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Aid effectiveness: a relevant agenda for the Asia Pacific region?

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This paper explores whether the aid effectiveness agenda remains relevant to the Asia Pacific region, where levels of aid dependency are decreasing, and whether if it influences the behaviour of countries and development partners.

We found that while the aid effectiveness agenda remains relevant to a range of aid contexts, a differentiated approach is required which takes into account country capacity, level of economic development and local support needs. Understanding and responding to such differences should be at the heart of aid effectiveness efforts in the Asia Pacific region in the future.

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Summary

A decade on since the First High-Level Forum on Aid Effectiveness (2002), there is a certain level of fatigue with the aid effectiveness principles. This is in part a response to the changing aid landscape and the emergence of new development partners, such as China and Korea, who have only recently joined the dialogue on what constitutes good donorship. It is compounded by decreasing levels of aid dependency, and the recognition that the aid effectiveness principles are much harder to operationalise than originally envisaged.

This paper explores the extent to which these principles are relevant and influential in the Asia Pacific region, where rapid economic and political change is transforming the aid environment and in many countries, particularly in Asia, it is leading to decreasing levels of aid dependence. As a result, there is a degree of scepticism about the usefulness of the aid effectiveness, making it a good place to investigate their continuing significance.

We grouped countries into three categories:

- **Low aid dependency countries**, where aid is up to 5% of total health expenditure (THE): Indonesia, Maldives, Malaysia, Philippines, Sri Lanka, Thailand and Vietnam, as well as China and India. These countries have a relatively high number of development partners engaged in the health sector and most, though not all, have relatively good health indicators.

- **Medium aid dependency countries** (aid is between 5 and 20% of THE): Bangladesh, Fiji, Laos, Mongolia, Myanmar, Nepal and Pakistan. These are predominantly poorer countries, with high health need, and a similar numbers of donors as the low aid dependency countries.

- **High aid dependency countries** (aid is 20% or more of THE): Cambodia, East Timor, Papua New Guinea, Samoa, Solomon Island, Tonga and Vanuatu. These are predominantly lower-middle income countries with high levels of health need and (Cambodia aside) all relatively small by regional standards, with a less complex donor environment.

In addition we conducted six case studies of countries across these categories (Cambodia, East Timor, Indonesia, Nepal, Tonga and Vietnam) and looked at the experience of India and China.

We found that many of the issues and challenges that prompted the development of the Paris Declaration in 2005 stubbornly persist in the Asia Pacific region. The Paris principles continue to provide an important, relevant framework for addressing these challenges, but the best responses are likely to be different in each type of country. In other words, support for the aid effectiveness agenda, as broadly defined, may not necessarily translate into support for the aid effectiveness mechanisms associated with it. So, for example, harmonised approaches such as joint analytic work or pooled funding may not always be relevant or welcome.

A more nuanced approach to aid management challenges, which informs a differentiated application of the aid effectiveness principles, will help to address the current ‘fatigue’ and can provide the basis for a way forward.

1. Introduction

Over the past decade the concept of 'aid effectiveness' has become a central aspect of development co-operation, influencing the aid polices of almost all development agencies and affecting the way that many people engaged in the aid business think about, and judge the success of aid. Most closely associated with the 2005 Paris Declaration on Aid Effectiveness, and the series of global commitments and high-level meetings facilitated by the Development Assistance Committee (DAC) of the OECD, the aid effectiveness agenda has also been influential in health, notably through the establishment of the International Health Partnership (IHP+) in 2007, which aims to put the international principles for effective aid and development co-operation into practice in the health sector.

Since the fourth and final high-level meeting in Busan, Korea, in 2011, the aid effectiveness agenda has evolved further, with donors and countries signing up to a 'Global Partnership for Effective Development Co-operation'. The Busan outcome document recognises a shift in focus from aid effectiveness to development effectiveness, and a much greater emphasis on the inclusion of new partners (such as China and India), civil society and the private sector. This shift is in part a response to the changing aid landscape and the emergence of new donors who do not necessarily value aid effectiveness principles. In part, it is also an acknowledgement of growing fatigue with the aid effectiveness agenda itself.[1] Implementing the Paris principles has been much tougher and slower than anticipated, and the strong focus on the processes of how aid is provided has distracted attention from what aid achieves. That said, the IHP+ goes from strength to strength: it now has 59 signatories (33 countries and 26 development partners), and the leaders of the World Bank and the WHO recently re-confirmed their commitment to the initiative.[2]

There is an ongoing debate as to whether the era of aid effectiveness is losing momentum, or whether it is simply being repackaged and 'relaunched' through a different mechanism. This paper looks at the continuing relevance and influence of the principles of aid effectiveness in the Asia Pacific region, where rapid economic and political change is transforming the aid environment and levels of aid dependence are decreasing. As a result, there is a degree of scepticism about the usefulness of the Paris principles in this region, making it a good place to investigate their continuing significance.

Two related questions are explored: is the aid effectiveness agenda, as defined by the Paris principles, (still) relevant to the Asia Pacific region? And, does it have influence among developing countries and development partners, that is, does it affect the way that aid is provided and received in practice?

2. Methodology

A mixed methods desk review approach was used, combining qualitative and quantitative techniques.

Health, wealth, and the aid environment

To gain a sense of the different types of aid contexts in the region we compiled data for all countries in the Asia Pacific on: wealth (GNI); health status (maternal mortality, infant mortality and immunisation rates); and country context (population size and economic growth). We then compared this to data on the aid environment using two indicators: development assistance for health (DAH) as percentage of total health expenditure (THE), which we used as a measure of aid dependency in the health sector; and, the number of donors providing aid in the health sector, to signify how 'crowded' the health aid environment is. Other studies looking at aid dependency at national level have used the ratio of aid to GNI.[3] As this paper focuses on health we have used THE, which we consider is an appropriate equivalent given that it captures public and private expenditure in the health sector.

[1] Sohpal C et al (2008). Cambodia evaluation of aid effectiveness: independent review team final report. Council for the Development of Cambodia (CRDB).
[2] Poverty, health and the human future. Jim Yong Kim's speech at World Health Assembly, 21 May 2013 (World Bank website, news section).
[3] Glennie J and Prizzon A (2012). From high to low aid: a proposal to classify countries by aid recipient. ODI Background Note.

Our data sources were:

World Bank databank: population size, GNI per capita and economic growth.
Asian Development Bank statistics: for Myanmar data not available from World Bank.
WHO Global Health Observatory: infant mortality; maternal mortality; percentage of fully immunized children (FIC); DAH as a proportion of THE and GHE; out-of-pocket payments as a proportion of THE.[4]
Institute of Health Metrics and Evaluation Global Health Data Exchange: number of donors per country.

We used the data analysis to identify categories of countries in which the aid environment was likely to be similar: low, medium and highly aid-dependent countries. We then conducted case studies of six countries (Cambodia, East Timor, Indonesia, Nepal, Tonga and Vietnam). The choice country was informed by the authors' knowledge: in most cases, the case study author had carried out relevant work in country within the last three years, giving a good contextual understanding of the issues. In addition, information was collected on the two 'giants' of the region, China and India, as it was thought that these countries would provide important insights for donors on how to engage with fast-growing, economically powerful countries. Each study was based on a literature review, key informant interviews and the author's knowledge, and followed a common format.

Literature review

We then attempted to compare and enrich the findings through a review of academic and grey literature. We used Pub Med for published literature on health aid to the Asia Pacific region, applying the search terms shown in Table 1. The terms relate to aid provision broadly; SWAps (as these have been the subject of academic inquiry over the last decade); and specifically to the case study countries. In general we excluded articles published before 2000, as this is when the major scale up in health aid and the interest in aid effectiveness began. Articles chosen for abstract review included all those concerned with the provision of health aid to developing countries; articles selected for full review looked specifically at effectiveness, aid modalities, or the role of development partners in influencing health sector development.

We also searched a number of key websites including AusAID, DFID, Global Partnership for Effective Development Co-operation, Overseas Development Institute, DAC, World Bank and WHO.

Table 1: Results of peer reviewed literature search

	Search term	Articles returned	Chosen for abstract review	Relevant articles
1	Aid AND Health AND Asia OR Pacific	206	30	3
2	SWAps AND Health AND Asia OR Pacific	33	3	3
3	Cambodia AND aid AND health	17	9	5
4	China AND aid AND health OR ODA	112	2	2
5	East Timor AND health	38	5	1
6	India (Bihar)	101	2	1
7	Indonesia AND health AND aid	37	4	0
8	Nepal AND health	36	1	1
9	Tonga AND health	40	4	4
10	Vietnam OR Viet Nam AND health	11	2	1

[4] For most countries, DAH as a proportion of THE and GHE was derived as follows: per capita THE and per capita GHE were each multiplied by population to get national THE and GHE figures for each country; DAH disbursement figures for each country were then divided by national THE or GHE to derive the ratio of DAH to THE and GHE (all figures in 2009 US$). The calculations are shown in Annex 1. Data was not available for Maldives, Samoa, Tonga and Vanuatu; for these countries we used external resources for health as percentage of THE as a proxy for DAH.

3. Findings

The data on wealth, health and the aid environment in the health sector for 23 countries in the Asia Pacific region[5] is presented in Table 2. It shows a large and diverse region, incorporating more than half the world's population and including the largest and the smallest countries, as well as the richest and the poorest. Although Asia is the world's fastest growing region economically, it contains the majority of the world's poor, many of whom live in middle income countries and – because of its population size – the bulk of the global burden of disease.[6]

Table 2: Compilation of indicators for the region

Country	Economic Indicators				Health Indicators				Aid environment in health			
	Income level	Population (Millions)	Per capita GNI	Economic growth %	IMR	MMR	% FIC	OOP as % THE	# donors	DAH as % THE	DAH as % GHE	DAH $ -Total Disbursements
Bangladesh	Low	150.5	$1940	6.7	37	240	96%	61	23	8.24	24.54	$285,390,000
Cambodia	Low	14.1	$615.2	7.1	36	250	94%	57	24	31.09	83.54	$198,690,000
China	UMIC	1344.0	$8390	9.3	13	37	99%	35	23	0.08	0.14	$226,390,000
East Timor	LMIC	1.2	$5200	10.6	46	300	67%	4	16	42.51	76.15	$27,070,000
Fiji	LMIC	0.9	$3,720	2.3	16	26	99%		4	7.02	10.01	$9,310,000
India	LMIC	1241.0	$3620	7	47	200	72%	59	25	1.17	4.00	$774,860,000
Indonesia	LMIC	242.3	$4500	6.5	25	220	63%	50	19	1.22	2.48	$224,240,000
Laos	LMIC	6.3	$2580	8	34	470	98%	40	20	19.30	57.99	$55,260,000
Malaysia	UMIC	28.9	$15650	5.1	6	29	99%	42	5	0.01	0.01	$670,000
Maldives	UMIC	0.3	$7430	7.5	9	60	96%	49	3	3.57	5.87	836,000
Mongolia	LMIC	2.8	$4290	17.5	26	63	99%	40	19	7.74	14.06	$25,670,000
Myanmar	Low	48.3	$876.2	10.42	48	200	99%	81	15	12.63	103.58	$103,820,000
Nepal	Low	30.5	$1260	3.9	39	170	92%	48	22	16.44	49.46	$146,700,000
North Korea	Low	24.5			26	81	94%		4			$30,980,000
Pakistan	LMIC	176.7	$2870	3	59	260	80%	63	22	11.54	29.99	$436,230,000
Papau New Guinea	LMIC	7.0	$2570	9	45	230	61%	12	12	24.72	34.55	$83,800,000
Philippines	LMIC	94.9	$4140	3.9	17	99	80%	56	19	1.96	5.55	$141,450,000
Samoa	LMIC	0.2	$4270	2.0	16	100	91%	7	5	22.68	25.89	$8,252,000
Solomon Islands	LMIC	0.6	$2350	9.0	18	93	88%	3	5	37.26	39.90	$21,450,000
Sri Lanka	LMIC	20.9	$5520	8.3	11	35	99%	46	20	4.11	9.19	$60,020,000
Thailand	UMIC	69.5	$8360	1	11	48	99%	14	18	0.50	0.67	$62,020,000
Tonga	LMIC	0.1	$5000	4.9	13	110	99%	11	3	25.25	31.06	$5,190,000
Vanuatu	LMIC	0.2	$4260	1.4	11	110	68%	7	5	23.00	25.50	$5,215,000
Vietnam	LMIC	87.8	$3250	5.9	17	59	95%	56	27	3.85	10.16	$279,970,000

3.1 Data analysis

The majority of countries in the region (n = 19) are lower- or upper-middle income countries. Many low income countries such as Cambodia are on track to graduate to lower-middle income status in the coming years. Linked to this growth in national income is a decline in the relative importance of aid: a recent OECD survey[7] shows that aid dependency in East Asia has declined by one third since 2005. Even though absolute levels of aid to this region continue to grow, economic growth means that aid dependency is likely to remain on a downward trajectory. Dividing the countries into roughly equal groups, three broad categories of aid environment can be identified from an analysis of the data in Table 1 (see also Figure 1):

- **Low aid dependency countries** (aid is up to 5% of THE): Indonesia, Maldives, Malaysia, Philippines, Sri Lanka, Thailand and Vietnam, as well as China and India.

  These countries are richer than other countries in Asia (half are upper-middle income countries, the rest lower-middle income) so unsurprisingly the contribution of aid to health spend is proportionally low. While most countries in this group have relatively good health indicators, as

[5] Defined as the WHO regions of Western Pacific and South East Asia, plus Pakistan, and excluding countries smaller than 100,000 people.
[6] Glassman A et al (2012). Global health and the new bottom billion: How funders should respond to shifts in global poverty and disease burden. Center for Global Development Brief.
[7] OECD (2013). Outlook on aid: survey on donors' forward spending plans 2013-2016.

would be expected for middle income countries, Indonesia and India both have high maternal mortality and relatively low immunisation rates. Despite the low level of aid dependency, the number of partners supporting the sector is relatively high (18-27 for all countries except the Maldives, which as a very small country has just three partners).

- **Medium aid dependency countries** (aid is between 5 and 20% of THE): Bangladesh, Fiji, Laos, Mongolia, Myanmar, Nepal and Pakistan.

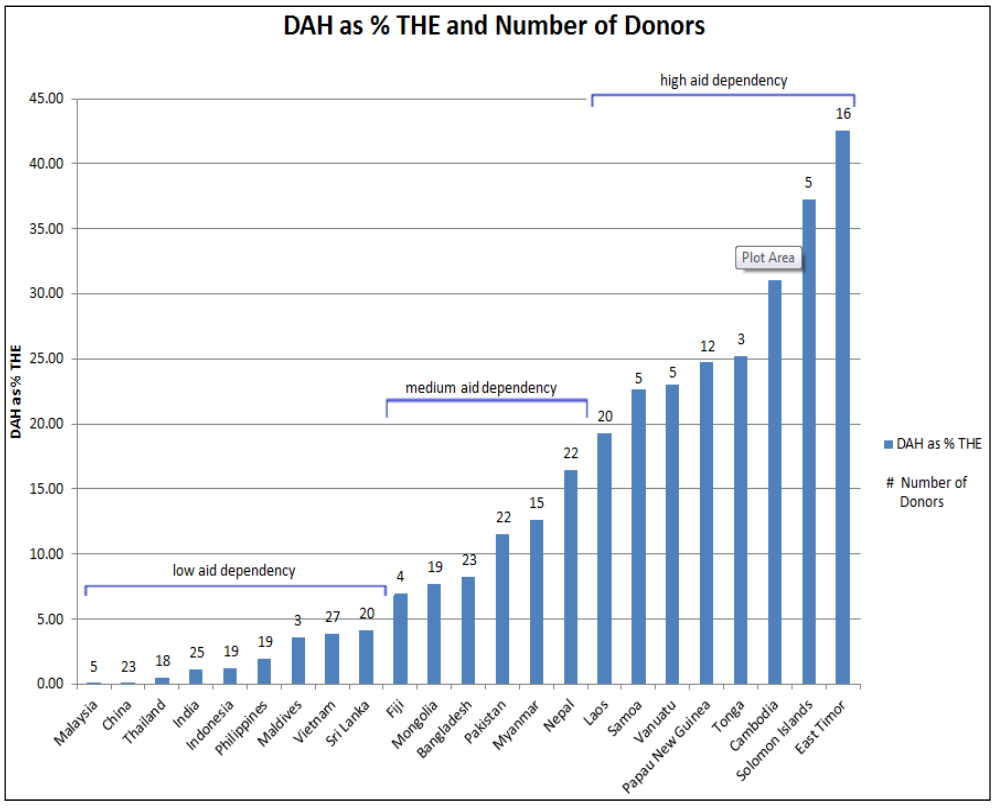
  These are predominantly poorer countries (all the low-income countries are included here) with high health need (Pakistan has low income country-level health indicators, with MMR at over 200, and IMR over 50). With the exception of Fiji, the donor presence is similar to low aid dependent countries – between 15 and 23 per country.

- **High aid dependency countries** (aid is 20% or more of THE): Cambodia, East Timor, Papua New Guinea, Samoa, Solomon Island, Tonga and Vanuatu.

  Counter-intuitively, the countries with the highest aid dependency levels are also lower-middle income countries (with the exception of Cambodia). However many have high health need and health indicators at the level of low income countries. Cambodia aside, these are all relatively small countries by regional standards, and the majority are Pacific Island countries. Their donor environment is generally less complex than larger countries. The small islands have between three/five partners each, while Papua New Guinea and Cambodia have 12 and 24 respectively.

Looking at DAH as a proportion of GHE and ranking countries (from lowest to highest) puts countries in a similar order to the DAH as a proportion of THE ranking. Thus the countries included in each category are roughly the same regardless of whether GHE or THE is used as the denominator of aid dependence (the anomaly is Myanmar which moves from a medium to a highly-aid dependent country).

Figure 1: Aid dependency in the Asia Pacific region



3.2 Case study findings

Low aid dependency countries

Common themes and key points emerge from the country case studies of Indonesia, Vietnam and China. China is discussed separately (see Box 1) because of its unique context in terms of size and strong economic performance.

- Despite the relatively low levels of aid dependence, **both Vietnam and Indonesia have championed the aid effectiveness agenda at senior levels of government, and remain closely engaged with the new Global Partnership**. Vietnam was the first country to localise the Paris Declaration, in the form of the *Hanoi Core Statement* (2005), and has more recently adapted the new Global Partnership commitments into the Vietnam Partnership Document. In Indonesia 26 donors and the government signed the *Jakarta Commitment* on aid effectiveness in 2009; Indonesia also co-chairs the new Global Partnership.

- Contrary perhaps to expectations, Vietnam and Indonesia **face a number of aid effectiveness issues in the health sector**. Both countries host a large number of donors in health, 27 and 19 respectively (see Table 2) and, related to this, health aid is fragmented. In Vietnam there were almost 1000 separate disbursements in 2009-2010, and over 750 in Indonesia.[8] The Government of Vietnam insists that that all projects over a certain size establish a programme implementation unit (PIU), which means that aid tends to be quite verticalised. Further, aid effectiveness challenges in the health sector are more acute than in other sectors due to the low use of public financial management systems (even though use is high for overall aid), and the fact that very few donors (i.e., only the EU) channel health support through the government budget, although Vietnam has a long-standing and large programme of general budget support managed by the World Bank.

- **Efforts to address aid effectiveness challenges in health have been only partially successful**. In Vietnam, there are established mechanisms for donor co-ordination and joint review but not all partners participate, or participate actively, and there is little evidence that these fora have reduced fragmentation or have influenced how donors programme their health aid. For example, a recent informal survey found no link between the Joint Annual Health Review and the planning process in the health sector.[9] A survey commissioned by the EU quotes one development partner as saying that "the MOH does not like to see an 'organised sector' and likes to keep projects separate to keep control"[10] suggesting that MOH may not be fully supportive of aid effectiveness efforts. The PIU policy suggests that this opinion is plausible. Similarly, there are questions as to **how far the aid effectiveness agenda has 'penetrated' beyond the national level** and affected ways of working at decentralised levels. A recent assessment of support to HIV in Vietnam and Indonesia found major donors working in parallel and duplicating efforts (for example, in training) at the provincial or district level.[11] The provision of Global Fund grants in Indonesia was particularly contentious, creating uneven salary structures and parallel reporting systems at decentralised level.[12]

- Finally, **although overall donor dependence in health is low, it is high in certain areas**, particularly HIV. In Vietnam, more than 55% of all health aid is spent on sexually transmitted infections (STIs) including HIV, compared to just 19% spent on 'basic health care'.[13] In Indonesia around 60% of all expenditure on HIV comes from donors (2010), compared to 6% of funding for health systems.

[8] WHO Global Health Observatory, summary country statistics for governance and aid effectiveness.
[9] Personal communication (Dodd, March 2013).
[10] Action for Global Health (2011). Health spending in Vietnam. EU Health ODA and Aid Effectiveness Country Briefing 5.
[11] Godwin P and Dickinson C (2012). HIV in Asia: transforming the agenda for 2012 and beyond. Report of a joint strategic assessment in ten countries, final report. AusAID Health Resource Facility.
[12] Ibid.
[13] Action for Global Health, cit.

Box 1: Bilateral support to health in China: the example of DFID's Urban Health Programme[14]

Given its rapid growth, many donors are now pulling out of China: DFID's aid programme to China ended in 2011, while AusAID will conclude its bilateral support in 2012-2013. Overall, health gains in China have been impressive but inequities remain between poor western and richer eastern provinces, urban and rural areas, and different social groups. A recent study in The Lancet found that children born in some parts of the Chinese countryside are up to six times more likely to die by the age of five than their counterparts in wealthy cities.[15]

Between 2001 and 2007, DFID provided £10 million to China through the Urban Health and Poverty Project. With relatively modest funding, the project sought to influence government policy rather than intervene at service delivery level. A *de facto* private health care system operates in urban centres within the structure of a former nationally-funded and managed health system. This has weakened health systems and neglected public goods like preventative health. Many poor people cannot afford basic health care, because of the high level of out-of-pocket payments. And, because health care costs are so high, people tend to save money in case of an emergency, which has implications for levels of domestic consumption.

The DFID project introduced the use of community health service centres and the concept of general practitioners being the first point of contact. DFID supported local governments in piloting Medical Financial Assistance (a scheme providing money to poor people to pay for health services). Lessons from these pilots were fed into the design and implementation of a national initiative that was subsequently introduced and now provides financial assistance in 86% of urban districts across China.

While the DFID programme was not the only influence on the scale up, key informants who worked on this project point to it as a good example of 'aid effectiveness' in middle-income countries: the provision of high-level international expertise to help build capacity within Chinese institutions, and piloting of new approaches in a low-risk way, separate from the government system (so if they fail, there is no embarrassment for government), but at sufficient scale to show that its replicable. "*This was mature use of aid – we were very influential with a very small amount of money,"* commented one DFID staff member who worked on the programme.

[14] Source: UK Government (2009) DFID and China. House of Commons International Development Committee, Third report of session 2008-09.
[15] Tang S et al (2008). Tackling the challenges to health equity in China. Lancet 372(9648): 1493-1501.

Medium aid dependency countries

This section reports on the case studies from Cambodia, Nepal and India. Although Cambodia falls into the 'highly aid dependent' category, it has been included here because its aid dependency is on a downward trend and the country is on track to achieve middle income status. Further, Cambodia's size, geographic location and number of donor partners make it more similar to the countries in this group than to the Pacific Island nations (the majority of countries in the highly aid dependent group). We report findings from Bihar, India in this section (see Box 2 overleaf) as Bihar has many of the characteristics of a medium aid dependent country, even though India as a whole has low aid dependency.

The aid effectiveness challenges emerging from these three case studies are very similar to those found in Indonesia and Vietnam, but there are also some important differences related to government capacity.

- As in Vietnam and Indonesia**, there is explicit commitment to the aid effectiveness agenda at higher levels of government in Cambodia and Nepal**. In Cambodia, a declaration, an action plan and a results framework focused on improving harmonisation and alignment have been developed, while Nepal is a signatory to the Paris Declaration and has participated in its monitoring survey.

- Despite this commitment, the health sector continues to face **significant aid effectiveness challenges**. In Cambodia, aid to health remains fragmented – in 2006 there were over 100 projects.[16] Similarly in Nepal a recent review found "shortcomings in the harmonisation and alignment of donor support" in the health sector. [17] There are also clear distortions in funding, with a big growth in vertical, disease-specific funds in both countries. In Cambodia, MDG 6 (on HIV, TB and communicable diseases) accounted for 47% of all disbursements in health in 2010.[18] In Nepal, support for MDG 6 increased almost ten-fold between 2000 and 2010, compared to a three-fold increase in support for health policy and administration.[19]

- Both countries have mechanisms to promote harmonisation and alignment in the health sector. In Cambodia there is a sector co-ordination group (established in 1999), a number of technical working groups, and pooled funding through a multi-donor trust fund. In Nepal, the government and 12 development partners signed a 'Statement of Intent' to improve aid effectiveness in health in 2004, and in 2010 a Joint Financing Agreement was co-signed by the government and eight development partners. However, as in Vietnam, these **coordination mechanisms do not appear to have achieved their full potential**. For example, not all partners participate and the quality of policy dialogue is reported to be sub-optimal.[20]

- An issue which emerged in Nepal and Cambodia, but was not reflected in the case studies on Vietnam and Indonesia, is the **low capacity in the MOH to steward the sector, lead co-ordination efforts and hold donors to account**.[21] Further, in both countries health sector plans and monitoring frameworks are described by development partners as weak (which is often the reason given by donors for not aligning behind such plans).

- A final, additional factor present in Nepal and Cambodia is the **emergence of non-traditional donors** such as China and Korea. In Cambodia, such donors provide around a quarter of aid, with the bulk coming from China for capital/infrastructure projects. Global research suggests that these donors tend not to participate in donor co-ordination mechanisms, a finding which holds true in Nepal and Cambodia.[22]

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[16] VBNK/RBMG (2010). Cambodia country study report: Phase two evaluation of the Paris Declaration.
[17] Vaillancourt D (2012). Aid effectiveness in Nepal's health sector: Accomplishments to date and measurement challenges. International Health Partnership.
[18] WHO Global Health Observatory, summary country statistics for governance and aid effectiveness.
[19] Ibid.
[20] Vaillancourt, cit; Martinez J et al, (2011). Kingdom of Cambodia: Overall assessment for Mid Term Review of Health Strategic Plan 2008-15.
[21] Vaillancourt, cit.
[22] Sources: Old puzzles, new pieces: development co-operation in tomorrow's world. 2012 CAPE Conference (London, 14-15 November 2012) www.odi.org.uk/CAPE2012; Vaillancourt, cit.; and Greenhill R et al (2013). The age of choice: developing countries in the new aid landscape. A synthesis report. ODI Working Paper 364.

Box 2: The Health SWAp in Bihar State, India

India receives over $2 billion in health ODA. Like China, India has grown rapidly over the last decade and is in the process of establishing its own aid programme, the 'Indian Agency for Partnership in Development'.[23] At the same time, many donor partners are now looking to wind down their support to the country. The UK, a major donor particularly at state level, has announced that it will withdraw all bilateral funding by 2015.

India has a federal government structure which provides the states with considerable autonomy. Bihar is one of the poorest states and one of the largest, with a population of 83 million people – larger than that of many countries in the region.

Since 2010, DFID has engaged in a Sector Wide Approach to Strengthening Health Systems (SWATSH) in Bihar state, providing £145 million over six years to help the state government improve health, nutrition and water and sanitation outcomes. The bulk of these funds (£120 million) are channelled through the central treasury to the state government as earmarked budget support, with the remainder spent on technical support. Although the programme is called a 'sector wide approach', a label usually associated with harmonised donor support, DFID is the only donor supporting the programme. Nevertheless, an independent review found co-ordination with other health partners active in Bihar to be good.[24]

The review also found that the programme had encountered (and overcome) many of the aid effectiveness issues often reported at national level: delays with procurement, sustainability of technical assistance (TA) and knowledge transfer, and building a partnership with government. A critical factor in the programme's success was the use of national staff, both as part of the programme and in the form of TA.

DFID's decision to develop a SWAp at state level provides an example of how to engage in large countries – of which there are many in Asia – especially where regional inequities are present. The extensive and successful use of national staff is also likely to be relevant to higher-capacity environments common in this region.

[23] *India sets up $15 billion global aid agency*. Global Post, July 2, 2012; *India setting up foreign aid agency*, Hindustan Times, 17 July 2011.
[24] Independent Commission for Aid Impact (2012). Evaluation of DFID's support for health and education in India.

High aid dependency countries

The highly aid dependent countries in the Asia Pacific region are a unique group, with quite different characteristics from aid dependent countries in Africa. We found common themes from the case studies on Tonga and East Timor:

- The **institutions of aid effectiveness, and political commitment to the agenda, appear less developed** in both countries. Tonga has not signed the Paris Declaration, nor does it have a formal donor co-ordination mechanism. This is partly due to its small size and relatively limited number of active partners, which make it easier to keep track of health aid. East Timor does have a formal commitment to the Paris Principles and is a member of the DAC's Fragile States group (which tracks aid effectiveness issues in fragile countries). Coordination in health is relatively recent, with a health development partners' forum established in 2012.

- **Aid to health is dominated by single bilateral agency, Australia**. In Tonga, Australia is the only significant donor involved in the non-capital aspects of the health sector (this is also the case in other Pacific Island countries, including Samoa, Solomon Islands and Vanuatu). Similarly in East Timor 35% of health aid comes from Australia, which is also the largest donor in the sector.[25]

- Even so, in both countries **there are a number of other partners active in the sector, and the influence of the non-traditional donors is growing**. In East Timor over 20 partners provided funds to health, through over 200 disbursements, in 2009-2010. Although there are no figures on Chinese support to the health sector, China's aid to other sectors (in particular infrastructure) is reported to be substantial.[26] In Tonga, Japan and China both fund health infrastructure, while New Zealand and some Australian institutions provide support for the delivery of clinical services.

- Both countries **lack an overarching framework setting out priorities for donor support in the health sector**, though for different reasons. In Tonga, the government does not see the need for one. In East Timor, limited experience within government with sector wide practices, combined with wariness about allowing external partners too much influence, means that such a framework has yet to be developed. One study commented: *"the MOH often operates reactively in its dealings with development partners. This may have as much to do with lack of confidence as with lack of capacity; it could also be influenced by memories of joint working in the early reconstruction period that some saw as a threat to sovereignty*".[27]

- Although strong management and leadership in the Tongan government mean that aid is broadly aligned with government priorities, there are examples of inefficiencies and gaps. For example, **use of government systems (especially procurement, planning and budgeting) is patchy in the health sector, even though these systems are robust by international standards**. In Timor, the lack of a strategic framework for donor engagement has meant unbalanced investments across sector priorities, with the bulk of funds going to non-state providers for service delivery, and the strengthening of governance and leadership capacity neglected.[28]

- In both countries there are **concerns about the quality of TA.** Although this is a concern across many developing countries, the small size and relative isolation of the Pacific means that problems may be even more acute in this region, as much TA is supplied from a remote base and comes in the form of short TA missions. In Tonga, this is the way UN agencies and the Secretariat for the Pacific Community provide their support. In Timor, a recent study found that TA to the health sector is supply driven, poorly integrated with government systems and not clearly linked to capacity building outcomes.[29]

[25] WHO Global Health Observatory, summary country statistics for governance and aid effectiveness.
[26] Kingsbury, D (2012). China's interest in East Timor. Posted on Deakin Speaking Blog 10 August 2012. http://communities.deakin.edu.au/deakin-speaking/
[27] Zivetz, (2006), quoted in the AusAID Health Delivery Strategy for East Timor.
[28] Martinez J (2011). Joint design of support to the Timor-Leste Health Sector by the MOH, AusAID, European Commission and World Bank 11-31 May 2011. AusAID Health Resource Facility.
[29] Ibid.

3.3 Results of peer reviewed literature search

As Table 1 shows (page 4, Methodology), we found relatively little in the peer reviewed literature. The majority of abstracts rejected were quantitative analyses of health aid distribution patterns, while only a small number of articles were qualitative analyses of the health aid provision. Indeed, we found the grey literature a much richer source of information on this topic.

A dominant theme in the articles found through the non-case-study specific searches was the challenge of implementing aid effectiveness objectives. For example, an article on the impact of the IHP+ shows progress in alignment with country priorities, but little change in use of country systems.[30] An article on SWAps noted the recent tendency of donor funding for disease control programmes to bypass established co-ordination mechanisms.[31] Nevertheless, all articles pointed to the persistence of problems that the aid effectiveness measures were designed to address, suggesting the continued relevance of those measures. A second common theme was around the evolution and adaptation of the aid effectiveness agenda, both at the global and country level. Examples include: evolutions in approaches to donor co-ordination over the last decade, different interpretations of the SWAp across different countries, and different expectations of aid co-ordination instruments within a single country. [32]

No articles attempted to differentiate between different types of aid environments and the implications for aid management challenges, as this paper has done, suggesting that the approach taken here is original.

We found some articles relevant to the case study countries. For the low aid dependent countries, one article from China discusses the role of private philanthropy in supporting tobacco control efforts, including at lower levels of the administration (province and city). It notes that these efforts focused on "policy change and building the Chinese research knowledge base", in line with our case study findings which point to these two forms of engagement as effective in low aid dependency, high-capacity environments.[33] A second article, which looks at co-financing for family planning across a number of countries, notes that "China, India and Indonesia now contribute most of the funding for their own programmes", again in line with our findings that provision of financial resources is a less important aspect of aid in richer countries.[34] For Vietnam, only one relevant article was found, describing mixed engagement from different parts of the MOH in donor-led aid effectiveness efforts, and consequently, the limited impact of these efforts.[35] For Indonesia, the articles selected for abstract review focused on support provided by donors during the 2004 tsunami and were therefore not relevant to this study.

A number of relevant articles on Cambodia were found. Only one looks directly at approaches to aid management[36] (i.e. the SWAp), while others focus on the role of donors in supporting sector reform. Themes include: strengthening links between vertical programmes and broader sector planning efforts, addressing health systems constraints to improved service provision, the need for donors to adapt their expectations and methods to country realities, and the distortionary effects of funding for vertical programmes, in this case Avian Influenza. [37] Literature on Nepal is scarce, but the one article found

[30] Shorten T et al (2012). The IHP+: rhetoric or real change? Results of a self-reported survey in the context of the 4th HLF on Aid Effectiveness in Busan. *Global Health*, May 31;8:13.
[31] Peters DH, Paina L and F Schleimann (2012). Sector-wide approaches (SWAps) in health: what have we learned? *Health Policy and Planning.* Dec 11 [E-pub ahead of print].
[32] Hill PS et al (2012). Planning and change: a Cambodian public health case study. *Soc Sci Med*. Dec;51 (12):1711-22; Sundewall J and Sahlin-Andersson K (2006); Peters, Paina and Schleimann, cit.; Sundewall J, Forsberg B and G Tomson (2006). Theory and practice: a case study of coordination and ownership in the Bangladesh health SWAp. *Health Res Policy Syst*. May 16;4:5.
[33] Redmon P et al (2013). Challenges for philanthropy and tobacco control in China (1986-2012). Global Health Institute, Emory University, Atlanta, Georgia [e-pub ahead of print].
[34] Sources of population and family planning assistance (1983). *Popul Rep J*. Jan-Feb;(26):J621-55.
[35] Dodd R and Olivé JM, (2011). Player or referee? Aid effectiveness and the governance of health policy development: Lessons from Viet Nam. *Glob Public Health*. 6(6):606-20.
[36] Walt G et al (1999). Managing external resources in the health sector: are there lessons for SWAps? *Health Policy Plan*. Sep;14(3):273-84
[37] Soeung S et al (2007). Developments in immunization planning in Cambodia: rethinking the culture and organization of national program planning. *Rural Remote Health*. Apr-Jun;7(2):630; Chhea C, Warren N and L Manderson (2010). Health worker effectiveness and retention in rural Cambodia. *Rural Remote Health*. Jul-Sep;10(3):1391; Hill, PS (2000). Planning and change: a Cambodian public health case study. Soc Sci Med. Dec;51(12):1711-22; Ear, S (2011). Avian influenza: the political economy of disease control in Cambodia. *Politics Life Sci*. Fall; 30(2):2-19

focuses on low capacity in the MOH to lead the SWAp and donor co-ordination efforts, pointing to the fact that the government does not even have complete information on the activities of all health partners operating in the country, which is very much in line with our case study findings.[38] No articles pertinent to aid effectiveness could be found for Bihar, however one did look at the importance of working at decentralised level to address public health issues, which is in line with our findings on good practice for donors working in large countries.[39]

For the highly aid dependent countries of the Pacific, two of the four articles reviewed for Tonga concerned regional health programmes (on lymphatic filariasis and child health indicators) and the third focused on a regional issue (migration of health workers to Australia and New Zealand), indirectly re-enforcing our finding that health aid to the Pacific tends to be approached on a regional basis, making alignment with specific country needs more difficult. The fourth article on Tonga looks at the experience of health sector reform arguing that strong country ownership of the process, combined with a focus on institution building, were keys to success. [40] Although the aid effectiveness principles are not explicitly referenced, the sentiment of the article points clearly to their relevance. The one relevant article from East Timor describes poor donor co-ordination in the initial period after independence, and the subsequent, gradual shift in donor support from NGOs to government as the new authorities became established. [41] Again, this points to the relevance of the aid effectiveness agenda.

4. Discussion

The discussion is structured around the two questions outlined in the methodology:

- Does the aid effectiveness agenda remain relevant to the Asia Pacific region?
- Does the agenda have influence with development partners and donor countries?

4.1 Is the aid effectiveness agenda relevant to the Asia Pacific region?

Overall, evidence collected through the case study analysis suggests that the answer is 'yes'. However, there are subtle but important differences in the type of aid effectiveness challenges affecting different types of countries.

One of our starting assumptions was that aid management challenges would be less apparent in countries where levels of aid are relatively low, given that these countries are richer and more developed, and have stronger governments. However, we found that many of the 'classic' aid effectiveness issues related to harmonisation and alignment were present in two of the case study countries (Indonesia and Vietnam), suggesting that the agenda is relevant even in low aid dependency environments. Particular issues in these countries include: the distortionary effect of aid for HIV; the proliferation of small projects, which are likely to be of low impact and to have high transaction costs; and the impact of multiple partners working at district/decentralised level.

A similar set of issues were noted in Nepal and Cambodia. This is unsurprising as these countries are typical of those for which the aid effectiveness principles were designed: reasonably high levels of aid, and a crowded aid environment. A perceived difference between these countries and the low aid dependent ones is the capacity within government to lead aid effectiveness efforts and to develop plans and strategies that donors want to invest in and align their support to. This can create a 'vicious circle' of donors bypassing government systems, which then lack the required investment, fail to improve, and again fail to attract donor resources. The same cycle can occur for national health plans and strategies. On the other hand, there is evidence to suggest that, even when national plans have been independently assessed as robust, partners may still be reluctant to increase support to recipient governments: a synthesis report on aid effectiveness in the health sector concludes that "there is limited evidence as yet to suggest that improving the quality and robustness of the National Strategic Plans will

[38] Giri A et al (2013). Perceptions of government knowledge and control over contributions of aid organizations and INGOs to health in Nepal: a qualitative study. *Global Health*. Jan 18;9:1.
[39] Kalita A et al (2009). Empowering health personnel for decentralized health planning in India: The Public Health Resource Network. *Hum Resour Health*. Jul 20;7:57
[40] Soakai S (2006). The experience of health sector reform in Tonga. *PNG Med J*.Sep-Dec;49(3-4):104-7.
[41] Alonso A and Brugha R (2006). Rehabilitating the health system after conflict in East Timor: a shift from NGO to government leadership Health Policy Plan. May;21(3):206-16

result in increased funding from development partners, although this appears to be an expectation among national stakeholders".[42]

Similarly, our Vietnamese case study observed the anomaly that many of the donors willing to provide general budget support provide their *health support* in the form of projects; indeed only one partner channels its support for health through the budget. In Tonga we found patchy use of government systems, despite their relative strength. These findings suggest that the decision to provide flexible financing in support of national strategies, such as pooled funding or budget support, as well as use of national systems, is as much driven by overall donor policy as by the specific country circumstances – though clearly the findings are anecdotal and would need to be tested elsewhere.

The fact that aid effectiveness challenges are similar in low (and medium) aid dependent countries raises an interesting question as to why they persist in the richer countries. One hypothesis is that the political economy associated with multiple, small aid transactions makes government reluctant to move away from projects.[43] Another explanation could simply be that bad behaviours get entrenched, and as aid levels proportionally decrease there is less urgency to address them. Less pressure or interest from recipient countries on aid effectiveness may in turn decrease the urgency in donor country programmes to comply with the Paris principles.

The highly aid dependent countries in the Asia Pacific are very different from those in Africa: they are small, dominated by a single donor, and as a result have a less complex aid environment. Nevertheless, some of the aid effectiveness issues documented in low and medium dependency Asian countries are also present here. In particular, the lack of an overarching framework to guide donor spending has resulted in a poor balance of investments across the sector. An additional issue, common to many countries – but seemingly more acute in the Pacific – is the poor quality and supply-led nature of TA, which is often designed 'for the region' rather than tailored to individual country needs.

4.2 Does the aid effectiveness agenda have influence?

All the Asian countries reviewed in this study have made public commitments to aid effectiveness, and many are engaged in the multilateral process run previously through the DAC and now through the Global Partnership for Effective Development Co-operation. It is worth noting that the countries most engaged (at least from our sample) are also those with the lowest levels of aid dependency. The Paris Declaration as a global agreement appears to have less traction in the Pacific than elsewhere – likely a reflection of the less complex country aid environment and possibly the fact that countries were less involved in aid effectiveness workstreams at the DAC. However AusAID's current focus on aid effectiveness is likely to mean a greater focus in future, as also evidenced by nascent health sector SWAps in Solomon Islands and Samoa.

Commitment to aid effectiveness by senior government officials does not necessarily translate to the sector level. In Vietnam and Timor for example, the case studies suggest that the MOH prefers to engage with donors individually. Even where the architecture for donor coordination has been in place for many years – as it has in most of the countries reviewed – progress towards aid effectiveness objectives remains slow, suggesting that they have limited impact. As has been observed in many settings, the transaction costs associated with harmonisation are usually high, and out of proportion to the efficiency gains they deliver.[44] Further, it is often the same partners engaging in these mechanisms: they have not managed to attract the so-called 'non-traditional' partners such as China, suggesting that the agenda does not have the same traction with these players. One likely reason is that the new donors have not been part of aid effectiveness processes – notably the first three high level fora – as this work was led by the OECD/DAC and the new donors are not members. They thus have less history, less understanding, and less commitment to aid effectiveness principles.

While aid effectiveness challenges are present in all countries reviewed, the best responses to these challenges are likely to be different in each type of country. In other words, support for the aid effectiveness agenda, as broadly defined, may not necessarily translate into support for the aid effectiveness mechanisms associated with it. For example, harmonised approaches (such as joint

[42] OECD (2011). Better aid. Aid effectiveness in the health sector: progress and challenges.
[43] Dodd and Olivé, cit.
[44] Severino J-M (2010). The end of ODA (II): the birth of hypercollective action. Center for Global Development, Working Paper 218; OECD (2001) cit.

analytic work and pooled funding) may not always be relevant or welcome. The experience from China and Vietnam suggests that governments may prefer exposure to a range of international experiences, to spark ideas and feed into their own debates. These countries are able to clearly articulate their TA needs, and to make good use of expert support when it is provided.

Similarly, pooling resources and channelling them through the budget may not always make sense in low aid dependent countries, and the policy dialogue associated with it may not always be welcomed. This is for a number of reasons, most fundamentally because lack of resources is not the core problem that donor support is helping to address; rather, it is the distribution and use, or governance, of resources. Related to this, the level of aid is so low in relative terms that it cannot be used to 'buy a seat' at the policy dialogue table to influence governance and reform agendas. Thus, the recognised *quid pro quo* for budget support (that donors relinquish control over the day to day management of their aid, in return for more strategic engagement with the government) may not be valid when aid volumes are so low. Equally, in richer countries, where governments are stronger and governance arrangements well established, external input into the policy process may not be welcomed.

Conversely, in smaller and less complex countries like those in the Pacific, there are questions about how well aid mechanisms dependent on high level policy dialogue can work. This is because the small number of active donors means that responsibility falls to a single development partner to tackle tough policy issues. Equally, geography and size make it difficult for donors to recruit experienced health staff in all small countries, or to recruit them for long periods, undermining the quality of the policy debate.

5. Conclusions

This study suggests that grouping countries according to their level of aid dependence is a simple but useful approach to identifying their aid effectiveness challenges. The groups that emerged from the data comparison make intuitive sense, encompassing as they do: low aid, rapid growth, richer countries; high-aid, many donors, low-income countries; and the Pacific countries which are richer, but also aid dependent, and relatively isolated. This suggests that grouping reflects a 'common sense' approach.

The identification of different challenges in different aid contexts in turn helps to inform a differentiated application of the aid effectiveness principles and a more nuanced understanding of 'good donor behaviour' in different settings:

- In low aid-dependent, richer countries access to international expertise and technical support is likely to be more important than financial support. In addition, donors are likely to have a role in helping governments to pilot new approaches – reducing risk for the government and giving them space to experiment. Finally, particularly in larger countries, it may make sense for donors to focus their support on poorer districts or provinces, working with local authorities and through government systems (i.e. following the aid effectiveness principles) to the extent possible.

- In medium aid-dependent countries, the core aid effectiveness principles of harmonisation and alignment remain relevant. A key issue in these environments is strengthening government capacity for stewardship and leadership to carry forward the aid effectiveness agenda. This is a necessary prerequisite to better alignment and should help countries to shift from a cycle of weak plans and systems bypassed by donors, to a virtuous cycle in which donor investment in and use of national processes helps to strengthen them. For their part, donors need to focus part of their support on strengthening such leadership and stewardship functions. Further, being clear about the 'rules of the game' (i.e., when plans are 'good enough' to be funded, and how this will be judged) will provide an important incentive to recipient countries to strengthen these plans.

- In the highly aid-dependent countries of the Pacific, there is less need for a formal or elaborate co-ordination architecture. Current inefficiencies and gaps in donor provision could likely be addressed by a strong steer from government, based on a clear articulation of sector priorities, needs and gaps, which would also, more importantly, drive more efficient domestic spending. In countries where policy dialogue is an important element of donor engagement, donors need to ensure their staff have the right skills and background to engage. SWAp and 'policy dialogue' processes were designed for countries where there are many voices around the table, helping to depersonalise tough negotiations, so applying this approach in contexts where there are very few countries is likely to be difficult.

The boom in development assistance is over, with 2011 registering the first contraction in overall aid for many years, and a contraction in health ODA. [45] The end of the MDG era is in sight, and new development priorities are being established for the post-2015 period. And, the principles of aid effectiveness have morphed into a new agenda around development effectiveness. As this new era of development co-operation takes shape, and new ways of doing business are established in the aid world, it may be a good time to revisit the continuing relevance of the 'original' aid effectiveness agenda.

This paper suggests that many of the issues and challenges that prompted the development of the Paris Declaration over a decade ago stubbornly persist in the Asia Pacific region. The Paris principles continue to provide an important, relevant framework addressing these challenges. However, the tenuous link between use of aid effective approaches and better results has resulted in a certain fatigue with the aid effectiveness agenda. In the region, this is compounded by decreasing levels of aid dependency. Although a growing body of evidence is emerging on the positive impact of adhering to aid effectiveness principles[46], more is needed. A more nuanced approach to aid management challenges, which informs a differentiated application of the principles, will help to address fatigue, enhance the evidence base, and will help ensure the continued relevance of the aid effectiveness agenda to the region.

[45] OECD (2013) Outlook on aid, cit.; Institute for Health Metrics and Evaluation (2012). Financing Global Health 2012: the end of the golden age?
[46] IHP+ (2013). Better results through effective development co-operation: the heart of the work we do.

Annex 1. Calculations of development assistance for health (DAH) as a proportion of total health expenditure (THE)

A	B	C	D	E	F	G	H	I
Country	per capita THE	per capita GHE	Population - 2010 (millions)	DAH $ - Total Disbursements	Total THE (B*D)	Total GHE (C*D)	DAH as % THE (E/F)	DAH as % GHE (E/G)
Bangladesh	$23.29	$ 7.82	148.69	$285,390,000	$3,462,990,100.00	$1,162,755,800.00	8.24	24.54
Cambodia	$45.19	$16.82	14.14	$198,690,000	$638,986,600.00	$237,834,800.00	31.09	83.54
China	$ 220.88	$118.39	1348.93	$226,390,000	$297,951,658,400.00	$159,699,822,700.00	0.08	0.14
East Timor	$56.86	$ 31.74	1.12	$27,070,000	$63,683,200.00	$35,548,800.00	42.51	76.15
Fiji	$154.28	$108.19	0.86	$9,310,000	$132,680,800.00	$93,043,400.00	7.02	10.01
India	$54.25	$ 15.82	1224.61	$774,860,000	$66,435,092,500.00	$19,373,330,200.00	1.17	4.00
Indonesia	$76.89	$ 37.74	239.87	$224,240,000	$18,443,604,300.00	$ 9,052,693,800.00	1.22	2.48
Laos	$46.17	$15.37	6.2	$55,260,000	$286,254,000.00	$95,294,000.00	19.30	57.99
Malaysia	$367.92	$204.24	28.4	$670,000	$10,448,928,000.00	$5,800,416,000.00	0.01	0.01
Mongolia	$120.11	$66.17	2.76	$25,670,000	$331,503,600.00	$182,629,200.00	7.74	14.06
Myanmar	$17.14	$2.09	47.96	$103,820,000	$822,034,400.00	$100,236,400.00	12.63	103.58
Nepal	$29.78	$9.90	29.96	$146,700,000	$892,208,800.00	$296,604,000.00	16.44	49.46
North Korea			24.35	$30,980,000				
Pakistan	$21.78	$8.38	173.59	$436,230,000	$3,780,790,200.00	$1,454,684,200.00	11.54	29.99
Papua New Guinea	$49.42	$35.36	6.86	$83,800,000	$339,021,200.00	$242,569,600.00	24.72	34.55
Philippines	$77.33	$27.33	93.26	$141,450,000	$7,211,795,800.00	$ 2,548,795,800.00	1.96	5.55
Samoa								
Solomon Islands	$106.61	$99.56	0.54	$21,450,000	$ 57,569,400.00	$53,762,400.00	37.26	39.90
Sri Lanka	$69.96	$31.31	20.86	$60,020,000	$1,459,365,600.00	$653,126,600.00	4.11	9.19
Thailand	$179.15	$134.43	69.12	$62,020,000	$12,382,848,000.00	$9,291,801,600.00	0.50	0.67
Tonga								
Vanuatu								
Vietnam	$82.87	$31.36	87.85	$279,970,000	$7,280,129,500.00	$2,754,976,000.00	3.85	10.16

Data source: WHO Global Health Observatory.

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