson, and Walt.

53 Interview with Båge.

54 These and other arguments for budget support can be found in OECD/DAC 2001 and Norad 2003.

55 Interview with Sinding.

56 Interview with Tyson.

57 Interview with Tyson.

58 Interview with Sinding.

59 In particular, it is clear that budget support has not delivered much in terms of making aid flows more predictable. This is perhaps because budget support is a high-profile type of assistance and also relatively easy to cut. There have been a number of cases, notably in Uganda, where donors such as DFID have come under pressure at home to withdraw budget support in response to reported incidents of human rights abuses or other political problems (DFID 2004)

60 Available upon request.

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Annex 1: Terms of Reference

Evaluation of Sida's Programmatic Approach to the Health Sector: Terms of Reference for a Preparatory Study

Evaluation purpose

Sida plans to undertake an evaluation of its support in the health sector, with a particular focus on how the organisation has responded to recent changes in goals, context and modalities of work. To that effect, a preparatory study that outlines the main trends and changes in the context in which Sida operates is required to help define the scope and the issues to be treated in the subsequent evaluation.

Drawing on existing material and interviews, the primary goal of the preparatory study is to provide a comprehensive and systematic description of trends and changes affecting the health sector, along with a general characterisation of their relative importance for Sida's work. Subsequently, such a description will form the basis for a closer scrutiny of Sida's actions in the health sector.

Intervention background

The health sector is one of the largest within the area of Swedish cooperation support, with total Swedish cooperation support for the area coming to 1,721 MSEK during 2003, equivalent to 10.5 per cent of Swedish development cooperation in general. The bulk of this sum is handled by Sida. Within the organisation 65 per cent of total funds are administered through DESO/Health and embassies, with departments such as SEKA and SAREC accounting for minor percentages.

Divided into sub sectors, cooperation with Health Services is the largest part with over half (53 per cent) of total Sida funding for the area in 2003. It is followed by the parts for General Health (29 per cent), Health Systems (14 per cent), and Public Health (four per cent). There have been recent changes in the guidelines and policies for this area, viz. the focus on health as a tool for economic development which is established in the 2002 policy for the area. Furthermore, specific fields of the sector – most notably HIV/AIDS – have received increased attention during the last few years.

At the same time, there are a number of changes in the context in which Sida's health cooperation operates. Some of these are related to broader trends in development cooperation (e.g., increased efforts at harmonisation, increased used of sector wide approaches), whereas others are specific to the health sector (the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria for instance). Moreover, while factors such as the above are the result of calculations and interactions among parties, other changes are beyond strategic agency altogether. For example, that is the case of the rise of pandemics or new patterns of contagion related to the increased mobility of persons.

In sum, the universe of problems, actors and activities in which Sida's health support operates is subject to processes of transformation and evolution. While the overall purpose of the eventual evaluation will be to assess how Sida has reacted to such changes (along with internal factors such as new guidelines and regulations, changed internal patterns of work, etc.), the goal of the present study is to provide a summary of these transformations.

Stakeholder involvement

Being a preparatory study, there is less scope for stakeholder involvement than in a regular evaluation. However, Sida's Health division should be involved in the process both as a provider of data (through interviews) and for providing feedback and comments on the results of the study. It bears noting, however, that neither the evaluation nor the preparatory study shall be limited to that unit. On the contrary, care should be taken to collect views and standpoints from all those in the Sida staff who deal with matters pertaining to health.

Evaluation questions

The overall purpose of the preparatory study is in the first place descriptive, i.e., it shall provide a systematic overview of recent changes affecting the health sector. More in particular, the study should describe the nature and extent of trends and tendencies with regard to the following general issues:

- Health problems and challenges (for instance, new epidemics, remedies).
- Aid modalities (e.g. harmonisation, budget support).
- Interactions between donors and developing countries (e.g. enhanced partnership, conditionality, efforts to increase local ownership).
- International actors (for instance, the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria)
- Goals (e.g. MDG, "Three by Five")
- Interaction with other areas of development cooperation (e.g. the increased stress on the link between poverty reduction and health support).
- Availability of funding.
- Any other issue or area that may appear in the overview.

The time span considered should be 1995–2004, with a focus on the last five years.

While the former questions pertain to the purely descriptive purpose, the study holds an additional purpose in that it should attempt to assess their relative importance for Sida. In other words, the consultants are asked to make an informed judgement as to the trends' potential importance for Swedish development cooperation in the sector. Such an assessment should be based on interviews, material gathered from other actors in the field, and the authors' own judgement.

Recommendations and lessons

The goal of the present study is to provide the subsequent evaluation with a suitable and adequate focus. Accordingly, the primary outcome should ideally be an outline of major trends and changes in the sector, along with their estimated importance for Swedish interventions in the field. The eventual evaluation may then juxtapose such an outline (combined with an overview of internal changes and processes) with Sida's actions in the sector as indicated by policies, composition of projects, methods of work, etc.

Methodology

Material for the study shall primarily be collected in Sweden and from the Internet. The consultants are requested to gather material from the following sources:

– Previous studies and evaluations performed by Sida, organisations in the UN system, other donors and similar actors in the sector. The consultants are requested both to make a comprehensive review of such publications, and to synthesise the contents of those works that are deemed most relevant.

– Interviews with Sida staff knowledgeable on the subject. Ideally, some fifteen interviews should be conducted with persons either currently or previously involved with the sector who possess sufficient overview. Furthermore, other Swedish persons active within the sector of global health (e.g. from Karolinska Insitutet and RFSU) should also be interviewed.

– Moreover, the assignment allows for a period of interviews and meetings with key global actors in the sector, preferably in Geneva where the offices of the WHO, UNAIDS, and the Global Fund to Fight AIDS, Tuberculosis and Malaria are located.

It will be the responsibility of the consultants to set up interviews and obtain the necessary documents.

Whenever this is possible, the study should strive to provide a mix of data using both qualitative and quantitative indicators of the changes presented. It is imperative that all statements, suggestions, and conclusions be supported with clear factual references, in order for the report to be used by the subsequent evaluation. If such references cannot be found, or if data on an issue differ, this should be clearly indicated.

Work plan and schedule

The assignment shall be performed during the spring of 2005, and be finalised before July 15, 2005.

The maximum time for the assignment is estimated as follows:

Literature overview:	2 weeks
Literature review:	6 weeks
Interviews in Sweden:	3 weeks
Interviews in Geneva:	2 weeks
Reporting	3 weeks
Total	16 weeks

The time for the assignment can be divided between two or three persons. Only one person shall be responsible for contacts with Sida, however.

Reporting

After an initial review of the material, the consultant(s) are asked to provide a written inception report of maximum 15 pages concerning what they see as the main directions of enquiry and data. This report will be discussed at a meeting with Sida staff, who will then be able to provide feedback on these suggestions.

For the final report, the consultant(s) are asked to synthesise their findings in a report with a maximum length of 40 pages (excluding appendixes). Format and outline of the report shall follow the guidelines in Sida Evaluation Report – a Standardized Format. The evaluation report must be presented in a way that enables publication without further editing.

The report shall present different trends along with a motivated judgement as to their importance from the perspective of Swedish development cooperation. A draft of the report should be delivered to Sida on June

14, 2005 for comments. After receiving Sida's comments, the consultant(s) will make the necessary revisions and hand in a final version of the report within two weeks. It is the responsibility of the consultant that the report be written in correct and comprehensible English, which is a condition for its approval.

The evaluation assignment includes the completion of Sida Evaluations Data Work Sheet (including an Evaluation Abstract) as defined and required by DAC. The completed Data Worksheet shall be submitted to Sida along with the final version of the report. Failing a completed Data Worksheet, the report cannot be processed.

Furthermore, after the completion of the report the consultant(s) should actively participate in a possible workshop at Sida presenting the main conclusions of the report.

Annex 2: List of people interviewed

The ToR states that the interviewees should be Sida staff, other people in Sweden knowledgeable about the subject and key actors in Geneva. However, following the inception phase it was decided, in consultation with Sida, to make a few changes to this in order to allow for a broader sample of interviewees. Hence, the people interviewed represent views from a variety of organisations both in Sweden and internationally, i.e., in Oslo, Geneva and London. The selection of interviewees has been based on the guidelines provided in the ToR and subsequent consultations with Sida. The interviewees are key people in their respective organisations. Actual names have been suggested by the consultants, by Sida, and by other interviewees. Each interviewee was given the opportunity to give broader comments on general trends and changes in order to cross-check the list of issues we had originally arrived at (see description in section two).

In some cases the suggested interviewees had retired, resigned, were on leave of absence, or were no longer affiliated with the organisation in question. For Swedish interviewees this occurred for interviewees at Sida/SAREC and at the Swedish National Institute for Public Health. All in all, we have been in contact with more than 10 people who, for the reasons mentioned above, were unable to participate. In such cases, other interviewees were selected. Great effort was put into trying to ensure that interviewees were knowledgeable about the subject.

Name	Institution
Hanna Akuffo	Sida/SAREC Deputy Head of Division at Division for University Support and National Research Development
Christina Båge	Sida/MULTI
Per Dans	Sida/INEC
Christina Larsson	Senior programme officer, Sida Health Division
Karl-Anders Larsson	Sida/POM
Anders Molin	Head of Sida's Health Division
Bengt Gunnar Herrström	Ministry of Foreign Affairs: Global Development
Lennarth Hjelmåker	Ministry of Foreign Affairs:
Ann Svensén	RFSU
Hans Rosling	Professor of International Health at Department of Public Health Sciences, Division of International Health (IHCAR).
Bosse Pettersson	Swedish National Institute for Public Health
Paul Fife	Norad
Sigrun Mogdahl	Senior Executive Adviser, Global Initiatives, Norad

Tore Godal	Advisor to the Bill and Melinda Gates Foundation
Bo Stenson	Acting Deputy Executive Secretary: GAVI Secretariat
Tim Evans	Assistant Director-General, Evidence and Information for Policy: WHO
Ann Kern	Independent Consultant w. exp from WHO, AusAid, GAVI, the Olso Group
Barbara Turner	USAID
Stewart Tyson	Head of Profession for Health, Policy Division, DFID
Steven Sinding	Director-General of the IPPF
Veronica Walford	Director, HLSP Institute
Kaori Miyamoto	Principal Administrator, Policy Coordination Division, Development Cooperation Directorate, OECD
Julia Benn	DAC statistics department
Gill Walt	Professor of International Health Policy, London School of Hygiene and Tropical Medicine

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Stephen Goss, Roger Blech, Guy Scott, Christopher Mufwambi

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Joint Seminar, Brussels, November 2003
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