The Aid Effectiveness Agenda: Bringing Discipline to Diversity in Global Health?

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Health aid is increasingly characterised by diversity, complexity and innovation - new institutions, new ways of raising money and new approaches to delivering assistance. Although bringing "order" to this "chaos" has been a recurrent theme in international health, expectations are often unrealistic. This article charts the practical and conceptual evolution of approaches to aid effectiveness in the health sector, from their intra-sectoral origins to current efforts which seek to bridge global and country policy agendas and engage new actors. While these efforts represent an important step forward, the paper concludes that in the new globalized environment, accountability cannot be located in a single institution or mechanism. Global health will need to learn to accommodate less definitive, less linear and more diverse forms of governance.

INTRODUCTION

Over the last decade, international health has entered one of the most dynamic periods in its history. Politicians, movie stars and activists have all pledged their support to combating ill health in poor countries. Available resources have risen, a plethora of new health organizations have been created, and civil society and the private sector have been mobilized. Diversity and innovation have also characterised the work of health organisations, with new approaches being pioneered and tested. The enthusiasm generated by these rapid changes has, however, been shadowed by a growing uneasiness, a sense that things are getting "out of control." Concerns are expressed at two levels: at global level, health governance is thought to be under threat ("there is no-one in charge");[1] at country level, it is recognized that the plethora of new organizations and approaches is increasingly difficult for countries to manage.

Principles of "aid effectiveness" such as harmonization, alignment and instruments to operationalize them, such as the sector-wide approach (SWAp), have long been regarded one means of bringing "order" to health aid at country level. More recently, these concepts have been extended to the global level in an attempt to shift the increasingly diverse aid environment from its current unstructured plurality towards a more purposeful plurality. This paper seeks to show that, while concerns about increasing complexity and lack of coordination in heath aid are well founded, expectations about what the aid effectiveness agenda can achieve are often unrealistic. Building on earlier work which suggests that global health governance can no longer be adequately understood or described using structural metaphors such as architecture,[2] we argue that structural responses to the fragmentation in global health – as promoted by the aid effectiveness agenda – only take us so far. As discussed below, there are important, practical lessons here for the range of new initiatives which seek to

address ineffective provision of health aid, including the recently-launched International Health Partnership.

AID EFFECTIVENESS: ORIGINS AND CURRENT CHARACTERISTICS IN HEALTH

From a health perspective, at least four distinct evolutions in the aid effectiveness agenda can be identified: intra-sectoral co-ordination (within the donor group); sector-wide approaches; supra-sectoral co-ordination (linking to aid effectiveness efforts at higher levels of government such as finance and planning); and, most recently, an attempt to exert global pressure on country-level action. These different phases are discussed below.

A concern with the effectiveness of aid first emerged in the 1980s, when donors began to realize that the presence of multiple development partners, with multiple agendas, was distorting local process and imposing high transaction costs on weak administrations. In health, calls for better co-ordination between development partners became prominent in the mid-1990s. They emphasized the growing number of channels *via* which health aid was delivered, and the "unruly melange of external ideas and initiatives" which accompanied this proliferation[3] and the burden placed on recipient governments by lack of co-ordination and overly complex donor procedures.[4] The initial response – *intra-sectoral co-ordination* - was modest, focusing on the need for better co-ordination among aid givers. This took various forms and often involved a variety of mechanisms: international co-ordination offices in ministries of health; geographical zoning; co-ordination around a particular programme.[5]

In the 1990s, calls for better co-ordination between health partners evolved into a discussion of the need for a coherent approach to health policy which encompassed the whole sector. By the end of the decade, aid effectiveness in health was synonymous with the *Sector-Wide Approach* (SWAp), which was in turn associated with health sector reform.[6] Key aspects of the SWAp were: common donor approaches to planning, review and monitoring, resulting in a reduction of management costs ("transaction costs") for government; agreement around core packages of interventions; a holistic approach to sector development; and moving towards pooled and basket funding.

The SWAp has retained a conceptual appeal over the last decade. However, in practice its application has been problematic, and limited to a small set of countries. The authors searched three major health policy journals (*Health Policy and Planning*, *Health Policy Quarterly*, and *Social Science and Medicine*) between 1990 and 2007, and found 14 articles that looked at experience of donor co-ordination or SWAps at country level. Of these, six articles focussed on Bangladesh or Uganda – illustrating that the pool of experience is limited. Further, many articles highlight consistently negative themes about how difficult SWAps are to implement successfully.

At the *supra-sector* level the Development Assistance Committee (DAC) of the OECD is the centre of work on aid effectiveness. The DAC is the forum where bi-lateral and multi-lateral partners meet to discuss their development assistance policies. In 1992 it developed principles and guidelines for improving the co-ordination of foreign resources.[7] Since then, it has focused its energies on

developing and then monitoring the Rome and Paris Declarations,[8] which together provide the core content of the aid effectiveness agenda today:

- *Harmonization* (co-ordination and use of common procedures)
- *Alignment* (following country policies and where possible making use of country systems)
- *Managing for results* (donors relinquish control of the day to day management of aid funds, and instead focus on results in terms of better development outcomes).

The Paris and Rome Declarations represent a conceptual shift in aid effectiveness thinking in that they are global level agreements to be implemented at country level. To date, the focus has been on supra-sectoral issues such as harmonising aid management practices and increasing the use of country administrative systems. While such changes impact health, health is not at the centre of these discussions.

In 2007, the health aid community proposed a further specific development on the Paris Declaration: the International Health Partnership (IHP). Like the Paris Declaration, IHP is a global agreement to be implemented at country level. Launched in 2007 by the UK government with support from eight developing countries, eight international health organizations and five bilateral donors, as well as the World Bank and the African Development Bank, IHP differs from previous aid effectiveness efforts in health in significant ways. First, it has engaged the major new health players: the Global Alliance for Vaccines and Immunization (GAVI), the Global Fund to Fight AIDS, TB and Malaria, and the Gates Foundation. Second, it shifts the focus of accountability for aid effectiveness onto donors by seeking to set targets in relation to issues such as volatility of funding, coherence between partners, and alignment behind country plans. Finally, because IHP is a global agreement, it can bring global leverage to bear on addressing local problems. This is particularly important when increasing amounts of health aid are being provided by organisations such as global health partnerships that do not maintain a country presence.

AN INCREASINGLY COMPLEX GLOBAL ENVIRONMENT

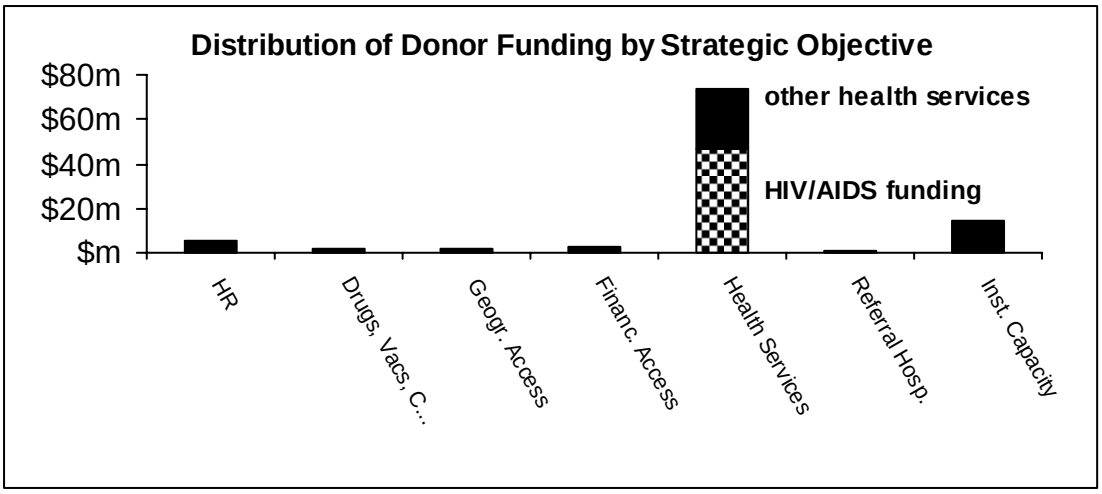
The evolution in approaches to aid effectiveness described above has been driven by dramatic changes in the health aid environment. Aid for health has risen rapidly, new types of health donors have emerged and new channels for delivering assistance have been established. These changes have had a profound impact at country level.

Over the last 20 years Official Development Assistance (ODA) for health has risen six-fold, from US$1.7 billion in 1985 to over US$9.7 billion in 2005. Health is also capturing a greater share of total ODA: rising from 3.5 percent of all ODA in 1985 to over 10 percent in 2005.[9] The rise in health aid has been associated with a proliferation of new institutions: there are now well over a 100 major international organizations involved in health, far more than in any other sector, and literally hundreds of channels for delivering health aid.[10]

Many of the new health organizations are global health partnerships which focus on single diseases or issues. Indeed, increased funding for HIV and AIDS accounts for a large share of Health ODA increases in recent years. From 2001 to 2005 HIV-related commitments amounted to 27.2% of Health ODA to 67 of the poorest countries; compared to just 9.6% in the previous five-year period.[11]

The impact at country level of this increasingly complex aid environment in health has been well studied.[12] This research is showing that the support provided by single-issue donors may not be in line with government priorities; that health systems approaches may be insufficiently funded; that health aid can be unpredictable, short-term and volatile, making it difficult for recipient governments to increase spending on recurrent costs (such as salaries or long-term drug treatment) based on donor commitment; and that the large number of health donors can impose high transaction costs on government. Evidence from Rwanda illustrates these challenges: the government has identified seven strategic objectives for health, but donor funding is heavily earmarked to just one of these, making it impossible for government to make balanced investments across the sector[13] (see figure 1).

Figure 1: Distribution of Donor Funding for Health by Strategic Objective in Rwanda



Source: Government of Rwanda

AN EVOLVING ANALYSIS: FROM INTERNATIONAL TO GLOBAL HEALTH

This paper commenced by tracing the evolution of the aid effectiveness agenda as it has affected the health sector and briefly describing the changing aid environment to which aid effectiveness efforts are responding. These changes in both the aid environment and donor responses have been accompanied by a parallel development of the analytical and conceptual approaches that frame our understanding of these progressions. Understanding the evolution in these frameworks enables us to locate the origins of the latest iteration of aid effectiveness efforts in health - the International Health Partnership - and assess the challenges it is likely to face.

In the mid 1990s, *policy analysis* of the health aid environment at country level raised concerns about the potential negative impacts of donor behaviour on health systems development. Around the same time, a *political dimension* to the analysis of health aid was introduced, and the evolution from "international" to "global" health described. This was followed by a deeper examination on the impact of *globalization* on health development. Most recently, the need for a new understanding of global health governance to make sense of these changes has been identified.

"Political" and Policy Analysis

In 1996, Buse and Walt argued that development assistance in health could, if provided in the wrong way, "weaken rather than improve fragile health systems,"[14] a theme echoed by many other studies.[15] One of the most common criticisms was that donors failed to understand the politics of reform, by focusing on the technical aspects of reform without looking at the political context in which reforms were implemented.[16] For example, promoting decentralization without understanding the consequences for central authorities[17] or failing to understand that a SWAp will be resisted by departments that benefit from direct donor support.[18] Pushing for reform in such an environment can, it is argued, undermine local ownership of policy making processes, making reforms unsustainable.[19]

International to Global Health

Reich extended political analysis to the international level, noting that the priorities of health donors were "more influenced by politics than science,"[20] and as result that health aid was often distorted towards fashionable, high-profile issues. This represents an early example of interest in "international health" and a recognition that global decisions have local consequences. According to Kickbusch, the idea of "international health", that international institutions and richer countries had an obligation to support poorer countries to achieve health goals, was "invented" by WHO in the 1970s.[21] Very quickly other institutions joined WHO in providing such support – notably the World Bank in the late 1980s - and an "international health system" was born.

The evolution towards global health began in the post-Cold War period, when international institutions and bilateral donors were joined by influential actors from the non-state sector, including global partnerships, private foundations and civil society groups. Private (non-DAC) donors often exert significant financial leverage, with institutions such as Gates Foundation, Merck and Bloomberg contributing a growing proportion of health aid.[22] This presents a challenge to the traditional hegemony of state actors, and to the role of the United Nations agencies - the collective voice of the nation-state.

Globalization

Aid for health has been further complicated by forces associated with globalization – faster communication, the emergence of global-country networks, and increasingly porous borders between health and other aspects of development.

Ease of communication and travel in the globalized world has facilitated a flow of ideas between organizations and helped develop cross-institutional networks.[23] This "new political ecosystem"[24] has led to a qualitative change in the way policy is made, with the emergence of global movements and "moral networks" that seek to mobilise support for single issues such as HIV and reproductive health. The increasing number of issue-specific networks in health, and the growing ease with which Northern lobby groups can link with and support Southern counterparts, are putting pressure on aid providers to favour certain high-profile issues. Figure 1 provides concrete example of this trend.

Globalization analysts also point to the opening up of a new political space for health in "high politics", as issues such as SARS and access to medicines attract the attention of trade and foreign policy experts. Equally, there is an understanding that the determinants of health are now not only multi-sectoral but also supra-national. For example, international trade agreements may facilitate trade in tobacco; global financial crisis may affect funding for health; international travel facilitates the spread of communicable diseases.

A New Understanding of Global Health Governance: "Open-Source Anarchy"

Fidler argues that to make sense of these changes, we need a new understanding of global health governance.[25] He shows how changes associated with globalisation have led to an "unstructured plurality" in global health. Rejecting the "architecture" analogy, he offers an alternative metaphor in which he describes the range of influences on global health as "open-source anarchy". While "old-school anarchy" is essentially the anarchy of nation states (and thus finding mechanisms of control or discipline is also the job of states), open-source anarchy includes a range of non-state actors, from civil society organizations to the private sector. Managing this "anarchy", he argues, requires a strategy that takes us beyond state-centric approaches.

AID EFFECTIVENESS AND BEYOND: COLLECTIVE ACTIVE RESPONSES IN THE NEW AID ENVIRONMENT

As our understanding of the complexity of global health and its consequences for countries has deepened, so efforts to manage this complexity have evolved and been re-invigorated. Mirroring changes in global health, the "aid effectiveness" response has diversified, multiplied, assumed global and as well as international dimensions and been characterised by a synergistic and porous relationship with other development agendas. The International Health Partnership represents the latest and most significant example of the search for collective action responses appropriate to the new, globalized environment: engaging state as well as non-state actors, operating at global as well as country level, and seeking to influence broader agendas such as finance and planning, in favor of health. IHP thus

represents a conceptual shift from "resisting" anarchy, to accepting and trying to manage it. These defining elements of IHP are echoed by changes in the policy, structural and political aspects of the broader aid effectiveness agenda.

At a *structural* level, the multiplication of aid channels and informal and formal donor groupings has led to a proliferation in aid effectiveness processes. Core processes linked to the Rome and Paris Declarations are anchored in the OECD/DAC. These include the Paris Declaration Monitoring Survey, which monitors progress in 34 countries towards the aid effectiveness targets set out in the Paris Declaration[26] and aid effectiveness "summits", known as High Level Forums. Beyond the DAC, principles of aid effectiveness are inspiring fundamental reforms in aid management. An important example is UN reform, which aims to create a more coherent approach to planning, budgeting and monitoring across the spectrum of UN agencies present at country level. Another is an agreement with the European Union on *division of labour*, which aims to limit to three the number of EU donors active in a sector in any particular country. In HIV, the elaboration of the "Three Ones" - one national HIV plan, one co-ordinating body and one monitoring mechanism - represents an attempt to apply the Paris Declaration principles to one of the most crowded arenas of development assistance. Finally, there has also been a move to examine the applicability of aid effectiveness approaches to fragile states, since many aid effectiveness principles inherently favor well-performing countries able to promote the use of established country systems, and ensure alignment with existing national policies.

At a *policy* level, long-standing debates in health, between vertical and horizontal (or selective and comprehensive) approaches, find new expression in the aid effectiveness arena. Health systems advocates equate health systems support with "effective aid."[27] At the same time, disease-specific organisations demonstrate their commitments to aid effectiveness principles: for example, the Global Fund and GAVI both monitor their own progress towards indicators set out in the Paris Declaration. Equally, some civil society groups are re-defining their "watchdog" role in terms of monitoring progress towards aid effectiveness targets.

The evolution of the aid effectiveness agenda also has a *political* dimension. Development issues from debt relief to HIV now feature on the domestic political agenda of many rich countries. This has been matched by a push for bigger aid budgets, which culminated in the 2005 G8 Summit in Gleneagles, Scotland, when G8 leaders promised to write off debts and pledged significant increases in aid. Of the EU donors, Belgium, Finland, France, Ireland, Luxembourg, Netherlands, Spain, Sweden and Portugal have either already met, or announced timetables to reach, the target of providing 0.7 percent of gross national income (GNI) as aid, while Australia, Canada, Japan and the US have all pledged significant increases. These commitments were re-affirmed at the 2007 G-8 Summit in Germany.[28]

If and when these resources are delivered, we are likely to see an increasing focus on the way money is channelled - the *aid modality*. Crudely put, development agencies will need to shift large amounts of money, quickly, if they are to meet their aid commitments. One of the simplest ways to do this is to

channel aid through pooled mechanisms, or *via* the budget ("budget support"), as encouraged by the Rome and Paris Declarations. Thus a focus on *how* aid is channelled may crowd out other elements of the aid effectiveness agenda.

In summary, changes in global health are reflected in evolutions in the aid effectiveness agenda. The set of actors is diversifying. Similarly, while there is core aid effectiveness content (the Rome and Paris Declarations) and a central process (based at the DAC), the content of aid effectiveness is expanding, and catalysing other processes. Some of these processes are based around sectors (as in HIV), others around institutions (as in UN reform). Despite these multiple loci of influence, the current political context is driving a strong focus on the *aid modality*, perhaps to the exclusion of other issues. This in turn reinforces the criticism - present since the early literature of aid co-ordination - that "aid effectiveness" is a donor-driven process.

EMERGING FUTURES FOR AID EFFECTIVENESS

Fidler argues that in the context of "open-source anarchy" in global health, governance has to be re-imagined. Rather than formal architectures or hierarchies, the process of regulation and control occurs through the setting up of global health norms and policies, a set of "open source codes" which (as in software development) anybody can access, use, modify and improve. These deploy fragments from previous structures, extending them and recombining them to the emerging context. The aid effectiveness agenda can be understood as one of these "source codes". There is nothing intrinsically new about the current aid effectiveness agenda – but its repackaging gives it renewed relevance and application. With its roots in older debates on aid co-ordination - but now being played out by new actors in a new context - aid effectiveness attempts to influence global health governance by orchestrating a shift from *unstructured* to *purposeful* plurality.

IHP is the latest attempt to affect this change. By bridging global and local policy agendas, and by shifting the focus of accountability onto donors, it represents a significant step forward from previous approaches such as SWAps. However the analysis presented here suggests that attempts to regulate global health governance can never rest with a single process, mechanism, or institution. Control has always been diffuse, and is even more so in the new aid environment. IHP's limited membership is a case in point: while the initiative has so far attracted support from important non-state actors such as GAVI and the Global Fund, other major health donors – notably PEPFAR and Japan -- have not signed up. Conversely, it may well prove difficult to maintain the diverse coalition of actors *already* involved in IHP and negotiate meaningful progress at a speed that suits all involved, particularly when so many other aid effectiveness approaches and structures are "on offer".

CONCLUSIONS

Global health is today characterised by the growing influence of non-state actors and a corresponding decline in the traditional power base of nation states and the

UN. New forms of engagement and interaction are also emerging - with debates, dialogues and ideas happening across institutions and countries. Recognition that this multiplicity of actors and approaches is becoming increasingly difficult for developing countries to manage has prompted a renewed search for collective action responses.

The tension between the search for a strong center and the anarchic reality of multiple actors, processes and channels of influence is the paradox of global governance - including global health governance. This tension is particularly apparent in the health sector, because the aid architecture is so complex and fragmented, and because the response to that fragmentation is so active. Donors have always sought to assert control over this anarchy: informal appeals for co-ordination, structured processes such as SWAps, internationally agreed targets such as the Millennium Development Goals - all are examples of attempts to contain and direct the international development assistance agenda. IHP, applying global leverage on donors to secure local change, is the latest example.

By deconstructing the aid effectiveness agenda in terms of source codes, we do not seek to negate its importance. While aid effectiveness principles may not be implemented fully and completely in practice, they have a persuasiveness and resonance - as demonstrated in the enduring legacy of SWAps.[29] More concretely, these principles have led some donors to fundamentally reform their approaches to development assistance. In this sense, aid effectiveness as a "source code" is one strategy in the ongoing search for structure in the plurality that is global governance. It has made some progress - and is likely to continue to do so. But its span of influence will always be curtailed by the underlying plurality of actors and agendas, particularly in health, and their dynamic evolution. In today's environment of "open source anarchy" - involving a broader set of actors many of whom resist any form of state-centric authority - the task is even harder.

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The named authors alone are responsible for the view expressed in this publication.

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