Making the most of aid

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An outline is given of a round table process being used in many low-income countries to coordinate and strengthen the effectiveness of health aid.

The health sector round table process (Fig.1) is an instrument that many low-income countries are using to coordinate and strengthen the effectiveness of aid. The situation usually encountered before adoption of the process, when most countries have already formulated broad policies and plans, is indicated in Fig. 2. As a rule, donors are conducting or have contracted out studies on public expenditure, health ministry functions and structures, technical programmes and other matters. These studies are often well conceived and the results are generally useful. However, ministries of health lack ownership of and involvement in them, and consequently the results are not captured by the state planning process. Little time may be available for consensus-building, a prescriptive approach is adopted by the donors towards the governments, and agreements reached may be less than optimal.

The round table process is designed to capture the studies conducted by donors so that the government concerned takes a leading role in health reform and development. Furthermore, at an early stage the process should examine the capacity of the ministry of health to participate in and conduct studies and acquire ownership of the results. The round table process is thus usually driven by the country’s agenda and capacity to take the required steps.

As a rule the process begins after a macroeconomic round table has been organized by UNDP or a consultative group meeting has been coordinated by the World Bank, at which:

- consideration is given to the approach of the government in question to agreed macroeconomic benchmarks and the principles of good governance;
- broad agreement on overall development policies is reached between the government and its main development partners;
- donor agencies give an indication of financial and technical assistance;
- the government indicates specific sectors for in-country follow-up.

A working group or technical committee is usually established to lead the sectoral round table process, in which policies, strategies and plans are considered in increased detail. Attention is directed at health policy, strategic directions, priority programme areas, costs, finance and related matters, and the government’s position on these issues is explained. The detail on programme priorities may range from that of a fully developed five-year

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Fig. 1
The health sector round table process

Initiation of process

CONTENT
Development of policies, strategic directions, programme priorities

PROCESS
- Leadership by technical secretariat
- Consensus-building with major national and international stakeholders
- Negotiations

Completion of documents including:
- Sector analysis
- Macroeconomic environment
- Policies and strategies
- Programme priorities and directions

Political agreement at national level

Sector round table meeting

Bilateral negotiations

Coordination of implementation

Review, evaluation, new cycle
national health development plan to that of a one-year sector investment plan. In parallel, efforts are made to build consensus on government policies, strategies and priorities with key national stakeholders and external development partners. Negotiations are conducted with ministries as well as with donors, development banks and nongovernmental organizations in order to ensure their involvement and financial support for priority programmes. The participants in this process include development specialists from the health and other sectors and decision-makers from both government and donor agencies.

Political agreement is eventually reached and a formal sector round table meeting is then held in public with the purpose of securing agreement between the government and major external investors on vital issues related to policy, programme priorities, costs, finance and the coordinated implementation of the sector programme. A communiqué usually outlines what has
been discussed and indicates the commitments of both government and donors.

Following this meeting, work continues on producing a national health development plan or a sector investment plan. Programme action plans and work programmes at national and district level are developed within the framework of the agreements reached. Consensus-building and negotiations also continue. The process agreements now enter more formally into the bilateral negotiations.

Work also continues on ensuring the coordination of implementation between donors and government. Agreements are sought on responsibilities for fulfilling detailed action plans, joint evaluation, and financial and management arrangements, and on the timing of a review of results, reprogramming and the presentation to donors of annual budgetary requirements.

The observations made below are based on experience gained in countries of Africa and Asia which have adopted the round table process during the past five years.

Ownership of the round table process

Because of its flexibility, especially as regards the time frame, most countries felt that the sectoral round table process was theirs, notwithstanding the involvement of donors and technical agencies. Governments also derived confidence from their knowledge of past performance in other sectors and countries. Donors made efforts to ensure that their separate initiatives had an input into the government-led round table process.

Early agreement was often reached as to who was responsible for analysis and studies on the design and operation of the investment programme. This facilitated the internalization of the results into government planning. A formal round table meeting required the government to approve sector policies and budgets and helped to give it both ownership and leadership of the process.

Capacity-building

The round table process often required ministries of health to assume new roles and functions. There was a need to strengthen areas related to strategic planning on a basis of comprehensive analyses, partnership and negotiation. This partnership and institutional strengthening. Linkages were established with ministries of finance and planning to ensure a consistent internal position on issues related to actions that donors might request. For some ministries of health the round table process provided the first opportunity to discuss matters with all the donors together.

In some countries, planning and budgeting for the round table process included a capacity-building component from the outset. In others it became evident during the process that such a component was necessary so that the government could lead and direct. The most successful approach to capacity-building was to strengthen the essential functions of ministries of health across the board. Capacity-building sometimes extended to other ministries.
Consensus-building

There was a need to build consensus among key national actors both within and outside government. Major donors had to be included since the adoption of certain policy directions was a condition for aid. Some countries worked hard to reach internal consensus on priority programme areas, while others concentrated more on reaching understandings with the donor community, especially where there were perceptions that the round table process was driven by one major partner and that government ownership was lacking. Some countries involved district health teams, local government and the community through consensus-building workshops. The results achieved by the round table process reflected the effort put into consensus-building.

Quality of documents

The documentation for round table meetings was in two parts. The first, which was usually well prepared, gave details of the current situation. The second, concerned with objectives and indicators, varied greatly in quality between countries. In some instances, alternative scenarios were given in terms of core and non-core programme activities and corresponding budgetary requirements, and options for financing by donors were suggested. There were weaknesses in decision-making about priorities.

Effectiveness of aid

For most countries it is too early to assess the impact of the round table process on the effectiveness of aid. Furthermore, the different interests of the partners in the process influenced the results. For senior health officials, the process helped to increase the capacity for negotiation and strategic thinking, analysis and planning, and for health workers and the general public, it raised awareness of and involvement in national health development policy and operational issues.

Sound policies and strategies, backed by realistic programme priorities and budgets and linked to internal and external consensus-building and management of negotiations, enabled some countries to reach good aid agreements with their partners. In other countries the results were less satisfactory because of:

- a lack of solid content or proper attention to the process;
- insufficient linkage of the round table process to the day-to-day operations of ministries of health, resulting in a limited impact on the way governments and donors conducted business;
- limited ownership by ministries of health and unclear perceptions of how the process could meet their current interests and what gains could be achieved;
- insufficient understanding and agreement between donors and governments about key policy and operational issues.

Coordination of implementation

To an increasing degree, donors and governments reached agreement on working towards the coordination of matters
related to the implementation of national health priority programmes. This was usually indicated in communiqués that highlighted such matters as:

- minimizing duplication of effort;
- limiting the burden on government of planning, monitoring and evaluating individual projects in multiple-donor missions;
- working towards a yearly cycle for the round table process and a common evaluation of health development programmes or at least their major components;
- improving the quality of aid through common financial arrangements.

However, there have been substantial shortcomings in putting agreements into effect. Both governments and donors often failed to establish adequate follow-up mechanisms for dealing with questions of content and process at the technical and political levels.

**Cost and time**

It takes from six to 30 months after initiation of the process to reach the stage of the round table meeting. The cost, which ranges from US$50 000 to $400 000, depends on:

- the state of the content, i.e., policies, strategies, plans and supporting analyses at the start of the process;
- the level of agreement on content, both internally and externally;
- the capacity of the ministry of health.

**Outlook for the future**

The increasing gap between the resources available and those required to finance the health needs of people in low-income countries makes it important to manage both domestic and external resources well. Many countries are looking for ways to use aid more effectively, efficiently and transparently. In doing so they hope to attract additional funds on favourable terms. The round table process is an instrument being used to strengthen the effectiveness of aid for health.

Countries have tackled the issues both of content and of process, and have built government capacity to assume leadership on both fronts. Ministries of health have taken a long-term view, used participatory, non-prescriptive approaches and given special attention to consensus-building, all of which have contributed to good outcomes.

There has been a weakness, however, in the implementation of agreements made during sector round table meetings, often because of a failure to use technical and political follow-up mechanisms. Although there was a willingness of both countries and donors to improve donor coordination, action on this matter was slow to develop.

The process of improving the effectiveness of aid for health is complex, depending on both the socioeconomic environment of
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The recipient and the aid practices of the donor. Moreover, health development itself is complex, resulting from interaction between inputs from both within and outside the sector which are financed from a number of sources, including external aid. Nevertheless, the round table process should strengthen the effectiveness of aid. This is true on the content side, where policies, strategies and programme priorities become more clearly articulated, and on the process side, where greater internal and external agreement on issues of content lead to better aid agreements.

The round table process is evidently a suitable instrument for countries wishing to strengthen the effectiveness of aid. With other appropriate inputs it can help to improve health development.

The full cost of medical equipment

The costs of acquiring and using any piece of equipment may be divided into two categories, capital costs and running costs. The capital cost is recognized at the time of purchase, but the running costs are frequently not fully appreciated. This may result in inefficient use or, in extreme cases, total abandonment of the machine. Running costs must therefore be determined prior to purchase; they are of four main types: maintenance, manpower, services, and consumables.

Selection, purchase, and installation of equipment must be primarily the responsibility of the head of the department and his or her staff. In making such decisions, both the capital and running costs must be taken into account. When choosing equipment, account should be taken of the availability of spares and the supplier's willingness to train the hospital staff appropriately.