COMMISSION ON MACROECONOMICS AND HEALTH
A WHO commission examining the interrelations among investments in health, economic growth and poverty reduction

CMH Working Paper Series

Paper No. WG6 : 4

Draft for Discussion Only

Title

Qualitative Assessment of Bilateral Agency Views and Behavior --
Interviews with Non-Health Specialists

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Date: June 2001

ABSTRACT

This study aims to develop a better qualitative understanding of how non-health specialists in a selection of bilateral agencies view the health sector in the context of and agency development objectives and priorities. Knowledge and attitudes were elicited concerning: the importance of health within the larger development framework, approaches to improving effectiveness of the sector, the value of significantly increasing the flow of resources into the sector, and mechanisms for improved management of a greater influx of resources for health. Senior economists, policy makers and heads of regional departments of six bilateral agencies were interviewed.

All agencies consider health as a high priority, and an essential element in poverty alleviation and increased productivity. Investment in health was not generally perceived to have changed markedly in the recent decade, and projected increases in health budgets were foreseen to be moderate, and in a few cases significant. HIV/AIDS was most frequently cited as the dominant factor driving the increasing visibility and political importance of health.

Considerable symmetry was observed in the overall goals, objectives, and programming priorities among the agencies, as well as views on financing mechanisms. Respondents favored holistic approaches to achieving improved health outputs through greater intersectoral vision and programming. Single disease initiatives were viewed as effective mechanisms for garnering political support and attracting resources. Their potential for sustainability and integration into national health systems was considered limited, with possible risk to SWAp structures and established national health priorities.

Among all agencies the need for greatly increased resources for health is manifest, however most respondents held that the pace of acceleration must neither exceed the absorptive capacity nor preempt the priorities of recipient countries.

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1. INTRODUCTION

The purpose of this paper is to develop a better qualitative understanding of how non-health specialists in a selection of the major bilateral agencies view the health sector. The study focused on views of senior policy makers, managers and economists concerning the importance of health in the broader development context, their thinking on mechanisms which may enhance the flow of funds to health, and their views on the value of a significant increase in funding for health. Telephone interviews were conduced with senior officials of six bilateral agencies, five European, and one North American.

The paper aims to provide an overview of viewpoints from both a general and an agency-specific perspective, and to provide limited contextual information on the current policy setting of each agency.

The terms of reference for the study (see Annex 1) specify the need to obtain information on the procedures and constraints of agencies in processing larger financial flows, and further, to lay emphasis on the discussion of the details of administration. This latter subject was not explored in detail, as most respondents did not consider administrative systems a major obstacle and were concerned with broader policy issues. Most agencies favored the Sector Wide Approach (SWAp), a financing mechanism which may enable larger flows of funds with reduced levels of administration, on the part of both on the donors and the recipients. Absorptive capacity of recipients, and adequate delivery systems were perceived as the main constraints.

2. METHODS

Bilateral donor agencies of six countries were selected for study.

Country / Agency
- Canada - Canadian International Development Agency (CIDA)
- Denmark - Danish International Development Agency (DANIDA)
- Germany - Ministry of Foreign Affairs, GTZ and KfW
- Netherlands - Ministry of Foreign Affairs
- Sweden - Swedish International Development Agency (Sida)
- United Kingdom - Department for International Development (DfID)

Interviews were targeted for senior policy makers, chief economists, heads of development programs (multi-sector), and regional heads of development programs. A total of 17 interviews were undertaken. The number of interviews per agency was related to ease of contact and willingness to participate. In two cases, the interviewees were health professionals (BMZ, Netherlands), all others were economists, policy specialists and senior managers.

All interviews were conducted by telephone, and were of approximately 30-minutes duration. A semi-structured questionnaire was used based on the Terms of Reference for the assignment. Interview subjects received a modified copy of the terms of reference for the study emailed in advance of the interview. There was minimal use of prompting to trigger particular viewpoints. Interviews were manually recorded.

Questions centered on the following themes:

1. The position of health among the agency's current and future priorities
2. Factors driving sector priorities
3. Perceptions / opinions concerning effectiveness of development assistance in health, as reflected in the agency's programs, and/or globally
4. Approaches which are known to, or could potentially, improve effectiveness in development assistance in health
5. Views concerning the value of substantial increases in resources for health
6. Needed mechanisms and capacity required to process, program and utilize such an increase in financial flow
7. Perceptions concerning accountability
8. Views concerning the balance between long term institutional and health systems development versus scaled up disease eradication programs
9. Familiarity with, and views concerning, global partnership programs

Telephone interviewing as a research method has inherent limitations: limited selection and availability of interviewees, difficulty in steering content, manual documentation is seldom complete. The approach generated information which was relevant to, but also along the margins of, the subject matter. In some cases interviewees had relatively little familiarity with issues pertaining to the health sector. Responses are general, and somewhat superficial, but provided impressions, both individual and institutional. In the case of one agency, the Head of the Health Division was asked to review the findings reported in the interviews, to get a sense of the accuracy of the information. His conclusion was that the concerned persons were not fully updated. The same is likely to apply to other agencies. The interviews were undertaken primarily in May 2001, and do not therefore reflect recent developments in the emerging Global Health Fund.

Interviews were transcribed and the information examined according to:

1) clustering of responses across agencies.
2) agency-specific responses

In the findings, interview responses are preceded or supplemented by general information about the agencies' health-related goals and budgets. Availability of the latter in English was variable.

It is of foremost importance to acknowledge that the information contained herein is based on the views of individuals, and may not be reflections of agency views or policy.

Risk of interviewer bias is acknowledged. It is therefore relevant to note the background of the interviewer/author. The author is a public health specialist with a social science background, and 12 years of resident country and regional level work in bilaterally funded health projects in Africa and Asia. It can be concluded that the author's personal experience is primarily derived from the field, and less so from central level organizations.

3. RESULTS

3.1 General findings across agencies

The core mandate of all agencies is sustainable development and poverty alleviation, in which health plays an integral role. While there is symmetry in the objectives, and program directions of the agencies, their structures and means of allocating funding to health are heterogeneous. Factors cited in determining investment in health were varied, ranging from linkage to international development targets, government policy on regional relations, and heightened spread of communicable diseases (HIV/AIDS a leading factor), to the purely pragmatic -- the relative ease of financing health sector programs via a SWAp process.

Capacity to manage an increased flow of funds to the health sector was seen, in the first hand, in terms of recipient constraints. All agencies cited the poor absorptive capacity and weak management systems of recipient countries. Four out of six agencies are fully involved in SWAp financing, and consider it a key means of processing larger flows of funds. Channelling of funding via multilaterals was also cited. Agencies did not perceive that their own financing and management systems constituted a significant constraint. Insufficient human resources at central and country level could, however, be a limiting factor.

Several European agencies reported the following trend in overall strategy and sector programming:

- Reduction in the total number of countries receiving development cooperation support
- Concentration of financing to 2-4 sectors per program country
- Project assistance replaced by SWAp financing, with scaling up of financial commitments
- Reduction in the number of long term expatriate advisers in target countries, and fewer specialists at headquarters
- Efforts to develop regional initiatives and programming
- Increased indirect financing (via multilaterals, or other bilateral agencies)

A recurrent theme was the need to avoid a "monosectoral approach." The majority of respondents emphasized the need for broader solutions to achieving health outcomes. Integrated development programming, holistic approaches, and reduced "sectorizing" were highlighted in several interviews. Some respondents felt that the assumption that health outcomes are related to health sector investments is oversold and merits further study.

Many respondents emphasized the need to give greater attention to the role and the growing dominance of the private sector in health service delivery. Projects and sector programs are thought to be too narrowly focused on entrenched public sector health systems. A greater focus on regulation, quality, standards and financing partnerships with the private sector was felt to be urgently needed.

Clustering of responses around a number of other issues was observed:

- SWAp is seen as a key mechanism for improved effectiveness, given careful country assessment and selection
- There is need for balance between long-term investment in institutional capacity building and immediate interventions to alleviate disease and mortality

- Health sector financial commitment should increase gradually; reservations are numerous concerning the value of a rapid increase in financial flow
- Global health initiatives have a role to play in attracting public support and financing, however there is risk for unfavorable impact of these programs on national health systems and priorities

All agencies recognize the increasingly strong political profile of health globally, and the opportunities to strengthen support via new financing mechanisms and global programs. The work of the Commission, and the improved evidence base for the link between health and economic development, were considered of great importance.

3.2 Country / Agency Specific Findings

3.2.1 Canadian International Development Agency (CIDA)

The goals of CIDA parallel the international development goals outlined in OECD's *Shaping the 21st Century*[1]. CIDA has presented a five-year investment plan for four priority areas for social development in its Framework for Action 2000-2005, among which health figures prominently.[2]

Priority Areas	Base year budget* 1999-1000	Year 5 budget 2004-2005
• Basic Health and Nutrition	152	305
• Basic Education	41	164
• HIV/AIDS	20	80
• Child Protection	9	36

* in millions of dollars

Funding for health and nutrition will more than double from 2000 - 2005, and funding for HIV/AIDS will quadruple. These two programs account for half of CIDA's total social development budget. Cida has expanded its support for Roll Back Malaria, Stop TB and GAVI, and anticipates that these initiatives will have substantial impact. Improved effectiveness of development assistance is one of the four key commitments of Canada's Official Development Assistance (ODA) program.

The core mandate of CIDA is sustainable development and poverty alleviation. The policy branch of the agency has been transformed recently. It was characterised as more 'hard-edged,' analytical and strategic, and is following evidence in adopting strategies and plans. More emphasis is being placed on analytical approaches in decision making. There is increased economic capability and the agency is reportedly becoming more adept at dialogue with other government agencies.

The Bruntland initiative at WHO is found "enormously helpful" and the pairing of health and economic growth, a very compelling formulation. In the opinion of the senior policy maker interviewed, the agency's poverty alleviation agenda generates very little discussion of economic growth. There is need for more dialogue on what poor people in recipient countries want. An enabling environment with greater opportunities and thereby increased capacity, productivity and affluence, should be the focus.

The respondent stated that the key to becoming more effective is to invite change. CIDA would like to move in the direction of SWAp support and link its funding to the World Bank-supervised process. More patience is, however, needed in initiating these arrangements, and there is a tendency to 'want to be at the destination before starting the journey.' Caution was expressed also concerning setting goals which exceed 'what our own countries could achieve.'

Health, and particularly HIV/AIDS are a dominant feature in CIDA's priorities, as evidenced in the Social Development Framework. Regarding increasing financial flows in health, any new or increased programming must correspond with the priorities of the host country. As in the Poverty Reduction Strategy Papers (PRSP),[3] aid needs to be set within the context of sectoral priorities and a fiscal framework. There must be a clear connection between what the country is doing for itself, and what it is requesting support for.

Concerning development partnerships, CIDA supports the global health initiatives (HIV/AIDS, TB,Malaria). The garnering of enthusiasm and support for global programs, such as polio eradication, by means of publicity, involvement of foundations, and private sector sources was seen as highly positive. Concerning other types of partnerships, CIDA works actively with NGOs, PVOs and universities, but it was expressed that CIDA's focus on the role of the private sector in health is not sufficient.

Issues of Accountability

Concerning accountability, a strong emphasis was placed on the responsibility of the agency to be well managed, self-critical, and responsible stewards of the Canadian taxpayers' dollars. CIDA sector specialists were thought, however, to be more focused on accountability to recipient country beneficiaries.

The definition of effectiveness was seen in a broad perspective -- also in relation to the agency's standing in the eyes of taxpayers. The notion that CIDA assistance is appreciated by beneficiaries is not a sufficient evidence of effectiveness. In actuality the CIDA budget has decreased in real terms by 40% in the last 10 years. Thus it hasn't managed to retain its proportion of taxpayer contribution despite an otherwise strong economy. The agency's ability to relate its mission and activities to taxpayers is considered weak. New management is focusing more on accountability to taxpayers.

Concerning a potential increase in resources to the health sector, it is considered very difficult to spend resources well. A large influx of resources would tend to be spent multilaterally rather than bilaterally. Responding to a rapid mobilization of new funds would take time (12-18 months, as suggested in the Terms of Reference, is not feasible). A SWAp process would take 2-3 years to set up.

A greatly expanded flow of resources into the health sector would not present any insurmountable administrative or systems problems for CIDA. A SWAp setting would facilitate such increased flows. Efficiencies can be gained, for example, by using one auditor to perform an audit for several bilateral agencies. With reference to recipient country accountability, it was suggested that the focus should be shifted more to the recipient country's accountability to its own citizens, rather than to donor agencies.

CIDA recognizes the tension between immediate needs (e.g. addressed by disease eradication programs) and long term capacity building. CIDA programming is focused more on the

shorter term. It was pointed out that program cycles are seldom longer than the life-span of a government. The greatest concern expressed was that the agency operates in relative isolation, with the result that Canadian taxpayers are not interested and informed about CIDA's work.

3.2.2 Department for International Development (DfID), United Kingdom

Health is a key element in DfID's international development targets, which parallel the OECD's development goals[4]:

- Reduction by two thirds of IMR and CMR by 2015
- Reduction of maternal mortality by three-fourths by 2015
- Attain universal access to reproductive health services via primary care by 2015

Health outcomes are of critical importance with respect to both peoples' well-being and to economic development. The Head of Policy referred to the 'virtuous circle of health and development' whereby health is dependent on development and vice versa, while recognizing that there are multiple instruments for health development. Conflict resolution, infrastructure development and other inputs must precede or complement health inputs.

It was stressed that too often there is an implicit assumption that:

1) health inputs produce improved health outputs
2) health services derive solely from the public sector

Recognition of the multiple factors influencing health should be more apparent in health programming, as well as the recognition of the increasing role of the private sector in health service provision.

Health sector priorities and financing

Within DfID, financing for health has objectively increased over the past decade. This is congruent with observed growing health threats and issues. There is more funding for health both proportionally and absolutely, partly due to the Department's scaled down investment in infrastructure in recent years. For example, in the last financial year £1.1billion in development aid was committed, of which £393 million was classified as contributing to essential health care (i.e. health classified as primary or secondary component).

A driving factor in the agency's priorities for health is the link to international development targets. DfID must demonstrate concrete improvements in health outcomes (e.g. increase in numbers of attended births). These are 'hard-wired' into DfID's strategy. HIV/AIDS was also cited as the main force driving the increasing focus on health.

Effectiveness of development assistance in health

There is a perceived 'blinkered approach' among health specialists which is reflected in an excessively narrow vision of what determines health outcomes. This is observed in SWAP programs which are designed by health sector professionals.

Approaches to promote effectiveness of development assistance were cited as:

- SWAp financing mechanisms

- inclusion of the role and participation of the private sector
- joint donor working groups
- international commodity funds
- broader-visioned programming
- a wider range of professionals (e.g. non-health) involved in the design and management of SWAps

A twin-track approach to improved performance in bilateral health support was suggested:

- Assisting functioning health delivery systems, best supported by SWAps, with pooled funds
- Assuring that the health system promotes and delivers an improved supply of commodities sourced via an international consortium of private sector suppliers

Views on the value of increased investment in health

The proposition of multiplying investment in the health sector was felt by one respondent to be illusory, similarly the supposition that recipient countries could absorb a massive influx of funds. The development assistance pipe clearly illustrates the weakness of this proposition. Effectiveness would be severely compromised by a rapid and sizable increase in financial flow. An example was cited: a study of the drug sector showing that for $100 spent on drugs, $20 of the commodities reach the recipient (reference not cited). The delivery capacity in developing countries was characterized as "an absolute."

A need for further definition of the source of increasing funds for health development was highlighted in the interview. One scenario is an overall increase in the development budget, another is to take existing funds from another sectoral window. These have different implications for the capacity of the agency.

With respect to global initiatives, for actions such as massive vaccine purchases, large amounts of funds can be committed. At national level, this would need to be assessed on a country specific basis. Where there is a well conceived SWAp and a well functioning management structure, there may conceivably be capacity to absorb a large increase in resources. Few countries would fit this precondition.

Concerning mechanisms to promote effectiveness in health development assistance, the first prerequisite lies with the recipient countries in setting appropriate health priorities. There is much scope for public investments which are more appropriate (in supporting health). A greater recognition is needed of the fact that people use public sector health services very little. The link between health sector spending and health should be studied and taken into the equation. A significant proportion of health problems are attributable to conflict and other issues outside the sector.

There were diverging views on global partnership programs. One respondent felt that a common architecture is needed for the various global programs and that the proliferation of single disease frameworks does not constitute a useful solution. Another respondent felt that the global partnerships are "going somewhere" and that they mark an important moment in health history. The critical mass of interest and influence that has been mobilized around these programs is generating enthusiasm and resources. There is some risk of verticality, and hopefully these programs will not repeat the mistakes of the past.

The private sector offers efficient ways of getting services and messages to people. This has been demonstrated by the success of social marketing programs. There should be effort to develop complementarities between the public and private sectors, and to assist governments to assure the quality, regulation and attention to equity factors in private health service provision. One respondent summed up in conclusion that DfID's health focus was too tilted toward the public sector. Each country must determine what degree of public health services provision it can afford, and not avoid addressing the critical issues of access to and quality of private services.

3.2.3 Swedish International Development Agency (Sida)

Sida has poverty alleviation as its primary goal, with focus on economic growth, political independence, economic, social and gender equality, democracy, and sustainable natural resources development. Priorities in the health sector focus on three areas:[5]

- Health systems development
- Sexual and reproductive health and rights and child health
- Public health programs

Four interviews were conducted with Sida, including Regional Department Heads for Africa, Asia and Sida 'East' (Eastern Europe, Russia, Central Asia) and the Head of Policy. The responses may reflect primarily bilateral health assistance and not take into account multilateral, credits and other forms of support.

Priorities and financing of health within the larger development portfolio

There was a perceived stability in recent years in the level of resources committed to health at Sida, however this trend has recently turned. The former was caused in part by an internal government decision to impose budget ceilings for disbursements, affecting most sectors. In 2000 the budget for health increased by 23%, and some regions will see significant increases in the coming years.

HIV/AIDS will receive increased funding, however those resources are not all strictly within the health sector. One respondent felt that the increase of AIDS funding may cause the health portfolio to appear larger, however, it must be borne in mind that AIDS-related health issues absorb so great a share of health budgets (in Africa) that proportionately less may be remaining for general health needs. One general perception was expressed that interest in funding mainstream health and education programs has decreased.

Sida 'East' addresses health in the context of the general problems stemming from the economic transition of the former Soviet Bloc countries. The expensive, hospital-based services, inefficient delivery systems, and irrational use of high technology produce very poor health outputs in relation to a very high investment. An advantage in working with the health sector is its link to social services, such as elderly care, child welfare, etc. Health development investment increased by 100% in 2000 and the regional program looks forward to continued growth in health support.

The Africa Department interviewee reports that investment in health in the region has been stable for a number of years. The overall Africa budget is doubling, from SEK 2.5 billion to

SEK 5 billion over three years. Health plays an important role in terms of Sida's poverty alleviation targets, and is also important from the standpoint of production. The spread of HIV/AIDS, TB and malaria have brought health into a sharper focus.

In the Asia Department health is of decreasing importance. The government's policy regarding relations with the region influence the development portfolio. Country strategy determines whether health is included as a component. Sida's strategy is focused primarily on environment and democracy issues in Asia.

Factors influencing investment in health

Sida's investment in health is determined by government policy on regional relations, country strategies and emerging and immediate needs. The spread of communicable diseases, especially HIV/AIDS and TB, has called greater attention to health. In the case of Eastern Europe, parliament gave guidelines setting the terms for development policy, one component of which was the Neighborhood Countries Program, emphasizing social sector support for former Soviet and Eastern bloc countries. Sweden contributes to sectors where there is Swedish technical know-how and capacity, and health systems development and management is one of those areas.

Concern was expressed that new specialized programs, such as trafficking, special democracy issues and others, may be pushing back the boundaries of basic health and education programs, and absorbing resources which could be attributed to these sectors.

Sida is increasingly looking at what other donors are doing, and learning from their experience. There is an intention to link research and programs in development assistance.

There has been a trend in recent years of expanding country programming in DAH in Sida East, and there is a current movement toward such an expansion in Africa. New programs are under development in Malawi, Rwanda and Burkina Faso.

Effectiveness of development assistance in health

If effectiveness refers to results, these vary at country level. One respondent observed that efforts which are successful at improving health service delivery and management at district level are still confounded by central level institutions which are inefficient and corrupt. In the view of one interview subject, perhaps a better question is whether the approaches are efficient enough.

SWAps are a step in the direction of better effectiveness. It can't yet be maintained that they are more effective in securing health outcomes. It was observed that SWAp programs are not yet sufficiently cohesive and transparent. A benefit of the current learning process is that SWAps will help us to better define and understand the problems.

A number of approaches for enhanced effectiveness were cited:

- SWAp
- pool funding at district level
- increased collaboration among donors on policy, procurement and aid administration
- continued focus on prevention

- promote a willingness among donors to contribute to a SWAP via flexible participation options
- at the agency level reduce 'sectorizing' and work in multi-disciplinary thematic groups
- channelling resources via other donors (silent partner approach) or multilaterals

Sida is experimenting with forms for channelling health funding via other agencies. In Malawi, where Sweden does not have an embassy, funds are channelled through Norad and UNFPA, likewise via Danida in Zimbabwe. It was pointed out that the principle of having fewer donors is an important efficiency factor for recipient governments.

A rapid and significant increase in health funding - a theoretical question

An increase in DAH would only be effective as a long term strategy. If it is gradual, it can be planned for at recipient and donor levels, but its usefulness will be in relation to the success of other reform activities which will determine whether there is an enabling environment. A drastic increase in health financing (e.g. over 12-18 months) would not be effective and could halt the reform process. There was a high degree of skepticism concerning greatly increasing resources in countries with weak management infrastructure and poor prospects for sustainability (Russia cited as an example).

A gradual increase in funds to the health sector, both in absolute and relative terms, is the only effective way to enlarge the investment in health. In recipient countries a systematic approach to developing a state health budget is often lacking. This impedes dialogue on the basic issues of health sector priorities. There is also an absence of systems to reliably measure and track changes in health. Rational planning and budgeting systems must provide a basis for discussing and following up priorities. In the absence of these, a massive influx of funds cannot be made good use of.

Administrative systems are only part of the constraints. There is an interdependence in the programmatic constraints and financial flow bottlenecks. Capacity is lacking in both respects, and neither should be viewed in isolation.

Sida's own capacity will continue to be limited in its ability to process larger flows of funds. There will be no increase in its administrative budget, thus no additional personnel resources in the foreseeable future. Therefore there is need to apply new models for cooperation, (e.g. disbursing resources via other donors or multilateral agencies). SWAp is also an option which can offer heightened efficiency.

Accountability

Sida officials perceived themselves as accountable to the Swedish government, the Director General of Sida, and the Swedish taxpayers, as well as to the ultimate beneficiaries of Swedish assistance in the recipient countries.

Global partnerships

Sida's Health Division recognizes the need to increase funding in health. Sida will support the Global Health Fund as a complimentary resource for health.

Concerning the global disease-specific initiatives, it was felt essential to link interventions and assistance to reform processes and to the restructuring of systems. There is a felt risk in general that programs with 'special issues focus' will draw resources and attention away from the fundamental problems of ineffective delivery systems. One respondent stressed the need that some portion of global initiative funds should be dedicated to institutional development.

Hope was expressed that constructive outcomes would result from the programs (e.g. Roll Back Malaria, Stop TB, etc.), however there were reservations that the programs will be short-sighted and narrow. The practical results of massive disease eradication programs were seen as inherently short-term.

Some risks were seen in the increasing the visibility of the global disease eradication programs. A horizontal integrated approach was felt to be preferable. Recipient countries may not develop the infrastructure and systems to carry out the program activities, rendering them unsustainable. It was suggested that if the funding is placed in a pool and not earmarked, the resources can be a positive force.

One virtue of single issue programs, acknowledged by all, is their ability to attract resources, particularly from the private and voluntary sectors.

A successful single-issue program, 'No TB Baltic,' was cited, involving a partnership between the Nordic countries, and launched in recognition of the urgent need to halt TB in the Baltic states. Financing was provided on two conditions which assured linkage with sector reforms:

1) in-built sustainability in the design of the program
2) mandatory restructuring of the TB service delivery system

Reduction in TB cases is being observed in the third year of the program.

With regard to partnerships, it is important to address the private sector. The fact that private health financing is a major part of the sector in many developing countries can't be overlooked, however this hasn't been a focus for Sida.

3.2.4 Ministry of Foreign Affairs, Netherlands, Department of Social and Institutional Development

Focus on health in the development portfolio

The Ministries of Foreign Affairs and Development Cooperation in Netherlands work in consort. There are regional as well as thematic departments responsible for development cooperation and general bilateral relations. Implementation is delegated to embassies. The overarching goal of Netherlands' development assistance is poverty reduction, therefore there is a strong emphasis on basic education and health.

Health is one of the top priorities in development cooperation. There has been an increase in the overall development budget in the last few years due to an economic boom. The development assistance budget accrues from a steady 0.8% of GNP, and therefore the amounts fluctuate depending on the nation's economy. It is difficult to predict how the budget will look in the future. There is no long term planning for development investment, as the budget is determined by overall performance of the economy. Funding to the health sector has increased both in absolute and relative terms, due to a shift in investment from productive

sectors to social services delivery. Currently health occupies 20-25% of the development assistance budget.

In 1999 the Netherlands reduced its core program countries to 17, four of which are phasing out. Further there was a reduction in the number of sectors in each country, which now number 2-4 per country.

One of the driving forces in the heightened interest in health has been enhanced international political interest. Bruntland, Jeffrey Sachs, and the World Bank all have made health more politically visible. There is more coverage in the media, more publications, heightened awareness of the AIDS epidemic, all contributing to this trend of increased visibility. At a purely pragmatic level, the institutional setting for developing SWAps in the health sector is favorable, given the involvement of usually only one ministry. This makes it expedient to invest in health SWAps.

At the national level, the current Minister of Development Cooperation has a strong interest and some background in health, spurring and reinforcing a renewed interest in health.

Effectiveness of DAH

Netherlands is currently carrying out an evaluation of its health sector support of the last 10 years. While conclusions should not be preempted, there is already some understanding of main factors for success. A key factor is the transition to SWAps, and the reduction in project interventions. As a way of working, SWAp is seen as very promising, however the link between the SWAp and better health outcomes has not been demonstrated.

It was observed that there are philosophical dimensions to the question of effectiveness in development assistance (which are not amenable to measurement), moreover it needs to be viewed on a country-by-country basis. Generally the declines seen in fertility, and infant and child mortality can be attributed to some degree to effectiveness in DAH. On the other hand, little is known regarding how health systems reform, for example, has impacted health outcomes.

Global health initiatives - mixed views

The Netherlands supports the Global Health Initiatives, and these are viewed positively. The traditional vertical programs such as immunization and family planning have proven to be very effective, although they are not readily integrated into the institutional infrastructure, and are not sustainable. The global trend is to focus on reducing specific communicable diseases. It was felt that this type of focus should not become a dominant strategy.

According to one respondent, the Netherlands' government is not convinced that the Global AIDS Fund can improve the HIV/AIDS situation through the injection of billions of dollars. Many prerequisites are lacking. Recipient institutions must be put in place and capacity developed before scaling up the programs. Massive inputs of funding can cause more duplication of efforts, inefficiency and waste.

The potential of the global partnerships are seen as the following:

- If they are well integrated in the health system, positive outcomes can be realised

- The programs attract political attention and resources
- Global programs stimulate public/private partnerships, and provide momentum for collaboration (e.g. IAVI).

The global partnerships have demonstrated that partners with different agendas can work toward a common objective.

One respondent from the Netherlands observed the growing trend toward privatization of health services, and considered it an inevitable development in some countries (Bangladesh cited as an example). Ministries therefore need to be assisted to change their focus and ways of working in order to adapt to this reality. Ministries of Health will increasingly become regulatory, policy making institutions, whose mandate is to assure quality standards, and essential public health services and safety nets for the poor. This transition is seen as a coming focus in DAH.

Increase in health resources

While there is a clear need for more resources in health, absorptive capacity is seen as a major constraint. At the recipient level, a drastic increase in funding for health would result in unspent funds or funds spent unwisely and ineffectively.

Regarding Netherlands' capacity to manage a larger flow of funds, the current capacity is perceived as stretched to the limit. In recent years, while the budget for development assistance has increased, resources for manpower have not kept pace. The SWAp approach is perceived to require fewer agency or technical personnel. However there is a need for more generalists who have capabilities in policy, programming and management to monitor these programs.

Regarding processing larger flows of health resources, the problems are not perceived as being at the administrative or management systems level. Netherlands has very flexible financial procedures. Human resources could be a limiting factor, however. Netherlands has the highest ratio of funds to personnel. Netherlands is looking into the option of establishing de-linked funds (i.e. parallel funding) for supplemental technical assistance in countries (Bangladesh cited as an example) where financing is exclusively via SWAp pool funding.

Accountability

Accountability was seen to exist at several levels:

1. At the central level, to the Director of the Department of Social and Institutional Development and the Department of Finance
2. Policy-wise, to the Minister of Development Cooperation and the Division of Social Policy
3. To the embassies implementing the programs
4. As public servants, accountability to the taxpayers

3.2.5 German Ministry of Economic Cooperation and Development (BMZ), GTZ and KfW

3.2.5.1 Ministry of Economic Cooperation and Development

Development Cooperation in Germany is planned and financed by the Federal Ministry for Economic Cooperation and Development (BMZ). Two agencies are responsible for implementation and management of technical cooperation:

1. GTZ - (German Technical Cooperation) responsible for advisory services in technical cooperation
2. KfW (Kreditanstalt für Wiederaufbau)- responsible for investment services

Interviews were held with representatives of BMZ, GTZ and KfW. Germany prioritizes poverty reduction and social sector development. A strong commitment to health at high political levels was reported. This is congruent with global priorities in health as reflected in the G8 Summit and emerging UN global programs. There is a high level of support for HIV/AIDS. Focal areas in health include:[6]

- health system reform
- support to the fight against HIV/AIDS
- access to family planning services
- improved access to essential drugs

There is a process underway to concentrate development cooperation by reduction in the number of countries supported, and in the number of sectors supported per country.

Germany differs from other European bilateral donors, both in structure and history. It was expressed that Germany is just now 'getting its financial household in order' subsequent to the massive investment in reunification and development in former East Germany. For this reason there has not been scope for increasing international development assistance. The stable level of investment in health and other sectors will continue for some time into the future.

From the perspective of BMZ, the most important contribution to be made is the strengthening of health systems. Effectiveness is best achieved by programs which enable health systems to develop. Holistic approaches are needed to strengthen health systems. The main successes observed have been in the areas of decentralization and health financing.

Concerning the single disease frameworks (e.g. Roll Back Malaria, Stop TB, etc) reservations were expressed that these programs will bias the balance of resources, and may even cause health systems to deviate from their overall programs. While some campaigns may be successful (e.g. polio eradication), these are generally not sustainable. In political terms, however, the increased funding and dialogue which these programs motivate can be taken advantage of to the benefit of the sector. There was no certainty expressed that a global health fund would enable BMZ to scale up the health sector financial flow substantially.

Taking the example of SWAp, it was observed that considerable time is required to develop the capacity to manage SWAps. Likewise it will take time to develop mechanisms for global health funds, and to assure the requisite absorptive capacity in recipient countries.

Global partnerships may provide indirect benefits. Support from the private sector is a positive element, and there is need to explore ways of working together. Concern was expressed regarding how the massive contributions from foundations will influence global health policy (e.g. US$ 750m from Gates). Care must be taken to monitor the agenda setting which accompanies these actions. A scenario is emerging in which the agenda is increasingly being set by foundations and NGOs. Another major actor to be carefully observed is the media.

3.2.5.2 GTZ

GTZ is the main implementing agency on technical cooperation for the Federal Ministry of Economic Co-operation and Development. Health comprises 8-10% of the total GTZ budget. This is an increase over earlier levels of 4-5% of the total.

The increased funding level was stimulated by the pre- and post-Cairo commitments to expand programming in reproductive health and HIV/AIDS. Strengthening of health systems has been another focal area of investment. A target budget level for technical cooperation in health is DM 100 million per annum.

The impetus for increased interest in health has also been driven by the heightened international discussion on health (e.g. G8 Summit in Okinawa). An anticipated stimulus to increased investment in health is GTZ's new poverty reduction strategy which points in the direction of an increase in health-related activities.

Generally it was felt that the international discussion on increasing financial flows in health is 'oversized' (i.e. too great in scale).

Effectiveness of DAH

Interviewees focused on their own agency in responding to the question of effectiveness of DAH. There was a general perception that effectiveness (results) of the agency's contribution was good, and that, given the planning and evaluation mechanisms used by GTZ, programs demonstrated satisfactory effectiveness.

A technical in-country presence, giving advisory services, both at central management as well as peripheral level was held as a prerequisite to effectiveness. In particular technical cooperation was considered essential for institutional reform programs.

SWAp programs are viewed with a certain skepticism, for reasons of insufficient capacity in recipient countries. Citing the case of Tanzania, there are senior experts at the central level, capable of designing and managing programs, but the requisite capacity to implement the SWAp at provincial and district level is not there. There is a need to structure the development downwards in the system. The combination of pool funding without substantial technical cooperation was not thought to be a very sound approach.

Great care and caution was advised regarding placing large sums of health resources into systems which do not have the necessary absorptive capacity. The SWAp pool-funding model is difficult for GTZ given the agency's mandate to provide technical cooperation. GTZ

provides know-how and coaching in a participatory manner, via long term technical cooperation, and there is not always scope for this approach in the SWAp environment.

Selecting countries for SWAp programming should be done with great care. Citing the example of Ghana, held as a SWAp success story, it must be considered that 15 years of capacity building preceded the SWAp, as well as a solid human resources infrastructure which remains from earlier decades. These factors dispose favorably to SWAp in Ghana.

Donor coordination was cited as an element in the effectiveness in DAH. GTZ works with Ministries of Health on harmonization of donor and host government procedures and administrative systems.

The value of an increased flow of funds to health

Increased resources in health are perceived as 'desperately needed,' however, the focus on money alone can be misleading, as it will not solve the problems. The interviewees expressed a strong conviction on the need to enhance implementation capabilities and systems development, and to address these through technical cooperation.

Global partnerships

GTZ is examining the global health initiatives, however a key question concerns the sustainability of these programs. Building systems to deliver and sustain the services is the most important factor for their success, otherwise failure is unavoidable.

The global initiatives (Roll Back Malaria, Stop TB, etc.)have provided a stimulus to the health sector, but there is a risk of overburdening partner countries with too many separate programs. The 'slim' management structures in recipient countries can easily be overwhelmed. The question must be posed whether these programs parallel the priorities of the partner governments or whether they are imposed.

There is risk of counteracting the positive gains of SWAps by putting in new vertical structures associated with the disease eradication and immunization programs. The creation of GAVI has caused some confusion in recipient countries. One of the rationales for GAVI was that EPI was not efficient enough. However it was considered a poor solution to add a new structure rather than enhancing the efficiency of the already existing structure.

Mechanisms for more effective DAH

The following means for improving the effectiveness of DAH were given:

- Greater donor coordination
- SWAp
- Codes of conduct - a stringently developed instrument whereby donors underwrite how to utilize funds ethically
- Strengthened capabilities for country planning, commensurate with capacity for implementation
- Decentralisation of administrative and political structures
- Long term technical cooperation

Among the various agencies which provide DAH, each has its comparative advantages to offer, and these must be safeguarded and made use of. The role of the financing agencies is at risk of being diminished. SWAps and budget support to Ministries may operate with very little technical support, and there is reason to question whether this is entirely sound.

Given as an example, any restructuring process, whether in our own home country institutions, or with our technical cooperation partners, requires advice and coaching from an outside source. The notion of not providing this resource is not consistent with best practice -- in corporations, government, and in development cooperation.

The role of the private sector, and its regulation, needs to be taken up very urgently. This was also stressed by the BMZ representative There has been an overwhelming tendency to see the health sector exclusively as a public service, rather than seeing health as a system which incorporates public and private sources. Public/private partnerships is an example of an area where Germany can provide much experience and a useful study model. The interview with KfW also emphasized the importance of the private sector.

Accountability

GTZ officials consider themselves primarily accountable to the Ministry of Economic Cooperation, as well to recipient country governments and beneficiaries. The BMZ representative, to the Head of the Department of Development Cooperation, and the Minister.

3.2.6 Denmark - DANIDA

Health has traditionally been one of Danida's prime focal areas, for its clear humanitarian character, and its importance for human resources development. Poverty alleviation is the prime objective of Danida. There is a growing realisation that improvement in health is not a monosectoral activity. Education, infrastructure and agriculture all play important roles. Much depends on how health is defined. It is not always clear, for instance, where HIV/AIDS and nutrition fit in from a sectoral perspective.

There is a perceived steady trend in investment in health sector cooperation. That is partly related to the way Danida works, which is considerably different than 10 years ago, focusing today on streamlined SWAp-oriented programming.

Danida's approach to supporting improved outcomes in health includes:

1. Support to Ministries of Health, and in particular health systems development
2. General social development
   - improvement of livelihood (including water and sanitation and rural development)
   - support to education

Danida, as with other European donors, is working in fewer countries and with fewer sectors per country, but providing concentrated assistance (e.g. large programs, but in fewer countries). Some countries are in the phase out period, or targeted for phase-out. To illustrate:

- Tanzania - four sectors at work, of which health receives DK 100m/year ($US 15m)
- Mozambique - receives DK 20m/year ($US 3m), but is phasing out over the next 5 years
- Zimbabwe - health sector presence is being maintained, despite unfavorable political conditions, due to the 30% prevalence of HIV among adults of reproductive age

Driving factors in health priorities

There is increasing interest in Denmark for supporting humanitarian services. HIV/AIDS receives a significant share of financing (although there is no evidence that funding has produced solutions), and has been a factor in attracting funds and attention to the health sector. Other sectoral inputs such as water and sanitation are not formally classified as health, but can have important health impacts. It is relatively easy to garner support for health. The general public understands and supports the need for health assistance. Through involving and informing the public, demand is created for DAH.

Effectiveness of DAH

One respondent commented that development assistance in health is by no means sustainable. If sustainable is what is meant by effective, then we must conclude that effectiveness of DAH is poor. Danida's inputs far exceed the financial, management and infrastructural capabilities of the recipient countries. Some health sectors would collapse if donor support to certain countries was withdrawn. Some ministries are funded in excess of 50% by external support.

Another respondent replied that, based on global indicators, we could conclude that health sector inputs have contributed to some of the improvements. Broadly speaking, more results are seen from Danida's health programs than other sectors.

Effective approaches from the management perspective include:

- SWAp as "the way forward." The volume of investment in health has been maintained by the SWAp approach. Effectiveness is achieved by building in all of the externalities which would have been part of a project approach, however countries suitable for SWAp must be selected with great care.
- Decentralisation - funding the sector through lower levels in the system
- Improved local level accountability
- Joint collaboration on selected issues (e.g. user fees and exemptions)

There is no "quick fix." The problems are not inherently financial and therefore funding is not necessarily the answer. Health problems are closely related to poverty, and therefore massive disease eradication campaigns are not a long-term solution. There is a need to focus on structure and capacities. Vaccination programs may be effective, however the official interviewed did not subscribe to disease or intervention-focussed programs as promulgated by WHO and Unicef. Danida's program countries do not generally have the capacity to deliver, therefore it is not productive to focus overly on disease eradication programs.

An increase in the flow of funds to the health sector

Danida's capacity to program and manage a greater flow of funds in health would depend on whether there is an existing SWAp into which funds can be channelled. If it is a new program which must be designed and negotiated, then time is required and current capacity would be

stretched. However this may be a moot point, as funding levels are based on the agency's priorities. The more decisive factor is the insufficient absorptive capacity of recipient countries. There is no lack of financing, rather resources are held up in the pipe.

Partnerships in health service delivery

Given Denmark's strong belief in the importance of civil society there is a heavy emphasis on the role of the public sector. It was stressed that provision of health care through NGO providers should not become a dominant source of service delivery, as NGOs do not contribute to improving the structures and institutions of government, and may even undermine the public sector. DANIDA has just formulated a strategy concerning support through NGOs. Their role in advocacy is considered very valuable.

One respondent characterized disease-specific programs as publicity-oriented and emphasized that efforts must be made to assure that these do not compete with or hamper the build-up of sustainable systems.

Accountability

Accountability was perceived on two levels: to the Danish politicians and taxpayers, and secondly, to the countries DANIDA supports.

4. DISCUSSION

The limitations of the method for performing the study must be a primary consideration in drawing conclusions about the findings. One effort at verification revealed that non-health specialist respondents were not thoroughly informed on agency priorities and budgets for health. An underlying assumption of the study was that interview subjects would be decision makers concerning health programming and budgeting. This however, is not always the case, and in at least one agency, the head of the health bureau is the key the decision maker.

A more complete and accurate study could incorporate a desk review of the most recent policy statements, budget projections, and current programming of the agencies. Terms and expressions were interpreted variously by respondents e.g. terms such as G*lobal health initiatives, Effectiveness in health, Agency financing for health.* Similarly, in discussion of budget allocations, some respondents referred to bilateral funding only, others to the broader budget portfolio of the agency.
To insure the strongest possible support for health as well as the important articulation between the sectors in working towards the common goals of poverty reduction, intersectoral dialogue, including policy level is critical. The need for a broader vision, beyond the boundaries of health, was highlighted. Multisectoral representation in dialogue on the Global Health Fund may provide valuable perspectives and insure an even broader support base.

The need to pay serious attention to issues of absorptive capacity, and set realistic time frames for scaling up funding for health was a universal response among agencies. The need to incorporate experience and lessons learned to date, taking into account known constraints, is imperative in the development of new global programs.

Annex 1

BILATERAL AGENCY INTERVIEWEES

Canada

Brian Emmett	Vice President, Policy, CIDA

Denmark

Nanna Hvidt	Head, Bilateral Relations, East, Central and West Africa, Ministry of Foreign Affairs
Ola Moseby	Undersecretary for Bilateral Relations, Ministry of Foreign Affairs

Germany

Dr. Schmidt Ehry	Senior Planning Offficer, GTZ
Martina Kampmann	Director of Policy, GTZ
Dr. Rolf Kort	Head of Education and Management, GTZ
D. von Rabenau	Head, Eastern Europe Department, KfW
Thomas Ketrich Woik	Department of Development Cooperation, Ministry of Health

Netherlands

Joost Andriessen	Responsible for South Asia, Ministry of Foreign Affairs and Development Cooperation
Eric Verbiest	Financial Controller, Ministry of Foreign Affairs, Department of Institutional and Social Development
Marijke Wijnrok	Ministry of Foreign Affairs and Cooperation, Netherlands, Department of Social and Institutional Development, Social Policy Division

Sweden

Jan Bjerningar	Head of Asia Department, Sida
Lars Ekengren	Head of Africa Department, Sida
Staffan Herrström	Head of Sida East Department (Eastern Europe, Baltic States, Russia, Central Asia), Sida
Jan Olsson	Head of Division of Policy and Socioeconomic Analysis, Sida

United Kingdom

Richard Manning	Head of Policy, DfID
Adrian Wood	Chief Economist, DfID

Annex 2

Commission on Macroeconomics and Health

Working Group 6: Development Assistance and Health

Topic 2: Effectiveness of Development Assistance in Health (DAH)

Paper 2.X: Qualitative Assessment of Bilateral Agency Views and Behavior

Terms of Reference

Background

- These Terms of Reference are for a paper to be prepared on behalf of Working Group 6 of the Commission on Macroeconomics and Health. The Commission's Sixth Working Group (WG6), addresses as its critical issue the question "**How much, and what forms of development support are needed to improve health outcomes for the poor?"** The work will be conducted within the framework of the overall mandate of the Commission on Macroeconomics and Health (CMH) bearing in mind the terms of reference of the CMH's Working Groups 1 to 5.

- Complementing activities in Working Group 1 (Health, Economic Growth and Poverty Reduction), the WG will clarify the issues that non-health specialists, particularly macroeconomists and staff of Ministries of Finance and Planning, consider in managing development assistance to achieve health sector goals. It would focus on the effectiveness of various forms of international developmental assistance in health (DAH) and their interactions with country policies, players and priorities.

- Its work will aim to clarify the factors, at country as well as donor levels, that inhibit or facilitate the translation of policy objectives and resources into actions designed to improve health sector performance and/or health outcomes on the ground – assessing the degree to which DAH is doing the right thing and doing things right. It will examine activities of various types, including those directed at specific country issues (whether diseases-specific or systemic), and, as feasible, at alternative forms of cooperation, such as activities which aim at the provision of international public goods, linking with the recommendations of Working Group 2 (International Public Goods in Health). The objective of the work will be to help both donor agencies and countries to achieve their stated main objective -- poverty reduction – through improving health systems and health outcomes by adjusting the level, format and management of development assistance for health (DAH).

Objective of this Paper

- The purpose of this paper is to develop a better qualitative understanding of how non-health specialists in a selection of the major bilateral agencies view the health sector, including specifically their sense of why health is important, what approaches to improving it work, their views on the value (or not) of significantly increasing the flow of resources into the sector, and their current thinking on the mechanisms that should be employed to manage the flow of resources in the sector. The paper should aim at producing an overview of viewpoints and opinions in the donor organizations, plus enough information on their

procedures and constraints to permit some well-grounded judgment on their capacity to handle much larger financial flows in the health sector.

Approach and Agency Coverage

- The work will include the identification of respondents and interviews with an appropriate mix of managers and staff of leading bilateral development agencies. Some of the agencies of relevance include those of Sweden, Norway, Denmark, Finland, UK, the Netherlands, Ireland, Canada and Japan. The author should make a selection of agencies based on the availability of making contacts with the relevant people at the agencies.

Respondents

- The focus on this particular effort is to get the views of non-health specialists about the quantity, quality and effectiveness of DAH. Interviews should be conducted with 4-5 key decision makers, external to the health sector per se, for interviews on their views and perceptions on development assistance and health (DAH). We are particularly concerned with the views of country level directors, chief macroeconomists, senior analysts (e.g. on social development, poverty, gender etc), and those who have primary responsibility for setting out the broad directions of policy and lending programs.

Scope of Interviews/Discussions.

- Interviews need to cover questions such as: To whom do various respondents feel accountable to (hence the question on evaluation) – as between their clients (and are these the borrower, its agents, or the consumers, or what mix of the three) and their bosses/owners? What do these people think their bosses (e.g. owners, other stakeholders) are expecting? How do these views influence their thinking on whether or not DAH is a good thing? Effective? It is increasingly evident that one of the obstacles in the implementation of SWAps, which are being designed to reduce fragmentation/ enhance coordination etc. is the unwillingness of agencies to jettison the use of their own 'administrative rules of the game' –(e.g. on financial management/procurement/monitoring and evaluation procedures) to those in place at the country level. Hence, learning more about whether and why and how respondents believe that the 'rules of the game' of managing foreign assistance should be adjusted is a key question. What rules can and should be altered? Why? If the direction of change is 'obvious' what does respondent think are the constraints to change? In this sense, discussions of the details of administration would be important.

- It would be useful to solicit views on the degree to (or conditions under) which rapid and significant increases in levels of DAH are likely to be helpful in overcoming problems in the health sector. Do respondents see a tension between the time horizons required for institutional development/building and the desire to do something immediately to address the major emerging diseases? Many health sector specialists debate the relative merits of short term/emergency/disease specific approach vs. a focus on institution building – How do non-sectoral specialists see the tradeoff.

- It would also be useful to learn more about what these respondents think it would take to make good use of a rapid increase in DAH. What would they or their agents (e.g. cooperating agencies in the case of USAID) need to do in order to be able to quickly (i.e. within 12-18

months) double or triple the transfer of resources to the health sector. What mechanisms are in place to facilitate this? What would these agencies need to do to manage an increase in the flow of resources of the sector. What do they think are the major constraints to the disbursement of funds – how would rapid infusions of new resources work relative to the disbursement problem?

- Last, given the recent proliferation of 'partnerships' and disease-specific global initiatives (GAVI, IAVI, Roll Back Malaria, Stop TB etc). How much do respondents know about these global partnerships? Are these seen as wholesaling mechanisms? What do they think will emerge from these partnerships? What do the respondents believe are the key ingredients for an effective partnership? What should be the balance of partnerships with other providers of DAH and national/local agencies /consumer groups as partners.

Reporting and Schedule.

- The study will be conducted during March-June of 2001. A first draft (20-25 pages) should reach WG6 by 3 May. In addition, the author will be invited to participate in a seminar/brainstorming session with authors at the very end of May to assist in the preparation of synthesis of this and other papers being prepared for WG6. We anticipate that this work could be completed in about 20 working days. All reports and administrative correspondence should be submitted to Mr. Bjorn Ekman (bjorn.ekman@luche.lu.se and Ms. Susan Stout (sstout@worldbank.org) who share responsibility for the management of WG6 activities and will be responsible for communication with the Co-chairs and members of the WG.

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