MOPAN: Report from the 2003 Pilot Exercise

Final Report

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Executive summary

Background

What is MOPAN?

1 The Multilateral Organisations Performance Assessment Network (MOPAN) was launched in 2002 in response to an increased focus on the performance of multilateral organisations at country level. MOPAN is an informal network of like-minded donors. The members are Canada, Denmark, Germany, the Netherlands, Norway, Sweden, Switzerland and the UK.

2 The general purpose of MOPAN is to improve the flow of information on multilateral performance from country level to headquarters; to allow the members to be more effective stakeholders in the multilateral organisations; to increase accountability to their parliaments, and to better understand the work and the priorities of the organisations concerned. MOPAN's immediate objective is to monitor the performance of multilateral organisations at country level against their own mandates, assed primarily in terms of their support for national policies and institutions, as well as their participation in aid coordination activities and other partnerships (cf. Terms of Reference, Annex 3).

The 2003 Pilot

3 In the course of 2003 it was decided to run a pilot performance assessment of some multilateral organisations. It was agreed to focus on *health*, since this is an important issue to the multilateral organisations as well as to the MOPAN members. Health relate to several of the Millennium Development Goals. The selected multilateral organisations were: WHO, UNICEF, the World Bank, and the Regional Development Banks (RDBs), which include, in this exercise, the African Development Bank (AfDB), the Asian Development Bank (ADB), and the Inter-American Development Bank (IDB).

4 Country selection was based on the requirement that a minimum of three MOPAN members were involved in the health sector in the respective countries. To include a specific country it was also necessary that one member country volunteered to act as country level coordinator. In this way 8 countries were included in the pilot: Uganda, Bangladesh, India, Ghana, Nicaragua, Mozambique, Malawi and Vietnam.

5 The MOPAN members decided to test an approach that could be rapidly concluded and at low costs, making use their own country office staff as main informants. A methodology was designed for soliciting information and perceptions on a number of performance related issues from officers responsible for the health sector. The exercise consisted of two main components: (1) *Individual questionnaires* containing 35 questions regarding various aspects of multilateral performance (cf. Annex 1), and (2) group discussions attended by MOPAN member country office staff,

assisted by a discussion guide (cf. Annex 2) and summarised in the form of *Country Reports.* In total, 37 questionnaires and 8 country reports were received.

Strengths and weaknesses of the methodology

6 The quality of the data collected would depend on the sector experience of the respondents, their time of service in the country, and familiarity with the selected multilateral organisations. A majority of the respondents scored high on these criteria: 60 per cent of the respondents spent more than two-thirds of their working time on health issues; 60 per cent of the respondents had worked in the respective countries for two years or longer; 80 per cent of the sample unit had attended meetings with WHO, the World Bank, and UNICEF in the last three months and 60 per cent of the respondents had had bilateral meetings with these organisations in the same period.

7 The main weakness of the methodology is the small size of the sample, making it impossible to draw any statistically robust conclusions. However, the material does point out salient features of the multilateral organisations as perceived by experienced bureaucrats.

8 It should be underlined that the findings presented in this report are *perceptions* only. Some of the representatives of the host governments and the multilateral agencies that were given the chance to respond to the conclusions drawn by the MOPAN working groups have objected to some of them. Some of the objections are related to questions of fact that have been shown to be erroneous, which indicates that the MOPAN group possessed limited information about a matter. In other cases, it is the perceptions of events that differ between the MOPAN group and multilateral representatives. Such cases may always be subject to dispute. Perceptions do not necessarily correspond with "reality".

9 A special caveat applies to the results with respect to the Regional Development Banks (RDBs), especially IDB and AfDB. Some of the respondents did not answer any of the questions related to the respective RDB in their region, and among the respondents that did answer there was a high percentage that answered that they had no information on the issue. The reason was not that these organisations do not operate in the health sector. IDB and AfDB have specific health projects or are involved in the health sector more indirectly via other projects in all the selected countries, but they were generally not viewed as key actors in this sector. When referring to the survey results in the Main Report, the RDBs are mostly grouped as one category. Admittedly, this might conceal important differences in mode of operation and performance, although, in this material, limited as it is, the variations in the responses were not significant. Nevertheless, observations with respect to the RDBs must be treated with caution, and IDB and AfDB are therefore not included in the organisation specific summaries below. ADB is mentioned because of the quality of additional information in the Country Reports.

10 Lessons on the methodology and implementation of the 2003 Pilot is summarised in a separate paper and will form an important input to discussions on how to improve design and methodology for any follow up studies. The findings of the Pilot, presented in this Report, will be

discussed with the selected multilateral agencies and with other actors involved before any decisions on the next phase of MOPAN will be made.

General findings

On contributions to policy-making

11 A majority of the respondents believe that national health policies have become more poverty oriented during the last three years, and that the multilateral organisations have made substantial contributions to these processes. Regarding the multilateral organisations' contributions to the health components of the Poverty Reduction Strategies the responses are less clear.

12 By and large, technical advice provided by the multilateral agencies is viewed as appropriate. Generally, the multilateral organisations are perceived to have the ability to change and are believed to have become more open and flexible in recent years.

On country ownership

13 The multilateral agencies have agreed to foster ownership in developing countries. In order to evaluate the extent to which the multilateral agencies are perceived to have fulfilled this aim the respondents were asked to assess the multilaterals along following parameters: the multilateral agencies' contributions to enhancing national and local capacity; contributions to promoting participatory processes; willingness and ability to align with host governments' procedures; and willingness and ability to lower flags.

14 Few of the respondents believe that any of the organisations have been very effective in building capacity for health policy formulations at central or sub-national levels. Generally, the multilaterals are viewed as weak with regard to promoting participatory processes, i.e. actively supporting initiatives with the aim to strengthening wider national and local participation.

15 With respect to alignment there still seems to be a long way to go: Few of the respondents are of the opinion that the multilateral agencies have started to disburse funds through government budgets or have adopted governments' procurements procedures. There is a common consensus that donors need to lower their flags to enable the recipient institutions to take ownership. Findings from this study indicate that the multilaterals, in general, seem hesitant to do so, partly because they in practice are balancing concerns for enhancing ownership and the immediate need for funding at the recipient end.

On aid coordination

16 It is broadly agreed that donor cooperation and coordination should increase in order to make aid delivery more efficient. Donor cooperation and dialogue were addressed according to the following parameters: the level of donor cooperation; more generally, the level of transparency and information sharing; types of bilateral-multilateral interaction; and the level of harmonisation of procedures.

17 On the level of donor cooperation no unambiguous tendency can be discerned. On the issue of information sharing, with the exception of the World Bank, few of the respondents believe that the multilateral agencies were doing so unsolicited. Still, the multilateral agencies were viewed as forthcoming and willing to share information upon request. Seen in a 3-year perspective it is widely believed that the multilateral organisations have become more cooperative.

18 The most common form of interaction among the bilateral donors and the multilateral agencies is participation in the same health sector group or sector programs. The respondents have poor knowledge of harmonisation of procedures.

On relationships to multilaterals

19 One key finding is the existence of considerable information gaps on the activities of the multilaterals in the field. This needs to improve. The respondents appear to have considerably more knowledge of the World Bank than of the other organisations. The respondents definitely had the least knowledge of the RDBs. Overall it is believed that the multilateral organisations possess a number of comparative advantages which could be more effectively utilised if more transparent dialogue and co-operation were in place.

20 It is reported that increased donor cooperation sometimes have been at the expense of host governments being sidelined. In these cases the recipient governments' ability to take the lead has, therefore, not been enhanced.

On development effectiveness

21 Development effectiveness is a critical issue, but difficult to assess based on the data and methodology utilised for this study. Still, the MOPAN members decided to include a section on the issue. A slight majority of the respondents believe that they are able to make qualified opinions on development effectiveness of the World Bank, WHO, PAHO and UNICEF. Far fewer believed that they are in a position to do so with regard to the RDBs. The respondents were asked to assess development effectiveness along the following parameters: whether the multilateral agencies contributed to the governments' top priorities for the health sector; whether they followed up on their own strategic priorities in terms of specific actions for the health sector; and finally, whether result-based management systems were in place.

22 There was little difference in perceived effectiveness among UNICEF, the World Bank and the WHO. In terms of the first two selected parameters, far less than 50 per cent of the respondents hold the view that the multilateral organisations contribute very effectively in that regard. Few of the respondents knew whether result-based management systems were in place.

Personality matters

23 Despite the general remarks made so far, the overall picture emerging from this pilot study is a pattern of great discrepancies in how the different multilateral organisations are *perceived* to operate in the sample countries. There are also differences in viewpoint among donor representatives in the

same country. Individual characteristics and personal preferences, which do not necessarily refer to professional experience with the institutions, seem to be of vital importance in understanding how the various agencies are perceived and also how the multilateral agencies operate at the country level. This tells us something about how aid relations work in practice. Much of the work is based on personal contacts and interaction within a limited milieu, which seems to form the way in which these organisations operate in the field.

Limited decentralisation

24 The data also indicate that the multilaterals seem to lack clear and unambiguous structures within their own organisations. Most important decisions appear to be taken at headquarters and, in practice, the country representatives have limited room for manoeuvre, despite the expressed aim of increasing decentralisation.

Organisation specific findings

25 With one notable exception, the Country Reports to a very limited extent dealt with the selected multilaterals separately. In fact, a main feature of the methodology applied was to invite the respondent, when making assessments, to reflect on differences between the selected organisations. There was no attempt at establishing "objective" benchmarks. However, in the interpretation of the responses we have considered the organisations' different mandates and objectives. On this background some more organisation specific observations are warranted.

WHO and PAHO

26 PAHO is the regional branch of WHO in the Americas. WHO and PAHO have normative mandates, and do often operate in close cooperation with relevant ministries (cf. Annex 7 and 6, respectively). In the report, WHO and PAHO are largely dealt with separately, and it should also be noted that PAHO is only assessed by five respondents.

27 Few believe that WHO has revisited its health strategies in light of national PRSPs. However, a clear majority believe that the organisations' health strategies are in line with national ones. Hence, there was probably no need to revisit them. WHO is perceived as being efficient in fostering government control over new projects and initiatives. That WHO has a good and close relationship with host governments is a view that is widely held. Its technical support and capacity are largely viewed as being appropriate and flexible.

28 It is also viewed as one of the most important opinion leaders on health issues, which may be related to its mandate. Given its mandate one may have assumed the WHO to be viewed as an even more important opinion leader. WHO's mandate is seen as a strength, but some report that it does not always manage to be that leading normative agency with respect to health politics.

29 Some respondents hold that WHO should play a more active role in co-ordination between respective ministries of health and other partners. It is believed that many of the initiatives of WHO need to be more pro-actively shared with other donor organisations, especially initiatives in the area of macro-policy and more systemic change. It is reported from several countries that WHO has not been able to link with other ongoing programmes and that greater co-ordination seems to be needed.

UNICEF

30 *UNICEF* is the multilateral organisation that is probably most strongly involved in the districts, which may also be partly related to its mandate (cf. Annex 5). Its broad network and experience at district and local level and its ability in building capacity on the ground is viewed as the organisation's great strength. UNICEF is perceived as having wide experience in covering inaccessible areas and a leader in terms of adjusting its operations to local conditions. UNICEF is by many respondents praised for its ability to co-operate with local and non-governmental organisations.

31 However, several respondents report that it fails in transferring its lessons learned and its competence to other donors. UNICEF is believed to be working too much in isolation. It is suggested that UNICEF should advocate for closer co-ordination at district level. Based on its broad network and experience at local levels, it is advised that it also address systemic issues in the health sector at the national level.

32 The quality of technical support is generally regarded as being appropriate. UNICEF is moreover praised for its long-term commitment and for being flexible and responsive to host countries requests and priorities. A majority of the respondents believe that the heads of the local missions of UNICEF have become more able to take decisions without referring back to headquarters.

33 UNICEF is perceived as an important opinion leader. It is also stated in some of the country reports that UNICEF and WHO are autocratic organisations with limited institutional memory. Generally, UNICEF is not considered to be a key player in supporting PRSP processes or more general national health policies.

World Bank

34 The *World Bank* works mainly with central processes and often with broader policy issues where it plays a key role (cf. Annex 4). Generally, the respondents state that they possess more knowledge of the World Bank than of any of the other organisations. The World Bank comes out as more open and is perceived to be participating more frequently in the new forms of aid, such as SWAP, than the other organisations. The World Bank is the organisation that shares information most frequently.

35 With regard to the health sector policy it is reported that the World Bank plays a key role in the PRSP processes in most countries and that one of the Bank's strengths is its emphasis on improving the policy environment before financial assistance is provided. It is praised for contributing with long-term financial support backed with careful analyses. The World Bank is reported to be efficient in building capacity at the central level. In some

countries the World Bank has been active in combating HIV/Aids, but has been less active in the health sector more generally.

36 On the other hand, the World Bank is perceived as lacking technical capacity at country level. There seem to be few senior officials dealing with health issues on the ground. Several country reports hold that the World Bank has recentralised its management of health programmes with the effect that the Sector Manager's position has been transferred to Washington and important decisions are being taken at headquarters. This is viewed as a clear weakness.

37 Furthermore, the World Bank is perceived by many as being an intrusive organisation vis-à-vis other donors as well as host authorities. It is viewed as exceedingly influential due to its involvement with macroeconomics and its financial leverage. In some countries the World Bank is accused of setting up parallel structures with limited attention to sustainability.

ADB

38 The views on ADB are more diversified and differ greatly from country to country. One of the strengths of ADB is linked to its financial leverage. It is also perceived to have a strong regional base. In one country the agency is reported to be operating quite independently of other donors in the health sector. However, this is partly related to the fact that it is focussing on urban health. The fact that the ADB is not having a representative permanently stationed all its host countries are viewed as a constraint.

39 The ADB is considered to be too centralised and is seen as having little interaction with other donors. The ADB is reported not to attend health consortium meetings. Even if ADB is not a key player in the health sector it is suggested that it could take a more proactive role in its relationship with other donors in the sector.

Summary of main findings

- Co-ordination and co-operation between the MOPAN countries and the selected multilateral agencies have increased in the last three years, with the exception of the RDBs. However, the respondents have limited knowledge about the RDBs and the findings concerning them must therefore be treated with caution.
- Lack of communication and coordination with the multilateral development banks is seen as a question of attitude rather than of real constraints.
- The multilateral agencies are perceived to have contributed significantly to making national health policies more poverty oriented.
- The multilateral agencies are not perceived to have contributed to any significant degree towards building local capacity.
- The behaviour of the multilateral organisations is largely attributed to personal factors and not to institutional ones.

- All organisations are believed to perform poorly with regard to disbursing funds through government budgets, adopting host government procedures, and adopting reporting and accounting standards.
- Despite recent emphasise on country ownership, host governments are not perceived as having coordinated aid to the health sector more effectively over the last three years.

1. Introduction

MOPAN

In response to an increased focus on the performance of multilateral organisations at the country level the Multilateral Organisations Performance Assessment Network (MOPAN) was launched in 2002. MOPAN is an informal network of like-minded donors that includes Canada, Denmark, Germany, the Netherlands, Norway, Sweden, Switzerland and the UK. Among these countries there exist perceptions of having insufficient knowledge of the operation of many important multilateral organisations at country level. The like-minded countries are important financial contributors to the multilateral organisations and want to have more knowledge of and impact on these organisations. Moreover, increased co-operation among bilateral donors and multilateral agencies seems imperative in order to meet internationally agreed objectives and achieve real partnerships among donors and recipients. The MOPAN network has decided to carry out regular assessments of the work of selected multilateral organisations in a number of countries where member countries have their own bilateral programmes. As a rolling exercise within a longer time frame the intention is to assess most of the major organisations in important areas of their activities at country level (cf. Terms of Reference, Annex 3).

The general aims of the network are to improve the flow of information on multilateral performance from embassies and country offices to ministries and aid agencies; to enable donors to be more effective stakeholders in the multilateral organisations; to improve donors' understanding of the work and priorities of the organisations concerned; and to increase accountability within donor countries (cf. Terms of Reference, Annex 3).

The MOPAN pilot 2003

In the course of 2003 the MOPAN countries decided to run a pilot performance assessment of selected multilateral agencies. Given the time frame of the exercise, it was not possible to study their general activities; one specific area had to be chosen. It was decided to focus on *health*, since this is an important issue to all the like-minded countries and one which relates to several of the Millennium Development Goals. The key multilateral organisations involved in the health sector are:

- the World Health Organisation (WHO),[1]
- the United Nations Children's Fund (UNICEF),
- the World Bank, and

[1] In the case of Nicaragua the Pan American Health Organisation (PAHO) was included in the survey, as the regional branch of WHO in the Americas.

- the Regional Development Banks (RDBs), which in this exercise included the African Development Bank (AfDB), the Asian Development Bank (ADB) and the Inter-American Development Bank (IDB).

The immediate objective of the pilot exercise, according to the terms of reference, is to assess the performance of the above-mentioned multilateral organisations primarily in terms of:

- their role in the development of national health policies;
- their ability to foster stronger country ownership, including support to institutions in the health sector; and
- their participation in aid coordination activities and other partnerships (cf. Terms of Reference, Annex 3).

The proposed outcomes of the MOPAN monitoring exercise is:

- better information about and understanding of multilateral activities amongst political decision-makers, the public, and relevant ministerial authorities in MOPAN member countries;
- clearer picture of the value added that the different multilateral organisations can bring to common development efforts at country level:
- more informed dialogue with the multilateral organisations, both at headquarters and at country level (cf. Terms of Reference, Annex 3).

In addition, the intention is to reveal potential information gaps and to discern how cooperation and dialogue between the bilaterals and the multilaterals could possibly be improved. Ultimately, the pilot exercise will inform a decision on any possible follow-ups, and is a test of approach, design and methodology. Based on input from stakeholders and respondents an assessment of the methodology will be carried out as part of the planning process for the next phase.

The terms of reference, methodology and questionnaire were developed during a series of meetings involving representatives of ministries and aid agencies from all the MOPAN member countries. The MOPAN member wanted to make a light and rapid type of assessment. The overall purpose was also to involve the country offices of MOPAN members more fully in assessing the performance of multilateral organisations. These ramifications precluded studies of “real” effects of multilateral contributions at the country level based on the analysis of outputs and impact.

It was agreed to base the assessment on a study of *perceptions* among informed respondents at country level. Hence, the main research question has been:

- How do informed aid bureaucrats in the MOPAN countries, working in the health sector on a daily basis in various countries, perceive the performance of selected multilateral organisations?

Structure of the Report

The bulk of the report is structured along the lines of the three objectives mentioned above, but first we give a brief presentation of the methodology and discuss the quality of the data used. In Chapter 3 we examine how the contributions of the multilateral agencies to national health policies are perceived. Chapter 4 investigates how the multilaterals foster ownership in host countries. In Chapter 5 bilateral-multilateral dialogue and co-operation are in focus. We have included a small chapter (Chapter 6) where we raise the issue of development effectiveness.

2. Methodology and quality of data

Perception study and qualitative assessments

Initially nine developing countries in Africa, Asia and Latin America were chosen to participate in this pilot.[2] The selection of countries was directed by certain pragmatic concerns: that a minimum of three MOPAN members were involved in the health sector, and one of them volunteered to coordinate the exercise with the main responsibility for the Country Report. Based on the latter criterion, Tanzania had to be excluded from the exercise as no one volunteered to take the lead. This report therefore synthesises findings from eight countries: Uganda, Bangladesh, India, Ghana, Nicaragua, Mozambique, Malawi and Vietnam. The exercise consisted of two main components.

Firstly, individual questionnaires (cf. Annex 1) were filled in by the staff of country offices/embassies of MOPAN members. The questionnaire contained 35 questions regarding the quality of multilateral partnerships; recipient country responsiveness; alignment to national poverty reduction strategies (where applicable); and participation in and co-ordination of activities. A total of 40 questionnaires were received, of which 3 were not properly filled in, bringing the sample to 37.[3]

Secondly, Country Reports were prepared by the MOPAN lead agency in each of the 8 countries. A MOPAN working group was established in each country, which on average consisted of 4 donors. It was collectively responsible for carrying out the assessment. Besides reviewing the results of the questionnaires, the group was requested to arrange a focus group discussion, structured by a discussion guide (cf. Annex 2), and use both the questionnaires and the focus group discussions as input for the Country Report. In addition, the working groups in some of the countries solicited written comments from the government and some of the multilateral agencies involved.[4]

Before these events took place a preparatory meeting to discuss the objectives, design and methodology of the exercise was organised. It was an overall aim that the exercise be carried out in a transparent way. The MOPAN lead agency arranged informal consultations with the respective health ministries and the selected multilateral organisations and informed them about the exercise. How far the embassies/aid agencies should go in involving their local partners was up to them to decide.

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[2] The selection of countries was directed by certain pragmatic concerns: that a minimum of three MOPAN members were involved in the health sector, and one of them volunteered to coordinate the exercise with the main responsibility for the Country Report.

[3] Unfortunately all the questionnaires from Malawi were lost. It should also be noted, as will appear from the tables presented in this report, that we operated with 37 respondents on the World Bank, UNICEF and the RDBs while on WHO and PAHO we had 32 and 5 respondents, respectively, due to the fact that the respondents on Nicaragua were asked to replace WHO with PAHO.

[4] Bangladesh, Vietnam, India, Uganda and Mozambique.

The MOPAN members agreed to undertake a perception study, where the basic methodology has been to compare the behaviour of selected organisations. No clear benchmarks were developed. It should be underlined therefore that that findings presented in this report are mainly perceptions, which may differ from "reality". This methodology obviously has its clear weaknesses, but, as will be illustrated below, the fact that the respondents were highly experienced and knowledgeable of the issues raised adds weight to their statements. Still, the results of this report should be understood in the context of the different mandates of the selected organisations.

Acknowledging differences in mandate

As the various agencies have different mandates their operations must be assessed accordingly. Templates on the most important multilateral organisations, which outlined their mandates and objectives, were therefore worked out and sent to the respondents together with the questionnaire.[5] The mandates are briefly summarised here as they serve as important background information.

WHO does not run traditional projects and programmes like the RDBs, UNICEF and the World Bank. WHO works closely with the health authorities in the respective countries. Its aim is "the attainment by all people of the highest possible level of health". WHO's main role is to stimulate, inform, facilitate and monitor health policies and services. It offers policy guidance based on best practices and supports disease and epidemic surveillance. WHO's mandate is complementary to other UN institutions such as UNICEF.

UNICEF's mandate is "to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential". UNICEF is currently moving from vertical approaches to service delivery in immunisation, nutrition, and water and sanitation towards programmes guided by the rights of the child. UNICEF has extensive field presences in practically all developing countries.

The *World Bank* has a much less extensive network of country officers in the field than both WHO and UNICEF. However, there was a shift in 1997 towards decentralisation to the field offices, which implied that an increasing number of country directors were located at the country level. The World Bank's mandate is "to work with governments to achieve sustainable progress in reducing poverty, promoting growth, and improving the quality of people's lives in developing countries". The World Bank's approach to health issues is also shifting from its earlier focus on strengthening and expanding infrastructure and supplies of basic health services towards programmes addressing institutional, capacity and systemic problems in the health sector and core public health functions, together with efforts in communicable diseases and maternal and child health and nutrition.

[5] A template was not prepared for the African Development Bank or the Inter-American Development Bank.

The RDBs have similar structures and objectives as the World Bank, but with regional focus. The overarching goal of the ADB is poverty reduction. Its strategy rest on three pillars: pro-poor sustainable economic growth, social development and good governance. It recognises the link between sustainable economic growth and poverty (cf. Annex 8). Women's health is a priority area in the Health Sector Policy.

The AfDB's "mission is to promote economic and social development through loans, equity investments, and technical assistance" (http://www.afdb.org). The AfDB is strongly emphasising the issue of poverty reduction and social development as expressed in the Millennium Development Goals. One of AfDBs objective is to improve health services and education for the poorest ones among the African people (AfDB 2003).

The *IDB's* mandate is to foster economic and social development of the IDB's borrowing countries. One of IDB's overarching objectives is poverty reduction and promotion of social equity. It has endorsed the Millennium Development Goals and continues to support national poverty reduction strategies. A new Social Development Strategy has been developed, where the objective is to accelerate social progress conducive to the well-being of all (IDB 2002).

Experienced respondents

With this approach and methodology one critical variable is the experience of the individual respondents and participants in working groups. Or in other words, how informed do we consider their judgements to be? On this score, the sample comes out quite favourably, with 60 per cent having worked in the country for 2 years or longer.[6] One-third of the respondents held positions as health specialists and 60 per cent of the respondents spent more than two-thirds of their working time on health issues and only 16 per cent less than one-third of their time.[7]

Frequent bilateral-multilateral interaction

Another critical variable is the depth of experience of the respondents with respect to the multilateral organisations. We found a fairly high level of interaction with WHO, the World Bank and UNICEF, with 80 per cent of the respondents having attended meetings involving the three organisations in the last 3 months. On the other hand, the majority of the respondents had not attended a meeting where any of the RDBs had participated or had had bilateral discussions with such an organisation during the last 3 months.

[6] 35 per cent had been working in the respective country for more than 5 years, 25 per cent had been working there between 2 and 5 years, while only 27 per cent of the respondents had been employed for less than 2 years.

[7] 22 per cent of the respondents were head of office/aid sections, 32 per cent held positions as health specialists, 27 per cent were generalists or had other specialisations, and 14 per cent were advisers or occupied other positions.

Bilateral meetings between bilateral donors and representatives from the multilateral agencies were somewhat more rare than attendance at the same meeting. Approximately 60 per cent of the respondents had had bilateral discussions one or more times with representatives from these three agencies during the last quarter. At an aggregate level there are no significant differences regarding the frequency of interaction between the like-minded countries and WHO, the World Bank, and UNICEF. In sum, against this background one would assume that a majority of the respondents should be able to provide informed judgements about the multilateral agencies.

Diverse data – small questionnaire sample

A third critical variable in this approach concerns the representativeness of the survey data. This is obviously a weak point in the pilot exercise. 37 questionnaires constitute a very small sample, especially since this study aims to summarise findings from eight different countries where the local contexts obviously vary greatly. In order to try to identify some tendencies we have put the data into a database, but the results have to be regarded as qualitative information. Thus, one cannot make any robust quantitative conclusions based on this data.[8] Given the experience of the respondents, the findings for each country are probably a valid indicator of how the multilaterals' performance is perceived – from the point of view of bilateral donors. Comparisons between countries and organisations have much less validity and would merely be suggestive of certain trends, and possibly trigger questions to be followed up later by MOPAN.

A special caveat applies to the results with respect to the RDBs. Some of the respondents did not answer any questions on the RDBs, which provides us with an even smaller number of respondents on these institutions. Furthermore, when asked various questions about the RDBs, between 30 and 80 per cent of the respondents answered that they had no information. One possible explanation for the low response rate could be that the RDBs are not involved in the health sector in all the selected countries. However, this is not the case as they are all at least indirectly engaged in this field. The main reason for the dearth of knowledge about their work is therefore most likely that they are rather small actors, particularly the AfDB. Nevertheless, the AfDB does have specific health projects in all the selected African countries with the exception of Ghana. Even if the AfDB does not have a specific health project in that country, a health component is included in one of its broader projects: Poverty Reduction Project (www.afdb.org/projects). Nevertheless, due to the fact that the respondents' knowledge about the RDBs is limited, the perceptions of the RDBs presented in this report have to be interpreted with the utmost caution.

[8] That such a small sample not will provide very robust answers can be illustrated by an example. It was decided that PAHO and WHO should be lumped together even though these were different organisations. The number of respondents on PAHO was only 5. However, the results obtained with or without including PAHO are rather significant (cf. elsewhere in the report). This illustrates the problems faced with using such a small sample.

Unequal reporting

It is an additional problem, when synthesising the findings from this exercise, that the country reports vary greatly in terms of comprehensiveness, ranging from 4 to 30 pages. They also differ in terms of how the mandate has been interpreted. About half of the country reports are based on the submitted discussion guide, while the other half were primarily summaries of the questionnaires.

This is a pilot aiming to test methodology and design. A separate assessment of the methodology will therefore be developed. This methodology assessment will partly be based on input from informants and discussions with representatives from the multilateral organisations and will serve as vital components in the planning of the next phase.

3. Multilateral support of national health policies

What are the issues?

This section focuses on how selected multilateral organisations support national health policies. The aim is not to evaluate health polices per se, but to assess how aid relationships work in practice in processes of policy reform. The MOPAN countries want to learn whether multilateral behaviour conforms with international agreements as well as with national concerns, and they want to discover whether multilateral behaviour has changed in the past few years and whether they do in practice follow up on their own rhetoric.[9]

- Do the multilaterals operate intrusively or are they sensitive to and flexible vis-à-vis national stakeholders?
- How and in what way do they support policy-making and influence policy?
- What role do they play as advisors?

Again, it must be underscored that what we are investigating is *perceptions* only. They do not necessarily correspond with reality. Certain *stereotypes* of the multilaterals seem to be prevalent in many of the MOPAN countries. The World Bank has for example many times been portrayed as a financially mighty actor operating in an intrusive way. A common stereotype of UNICEF has been that it is a more kind-hearted organisation, but often penniless and therefore with limited capacity and influence. WHO has typically been described as an authoritarian and hierarchical institution. Common for all of them has been a perception of large bureaucratic colossuses with little ability to change. This study tries to reveal whether the perceptions of the MOPAN countries correspond with well-known stereotypes.

National health policies have become more poverty oriented

The majority of those giving and receiving aid today have agreed to make poverty reduction the key issue among the Millennium Development Goals (MDGs). So-called Poverty Reduction Strategies (PRS), probably first and foremost associated with Poverty Reduction Strategies Papers (PRSP), have

[9] UN member countries, as well as UN organisations and the World Bank have endorsed the UN Millennium Development Goals of 17 September 2001 (cf. UN 2000 and 2003). The multilateral institutions have also declared that they will work to transfer and foster ownership among host governments (see e.g. World Bank 1999; World Bank News Release No. 99). In addition, the various UN agencies have agreed to harmonise their operations in order to enable ownership at the receivers' end, and to reduce transaction costs by avoiding overlaps and duplications (cf. the United Nations Development Assistance Framework (UNDAF) and various other harmonisation and simplification efforts agreed, e.g. the triennial comprehensive policy review of the UN General Assembly).

become important instruments in this respect.[10] The majority of the countries referred to here have adopted such strategies, with two exceptions. Bangladesh is in the process of developing a PRSP, but has completed an interim PRSP that is a first step towards a full PRSP. India does not have a formal poverty reduction strategy, but the MOPAN group agreed that the Tenth Five Year Plan for India (2002-07), the National Health Policy 2002, and the National Population Policy 2000 replicate a comprehensive approach to poverty reduction. When poverty reduction strategies are referred to in this report the interim PRSP and the policy papers referred to above are included.

With regard to the PRS and health, as many as 87 per cent of the respondents answered that they believe national health policies have become more poverty oriented during the last three years. In some of the Country Reports, however, it was underlined that, in spite of improvements, a stronger poverty focus seems still to be warranted.

A majority of the respondents, 62 per cent, were of the opinion that the national poverty reduction strategies reflected what would be required to meet the MDGs on health.[11] However, differences exist among the various countries. In the Country Report on **Uganda** it is stressed that the Millennium targets are not similar to those of the PRSP, and in the case of **Nicaragua** the PRSP is not perceived to reflect what would be required to meet the MDGs on health. However, it is felt that the PRSP is a good starting point, although changes in the health sector need to go beyond the goals set out in the PRSP if one is to attain real and sustainable benefits for the population.

Substantial multilateral contributions in making health policies more poverty oriented

The respondents were asked to assess the role and influence of the selected multilaterals in making national health policies more poverty oriented in light of governments' top health priorities. The World Bank is the institution that receives the highest "score" with respect to influence on policy discussions and contribution to important analytical work. 70 per cent of the respondents believe that it has had a strong impact in this respect, compared to 63 per cent for WHO, and 41 per cent for UNICEF.[12] Nearly 40 per cent of the respondents held that the RDBs played no visible role in these processes, as is illustrated in the table below.

[10] A PRSP is also a precondition for drawing on the World Bank's and IMF's debt reduction facility, HIPC and on the IMF's soft loan facility, Poverty Reduction and Growth Facility (PRGF). The PRSP has to be endorsed by the boards of the World Bank and the IMF.

[11] These are: reducing child mortality of under 5 year olds by two-thirds by 2015; reducing maternal mortality by three quarters by 2015; halting and starting to reverse the spread of HIV/AIDS by 2015.

[12] Perceptions about UNICEF seem to vary widely: 32 per cent were of the opinion that UNICEF had provided only minor support in this respect.

Table 1:
On the role and influence of selected multilaterals in making national health policies more poverty oriented in light of governments' top health priorities

	PAHO	WHO	WB	UNICEF	RDBs
Strongly influenced policy discussions, contributed important analytical work	60 %	63 %	70 %	41 %	11 %
Provided minor support	20 %	16 %	14 %	32 %	19 %
No visible role	0 %	9 %	5 %	11 %	38 %
No information	20 %	9 %	8 %	11 %	22 %
Question not answered	0 %	3 %	3 %	5 %	11 %
N=number of respondents	5	32	37	37	37

Multilateral contributions to the health component of the PRS – the World Bank most influential

On perceptions of to what extent the multilateral organisations have contributed explicitly to the health component of the PRS, the respondents seem to have less knowledge of this issue compared to the multilaterals' contributions to the health sectors in general (cf. paragraph above). Between 20 and 30 per cent of the respondents had no information on this issue with regard to the World Bank, UNICEF, or WHO. More than 50 per cent of the respondents had no information about the RDBs.

However, as it appears from the available data, the multilateral organisations were mainly involved in policy discussions rather than in specific measures in this regard. In the opinion of 50 per cent of the respondents WHO had taken an active part in discussions on health with regard to PRS. The organisations were assumed to have a lesser role in financing preparatory work, with the World Bank and UNICEF receiving a "score" of 41 and 35 per cent, respectively. The World Bank is reported to be influential with regard to the text formulation of health issues in poverty reduction strategies. The perception of the World Bank as the strongest contributor to these processes is confirmed by some of the country cases, but also the WHO seems to have played an important role in the PRSP processes:

> *In **Nicaragua** the World Bank and the IDB were perceived as the strongest players in the realisation of the health component of the PRSP, even if PAHO and UNICEF also participated in forums where health issues of the PRSP were discussed. The World Bank and the IDB are believed to influence policy discussions. PAHO is perceived to be very involved within the health sector, but more directly with the MoH and not so much with the central planning ministry. PAHO is seen as being most important in terms of publicly stressing the problems facing health, but is sometimes perceived as being too*

critical. It is believed that other approaches would have been more effective and constructive.

*In **Bangladesh** all four multilateral agencies under review are considered to have provided support for the strategy. The World Bank is reported to have been particularly effective in highlighting the importance of the interim PRSP vis-à-vis the Government of Bangladesh (GoB). WHO's technical specialists have reviewed documents on behalf of the government, while UNICEF is perceived to have added value to the health sector policy by its activities outside the sector, particularly those related to water, sanitation and education. UNICEF's promotion of the rights-based approach to health care is also considered to be noteworthy with regard to health policy. Otherwise, UNICEF is not considered to be a major player in supporting the national interim PRSP in Bangladesh. With regard to the ADB, the perception among the donors is that until recently it has given greater priority to its own Poverty Agreement with the Government than to the Government's interim PRSP.*[13]

*In the health sector in **Vietnam** the World Bank is perceived to be active in issues of health financing, including health care for the poor, and in meetings on the Comprehensive Poverty Reduction and Growth Strategy (CPRGS), which is the term for Vietnam's PRSP. A World Bank Health Sector Review that appeared in 2001 is reported to have been a very useful document in terms of information about the sector. The World Bank, together with the Ministry of Planning and Investment and the Ministry of Finance, was the leader in the development of the CPRGS. The ADB financed a study for a master plan on health care and finance. UNICEF focuses on some major issues like injury and accident prevention and on early childhood development, but is perceived to have contributed little to the CPGRS. WHO is perceived as the lead donor with respect to the CPGRS and is seen as very active in supporting national strategies and programmes, as well as contributing to shaping health policies through their close cooperation with the Ministry of Health.*

Appropriate technical advice

A majority of the respondents assumed that WHO and the World Bank were using *international* experts with appropriate knowledge about the respective countries. As many as 69 percent believed that WHO did, while the figures for the World Bank and UNICEF were 51 and 41, respectively. However, it should be mentioned that at the same time as many as 32 per cent stated that the World Bank sometimes provided *international* advice inappropriate to national needs; the figures for WHO and UNICEF were 22 and 16 per cent.

[13] It could be mentioned that the presentation of the role of the ADB has been strongly objected to by the ADB itself, which claims that it has given input to the interim PRSP at many levels. ADB underscores the fact that there is no conflict between ADB's Agreement and the interim PRSP. It is held by them that MOPAN's comments do not accurately reflect reality.

UNICEF gets the highest score when it comes to using the best *national* experts; 46 per cent believed that it frequently did so. The figures for the World Bank and for WHO are 43 and 34 per cent, respectively.[14] Nevertheless, very few, between 3 and 5 per cent, stated that any of the organisations could generally be criticised for low quality and inappropriate technical advice.

WHO and UNICEF: leading opinion formers

Opinions of the role of the multilaterals in stimulating and broadening the public debate on health issues in the last 3 years diverge. WHO is reported to have been the strongest and most visible actor advocating health issues, which should be no surprise in the light of its mandate (cf. above). As many as 56 per cent believed that it had played a strong and visible role, while the figures for UNICEF and the World Bank are 41 and 27 per cent, respectively. UNICEF is the organisation that is believed to have been most actively supporting public health campaigns, but only marginally more so than WHO. In addition, UNICEF is perceived to be far ahead of the other organisations with regard to making its own documents available in local languages and in popularised forms. Few believed that the World Bank or the RDBs had been particularly active on these areas. However, as is illustrated in the table below, the three organisations have made their main contributions in various areas, which may be related to the organisations' different mandates and objectives. Given the mandates of WHO and UNICEF one would probably have expected the figures to be even higher.

Table 2:
What has been the role of the selected organisations in stimulating and broadening the public debate on health issues in the last 3 years?[15]

Multiple answers allowed	**PAHO**	**WHO**	**WB**	**UNICEF**	**RDBs**
It has played a strong and visible advocacy role on health issues	80 %	56 %	27 %	41 %	5 %
It has actively supported public health campaigns	60 %	63 %	19 %	65 %	3 %
It has made its own documents available in local language(s) and in popularised forms	60%	22 %	14 %	49 %	5 %
It is not actively involved in advocacy activities	0 %	3 %	24 %	3 %	32 %
No information	0 %	16 %	27 %	11 %	46 %
N= number of respondents	5	32	37	37	37

[14] 57 per cent had no information on the RDBs.
[15] The total number of respondents includes those who had no information about the issue.

Assumed weaknesses and strengths

In the light of the different mandates of the multilateral organisations, what are perceived as their strengths and weaknesses? Some salient features will be presented below. Arguments from the 8 Country Reports have been analysed to reveal some tendencies.

UNICEF – extensive local network, but should transfer knowledge to other actors.

Some strengths and weaknesses are stressed by a number of respondents. UNICEF's multi-sector mandate is perceive to give it great opportunities that are being appreciated, such as its inter-sectoral linkages and its capacity for cross-sectoral knowledge transfer. Another strength that is repeatedly stated is its network and experience at district and local level, and its ability in building capacity on the ground. UNICEF is perceived as having broad experience in covering inaccessible areas. It is, moreover, praised for its ability to co-operate with local and non-governmental organisations.

As far as drawbacks are concerned, reference has been made to the fact that UNICEF continues to act more as a project organisation and less as a policy formulating agency. UNICEF is perceived to be focusing its field staff on getting the job done rather than on building capacity at central levels. UNICEF seems to be less involved in policy making and participates less frequently in local forums for discussions on health. Moreover, it is held that UNICEF fails in transferring its lessons learned to other donors, and in working for closer donor coordination at district level.

WHO – technically competent, but should play its mandate in full.

General agreement seems to exist among the respondents on the strengths of WHO. Its technical support and capacity is largely viewed as being appropriate. Nearly all the respondents believe that WHO has a very good relationship with national governments. However, some respondents argue that WHO could play a more active role in coordination between MoH and other partners in health. Even if WHO's mandate is seen as a strength, it is believed that it does not always manage to be the leading normative agency with respect to health policies that it should be. Hence, it does not play its mandated role to the full.

Word Bank – influential, but lacks technical capacity at country level.

The World Bank is seen as exceedingly influential vis-à-vis host governments due to its involvement with macroeconomics and its financial leverage, even if its primary linkage is with the respective Ministries of Finance. Moreover, the World Bank is viewed as a very strong actor on multi-donor budget support and an active supporter of sector-wide approach programmes (SWAP).

On the other hand, the World Bank is perceived as lacking appropriate technical capacity at country level. There seem to be few senior officials dealing with health issues on the ground. Several country reports hold that the World Bank has recentralised its management of health programmes with the effect that the Sector Manager's position has been transferred to Washington

and important decisions are being taken at headquarters. This is viewed as a clear weakness.

The Regional Development Banks are different institutions operating in different contexts. As has been mentioned previously, any assessments of the RDBs should be treated with utmost caution. The various development banks are also perceived very differently among the respondents. Nevertheless, regarding the **AfDB** there seems to be a general impression that it works in a vacuum and is continuing with a project-focused approach. It is perceived to be an isolated and inefficient organisation. **ADB's** strength is linked to its financial leverage. It is also perceived as having a strong regional base. On the other hand, the ADB is considered to be too centralised and is seen as having little interaction with other donors. However, the ADB was perceived very differently in the various Asian countries. The IDB was perceived as an active, efficient and open Bank.[16]

There are some characteristics that are viewed as relevant to all the multilateral organisations.

- The multilaterals seem to have become *more open* and tend to share information more frequently than has been the case until recently. However, this has often taken the form of notifications rather than real consultations.
- Many of the informants attribute the behaviour of the various organisations largely to *personal factors* and not to institutional ones. The organisations seem to be structured in such a way that the effects of individual personalities come to dominate. Even if individual preferences are viewed as critical for organisational behaviour, it is held that they tend to respond more to the needs of the headquarters than to the host government in the country that they work in.
- It is seen as a general weakness that they are all very *hierarchical*.
- Moreover, the multilateral organisations are seen as being more *project-oriented* than many of the bilateral donors. Since many of the bilateral donors are moving more in the direction of sector programmes, there may in some instances be less cooperation among bilaterals and multilaterals at project level.
- It is suggested that the UN organisations should utilise to a larger extent the comparative advantages embedded in their *normative mandates* and entrenched in their charters, covenants, treaties and declarations.
- In addition, it is emphasised that there should be a clearer *division of roles* among the multilaterals, particularly with regard to the "new types of aid arrangements" like SWAP.

To sum up: the arguments presented above indicate that the perceptions of the MOPAN representatives do not always coincide with all the common stereotypes. The multilaterals are perceived to have the ability to change and are believed to have become more open and flexible in recent years. The existence of such perceptions will also be illustrated in the two following

[16] We have too little information to provide a clear characterisation of the IDB.

chapters. All the same, some of the stereotypes are confirmed. The multilaterals are still perceived as being hierarchical bureaucracies that sometimes respond more to the demands of their headquarters than to national needs.

4. Fostering ownership

What are the issues?

In the international aid community there exists a broad consensus view that if ownership is not fostered and seized on at the recipient end, real partnerships and sustainable development cannot be achieved. "More ownership and less donorship" was DAC's main message in its 1997 annual report (DAC 1998). Nowadays "ownership" is on everybody's lips in the international aid community. But what does it mean?

Judging by the ways in which 'ownership' has been used in the international aid debate it appears to be a complicated and fuzzy concept. Hardly any of the aid agencies have a clear operationalisation of it, and it is beyond the scope of this report to go into any thorough discussion of ownership.[17] In this study it was agreed to look at ownership not only from the point of view of the recipient government, at the central level, but also more broadly in recipient countries. Fostering local capacities is a key concern. In order to reveal how the multilaterals have contributed to spurring ownership the respondents were asked about the following issues:

- (1) the multilateral agencies' contributions to enhancing national and local capacity; (2) contributions to promoting participatory processes; (3) willingness and ability to align with host governments' procedures; and (4) willingness and ability to lower flags.

Rather low "scores" on capacity building

On the issue of how effective the multilaterals have been in building capacity for health policy formulation among important stakeholders during the last 3 years the answers differ. Very few of the respondents were of the opinion that any of the organisations had been very effective in this respect at the *central level*. The World Bank gets the "highest score", and 46 per cent believed that it has been *fairly effective*. 44 per cent held that WHO had been fairly effective, while the figure for UNICEF was 41 per cent. If PAHO is lumped together with WHO the figure rises significantly to 49 per cent, due to the fact that as many as 80 per cent of the respondents assessing PAHO believed that it had been fairly effective. However, between 16 and 22 per cent of the respondents believed that the organisations had not been effective in building capacity at central levels.

With regard to capacity building in public institutions at *sub-national levels,* even fewer were of the opinion that the organisations had been very effective in this respect. Still, nearly 50 per cent believed that UNICEF had been *fairly effective,* while the figures for WHO and the World Bank were 41 and 30 per

[17] For more thorough discussions on ownership see Killick 1998; Sida 2002; Molund 2000.

cent, respectively.[18] With respect to capacity building in the private sector and among NGOs the respondents possessed scant knowledge of all organisations. This could possibly be explained by the fact that the selected organisations have not been very active within these areas.

Weak on promoting participatory processes

Another means of fostering ownership is to encourage participation. On the issues of actions taken to promote participation among primary stakeholders, especially poor people and health workers, 49 per cent believed that UNICEF had actively supported initiatives that had resulted in wider national or local consultations, such as public hearings, conferences, beneficiary assessments and so on. The figures for WHO and the World Bank are 38 and 30. On the issue of whether the agencies have consulted widely on their own strategies and analytical work the World Bank gets by far the highest "score". However, at the same time as many as 46 per cent stated that the World Bank was primarily in dialogue with the Ministry of Health. The corresponding number for WHO was 41 per cent. Very few believed that UNICEF had such a limited range of discussion partners, supporting a perception of UNICEF as the organisation with the widest popular outreach.

Alignment – a long way to go

An important principle with regard to fostering ownership is alignment. The international aid community has agreed that their programmes should be aligned with national poverty reduction strategies or, for those countries that do not have one, the aid programmes should be adapted to national strategies in various areas. Alignment towards national policies, institutional structures and administrative procedures is viewed as an essential step towards enhancing and fostering ownership in partner countries (see World Bank 2003).

Few of the respondents seemed to believe that WHO and the World Bank had revised their health strategies in the light of national PRSPs. However, approximately 50 per cent believed that the two organisations' health strategies were in line with national strategies, so there was probably no need to revisit them. More than twice as many believed that the World Bank's new proposals and projects were identified on the basis of national PRSs than those who thought this was the case regarding the WHO. However, the World Bank's "score" is only 27 per cent.

The number of respondents that held the view that World Bank funds were disbursed through government budgets was also double the figure for WHO and UNICEF. Once again, though, the World Bank's "score" is low, only 32 per cent. Nevertheless, the Bank is believed to be the agency that participates

[18] However, the respondents have less knowledge about the role of the World Bank and WHO in this area. As many as 35 per cent of the respondents said that they had no information. It is not worthwhile summarising the results on the RDBs, since more than 50 per cent had no information on these issues.

most often in Sector Wide Approach-like arrangements. The figures for WHO and UNICEF are 56 and 43 per cent, respectively. There is a significant result regarding participation in pooled funding: 38 per cent are of the opinion that the World Bank participates in basket/pooled funding in the sector, while only 3-5 per cent believe that the other agencies do so. In many of the Country Reports a concern is raised that the mandate of organisations like UNICEF does not allow it to participate in these kinds of arrangement.

With regard to adopting governments' procurement procedures, only a small number believed that any of the organisations did so. The figure is somewhat higher with regard to noticeable steps taken towards accepting government reporting and accounting procedures. It is noteworthy that only about half as many respondents believed that the World Bank had done so compared to WHO and UNICEF. The figure for the World Bank is only 27 per cent. In sum, all the organisations were believed to perform rather poorly with regard to disbursing funds through government budgets, participating in basket/pooled funding, and adopting host government procedures, reporting and accounting standards.

On the issue of how far the selected organisations foster government control over new funding proposals only about 14 per cent believed that the multilaterals were only funding proposals that had been developed by the recipient. WHO is perceived to have become the most responsive to government requests and proposals in recent years. It could be mentioned that as many as 80 per cent believed that PAHO has become more responsive to government requests, but, as mentioned above, the sample is too small to draw any firm conclusions. The World Bank is believed to be most active in initiating new projects and taking the lead in identification and planning processes.

To sum up, the WHO seems to be the organisation that is perceived as the best in fostering government control over new projects and initiatives.

Table 3:
How far do the selected organisations foster government control over new funding proposals?

	PAHO	WHO	WB	UNICEF	RDBs
It funds only proposals that have been developed by the recipient of the aid	0 %	16 %	14 %	14 %	0 %
It has become more responsive to government requests and proposals in recent years	80 %	41 %	27 %	27 %	14 %
It initiates new projects and takes the lead in the identification and planning process	0 %	9 %	35 %	24 %	19 %
No information	20 %	34 %	19 %	32 %	49 %
Question not answered	0 %	0 %	5 %	3 %	19 %
N= number of respondents	5	32	37	37	37

Lowering flags: balancing different concerns

If the recipient countries are to be able to take ownership the donors need to "lower their flags". This issue was discussed in some of the focus groups. In one Asian country it was stated that WHO was the only organisation that had managed to do so. WHO was perceived as really managing to coordinate its activities with all relevant actors. It was praised for informing other actors about potential overlap or collaboration activities. In another Asian country it was reported that the multilaterals had been slow to "lower their flags". The UN agencies were perceived as being mainly concerned with demonstrating effectiveness to their clients. This created a conflict with the overall desire to "lower flags". In one of the African countries the question was raised as to whether it was wise for the multilaterals to lower their flags in the first place. It was argued that in some cases it was not, because the organisations had to find their own niches in order to attract supplementary funding, cf. UNICEF.

In practice, one probably has to balance different concerns: enhancing ownership and the need for funding. However, if the donors are serious about ownership they will have to give priority to the former.

What are the constraints of the multilaterals? Why are they not ready to act the way they preach? In one country possible constraints have been identified as lack of parliamentary oversight, weak governance, politicisation of the health sector, rigidity of the bureaucracy, and an overall perception that the interests of the civil service take precedence over national interests. In another country the World Bank and the RDB in question were considered to be working in isolation, with little interaction with other donors and without sharing information with them. The fact that some of the multilaterals had no representatives in the country is viewed as a constraint, e.g. the World Bank's health officers fly in for short missions. However, it was held that the lack of communication and coordination with the multilateral development banks is more a question of attitude than of real constraints. UNICEF did share its plans and activities with others, but was perceived as having its own agenda.

Little knowledge about participation in new funding mechanisms

On the role of the selected organisations in new funding mechanisms/global partnerships, such as GAVI (Global Alliance for Vaccines & Immunisation) and GFATM (Global Fund to fight against Aids, Tuberculosis and Malaria), the response rate of the respondents is rather low. The following answers should be treated with caution, therefore. Generally, UNICEF and WHO were perceived as being most active in these mechanisms, but WHO was perceived as being definitely most active in making efforts to ensure that the activities funded through these mechanisms were aligned with national planning frameworks and procedures. This seems to contribute to confirming the results from the issues raised above.

Host governments: ready to take ownership?

Despite the fact that many of the multilaterals have not been able or willing to lower their flags, have the recipient governments in general become more able to take ownership? In the majority of the countries it is reported that there is no indication that the government/Ministry of Health has coordinated aid to the health sector more effectively over the last three years. From one country it is even reported that there seems to have been a decline in the coordination of aid to the health sector under a new Minister of Health. It is argued that there seems to be little response to the need for aid coordination in the health sector. Nevertheless, in another country donors agree that the government is more securely in the driver's seat and that overall there is a growing commitment to the sector-wide approach. In yet another country the donors seem to be very optimistic; the government is seen as being more in control through the Sector Wide Approaches:

"*At least the Ministry of Health is in the lead and we can see it in the quality of discussions. We as partners try at times to push a point and the Ministry says this is how we want it … and they remind us that we also have the Memorandum of Understanding which is something that guides the relations within the sector*".[19]

To sum up: even if, as was illustrated in chapter 2 and will be illustrated in the subsequent chapter, the multilaterals have become more open and flexible and have shown willingness to change, there is a perception that their steps towards fostering national and local ownership are at best slow. This may appear somewhat paradoxical since the very aim of increased openness and co-ordination is precisely to foster ownership at the recipient end.

[19] Direct quotation from one of the country reports.

5. Donor cooperation and bilateral-multilateral dialogue

What are the issues?

Among donor countries and aid agencies today there exists a broad consensus on the need to increase donor cooperation and coordination. Many donors have therefore made strong commitments to co-ordinating their activities and harmonising their procedures with other partners both at country and sector level (see DAC 2003). The rationale for increased co-ordination and harmonisation is that the transaction costs of aid management will be reduced. Hence, at the recipient end one will get more value for money as the cost effectiveness increases. However, the most important reason for improved coordination and cooperation is that it may enable national governments to take genuine leadership of planned development in their own countries, despite their dependency on foreign aid. Strong ownership at the recipient side is seen as a vital precondition for any sustainable development (cf. Sida 2002; Killick 1998, cf. also previous chapter).

In this chapter the complex issues of donor cooperation and dialogue are addressed according to the following parameters: the level of donor cooperation; more generally, the level of transparency regarding information sharing; types of bilateral-multilateral interaction; and the level of harmonisation of procedures.

Level of donor cooperation varies

How have the like-minded countries perceived donor co-operation and co-ordination in the health sector? The perceived effectiveness of donor co-operation in the health sector was commented upon in nearly all the Country Reports, but no unambiguous tendency could be observed. In four of the countries – Bangladesh, Uganda, Ghana, and Malawi – donor co-operation was perceived to be good even if there still seemed to be room for improvement. In **Malawi** co-operation between multilaterals, bilateral donors, and even non-governmental organisations was perceived as functioning exceptionally well, especially during the food crisis. The food security crisis seems to have spurred more comprehensive co-operation. However, good donor co-ordination in Malawi does not seem to be related to the food crisis only. The "normal" donor co-operation in the health sector is also perceived as quite good and effective with regular meetings and ongoing discussions.

For the remaining four countries, Vietnam, Mozambique, India and Nicaragua, the co-operation is described as being somewhat less effective. For example, in Vietnam it is said that no one is taking the lead in coordination. Many examples of the lack of coordination and cooperation are given. Even if signs of improvement can be traced in some of these countries, such as

Mozambique, it is stated that weak cooperation between the multilateral and bilateral agencies affects the overall sector programmes. None of the multilateral agencies were described as taking the lead in co-operation in Nicaragua and India. However, in line with the "new" aid thinking and rhetoric it is not for the donors to take the lead; it should be the host governments themselves.

In the country discussion on India it does not seem as if the group had debated the issue of effectiveness on donor cooperation in the health sector specifically. However, it was underlined that the World Bank's approach to co-operation among its development partners in India was remarkably different from what is believed to be the case in other countries. Even if the Bank was forthcoming whenever approached it was not seen to be proactive in promoting co-operation. The World Bank was active in some forums, but passive in others. In India WHO appears to be a more active participant, particularly in informal donor co-ordination. UNICEF appears to be the most proactive among the three agencies in India.[20] In the case of Nicaragua PAHO and UNICEF are seen as most active in co-ordination. However, the World Bank has become more active recently, due to the appointment of a new country representative.

Transparency vs. protection of special interests

In order to optimise donor co-operation and co-ordination a transparent multi-agency dialogue is vital. Does such a dialogue exist in the countries investigated or do agencies protect their own special interests? The same focal groups that had generally speaking experienced the best co-operation and co-ordination with the multilaterals (cf. above) were more inclined to claim that a transparent dialogue existed. But as was underlined both in the case of Bangladesh and Uganda the multi-agency dialogue is characterised as transparent even if all the organisations to a greater or lesser extent protect their relationships with national governments. In the discussion on Malawi it was concluded that there was a transparent multi-agency dialogue. It was claimed that it cannot be argued that the agencies protect their own "special relationships" with the government. Still, in the same report it is stated that the sharing of information is not as extensive as one could have hoped for.

With regard to the somewhat more "negative" half of the sample countries, Vietnam, Mozambique, India, and Nicaragua, the answers are far more diverse. In the case of Vietnam the dialogue is not described as being very transparent, with the exception of dialogue with WHO, which is portrayed as inclusive, sharing results and good contacts. The World Bank and ADB are depicted as pursuing their own agendas and working directly with relevant government departments. They are not assessed as inclusive. UNICEF is described as an implementer of activities more than a contributor to policy

[20] The respondents in India chose not to assess the ADB due to the fact that, firstly, only direct health sector interventions were considered to be the focus of this exercise, and, secondly, the respondents were mainly officers responsible for the health sector and none of them had sufficient information on ADB's interventions.

dialogue. It is believed that UNICEF should have less to share and therefore also less to protect, but it was still felt that it was guarding its own territory of work. If transparency in multi-agency dialogue means actively sharing information, this is hardly the case in Nicaragua. However, what kind of information is being shared varies greatly among the various agencies. In the process of developing country assessments and country strategies/programmes all organisations tend to share documents. But they usually only share documents once they have been finalised.

As illustrated above, the answers are diverse and there seem to be great differences of opinion both across and within the countries surveyed. It is interesting therefore to find out whether they correspond with the results from more specific questions, but then presented at an aggregated level.

On information sharing – low except for the World Bank

The respondents were asked to what extent the selected organisations share information with other donors working in the health sectors about missions (timing, terms of reference, findings and so on). The World Bank is perceived as being much better than the other organisations in this respect. 43 per cent held that the World Bank shares information about missions in almost all instances, while 46 per cent assumed that it shares information about missions occasionally. The figures for WHO/PAHO are 27 per cent in all instances, and 49 per cent said that information was shared occasionally. For UNICEF the corresponding numbers are 16 per cent and 51 per cent, and in the case of the RDBs, 3 and 41 per cent.

The most common form of information sharing among all the organisations is dissemination of and consultation on findings. 57 per cent of the respondents believed that the World Bank shared such information. The figures for PAHO/WHO, UNICEF, and the RDBs are 35, 32 and 27, respectively. The World Bank is the organisation which clearly achieved the highest "scores" on all types of information sharing, which includes consultation on terms of reference, information on mission timing and itinerary, and debriefings at the end of mission. However, only with respect to the two latter items did it achieve scores above 50 per cent. For all the other agencies the "score" was rather low on all types of information sharing. The conclusion here must therefore be that there should be ample room for improvement in this respect.

Transparency practised upon request

Country assessments, strategies, and programmes are important steering documents for the multilateral organisations. To what extent are the organisations open and transparent in developing these tools? The organisations are not perceived as taking a proactive role in sharing documents during these processes, but more than 50 per cent of the respondents were of the opinion that all the multilaterals are forthcoming when information is requested. However, it should be mentioned that the RDBs do not follow this pattern. The figure for the RDBs is 24 per cent, but

as many as 35 per cent stated that they had no information about this issue. In this case the World Bank stands out as the most open and proactive organisation. 41 per cent of the respondents considered it to be proactive in these processes. 41 per cent also stated that it invites bilateral donors to comment on drafts. The figures for the other agencies were on average less than half of these scores. UNICEF seems to rank second after the World Bank.

Table 4:
In your experience, are the selected organisations open and transparent in their process for developing country assessments and country strategies/programmes? [21]

Multiple answers allowed	PAHO	WHO	WB	UNICEF	RDBs
It is proactive in sharing documents during the process	0 %	19 %	41 %	24 %	8 %
It invites comments on drafts	20 %	13 %	40 %	27 %	14 %
It is forthcoming when information is requested	40 %	59 %	54 %	54 %	24 %
Tends not to share	40 %	13 %	5 %	16 %	16 %
No information	20 %	19 %	11 %	19 %	35 %
N= number of respondents	5	32	37	37	37

On corporate behaviour – noticeable improvements

Viewed from the country level, to what extent have the four multilaterals changed their corporate behaviour in the last 3 years and in what ways? Here the answers vary greatly among the various countries.

> *In **Bangladesh** the WHO is perceived as having become more active in the health consortium. UNICEF has also become more active, e.g. by seeking the active engagement of other donors in reviewing its country programme documents. The same goes for the World Bank, but some donors believe that the recentralisation of the Bank's health operations has had a negative effect on its willingness to share information. This argument is highlighted also in several of the other country reports (cf. Chapter 3 and the paragraph on weaknesses and strengths).*
>
> *In **Ghana** some of the multilaterals such as the World Bank are believed to have changed their behaviour by fully joining SWAPs. WHO is felt to have become more open and accessible and respondents think that its capacity has increased. UNICEF and AfDB are perceived not to have changed their behaviour.*

[21] The total number of respondents includes those who had no information about the issue.

*In **Vietnam** it is believed that few changes have taken place, the exception being WHO under the new Country Representative. Previous efforts to improve coordination have allegedly led to few changes, despite good coordination in some sub-sectors. Coordination among the ministries in Vietnam is perceived as being poor. In the Health Sector Working Group that meets regularly in Hanoi, for example, in which donors interested in the sector contribute information about their programmes and plans, the World Bank, ADB and UNICEF are absent. Nor are any government representatives perceived to be participating, not even the MoH. The like-minded donors and WHO are thought to be very active in this forum. Nevertheless, generally speaking, even among the like-minded donors co-operation is assessed as poor, although they do still exchange information and ideas.*

*In **India** the World Bank is not seen as proactive in promoting co-operation, although always forthcoming whenever approached. There are differing interpretations of this kind of behaviour, but some maintain that it is not needed. There is a general agreement that the Bank shares information occasionally, but always upon request. A general opinion is that the Bank is inactive in informal coordination meetings, but an active participant in theme groups, such as UNAIDS. Most members stated that the level of co-ordination with the Bank has increased during the last three years. The country director has taken steps towards greater co-operation in this period. Action has been taken to avoid overlap and duplication of the work of others.*

With regard to WHO, the respondents in India are divided on whether the level of co-operation had increased, but did state that WHO had taken steps to avoid overlap and duplication. The views were also mixed regarding noticeable changes in the management and attitudes of local offices. Some felt that the country officer had been empowered to take decisions, while a majority held that this was not the case.

In India all of the respondents stated that the level of co-ordination with UNICEF had increased during recent years. Most of them also believed that measures were taken to avoid overlap and duplication with other actors. Only a few thought that the head of UNICEF country office was empowered to take decisions without referring back to its headquarters.[22]

*In **Mozambique** the level of coordination between the like-minded countries and UNICEF was believed to have increased during the last few years. Opinions of the level of co-ordination with regard to the World Bank are divided, while it is perceived to have decreased or as being non-existent with respect to WHO, which is thus found to be*

[22] It should be added that there does not exist a health sector working group in India, which has made co-ordination difficult. UNICEF was particularly dissatisfied with this fact, and claimed that it would initiate dialogue amongst donor agencies and support the constitution of such a working group (cf. summary of discussion between MOPAN representative and UNICEF, India).

working in isolation. It is argued that UN organisations need to coordinate instead of fighting for their own image and position. It is suggested that they make better use of their knowledge and experience, and that they define their specificities, whereby they can bring valuable input to the overall aid partnerships. On the other hand, UNICEF's head of mission is perceived as improving the agency's image in terms of cooperation, communication, and decision-making.[23]

Types of multi-bi interaction

More specifically, what kind of co-operation has taken place between the like-minded countries and the various multilateral agencies in the last 3 years? Obviously, the forms of co-operation vary greatly among countries and organisations. Still, in the following we shall try to suggest some general trends. The most common form of interaction between the like-minded donors and the multilaterals is participation in the same health sector group. On average 75 per cent had participated in health sector coordination groups with the various agencies, again with the exception of the RDBs, where the figure is 43 per cent.[24]

The second most common form of interaction is participation in the same sector programme. More than 50 percent of the respondents said they had worked together with the World Bank in planning or strategy formulation. In addition, the majority of respondents held that they had the most extensive co-operation with the Bank. WHO and UNICEF rank second and third, respectively.

Co-operation has increased

At a general level a majority of the respondents had the view that coordination with PAHO, WHO and the World Bank had increased in the last 3 years, again with the exception of the RDBs, where no coordination was believed to be the rule. Is there any evidence of more coordinated behaviour amongst the multilaterals? 60 per cent knew of cases where the World Bank had taken concrete steps to avoid overlap with other donors. The figures for WHO and UNICEF are 50 and 41 per cent, respectively. Still, between one-fourth and one-fifth believed that the World Bank, UNICEF, WHO, and PAHO worked too much in isolation. Approximately 40 per cent had the same opinion of the RDBs. The results are illustrated in the tables below:

[23] It could be mentioned that many of the perceptions presented here are not shared by the multilateral organisations themselves. However, most of them were shared by host government representatives.

[24] Even if the sample on the PAHO is very small, it should be mentioned that 100 per cent of the respondents answered that they had participated in such coordination groups.

Table 5:
Has your level of coordination with the selected organisations changed during the last 3 years?

	PAHO	WHO	WB	UNICEF	RDBs
Increased in last 3 years	40 %	59 %	60 %	57 %	24 %
Remained unchanged	40 %	25 %	22 %	19 %	5 %
Decreased	0 %	3 %	11 %	5 %	0 %
No coordination	0 %	6 %	3%	14 %	51 %
Question not answered	20 %	6 %	5 %	5 %	19 %
N= number of respondents	5	32	37	37	37

Table 6:
Is there evidence of more coordinated behaviour amongst the selected organisations? [25]

Multiple answers allowed	PAHO	WHO	WB	UNICEF	RDBs
I know of cases where the organisation took concrete steps that avoided overlap with other donors	0 %	50 %	60 %	41 %	16 %
I know of cases where the organisation failed to prevent unnecessary/ conflictual/wasteful overlaps	0 %	6 %	11 %	14 %	3 %
I find that the organisation today works too much in isolation from other donors in the health sector	20 %	22 %	24 %	22 %	38 %
No information	40 %	13 %	8 %	19 %	30 %
N= number of respondents	5	32	37	37	37

Poor knowledge of harmonisation of procedures

Another key issue in the aid discourse in recent years has been harmonisation of procedures with **other donors** in respective countries, in addition to alignment to the procedures of host governments (cf. chapter 4). For all the organisations, between 60 and 100 per cent of the respondents had no knowledge of harmonisation of procedures, such as harmonisation of salary levels, fee rates for national consultants, procedures for international tendering and procurements and so on.[26]

Field behaviour: institutions count – personality decides

The respondents were also asked whether they had observed changes in management and attitudes in the local offices of the selected agencies over the last 3 years. A majority of those who answered the question were of the opinion that the heads of the local missions of the World Bank and UNICEF have become more able to take decisions without referring back to

[25] The total number of respondents includes those who had no information about the issue.
[26] Since the response rate was so low, there is not much to be gained by elaborating these results.

headquarters.[27] A majority of the respondents assumed that this had not been the case for PAHO, WHO and the RDBs.

On the issue of whether the communications skills of the mission staff and their attitudes to working with others had improved significantly, a majority of the respondents that answered this question believed that communication skills had improved for all the organisations with the exception of the RDBs.[28] Another interesting result is the fact that a clear majority of the respondents held that the head of mission of the World Bank, UNICEF and WHO had contributed to significantly improving cooperation. That individual factors and personality is important also stands out clearly from the country reports.

How to improve multi-bi dialogue and co-operation?

What can MOPAN members do to improve dialogue and co-operation with the four multilaterals? Here the answers vary among the different countries, which reflects the very different context in which the multilaterals are operating. However, some of the suggestions formulated in the country reports have general relevance. These are summarised as follows:

- There seems to be a considerable knowledge gap with respect to the multilaterals.
- The bilaterals must do more to understand their multilateral partners and help foster their comparative advantages.
- It is felt that the main barrier to more partnership among donors is that not all are willing or able to give up on their own procedures and requirements, so that joint financing and project design can be implemented. These obstacles should be identified and then removed.
- PRSP and similar arrangements are viewed by many as a way to make it easier for donors to collaborate and share information, because it provides a basic country strategy on which all donors can build programmes or select components. However, in practice these strategies are not always felt to be useful as a framework for partnerships in the health sector, as they often include few health topics.
- Identify more meetings and visits for exchange of information between the bilaterals and multilaterals.
- Plan joint studies or research projects in which both parties have an interest.
- Invite multilaterals to share in monitoring and evaluation of programmes and projects and offer to join in theirs as well.
- The different multilaterals should be persuaded to have at least one person in the host country with responsibility for health.
- Work towards harmonisation of rates for consultants and certain specific activities.

[27] However, for the World Bank, which had the highest score, only 35 per cent ticked yes, while 22 per cent ticked no.

[28] Once again the response rate with regard to the RDBs is too low to draw any firm conclusions.

- Work through the counterparts, the MoH for example, to increase dialogue with the multilaterals, especially the development banks.
- The multilaterals must learn that they are accountable to bilateral stakeholders.
- Since it is the headquarters which determines the level of funding for the multilateral organisations, increased dialogue is also needed at this level. In this respect headquarters needs to listen more to country level comments.

6. Perceptions of development effectiveness

A critical issue, but difficult to address

It should be underscored that the ambition of this pilot is not to make an assessment of development effectiveness per se. Making any reliable judgement of development outcomes and impact is very difficult in itself and would require a far more complex and sophisticated methodology than utilised for this report. Nevertheless, representatives from the like-minded countries strongly urged that the pilot include a section on development effectiveness. The following paragraphs will hence deal with perceived effectiveness or assumptions of effectiveness, which obviously may depart significantly from 'real effectiveness'.

The informants were asked whether they considered themselves to be in a position to have informed opinions on the effectiveness of the selected agencies; about the main sources that may have formed their opinions; and about how to characterise the effectiveness of the different multilateral organisations with regard to achieving development goals.

Despite the fact that development effectiveness is hard to measure, a *slight* majority of the respondents believed that they have qualified opinions on the effectiveness of the World Bank, UNICEF and WHO/PAHO. Only 22 per cent of the respondents thought that they could assess the development effectiveness of the RDBs. If we split WHO and PAHO, 47 per cent believe that they possess such knowledge with regard to WHO. The figure for PAHO is 80 per cent, but again the sample of questionnaires assessing PAHO is too small to draw any conclusions. The number of respondents who believed that they were able to judge development effectiveness regarding the World Bank is higher than is the case with respect to UNICEF, WHO and the RDBs.[29] The most common source of information is their own observations, and then reports of the various agencies. Personal informants rank third.

Little difference in perceived effectiveness between UNICEF, the World Bank and WHO

The informants were asked to characterise the effectiveness of the selected multilaterals in terms of various parameters: whether they contributed to the governments' top priorities for the health sector; whether they followed up on their own strategic priorities in terms of specific actions for the health sector; and finally, whether result-based management systems were in place.

[29] The figure for the World Bank is 60 per cent, while the figures for WHO and UNICEF are 47 and 51 per cent. As many as 65 per cent of the informants believed that they were in *no* position to have an informed opinion about the RDBs.

60 per cent perceived PAHO as contributing *very effectively* to the host government's top priorities for the health sector. The figure for UNICEF, the World Bank, WHO and the RDBs are 43, 41, 41 and 5 per cent, respectively. Approximately 40 per cent believed that PAHO, the World Bank and UNICEF contributed to the government's top priorities *to some extent*, while 47 per cent believed that WHO does so.[30] In sum, there is little difference in perceived effectiveness between UNICEF, the World Bank and WHO.

On the issue of whether the organisations follow up on their own strategic priorities in terms of specific actions for the health sector, considerably fewer had any opinions. A quarter had no information on this matter regarding WHO, UNICEF and the World Bank; as many as 54 per cent stated that they had no information about the RDBs.

Of those who answered this question, approximately 30 per cent believed that UNICEF, WHO and the World Bank follow up on their priorities. About 30 per cent were of the opinion that they do so to some extent.[31] UNICEF gets a marginally higher "score" than the World Bank and WHO. 35 per cent believe that UNICEF does so to some extent.

On the issue of whether the organisations have result-based management systems in place, on average approximately 50 per cent of the respondents said that they had no information about the issue. Of those who replied, twice as many respondents believed that UNICEF had such a system in place compared to the World Bank and WHO.

In sum, the only significant results regarding effectiveness are that PAHO is perceived as very effective, while the RDBs are perceived as very ineffective. However, for the reasons mentioned above, any conclusion with regard to these agencies should be treated with the utmost caution, as there is also variation in the response among the RDBs. All in all, there is very little difference in the perceived effectiveness of UNICEF, the World Bank and WHO, even if it may be argued that the first is assessed as being slightly more effective than the other two. But again, looking at the various countries more specifically, important differences occur. In one of the Country Reports WHO is, for example, singled out as being by far the most effective agency.

> *In the Country Report on **Vietnam** WHO is praised for its effectiveness, for providing key advice and technical assistance, and for liasing well with others who could provide more funds. The World Bank's projects, on the other hand, are not perceived to be very effective. UNICEF is characterised as 'ambiguous,' since it focuses on its own programmes and its activities are not well coordinated with others. It is suggested that personnel changes may have negatively affected development effectiveness. Large information gaps with*

[30] With the exception of the RDBs nearly all informants believed that they had information on this issue.

[31] On the issue of whether the multilaterals had result-based management systems in place too few had any information on this matter to allow for a meaningful interpretation of the results.

regard to the effectiveness of the World Bank and UNICEF are believed to exist. WHO, on the other hand, is perceived as sharing its reports and evaluations. It is suggested that all agencies should be encouraged to do so. They should also be expected to participate in and contribute to the Health Working Group. By not communicating often enough the multilaterals may have missed opportunities for additional funding for future programmes. It is underscored that it would be useful to have presentations of programmes and evaluations to share lessons learned from the work done in the country in question as well as elsewhere, in order to identify best practices that could improve project performance. It is believed, though, that a sector-wide approach would encourage more sharing of ideas, plans and evaluations that could lead to joint recommendations to the MoH about activities. It is argued that if the multilateral organisations could join forces with the like-minded countries, recommendations to the MoH would have more impact.

*In the case of **India** it is emphasised that WHO has contributed to improvement in important areas. The government of India (GoI) is frequently assisted by WHO. It is believed that WHO has developed a framework for performance assessment, but its circulation and usage in India is perceived to be poor. WHO is seen as being effective in providing technical assistance to the GoI. Still, it was felt that WHO needed to be more proactive in collaborating with other agencies to increase development effectiveness. A majority of the members of the focus group held the view that both WHO and UNICEF contribute very effectively to the government's top priorities on health. UNICEF has also established a result-based management system. This system should allegedly be in place and in use. UNICEF and WHO were assessed as being equally effective, while the Bank was perceived to be somewhat less effective. It should be mentioned that considerably fewer felt they were in a position to comment on the World Bank.*

*In the case of **Malawi** the respondents felt that they were in no position to make any real assessment of effectiveness; nevertheless, they revealed their perceptions. There were great differences in perceptions of the effectiveness of the various organisations among the members of the focus group. However, there seems to be a pattern whereby UNICEF comes out on top with regard to effectiveness, while WHO is perceived as being in the process of improving. AfDB is judged as not being very effective. UNICEF is viewed as most effective regarding following up its own priorities, while the World Bank and WHO are viewed as less efficient in this respect. The Country Report on Malawi concludes that the current changes in the multilateral agencies had few implications for most of the aid programmes of the MOPAN countries. One possible explanation of this fact was suggested to be more "up-stream co-operation." A gradual move towards a programmatic approach has changed the mode of co-operation. However, this transition entails less use of the multilateral agencies as channels for project aid and more cooperation on policy.*

It is believed that increased co-operation will reduce transaction costs, and hence increase the cost-effectiveness of aid operations.

In the case of ***Nicaragua*** *PAHO and UNICEF are believed to have result-based management systems in place. The World Bank and the IDB are believed to do adequate monitoring, but their follow-up routines should be improved. It is felt that the various agencies appear to have a somewhat limited ability to participate in SWAPs and programme-based approaches. The multilaterals seem to prefer to maintain parallel relationships with the government outside the newly established donor mechanisms, which again may have negative effects with regard to effectiveness.*

Nearly all the Country Reports underline the fact that it is very difficult to have informed opinions on development effectiveness. This fact is most boldly spelled out in the reports on ***Uganda*** *and* ***Ghana.*** *In* ***Bangladesh,*** *on the other hand, it is believed that it is possible to have informed opinions on development effectiveness, although it will largely depend on the commitment of resources allocated to the respective missions. Hence, the report on Bangladesh concludes that it is possible, but difficult, to assess effectiveness, largely due to information gaps. There is a perceived lack of information on achieved results. Moreover, evaluations containing objective and verifiable indicators of performance as supplements to the existing ones, which focus on expenditure levels, seem to be needed. It is underlined, however, that this is an issue that is of equal relevance to the bilateral donors.*

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Multilateral Organisations Performance Assessment Network (MOPAN)

Questionnaire for MOPAN-member country office staff

Dear respondent,

The purpose of this questionnaire is to get your views and professional judgement on the performance of four selected multilateral organisations in the **health sector** in your country – WHO, World Bank, UNICEF and the respective regional development bank. (For some countries not all four of these organisations are active in the health sector). The TORs for the study and background information on each organisation are available for you to consult.

The issues relate to how these organisations are performing at the country level in terms of their support for country owned policies, PRS alignment and donor coordination. We are particularly interested in knowing whether you have observed important changes in recent years, and we refer to the last 3 years (i.e. since 1999).

The idea behind this questionnaire is to get your **personal assessment**, based on your observation of and contacts with the organisations – not an institutional response. You will also have the opportunity to participate in a group discussion with other MOPAN-member colleagues.

For each question you will be requested to differentiate your response for each organisation. You should also bear in mind the organisation's particular mandate when making your judgements, as some questions may not be relevant to the mandate and the organisations' presence at country level. Please note that for several of the questions it might be relevant to tick more than one box for each organisation. These questions are marked: *multiple answers allowed*. Where you find that your own experience and knowledge is too thin to make an informed opinion we encourage you to tick the 'no information' box. On the other hand, we would encourage you to add further comments or specific examples. In doing so, please identify the organisation you refer to.

Although it will not be possible to guarantee full anonymity in a survey based on such a limited number of respondents in each country, utmost care will be taken in the presentation of the findings from the exercise to prevent the possibility of linking particular views to individual respondents or MOPAN-members.

This is a pilot exercise, so we would value your views on the methodology.

Thank you for your cooperation,
MOPAN Working Group

Questions pertaining to the questionnaire and the methodology for the 2003 MOPAN exercise can be addressed to alf.m.jerve@cmi.no.

Questionnaire no. :_____
Please return questionnaire to MOPAN focal point:

Personal profile

This information is to give us an idea of how well you know the health sector and the multilaterals involved.

Q 1: Name country where you work: ……

Q 2: What is your position in the embassy/mission? (*tick one*)

21.6 Head of office/aid section
32.4 Programme officer – health sector specialist
27.0 Programme officer – generalist or other specialisation
13.5 Advisor/other

Q 3: How long have you worked with development assistance in the country where you are working now? (*tick one*)

27.0 0 – 2 years
35.1 More than 2 – less than 5 years
35.1 Over 5 years

Q 4: How much of your working time in your present capacity is related to the health sector? (*tick one*)

59.5 More than two-thirds
18.9 About half
16.2 Less than one-third

Q 5: What is the frequency of personal contacts with members of staff working with health in the 4 agencies?

	PAHO	WHO	WB	UNICEF	Regional Bank (RB)
Over the last 3 months how often did you attend the same meeting? (*tick one*)					
o Never	-	9.4	18.9	16.2	48.6
o 1-3 meetings	20	50.0	35.1	29.7	29.7
o More than 3	80	40.6	45.9	51.4	10.8
Over the last 3 months how often did you have bilateral discussions? (*tick one*)					
o Never	-	31.3	40.5	35.1	64.9
o 1-2 times	80	43.8	27.0	32.4	21.6
o More than 2	20	25.0	29.7	29.7	5.4

Strengthening of country ownership – quality of partnership with national stakeholders

There is broad consensus that aid effectiveness is partly dependent on the quality of donors' partnerships with national governments and other national stakeholders. The questions below aim at getting your views on a number of issues that may serve to assess partnership behaviour of the selected multilaterals in the **health sector** with the country ownership perspective in mind.

Health policy reform – the role of the multilaterals

Q 6: In your view, have there been important changes in national health policy during the last 3 years that make it ***more*** poverty oriented? (*tick one*)

Y 86.5 N 10.8 Not able to answer ❑

Q 7: If YES, what evidence would you emphasise: ……
……..
……..
……..
……..……
……..……
……..……
……..……
……

Q 8: In your view, what stands out as Government's three top priorities for the health sector?

1 ……..
2 ……..
3 ……..

Q 9: Considering the evidence mentioned in Q7 and Government's priorities in Q8, how would you assess the role and influence of the selected organisations in forming these policies?

Tick one per organisation	PAHO	WHO	WB	UNICEF	RB
Strongly influenced policy discussions, contributed important analytical work	60	62.2	70.3	40.5	10.8
Provided minor support	20	15.6	13.5	32.4	18.9
No visible role	-	9.4	5.4	10.8	37.8
No information	20	9.4	8.1	10.8	21.6

Comments/examples:
……
……
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……
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……
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……

Q 10: Do you find that the national poverty reduction strategy of the country adequately reflects what would be required to meet the Millennium Development Goals on health? [1]

Y 62.2 N 24.3 Not able to answer ❑

Comments:
……
……
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……
……

Q 11: To what extent, in your view, have the selected organisations contributed to the health component of the PRS?

Multiple answers allowed	PAHO	WHO	WB	UNICEF	RB
Had mostly a passive role or did not participate in the PRS process regarding health	-	9.4	5.4	16.2	13.5
Financed part of the preparatory work on health issues for the PRS	-	12.5	18.9	0.0	10.8
Took an active part in fora where health issues of the PRS were discussed	80	50.0	40.5	35.1	10.8
Had a strong influence on the text in the PRS dealing with health	20	15.6	24.3	8.1	8.1
No information	20	25.0	24.3	32.4	51.4

[1] Goal 4: Reduce by two-thirds, between 1990 and 2015, the under-five child mortality rate;
Goal 5: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio;
Goal 6: Have halted by 2015, and begun to reverse, the incidence of malaria, HIV/AIDS and other major diseases.

Comments/examples on the organisations' support to the national PRS process on health issues: ……
……
……
……
……
……
……
……
……

Capacity building in support of the national process of policy-making and planning in the health sector – the role of the multilaterals

Q 12: In your view, how effective has each multilateral been in building the capacity of different institutional stakeholders for health policy formulation during the last 3 years?

	PAHO	WHO	WB	UNICEF	RB
Capacity building in public institutions at central level. (*tick one*)					
- Very effective	-	18.8	16.2	8.1	2.7
- Fairly effective	80	43.8	45.9	40.5	8.1
- Not very effective	20	21.9	21.6	16.2	10.8
- Not active in this area	-	0.0	2.7	13.5	16.2
- No information	-	15.6	13.5	18.9	48.6
Capacity building in public institutions at sub-national level. (*tick one*)					
- Very effective	20	3.1	5.4	8.1	0.0
- Fairly effective	60	40.6	29.7	48.6	5.4
- Not very effective	-	25	18.9	8.1	10.8
- Not active in this area	-	-	8.1	8.1	13.5
- No information	20	28.1	35.1	21.6	56.8
Capacity building in private sector and NGOs. (*tick one*)					
- Very effective	-	3.1	5.4	10.8	5.4
- Fairly effective	20	18.8	8.1	24.3	2.7
- Not very effective	20	9.4	18.9	8.1	5.4
- Not active in this area	40	21.9	24.3	10.8	16.2
- No information	20	46.9	43.2	43.2	56.8

Comments/examples:

……
……
……
……
……
……
……
……

Q 13: What is your view with regard to the appropriateness of the technical assistance/advice on health policy/issues provided by the selected multilaterals?

Multiple answers allowed	PAHO	WHO	WB	UNICEF	RB
It can been criticised for low quality and inappropriate technical advice	-	3.1	-	5.4	-
The international advice provided is sometimes inappropriate to national needs	20	21.9	32.4	16.2	8.1
It uses international experts with appropriate knowledge about the country	60	68.8	51.4	40.5	16.2
It makes frequent use of the best national expertise	80	34.4	43.2	45.9	8.1
It does not provide technical assistance/advice	-	-	5.4	2.7	10.8
No information	-	18.8	13.5	24.3	56.8

Further comments:

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Q 14: In your experience, what has been the role in the last 3 years of the selected organisations in stimulating and broadening the public debate on health issues?

Multiple answers allowed	PAHO	WHO	WB	UNICEF	RB
It has played a strong and visible advocacy role on health issues	80	56.3	27	40.5	5.4
It has actively supported public health campaigns	60	62.5	18.9	64.9	2.7
It has made its own documents available in local language(s) and in popularised forms	60	21.9	13.5	48.6	5.4
It is not actively involved in advocacy activities	-	3.1	24.3	2.7	32.4
No information	-	15.6	27	10.8	45.9

Further comments:
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Q 15: In your experience, what actions have the selected organisations taken in the last 3 years to promote the participation of primary stakeholders (i.e. beneficiaries – esp. poor people, and health workers) and/or their representatives on issues of health policy and service delivery?

Multiple answers allowed	PAHO	WHO	WB	UNICEF	RB
Has actively supported initiatives that resulted in wider national and/or local consultation (public hearings, conferences, beneficiaries assessments etc.)	60	37.5	29.7	48.6	-
Has consulted widely on its own country/sector strategy and analytical work	-	18.8	35.1	21.6	8.1
Has mostly limited its dialogue to the Ministry of Health (or equivalent)	40	40.6	45.9	13.5	21.6
Has opened up to a broader range of national stakeholders	-	15.6	24.3	24.3	8.1
Not relevant to country programme	-	3.1	-	2.7	2.7
No information	20	18.8	13.5	21.6	54.1

Further comments:
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Progress towards alignment to national institutions, policies and administration

The international community has agreed to the principle of aligning their country programmes with national poverty reduction strategies. This is likely to involve working more closely within national institutions, policies and administrative regulations. The questions below aim to elicit your views on different ways in which the selected organisations are beginning to do this. If your country does not currently have a PRSP, please answer these questions in terms of the relevant alternative or national health strategy.

Q 16: In what ways are you aware that the selected organisations are taking steps towards alignment?

Multiple answers allowed	PAHO	WHO	WB	UNICEF	RB
The organisation's health sector strategy has been revised in light of the national PRS	20	15.6	16.2	18.9	2.7
The organisation's health sector strategy is largely consistent with the national PRS	40	56.3	48.6	45.9	21.6
New proposals and projects have been identified on the basis of the national PRS	20	9.4	27.0	18.9	13.5
Its disbursement of funds to the sector goes through government budgets – no off-budget accounts	20	15.6	32.4	16.2	10.8
It participates in Sector Wide Approach-like arrangements	20	56.3	62.2	43.2	-
It participates in basket/pooled funding in the sector	20	3.1	37.8	5.4	2.7
Its projects/programmes in the sector are administered through established offices – no separate project management units	40	34.4	27.0	24.3	5.4
Its technical cooperation programmes are oriented towards the PRS	60	28.1	27.0	37.8	10.8
It has started adopting government procurement procedures	20	3.1	13.5	2.7	-
It has taken noticeable steps towards accepting government reporting and accounting procedures	-	15.6	27.0	18.9	2.7
No information	20	15.6	13.5	18.9	43.2

Further comments:
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Q 17: What has been the role of the selected organisations in new funding mechanisms/global partnerships, such as GAVI and GFATM, if active in your country?

Multiple answers allowed	PAHO	WHO	WB	UNICEF	RB
It is involved in coordination mechanisms (ICC for GAVI and CCM for GFATM or similar coordination bodies)	80	59.4	35.1	54.1	-
It makes efforts to ensure that activities of these funding mechanisms are aligned with national planning frameworks and procedures	60	50	27.0	29.7	2.7
Not relevant	-	-	8.1	-	13.5
No information	20	25	32.4	43.2	59.5

Further comments:
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Q 18: How far do the selected organisations foster government control over new funding proposals?

Tick one	PAHO	WHO	WB	UNICEF	RB
It funds only proposals that have been developed by the recipient of the aid	-	15.6	13.5	13.5	-
It has become more responsive to government requests and proposals in recent years	80	40.6	27.0	27.0	13.5
It initiates new projects and takes the lead in the identification and planning process	-	9.4	35.1	24.3	18.9
No information	20	34.4	18.9	32.4	48.6

Further comments:

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Improving donor coordination – quality of partnerships

Most aid agencies today have made corporate commitments to harmonise their activities with both multilateral and bilateral partners at country and sector level. The assumption is that improved donor coordination and harmonisation will reduce transaction costs in aid management, and enhance efficiency and effectiveness.

In this section we ask for your assessment of how the selected multilaterals have been responding to such corporate commitments, as seen from their **health sector** operations.

Sharing of information

Q 19: In your experience, to what extent do the selected organisations share information with other donors working in the health sector about missions (timing, terms of reference, findings etc.)?

Tick one	PAHO	WHO	WB	UNICEF	RB
Almost in all instances	20	28.1	43.2	16.2	2.7
Occasionally	60	46.9	45.9	51.4	40.5
Never	20	15.6	8.1	18.9	18.9
No information	-	9.4	2.7	8.1	24.3

Q 20: In your experience, what type of sharing of information has been common?

Multiple answers allowed	PAHO	WHO	WB	UNICEF	RB
Information on mission timing and itinerary	20	31.3	56.8	16.2	18.9
Consultation on terms of reference	20	6.3	32.4	8.1	2.7
Debriefing by end of mission	20	21.9	51.4	16.2	10.8
Dissemination and consultation on findings	40	34.4	56.8	32.4	27.0
Has not experienced any of these	40	31.3	13.5	27.0	10.8
No information	-	12.5	2.7	13.5	35.1

Further comments on sharing of information:
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Q 21: In your experience, are the selected organisations open and transparent in their process of developing country assessments and country strategies/programmes?

Multiple answers allowed	PAHO	WHO	WB	UNICEF	RB
It is proactive in sharing documents during the process	-	18.8	40.5	24.3	8.1
It invites comments on drafts	20	12.5	40.5	27.0	13.5
It is forthcoming when information is requested	40	59.4	54.1	54.1	24.3
Tends not to share	40	12.5	5.4	16.2	16.2
No information	20	18.8	10.8	18.9	35.1

Further comments:
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The extent of coordination with the selected organisations

Too few of the respondents have answered this question.

Q 22: In your experience, do the selected organisations actively participate in local donor coordination structures, such as CCA, UNDAF, Health sector working groups or similar structures?

List coordination structure and tick one	WHO	WB	UNICEF	RB
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- Active participation	❑	❑	❑	❑
- Low participation	❑	❑	❑	❑
- No participation	❑	❑	❑	❑
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- Active participation	❑	❑	❑	❑
- Low participation	❑	❑	❑	❑
- No participation	❑	❑	❑	❑
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- Active participation	❑	❑	❑	❑
- Low participation	❑	❑	❑	❑
- No participation	❑	❑	❑	❑

Further details:

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Q 23: How has ***your country*** cooperated with any of the selected organisations in the health sector since 1999?

Multiple answers allowed	PAHO	WHO	WB	UNICEF	RB
We have co-financed particular projects/activities	80	37.5	35.1	37.8	5.4
We participate in the same sector programme (SWAP)	-	68.8	70.3	51.4	2.7
We participate in the same basket-funding arrangement	-	6.3	27.0	2.7	5.4
We cooperate within the local coordination mechanism for global funds	20	59.4	40.5	51.4	5.4
We have worked together in planning/strategy formulation/ appraisal	40	46.9	54.1	43.2	10.8
We have undertaken joint field missions	20	31.3	40.5	43.2	5.4
We have carried our joint evaluations	60	28.1	45.9	29.7	5.4
We participate in the same health sector donor coordination group	100	87.5	73.0	81.1	43.2
No information/ not relevant	-	3.1	2.7	5.4	32.4

Further comments:
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Q 24: Has your level of coordination with the selected organisations changed during the last 3 years?

Tick one	PAHO	WHO	WB	UNICEF	RB
Increased in last 3 years	40	59.4	59.5	56.8	24.3
Remained unchanged	40	25.0	21.5	18.9	5.4
Decreased	-	3.1	10.8	5.4	-
No coordination	-	6.3	2.7	13.5	51.4

Further comments:
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Reduction of transaction costs

Q 25: Is there evidence of more coordinated behaviour amongst the selected organisations?

Multiple answers allowed	PAHO	WHO	WB	UNICEF	RB
I know of cases where the organisation took concrete steps that avoided overlap with other donors	-	50.0	59.5	40.5	16.2
I know of cases were the organisation failed to prevent unnecessary/conflictual/ wasteful overlaps	-	6.3	10.8	13.5	2.7
I find that the organisation today works too much in isolation from other donors in the health sector	20	21.9	24.3	21.6	37.8
No information	40	12.5	8.1	18.9	29.7

Examples or comments:
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Q 26: To your knowledge, is there evidence that any of the selected organisations have harmonised procedures ***with other donors in your country***?

Multiple answers allowed	PAHO	WHO	WB	UNICEF	RB
It has harmonised salary levels and other incentives for national staff working in country office	-	6.3	2.7	5.4	-
It has harmonised fee rates for national consultants	-	6.3	8.1	2.7	-
It has harmonised regulations/procedures for local tendering and procurement	-	-	10.8	-	-
It has harmonised regulations/procedures for international tendering and procurement	-	-	10.8	-	2.7
It has coordinated reporting formats with other donors	-	6.3	21.6	8.1	-
No information	100	59.4	59.5	64.9	73.0

Examples or comments:
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Country responsiveness

Q 27: Have you observed changes in the last 3 years in management and attitudes in the local offices of the selected organisations?

	PAHO	WHO	WB	UNICEF	RB
Head of the local mission is more able to take decisions without referring back to HQ (*tick one*)	- 20	Yes 21.9 No 31.3	Yes 35.1 No 21.6	Yes 27.0 No 18.9	Yes 21.6 No 78.4
The communication skills of mission staff and their attitudes to working with others have significantly improved (*tick one*)	- 20	Yes 50.0 No 21.9	Yes 45.9 No 13.5	Yes 51.4 No 10.8	Yes 8.1 No 16.2
The head of mission has contributed significantly to improved cooperation (*tick one*)	40 -	Yes 53.1 No 15.6	Yes 43.2 No 16.2	Yes 43.2 No 16.2	Yes 8.1 No 18.9
No information	40	15.6	2.7	18.9	43.2

Comments:
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Development effectiveness

While recognising that reliable assessment of development outcome and impact require more complex methodologies, we would like to use this opportunity to seek your opinion on a few issues related to the effectiveness of the selected organisations.

Q 28: Are you in a position to have informed opinions on the effectiveness of the selected agencies?

Tick one	PAHO	WHO	WB	UNICEF	RB
Yes	80	46.9	59.5	51.4	21.6

No	20	46.9	35.1	43.2	64.9

Q 29: What are the ***main*** sources you have used to form your opinions?

Multiple answers allowed	PAHO	WHO	WB	UNICEF	RB
Organisation's own reports	60	43.8	59.5	56.8	24.3
Government's reports	20	31.3	29.7	21.6	5.4
Independent research	-	6.3	8.1	8.1	2.7
Media reports	-	18.8	10.8	18.9	5.4
Own observations	100	75	83.8	81.1	45.9
Personal informants	80	50	45.9	51.4	29.7

Comments:
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Q 30: Based on the information you have, which of the following statements do you consider most applicable to the selected organisations?

	PAHO	WHO	WB	UNICEF	RB
It contributes to the Government's top priorities for the health sector (ref. your answer to Q 8) (*tick one*)					
o Very effectively	60	40.6	40.5	43.2	5.4
o To some extent	40	46.9	40.5	40.5	29.7
o No significant contribution	-	-	2.7	2.7	10.8
o No information	-	6.3	8.1	2.7	35.1
It follows-up on its own strategic priorities in terms of specific actions for the health sector (*tick one*)					
o Very effectively	40	31.3	27.0	29.7	2.7
o To some extent	20	28.1	32.4	35.1	10.8
o Not very effectively	-	6.3	2.7	2.7	5.4
o No information	40	-	27.0	21.6	54.1
It has a result-based management system in place (*tick one*)					
o Evidence of system in place and being used	40	15.6	32.4	37.8	2.7
o Evidence of adequate monitoring but no visible follow-up	-	9.4	8.1	8.1	5.4
o System not in place or not functioning	-	12.5	5.4	5.4	8.1
o No information	60	53.1	45.9	40.5	62.2

Q 31: Have the changes in multilateral performance you have observed had any implications for on ***your own*** programme in the health sector? Please give details.

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Your opinion on the methodology

Q 32: How long did it take you to fill in the questionnaire? Between 28 and 200 minutes. The majority spent between 1 1/5 hours.

Q 33: Did you consult (persons and/or literature) before filling in the questionnaire?
Yes 45.9 No 54.1

Q 34: Could you suggest any additions or deletions?
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Q 35: Do you think you have sufficient knowledge and information about the multilaterals at country level to make the kind of assessments that a study such as MOPAN requires? Could the MOPAN objectives be achieved by an alternative methodology? Please comment!
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Thank you very much for your time.

Multilateral Organisations Performance Assessment Network (MOPAN)

Discussion Guide for Focus Group

The MOPAN exercise includes a focus group discussion with the participation of MOPAN-member country staff. To the extent possible officers responsible for the health sector should attend. Larger missions may decide to participate with two officers. The MOPAN focal point is responsible for organising the discussion and identifying a moderator. The group appoints a person to take notes and prepare a report of the discussion. A consultant may be hired for this purpose. Hence, the outcome of the focus group discussion constitutes what is referred to as the MOPAN Country Report in the Terms of Reference.

This Discussion Guide serves two purposes. It presents an outline of issues and headlines under which the outcome of the discussion should be reported to ensure some consistency in the feedback from different countries. Secondly, it is a guide for the discussion itself, but the moderator is free to conduct the discussion in the order that serves the group best.

The selected multilateral organisations differ in their mandates and programmes, and the group should clearly differentiate between them in the discussion, as well as in the report. Yet, the group is encouraged to make comparisons between the organisations as a means to stimulate the discussion.

It is expected that the group needs to set aside a minimum of 3 hours.

It is recommended to arrange the group discussion after the participants have filled-in and submitted the individual questionnaires.

1. On support to national health policy

What are the major health priorities for this country, in order that it reaches the Millennium Development Goals?
Are these well expressed in the national Poverty Reduction Strategy?
How well are the WHO, World Bank, UNICEF and the regional development bank supporting the national PRS?
What role do they play, in general, in shaping the health policy?

Bearing in mind their different mandates and country programme objectives, what are the *relative strengths and weaknesses* of the four multilateral organisations in supporting the national health policy?

2. On country ownership

Are there any indications that the Government/Ministry of Health coordinates aid to the health sector more effectively over the last 3 years?
What have the four multilaterals done to promote country ownership?
Have they been able to lower their flags?
What are the constraints?

3. On donor co-operation

How effective is donor co-operation in the health sector?
Is there a transparent multi-agency dialogue, or do agencies protect their own "special relationships" with government?
Have the four multilaterals changed their corporate behaviour in the last 3 years? In what ways?

4. On partnership with the selected multilaterals

What can the MOPAN-members do better to improve dialogue with the four multilaterals?
What issues need to be raised?

5. On effectiveness

Is it possible to have informed opinions about the development effectiveness of the selected organisations in the health sector?
What do we know and what are the information gaps?

6. On the MOPAN exercise

What advice will you give to enhance the quality and relevance of the MOPAN exercise itself?
How much time did the MOPAN focal point and the other participants, respectively, spend on the exercise?

21 February 2003

Terms of Reference

Multilateral Organisations Performance Assessment Network (MOPAN)

Joint Performance Assessment Exercise and 2003 Pilot

1. Background

1.1 A group of like-minded countries met during 2002 to exchange information and discuss possible cooperation on the monitoring of multilateral organisations. There is general agreement that with the increased focus on multilateral performance at country level, and the limited resources that each of the likeminded countries could devote to the monitoring of the organisations activities, there is much to gain from increased cooperation. To this effect, an informal network among likeminded donors called Multilateral Organisations Performance Assessment Network (MOPAN) has been established, initially consisting of representatives from Canada, Denmark, Germany, Netherlands, Norway, Sweden, Switzerland, and the UK
1.2 The MOPAN network has decided to carry out regular assessments of the work of selected multilateral organisations in a number of countries where members have their own bilateral programmes. As a rolling exercise, the monitoring should over time be able to assess most of the major organisations in important areas of their activity at country level.

2. Objectives

2.1 The general purpose of the MOPAN monitoring exercise is to improve the flow of information on multilateral performance from country level to headquarters; to allow donors to be more effective shareholders in the multilateral organisations; to increase accountability to their parliaments; and to better understand the work and priorities of the organisations concerned. A secondary purpose is to strengthen the engagement of MOPAN member country offices in the assessment of multilateral performance.

2.2 The immediate objective of the MOPAN monitoring exercise is to monitor the performance of multilateral organisations at country level against their own mandate, assessed primarily through their support to national policies and institutions, as well as through their participation in aid coordination activities and other partnerships.

2.3 The proposed outcomes of the MOPAN monitoring exercise will be:

- better information about and understanding of multilateral activities amongst political decision-makers, the public, and relevant ministerial authorities in MOPAN member countries,
- clearer picture of the value added that the different multilateral organisations can bring

to common development efforts at country level,
- more informed dialogue with the multilateral organisations, both at headquarters and at country level.

3. Design principles

3.1 The MOPAN exercise should be perceived as an opportunity for a critical, but constructive dialogue between the multilateral organisations and a number of likeminded donors, at country level as well as headquarters. It should be an open and transparent process involving the organisations assessed and host governments. Due consideration will be given to any ongoing reform or assessment processes within the multilateral organisations (e.g. the Country Focus Initiative within WHO). The MOPAN exercise should supplement the organisations' own monitoring activities and any other reviews and evaluations, and will not substitute these efforts to evaluate the development impact and effectiveness of the organisations.

3.2 There will be a joint minimum programme with a common methodology, although some members may decide to gather supplementary information or may already have planned a specific country monitoring exercise for 2003. The MOPAN monitoring exercise will be a light, rapid exercise. It will be organised so as to keep transaction costs for all concerned as low as possible, without undermining the validity of the assessments.

3.3 The annual monitoring exercise will be issue based, focused on a particular sector of relevance to the MDGs, and the key multilateral organisations operating in that sector.

3.4 The key players in the monitoring exercise will be the national embassies/country offices of the MOPAN donors, although technical advisers, consultants and national technical personnel may also be used. This is to ensure that there is clear ownership of the exercise amongst the MOPAN members' country staff; and that their knowledge is drawn on for the monitoring exercise and the subsequent Country Report. This is also a precondition for making the MOPAN exercise a forum for a productive dialogue with multilateral organisations at country level, within the common strategic framework of national development plans and poverty reduction strategies (PRSs).

3.5 At country level, the MOPAN representatives will form a working group and will carry out the assessment collectively. There will be a focal point in each country, responsible for coordinating the exercise. MOPAN headquarters staff will responsible for dialogue with the multilateral organisation at HQ level and for the preparation of a MOPAN Synthesis Report.

4. Methodological approach and focus.

4.1 The MOPAN exercise is based on the informed judgements of embassy or country office staff of MOPAN members about multilateral performance in country. The methodology is designed to focus on those aspects of performance on which they have good information through their direct contacts with the organisations and government authorities in the recipient countries. It will focus primarily on the quality of multilateral partnerships, country responsiveness, alignment to the national poverty reduction strategy (where applicable) and

participation in aid coordination activities.

4.2 This focus reflects the current emphasis in the international community on improving the way aid is delivered (through partnerships that encourage country ownership and participation), its relevance to country needs and priorities, and the degree of alignment to national poverty reduction strategies. Attention to these process issues will also strengthen national policy commitment and capacity, reducing duplication and transactions costs for governments, ultimately feeding into improved poverty reduction outcomes.

4.3 The MOPAN assessment cannot directly and fully assess the contribution of particular multilateral organisations to poverty reduction, since this would require an analysis that goes beyond the limited scope of the current exercise. It will however, draw on the informed assessment of the respondents in relation to the effective performance of the selected organisations. To the extent that the national poverty reduction strategy is becoming the key instrument for achieving poverty reduction impacts, progress with PRS alignment will also serve as an indirect measure of potential impact effectiveness.

5. The 2003 pilot exercise

5.1 MOPAN members have agreed to pilot the monitoring exercise during 2003 to test the approach, design, methodology and implementation of the monitoring exercise. Particular attention will be paid to the effectiveness of the dialogue with the involved organisations, the quality and usefulness of the information gathered and the lessons learned.

5.2 The pilot will monitor up to four multilateral organisations in 6-10 countries with a MOPAN member leading in each country and joining the process in other countries. The sector to be targeted, because of its centrality to the MDGs, is health. The organisations selected for assessment include the World Bank, WHO, UNICEF and the relevant regional development bank (AsDB). All of these are major players in the health sector and together they are broadly representative of multilateral country level activities within the sector. The organisations are also key partners in global funds relevant to the health sector, most notably the Global Alliance on Vaccine and Immunisation and the Global Fund to Fight Aids, Tuberculosis and Malaria.

Information sources:

5.3 MOPAN members will compile background information on:

- Organisation characteristics relevant for the issues to be monitored, e.g. mandate, corporate goals, corporate commitments to partnership, alignment and coordination, internal reform agenda, performance monitoring systems;

5.4 Perceptions of agency performance amongst MOPAN members in country:

- Individual perceptions: a questionnaire to be filled in by staff of country missions/embassies of MOPAN members.

- Focus group discussion: involving MOPAN member staff using a question guide.

Background information templates, questionnaire and focus group question guide are attached as annexes i-iii to these Terms of Reference.

Organisation/country selection:

5.5 The selection of multilateral organisations is based on their importance to the sector and a spread of different types of activities in the sector.

5.6 Country selection is based on the following criteria:
- at least 3 MOPAN members are involved in the selected sector;
- there is a significant activity of the selected multilateral organisations in the country;
- a reasonable geographical spread of countries;

A preliminary list of countries to be targeted in the 2003 pilot is provided in annex iv.

Outputs

5.7 Specific outputs of the 2003 pilot exercise are:

- MOPAN Country Reports prepared by the MOPAN country working groups. These will be structured around the topics covered by the focus group discussion, drawing on the individual questionnaires,
- A MOPAN Synthesis Report compiled by the consultant and the MOPAN HQ Group, based on the findings of the Country Reports and the full sample of individual questionnaires,
- A brief report on lessons learned from the 2003 pilot exercise and recommendations for the 2004 full monitoring exercise.

5.8 A consultant will be engaged (financed by Norway and Sweden) to finalise the questionnaire, support the country process via email, and compile a draft MOPAN Synthesis Report, in coordination with the MOPAN HQ group.

Consultation

5.9 Once the Terms of Reference and Questionnaires are finalised, MOPAN members will organise a consultation/information process to discuss the objectives and process of the MOPAN exercise:

- Within their own and related organisations (e.g. Ministries of Health), at HQ and country level;
- With each of the organisations to be monitored. A joint introduction letter on the MOPAN exercise has been sent to the respective organisations. At headquarters level

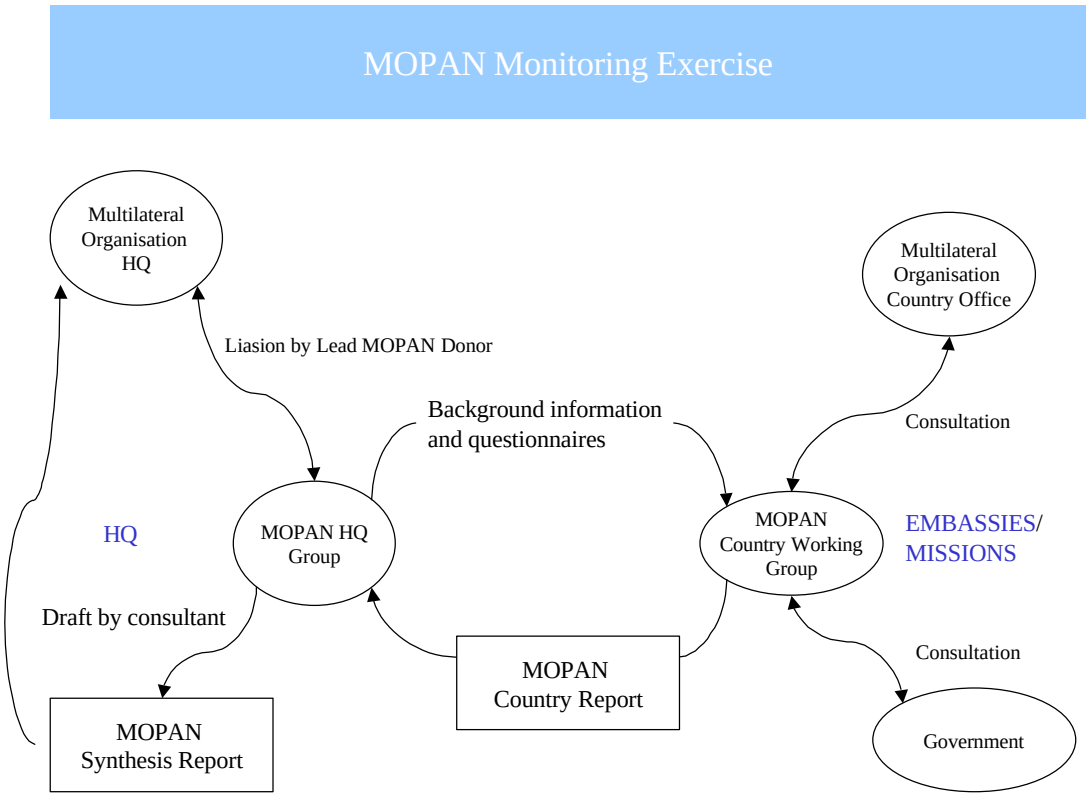
there will be a follow-up briefing by the lead MOPAN donor for each organisation, with the broadest possible participation by other MOPAN members. At country level, there will also be a preliminary consultation with the respective agencies by the MOPAN country focal point.

- With relevant representatives of the host government, e.g. relevant officials in the Ministry of Health, PRSP coordinators, aid coordination office, etc.

5.10 Once the Country Reports are finalised, they will be shared informally with representatives of the multilateral organisations concerned and with the government. Any comments received may be forwarded to the MOPAN HQ Group. The final Synthesis report will be shared with the multilateral organisations at HQ level. All reports will be available on request.

6. Activities

6.1 The steps foreseen in the 2003 pilot exercise are presented in the flow diagram below.



6.2 For each organisation to be monitored, a lead MOPAN member will be selected among the HQ group, who will be responsible for consultation with the organisation at headquarters

level. For the 2003 pilot UNICEF will be covered by the Netherlands, the World Bank by Denmark, WHO by Sweden, and the Asian Development Bank by Norway.

6.3 The lead member responsible will prepare background information for their organisation, according to the template attached at annex i, and send to the multilateral organisation HQ for information and comment. This will then be forwarded to the MOPAN country working groups.

6.4 At country level, the MOPAN focal point will be responsible for organising the following activities (the country working group will decide a format for distributing the workload):

- A preparatory meeting to discuss the objectives, design and methodology of the exercise and the structure of the Country Report,
- Distribution and collection of the individual questionnaires,
- Focus group discussion of the perceptions and judgements of MOPAN country working group of the relative performance of the organisations,
- Preparation and finalisation of the MOPAN Country Report,
- Informal consultation with government and the involved organisations.

6.5 The Country Reports will be forwarded to the MOPAN HQ group, where the consultant will prepare the MOPAN Synthesis Report in consultation with this group. The MOPAN HQ group will organise an evaluation of the pilot exercise and the lessons learned.

WORLD BANK BACKGROUND INFORMATION TEMPLATE

Note: Millennium Development Goals: Goal 1: Eradicate extreme poverty and hunger. Target: Halve between 1990 and 2015 the proportion of people who suffer from hunger. Goal 4: Reducing child mortality. Target: Reduce under 5 mortality by two-thirds by 2015. Goal 5: Improving maternal health. Target: Reduce maternal mortality by three quarters by 2015. Goal 6: Combat HIV/AIDS, malaria and other diseases. Target: Halt and begin to reverse the spread of HIV/AIDS by 2015.

	World Bank
Structure, organisation, governance and accountability	▪ World Bank Group comprises IBRD, IDA, IFC, MIGA and ICSID. ▪ IBRD is largest lender, accountable to shareholders, largest of whom are US, Japan, Germany, UK, France. ▪ IBRD is a major source of external finance for the HNP sectors in the developing world. ▪ Primary role is financing within the context of agreed development objectives. ▪ Less extensive network of country offices than WHO or UNICEF, but shift in resources and decision-making to field offices since 1997, and location of many country directors to the field.
Mandate, mission, aims and objectives (Institutional and Network)	Mandate is 'to work with governments to achieve sustainable progress in reducing poverty, promoting growth, and improving the quality of people's lives in developing countries'. The overarching goal is reduce poverty by working with borrowing countries and other partners towards the achievement of MDGs, improving living standards through supporting sustainable growth and investing in people. Human development in the Bank emphasizes: ▪ Expansion of opportunities through broad-based economic growth. ▪ Access by the poor to services that improve education, health, nutrition and population outcomes and reduce fertility. ▪ Appropriate social safety net programmes to protect especially vulnerable groups.
HNP Strategic priorities (Sectoral)	HNP sector strategy priorities are to : ▪ Improve HNP outcomes of the poor and protect the population from the impoverishing effects of illness, malnutrition and high fertility. ▪ Enhance the performance of health care systems by promoting equitable access to preventive and curative health, nutrition and population services that are affordable, effective, well managed, of good quality and responsive to clients. ▪ Secure sustainable health care financing by mobilising adequate levels of resources, establishing broad-based risk-pooling mechanisms, and maintaining effective control over public and private expenditure.

	Specific areas of emphasis include: ▪ Health systems strengthening, including sector policy reform, capacity building, governance, and health finance. ▪ Public health priorities, including strengthening of public health functions, the control of HIV/AIDS and other communicable diseases, and emerging health challenges such as growing burden of non-communicable diseases. ▪ Maternal and child health and nutrition, including immunization, reproductive health, integrated management of childhood illness, micronutrient deficiencies, and maternal nutrition. ▪ Increasing emphasis given to multisectoral interventions, such as collaboration on road safety, indoor air pollution and water, sanitation and hygiene.
Target populations	Priority groups include disadvantaged populations (e.g., the poor, populations emerging from conflict situations), as well as orphans (particularly those affected by HIV/AIDS), women of reproductive age, and increasingly children & youth (adolescents).
Links with MDGs 1, 4, 5 and 6 (see *Note*)	The Bank: ▪ Recognises links between sustainable economic growth, poverty reduction, and improved health, nutrition and population outcomes. ▪ Is fully integrating MDGs into its work. ▪ Supports efficient and appropriately financed health systems, without which MDG targets will be difficult to meet. ▪ Gives high priority to HIV/AIDS and other communicable diseases, reducing malnutrition, and improving maternal and child health through, e.g., a wide range of support to reproductive health services and immunization for childhood diseases.
Role, functions and activities	▪ Shift away from early focus on strengthening and expanding infrastructure and supplies for basic health programs, towards programs addressing institutional, capacity and systemic problems in health systems, core public health functions, together with ramped up efforts in communicable diseases and maternal and child health and nutrition. ▪ The Bank is giving greater attention to the private health sector and public-private linkages (e.g., NGOs). ▪ Sector-wide approaches in HNP are growing, as is support to HNP sectors through programmatic lending (e.g., PRSCs). ▪ Multisectoral initiatives gaining prominence, both within the context of achieving the MDGs (e.g., with water supply/sanitation and indoor air pollution), as well as other areas (e.g., road safety with transport sector).

Comparative advantages	▪ Knowledge Bank emphasizing dissemination of best practice and detailed analytical work. ▪ Scale of lending and improvements in flexibility of instruments to meet financing needs in priority areas (e.g., polio eradication, HIV/AIDS), and capacity to leverage significant resources from other partners. ▪ Influence on policies and priorities of borrowing countries. ▪ Active participation in a wide range of partnerships in the HNP sectors, among them UNAIDS, Global Alliance for Vaccines and Immunization, International AIDS Vaccine Initiative, Stop TB, Roll Back Malaria, Global Forum for Health Research, Global Alliance for Improved Nutrition. ▪ MDG focus is on country implementation and health systems strengthening
Budget	▪ Budget 1999 FY: IBRD/IDA $1.256 billion; IFC $230.2 million; MIGA $19.5 million. ▪ In 1999, social sectors accounted for 25% of IBRD/IDA lending. ▪ 33% lending for population and reproductive health, 15% nutrition, rest to health. Note: In FY02, the Bank adopted a new scheme based on economic sectors and themes reflecting corporate priorities by which to classify lending (See Annual Report, FY02, Box 2.1 & Table 2.2). ❑ In FY02, total lending for "Health and Other Social Sectors" amounted to $2.4 billion, of which $1.4 billion for health, nutrition and population. ❑ At $1.4 billion, HNP represented some 7% of total Bank lending ($19.5 billion) in FY02. ❑ Thematically, Health Systems Development and Communicable Diseases dominated HNP lending in FY02, followed by Child Health, Reproductive Health, and Nutrition.
Monitoring and evaluation, performance measurement systems	▪ Significance of Monitoring & Evaluation increased notably in recent years. ▪ Implementation Completion Reports (ICRs) used to determine project performance. ▪ Recent shift to sector-wide strategic evaluations, building international and national capacity to measure HNP outcomes for the poor, and progress towards MDGs (including monitoring of interim targets). ▪ Active in identification of intermediate indicators, performance measures and MDG trends analysis.
Organisational reform agenda	▪ Increased decentralization of staff in the HNP Sectors (and HD more broadly). ▪ Batch recruitment during FY03 focusing on filling skills gaps in health economists/finance specialists, and health specialists.
Key health strategy documents	▪ 1997 Health, Nutrition and Population Sector Strategy ▪ 2002 Health, Nutrition and Population Topical Briefing to the Executive Directors ▪ 2002 Public Health and World Bank Operations ▪ 2003 Health, Nutrition and Population and the Millennium Development Goals

UNICEF BACKGROUND INFORMATION TEMPLATE

Structure, organisation, governance and accountability	▪ Governed by Executive Board with 36 members, elected by UN Economic and Social Council. Board establishes policy, reviews programmes and approves budgets ▪ Headquarters in New York ▪ 8 regional offices and 125 national offices. Highly decentralised structure ▪ Programmes in 162 countries, financed with UNICEF funds
Mandate, mission, aims and objectives	Mandate is 'to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential'. Mandate overlaps with elements of mandates of ILO, UNDP, UNFPA, UNESCO and WHO. Activities related to water and sanitation and the fight against malaria (not exclusively related to children) are widely seen as acceptable UNICEF activities. Mission creep towards women as a target group has been observed. UNICEF's mission: ▪ Is guided by the MTSP and the 2002 'A World Fit for Children', the 1989 Convention on the Rights of the Child, etc. ▪ Mobilises political will and material resources and build capacity to form appropriate policies and deliver services for children ▪ Is committed to ensuring special protection for the most disadvantaged children. ▪ Responds to protect the rights of children in emergencies. ▪ Aims to promote the equal rights of girls and ensure their full participation in political, social and economic development. Through its mission and through EB decisions, UNICEF is adhered to co-ordination within the UNDG and CCA/UNDAF frameworks (at HQ level) and to contribution to PRSPs and participation in SWAps. Objectives: MDGs (see below). Priorities and actions set out in the MTSP (Mid-term Strategic Plan) for 2001-2005 and 'A World Fit for Children' (2000-2010).
Strategic priorities and health priorities	UNICEF is moving from vertical approaches delivery in immunisation, nutrition, and water and sanitation programmes towards integrated programmes guided by child rights. Priorities for the next 5 years are: ▪ Girls' education ▪ Integrated early childhood development ▪ Immunisation Plus ▪ Fighting HIV/AIDS ▪ Improved protection of children from violence, exploitation, abuse and discrimination

	Health focal areas 'reflect international development and health goals': Immunisation Plus: ▪ Strengthening routine immunisation: GAVI and Vitamin A Global Initiative; vaccine supply. ▪ Accelerated disease control: polio eradication; measles mortality reduction; maternal and neonatal tetanus elimination. Community health: child and maternal survival: ▪ Malaria. ▪ Community Integrated Management of Childhood Illnesses (CIMCI). ▪ Maternal and newborn health. HIV/AIDS ▪ PMTCT ▪ Prevention among young people ▪ Orphans ▪ Care and support of infected children Health in emergencies
Target populations	Children and adolescents
Links with MDGs 4, 5 and 6 (see *Note*)	UNICEF has set interim goals related to the MDGs: ▪ Reduce infant and under 5 mortality by at least one third by 2010 ▪ Reduce maternal mortality by at least one third by 2010 ▪ Reduce by 2005 HIV prevalence among young men and women aged 15-24 in the most affected countries by 25% and 25% globally by 2010
Role, functions and activities	Examples of activities reported in 2002 include: ▪ Provision of 2.3 million mosquito nets and 540 million vitamin A capsules through the Micronutrient Initiative ▪ Development of Nutrition Surveillance Systems, promotion of iodised salt ▪ Training for community growth monitoring ▪ Support for birth registration ▪ Provision of safe drinking water ▪ Support for PMTCT programmes in 47 countries ▪ Immunisation against measles in partnership with WHO and other agencies in the Measles Initiative ▪ Support for tetanus immunisation to reduce maternal mortality ▪ Life skills programmes for school children and adolescents to prevent HIV/AIDS

Comparative advantages	▪ Delivery of maternal health and child survival interventions ▪ Advocacy and communication ▪ Mobilising donor support and national governments ▪ Humanitarian assistance ▪ Extensive field presence ▪ Outreach ▪ Multi-sectoral work scope resulting in integrated approach
Budget	▪ Global budget approximately $1,225 million in 2002, from government/ inter-governmental organisations (64%) and non-government/private (33%). US is largest government donor, then Japan, then the Netherlands. ▪ 2001 spend: Immunisation Plus 24%; HIV/AIDS 7%; Integrated early childhood development 36%.
Monitoring and evaluation, performance measurement systems	▪ Reviews progress with implementation of World Summit for Children goals in *The Progress of Nations*, *The State of the World's Children* ▪ Has introduced results-based management ▪ Establishment of an independent Evaluation Office.
Organisational reform agenda	▪ not applicable
Key health strategy documents	▪ Recent Accelerating Progress Towards the Health MDGs (An Action Plan Storyline—Draft Revised November 22, 2002) ▪ Concept note for an action plan to accelerate progress toward the health, nutrition and population millenium development goals ▪ Operational Guidance Note for the Medium Term Strategic Plan (2002-2005 - Executive Directive 2002-029 dated 16 November 2002):*the Health section*

WHO BACKGROUND INFORMATION TEMPLATE

Note: Millennium Development Goals: Goal 4: Reducing child mortality. Target: Reduce under 5 mortality by two-thirds by 2015
Goal 5: Improving maternal health. Target: Reduce maternal mortality by three quarters by 2015
Goal 6: Combat HIV/AIDS, malaria and other diseases. Target: Halt and begin to reverse the spread of HIV/AIDS by 2015

	WHO	**World Bank**	**UNICEF**
Structure, organisation, governance and accountability	▪ Governed by 191 Member States through World Health Assembly, composed of Member State representatives. ▪ Executive Board has 32 members, elected by WHA. Secretariat headed by Director-General. ▪ 6 regional offices and 127 country offices. Regional offices with independent decision-making powers. ▪ Currently undergoing reform to strengthen coherence between international, regional and national levels. New Country Cooperation Strategies will clarify role and priorities. ▪ Works close to MOHs. Does not run 'programmes' or 'projects', unlike UNICEF and World Bank.	▪ World Bank Group comprises IBRD, IDA, IFC and MIGA. ▪ IBRD is largest lender, accountable to shareholders, largest of whom are US, Japan, Germany, UK, France. ▪ The Bank is now the major source of external finance for the sector in the developing world. ▪ Primary role is financing. ▪ Less extensive network of country offices than WHO or UNICEF, but shift in resources and decision-making to field offices since 1997, and location of country directors to the field.	▪ Governed by Executive Board with 36 members, elected by UN Economic and Social Council. Board establishes policy, reviews programmes and approves budgets. ▪ Headquarters in New York. ▪ 8 regional offices and 125 national offices. Highly decentralised structure. ▪ Programmes in 162 countries, financed with UNICEF funds.
Mandate, mission, aims and objectives	Aim is 'the attainment by all peoples of the highest possible level of health'. Health is defined in WHO's constitution as a state of complete physical, mental	Mandate is 'to work with governments to achieve sustainable progress in reducing poverty, promoting growth, and improving the quality of people's lives in developing countries'.	Mandate is 'to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential'.

	and social well being, not merely the absence of disease or infirmity. Principles in the constitution emphasise health as a fundamental human right, government responsibility for the provision of adequate health and social measures, and the importance of healthy development of the child. 4 strategic directions for 2002-2005: ▪ Reducing excess mortality, morbidity and disability, especially in poor and marginalised populations. ▪ Promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioural causes. ▪ Developing health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair. ▪ Framing an enabling policy and creating an institutional environment for the health sector, and promoting an effective health dimension to social, economic, environmental and developmental policy. Mandate complementary to elements of mandates of UNICEF, UNAIDS.	The overarching goal is reduce poverty by working with borrowing countries and other partners towards the achievement of IDTs, improving living standards through supporting sustainable growth and investing in people. Health, Nutrition and Population (HNP) sector strategies rest on: ▪ Expansion of opportunities through broad-based economic growth. ▪ Access by the poor to services that improve education, health and nutrition outcomes and reduce fertility. ▪ Appropriate social safety net programmes to protect especially vulnerable groups. Key principles influencing the HNP sector strategy are: ▪ Focus on the human dimension of development. ▪ Responsiveness to clients. ▪ Sound technical analysis and attention to outcomes. ▪ Recognition of the political dimension of reforms. ▪ Respect for diversity in values and social choices. ▪ Need for local ownership and partnerships.	UNICEF's mission: ▪ Is guided by 1990 World Summit for Children Plan of Action, 1989 Convention on the Rights of the Child, Convention on the Elimination of all Forms of Discrimination Against Women, International Conference on Population Development. ▪ Mobilises political will and material resources to help countries ensure a "first call for children" and build capacity to form appropriate policies and deliver services for children and families. ▪ Is committed to ensuring special protection for the most disadvantaged children. ▪ Responds to protect the rights of children in emergencies. ▪ Aims to promote the equal rights of women and girls and ensure their full participation in political, social and economic development. Goals (see MDGs below), priorities and actions for 2000-2010 set out in 'A World Fit for Children'. Mandate overlaps with elements of mandates of UNFPA, ILO, UNAIDS,

			WHO, UNESCO.
Strategic priorities and health priorities	Areas of work, and priorities within these, are: ▪ Communicable diseases – malaria; TB ▪ Non-communicable diseases and mental health – surveillance, prevention and management; tobacco; mental health and substance abuse. ▪ Family and community health – HIV/AIDS; making pregnancy safer. ▪ Sustainable development and healthy environments – food safety. ▪ Health technology and pharmaceuticals – blood safety and clinical technology. ▪ Evidence and information for policy – evidence for health policy; organisation of health services Increasing focus on risks to health; WHO identifies the top 10 risks globally as: underweight; unsafe sex; high blood pressure; tobacco consumption; alcohol consumption; unsafe water, sanitation and hygiene; iron deficiency; indoor smoke from solid fuels; high cholesterol; and obesity.	HNP sector strategy priorities are to assist countries to: ▪ Improve the HNP outcomes of the poor and protect the population from the impoverishing effects of illness, malnutrition and high fertility. ▪ Enhance the performance of health care systems by promoting equitable access to preventive and curative health, nutrition and population services that are affordable, effective, well managed, of good quality and responsive to clients. ▪ Secure sustainable health care financing by mobilising adequate levels of resources, establishing broad-based risk-pooling mechanisms, and maintaining effective control over public and private expenditure. Strategies have focused on: ▪ Decentralisation, contracting out. ▪ Health sector workforce reform. ▪ Strengthening organisational capacity. ▪ Raising awareness of equity and efficiency implications of health expenditure and resource mobilisation. ▪ Cost recovery for services. ▪ Hospital financing and reform. ▪ Risk pooling and insurance.	UNICEF has shifted from delivery of immunisation, nutrition, and water and sanitation programmes to integrated programmes guided by child rights. Priorities for the next 5 years are: ▪ Girls' education. ▪ Integrated early childhood development. ▪ Immunisation Plus. ▪ Fighting HIV/AIDS. ▪ Improved protection of children from violence, exploitation, abuse and discrimination. Health focal areas 'reflect international development and health goals': Immunisation Plus: ▪ Strengthening routine immunisation: GAVI and Vitamin A Global Initiative; vaccine supply. ▪ Accelerated disease control: polio eradication; measles mortality reduction; maternal and neonatal tetanus elimination. Community health: child and maternal survival: ▪ Malaria. ▪ Community Integrated Management of Childhood Illnesses (CIMCI). ▪ Maternal and newborn health.

		HIV/AIDS strategy in Africa (1999) focuses on: ▪ Advocacy for HIV/AIDS as a central development issue. ▪ Increased resources and technical support for African partners to mainstream AIDS into all sectors. ▪ Prevention efforts and enhanced care and treatment. ▪ Expanded knowledge base.	<u>HIV/AIDS</u> <u>Health in emergencies</u>
Target populations	No priority population groups specified.	Reducing the burden of disease on the poorest is a stated priority. No priority population groups specified.	Children, especially victims of war, disasters, extreme poverty, violence, exploitation, disabilities; women and girls.
Links with MDGs 4, 5 and 6 (see *Note*)	Many relationships between the 4 strategic directions and MDGs: ▪ Direct link to some priority areas of work, e.g. TB, malaria, HIV/AIDS, making pregnancy safer. ▪ Increasing focus on health and poverty issues, e.g. through the launch of the Commission for Macroeconomics and Health. ▪ Prioritising strengthening country level collaboration and programming that focuses on the MDGs. ▪ Prioritising health problems that impact on socio-economic development and have a disproportionate impact on the poor.	The Bank: ▪ Recognises links between sustainable economic growth and poverty reduction, and health. ▪ Integration of achievement of MDGs into its work (see PRSPs). ▪ Gives high priority to HIV/AIDS (see strategic priorities); no specific mention of child or maternal mortality. ▪ Supports the development of financing mechanisms for procurement of drugs and vaccines related to target communicable diseases.	UNICEF has set interim goals related to the MDGs: ▪ Reduce infant and under 5 mortality by at least one third by 2010. ▪ Reduce maternal mortality by at least one third by 2010. ▪ Reduce by 2005 HIV prevalence among young men and women aged 15-24 in the most affected countries by 25% and 25% globally by 2010.
Role, functions and	Focus on 6 core functions: ▪ Articulating consistent, ethical and	▪ Shift from early focus on strengthening and expanding infrastructure and	Examples of activities reported in 2002 include:

activities	evidence-based policies. ▪ Managing information by assessing trends and comparing performance; setting the agenda for, and stimulating research and development. ▪ Catalysing change through technical and policy support, in ways that stimulate cooperation and action and help to build sustainable national and inter-country capacity. ▪ Negotiating and sustaining national and global partnerships. ▪ Setting, validating, monitoring and pursuing the proper implementation of norms and standards. ▪ Stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health care management, and service delivery. Responsibilities include: ▪ Assist governments to strengthen health services. ▪ Technical, epidemiological and statistical services. ▪ Provision of information. ▪ Stimulate eradication of epidemic, endemic and other diseases. ▪ Work with other agencies to improve nutrition, housing and	supplies for basic programmes to addressing institutional and systemic problems. ▪ The Bank has invested heavily in training of health staff and managers, financed large-scale drug procurement programmes, and is starting to pay more attention to the private health sector and public-private linkages.	▪ Provision of 2.3 million mosquito nets and 540 million vitamin A capsules through the Micronutrient Initiative. ▪ Development of Nutrition Surveillance Systems, promotion of iodised salt. ▪ Training for community growth monitoring. ▪ Support for birth registration. ▪ Provision of safe drinking water. ▪ Support for PMTCT programmes in 47 countries. ▪ Immunisation against measles in partnership with WHO and other agencies in the Measles Initiative. ▪ Support for tetanus immunisation to reduce maternal mortality. ▪ Life skills programmes for school children and adolescents to prevent HIV/AIDS.

	sanitation. ▪ Promote scientific and professional cooperation. ▪ Promote and conduct research. ▪ Develop international standards for food, biological, pharmaceutical products.		
Comparative advantages	▪ The Global Health Agency ▪ Policy and normative guidance based on international best practice. ▪ Clinical guidelines and training for health personnel. ▪ Support for disease and epidemic surveillance.	▪ Knowledge Bank, detailed economic and sectoral work. ▪ Scale of lending, capacity to mobilise significant resources. ▪ Influence on policies and priorities of borrowing countries.	▪ Delivery of maternal health and child survival interventions. ▪ Advocacy and communication. ▪ Mobilising donor support and national governments. ▪ Humanitarian assistance.
Budget	▪ Global budget $2,223 million for biennium 2002-2003. ▪ Funding comprises regular budget funds from Member States and extra-budgetary funds. ▪ Recent shift towards increased expenditure on global priorities and in the regions.	▪ Budget 1999 FY: IBRD/IDA $1.256 billion; IFC $230.2 million; MIGA $19.5 million. ▪ In 1999, social sector accounted for 25% of IBRD/IDA lending. ▪ 33% lending for population and reproductive health, 15% nutrition, rest to health.	▪ Global budget approximately $1,225 million in 2001, from government/ inter-governmental organisations (64%) and non-government/private (33%). US is largest government donor, then Japan and the UK. ▪ 2001 spend: Immunisation Plus 24%; HIV/AIDS 7%; Integrated early childhood development 36%.
Monitoring and evaluation, performance measurement systems	▪ Corporate Strategy, which outlines expected results, will be used to monitor organisational performance. ▪ Common data set has been compiled to enable global reporting of results and facilitate monitoring and evaluation.	▪ Project Completion Reports used to determine project performance. ▪ Recent shift to sector-wide strategic evaluations, building international and national capacity to measure HNP outcomes for the poor and progress towards MDGs.	▪ Reviews progress with implementation of World Summit for Children goals in *The Progress of Nations*, *The State of the World's Children*. ▪ Has introduced results-based management.

Organisational reform agenda	▪ The Country Focus Initiative aims at strengthening the organizations presence in countries by increasing quantity and quality of staff at country offices, based on necessities expressed in Country Cooperation Strategies. ▪ Executive Board Reforms are discussed including the functioning and working procedures of the Board. ▪ Reforming Planning and Reporting for the organization as a whole and for Areas of Work by developing the Biannual Program Budget with a common format for all Areas of Work, and continuing to reform Annual and Biannual Reporting.	▪	▪
Key health strategy documents	▪ Numerous strategies for diseases, groups of diseases or health problems, i.e. recently adopted straegies for Child Healt and Development, for HIV/AIDS etc.	▪	▪

	Regional Development Bank (AfDB)	**Regional Development Bank (AsDB)**	**Regional Development Bank (IDB)**
Structure, organisation, governance and accountability			
Mandate, mission, aims			

and objectives			
Strategic priorities and health priorities			
Target populations			
Links with MDGs 4, 5 and 6 (see *Note*)			
Role, functions and activities			
Comparative advantages			
Budget			
Monitoring and evaluation, performance measurement systems			
Organisational reform agenda			
Key health strategy documents			

PAN AMERICAN HEALTH ORGANIZATION BACKGROUND INFORMATION TEMPLATE

	PAHO
Structure, organisation, governance and accountability	The Pan American Health Organization comprises the following: **The Pan American Sanitary Conference**—the supreme governing body in which each Member Government (35 countries and 6 other participating countries) is represented—meets every four years, defines the Organization's general policies, serves as a forum on public health matters, and elects the Director of the Pan American Sanitary Bureau. From 1986 on, the Conference approved PAHO's strategic orientations and program priorities for the coming quadrennium. **The Directing Council**—consisting of one representative of each Member Government—meets once a year and acts on behalf of the Conference in years when that body does not meet. It reviews and approves the Organization's program and budget. **The Executive Committee**—composed of representatives of nine Member Governments elected by the Conference or the Council for staggered three-year terms—meets twice yearly to consider technical and administrative matters, including the program and budget, and submits its recommendations to the Conference or Council. The Subcommittee on Planning and Programming of the Executive Committee was reorganized in 1984 to enhance the participation of the governments in planning the Organization's activities. It is made up of delegates from seven countries, meets twice yearly, and reports directly to the Executive Committee. **The Pan American Sanitary Bureau**—headed by the Director—acts as the Executive Secretariat and carries out the directives of the Governing Bodies. PAHO has 28 country offices and 10 regional or sub-regional centers or programmes. The PAHO office in Washington has a new organization with 5 Directors: **1. The Office of the Director**: • Establishes the policies and strategy of the Organization. • Manages the Secretariat and oversees the country offices and country representatives, the Caribbean Program Coordination (CPC) and the Field Office in El Paso, as well as the offices of the Deputy Director, of the Assistant Director, of the Director of Program Management and the Director of Administration. The office of the Director includes two units: Chief of Staff and Country Support. Chief of Staff Unit: • Serves as a communication and policy liaison between the Director's Office, the Executive Management Offices, Country Offices, CPC and FEP. • Secretariat of the Executive Management Meetings. • Manages the Director's agenda and scheduling.

	• Coordinates briefings for the Director. Country Support Unit (D/CSU): • Supports the Office of the Director in the political, managerial and technical aspects of PAHO's country operations. • Facilitates, reviews, analyzes and provides recommendations to the Executive Management Committee on issues of pertinence to technical cooperation at the country level. • Provides support to the development of country presence of the Organization. • Coordinates sub-regional initiatives and the relationship with sub-regional integration bodies. • Provides guidance, support to implementation and evaluates projects of technical cooperation among countries. • Ensures policy coherence of country programs with other programs of the Organization. **2. The Office of the Deputy Director:** • Acts for the Director, is a member of Executive Management and represents the Organization in the absence of the Director. • Serves as Secretary to the Governing Bodies. • Oversees official relations with the United States Government, including the Congress and Departments of the Administration. The Office of the Deputy Director includes four Areas: Health Analysis and Information Systems (AIS), Information and Knowledge Management (IKM), Emergency Preparedness and Disaster Relief (PED), and Public Information (PIN). In addition, the Office oversees the Organization's work involving Internal Audit Unit (IA), and the Ombudsman Unit (OMB). **3. The Office of the Assistant Director:** • Member of Executive Management. • Ensures that program plans and budgets of the four areas are prepared and executed according to organizational procedures and that coordination among the four Areas is optimal. • Promotes collaboration with Areas and Units in other Offices and with entities outside PAHO. • Provides strategic guidance for the development of public health interventions at regional and country level and ensures their consistency with global mandates. The Office of the Assistant Director includes four Areas: Family and Community Health (FCH), Disease Prevention and Control (DCP), Sustainable Development and Environmental Health (SDE), and Technology and Health Services Delivery (THS). **4. The Office of the Director of Administration:** • Member of Executive Management. • The Office of Administration is comprised of six areas: Human Resources Management (HRM); Financial Management and Reporting (FMR); General Services and Procurement (GSP); Publications (PUB); Legal Affairs (LEG); and Information

	Technology Services (ITS). In addition the office oversees the unit of country administrative support (CAS). **5. The Office of the Director of Program Management:** • Member of Executive Management. • Responsible for the operation of the Governing Bodies, the development of the corporate policy, the advancement of strategies for partnerships and resource mobilization; the planning, monitoring and evaluation of technical cooperation, the strategic and operational aspects of budgeting, the support to project preparation and management, and the development of technical cooperation at regional and country level in the areas of health policies, health systems and human resources. • Ensures program coordination and sound program management at all levels of the Organization. • Promotes the design and implementation strategies for Regional Programs and Pan American Initiatives. • Oversees inter regional collaboration; articulates normative functions and technical cooperation across global, regional, sub-regional and country levels of WHO and participates in the Global Program Management Group (GPMG). The Office of the Director of Program Management is comprised of four Areas: Strategic Alliances and Partnerships (SAP), Governance and Policy (GPP), Planning, Program Budget and Project Support (PPS), and Strategic Health Development (SHD).
Mandate, mission, aims and objectives	The Pan American Sanitary Bureau (PASB), the oldest international health agency in the world, is the Secretariat of the Pan American Health Organization (PAHO). The Bureau is committed to providing technical support and leadership to PAHO Member States as they pursue their goal of Health for All and the values therein. Toward that end, the following values, vision, and mission guide the Bureau's work. The fundamental purposes of the Pan American Health Organization are to promote and coordinate the efforts of the countries of the Region of the Americas to combat disease, lengthen life, and promote the physical and mental health of their people. In her Inauguration Speech, 31 January 2003, Dr. Mirta Roses, new Director of PAHO concluded that she intended: • to restore the Pan American Health Organization as the forum for Health in the Americas, opening it to the participation of all sectors of society. • to work to build consensus and forge partnerships, strengthening hemispheric and global solidarity and encouraging new social actors to get involved in the defense of health. • to address the new dimensions of health in the Hemisphere's economic, social, and political integration processes. • to advocate for the continuous improvement of health systems, promoting rapid advances in securing geographical, cultural, and

	financial access to health services and expanding social protection, in keeping with the mandates of the Summits of Presidents and Heads of State and Government. • to restore the pride and commitment of health workers and health organizations, emphasizing the importance of quality care and accountability, with practices based on shared and accepted evidence. • to make PAHO the public reference center for health information, utilizing and facilitating access to knowledge with all the instruments at its disposal within the framework of the electronic revolution and mass communication.
Strategic priorities and health priorities	These are expressed in the Strategic Plan 2003-2007 for the Pan American Sanitary bureau: **Special groups**: • PAHO will focus on low income and poor populations, ethnic and racial groups, especially indigenous people, women, and children. **Key countries**: • PAHO will lead strategic collaborative efforts among countries and partners and maximizing wider development initiatives like the PRSPs to accelerate health improvements in Bolivia, Haiti, Honduras, Guyana and Nicaragua. **Priority areas**: • PAHO will achieve its mision during the period 2003-2007 by focusing its technical cooperation on the following priority areas: - prevention, control, and reduction of communicable diseases; - prevention and control of noncommunicable diseases; - promotion of healthy lifestyles and social environments; - healthy growth and development; - promotion of safe physical environments; - disaster preparedness, management and response; - ensuring equal access to integrated, equitable, and sustainable health systems; and - promotion of effective health input into social, economic, environmental, and development policies.
Target populations	Latin America is the continent with the greatest inequities of health and access to health services. Reducing these inequities has long been a priority for PAHO and in her Inauguration Speech, 31 January 2003, Dr. Mirta Roses, new Director of PAHO stated that:The time is ripe for putting health at the forefront of social action and taking advantage of its undeniable contribution to the reduction of social and economic inequities. Health can mobilize all of society to obtain rapid, sustainable human development in the Hemisphere.
Links with MDGs 4, 5 and 6 (see *Note*)	In her Inauguration Speech, 31 January 2003, Dr. Mirta Roses, new Director of PAHO stated that: The Declaration of the Millennium Goals reflects an unprecedented political consensus on the state of the world and its vision for the future, setting measurable goals and specific timetables for human progress. These goals will be attainable if we can make them the standard, the dream, the aspiration, and the demand of individual people, groups,

	families, communities, and nations. They will be attainable if we can generate enthusiasm and muster the individual and joint efforts of a multiplicity of networks with different languages, beliefs, and realities, if we can revive trust, understanding, and solidarity among the countries. The health sector will bear a heavy responsibility in the attainment of the Millennium Goals and expects to benefit in turn from the progress made as a result of consensus-building among all the sectors. Since the Declaration of Health for All and the Alma-Ata conference on primary care 25 years ago, the world has not heard a call to collective action with so powerful a message.
Role, functions and activities	See Structure and mandate above, and the corresponding role and functions of WHO.
Comparative advantages	The same comparative advantages valid for WHO are also valid for PAHO. Besides, PAHO has a stronger presence in countries with more international and national experts than WHO offices in other regions. Unlike WHO offices in other regions, PAHO is also implementing projects, or facilitating implementation of projects and programmes of other agencies. PAHO also enjoys a special relationship with other institutions of the inter-American system such as the OAS, the IDB, and IICA and with the Hemispheric Summit process. Many health issues are critical from a regional perspective but less important from a global perspective - chagas disease is perhaps an example. Economies of scale and of scope in a region with many small economies is also a comparitive advantage for PAHO as a regional institution (as well at the other institutions of the IA system). This regional dimension of a regional institution, connected to other regional institutions and to political and policy dialogue processes of the hemisphere, provides a significant comparative advantage that is probably under developed.
Budget	▪ Regular budget $ 264.8 million for the biennium 2004-2005, $ 75.2 million from WHO and $ 189.4 from PAHO members. ▪ Other contributions, including voluntary or extra-budgetary contributions are not included in the budget ▪ Priorities in the budget follow the WHO priorities
Monitoring and evaluation, performance measurement systems	Details of the monitoring and evaluation of the Strategic Plan will be developed, and submitted to the Sub-committee for Planning and Programming, including appropriate measures of each objective, the identification of data sources, dta collection and analysis process.
Organisational reform agenda	A new organizational structure of HQ was introduced on 1 March 2003. PAHO is also part of WHO restructuring, i.e. the Country Focus Initiative.
Key health strategy documents	Strategic Plan 2003-2007 for the Pan American Sanitary bureau. Also, like the WHO, numerous strategies for diseases, groups of diseases or health problems.

	Asian Development Bank (AsDB)
Structure, organization, governance and accountability	• Governed by 61 member states – 44 Asian and Pacific and 17 non-regional countries. • Executive Board with 12 members elected by the Board of Governors • Japan and the US are the largest shareholders. • Centralized structure, decentralization is on-going. So far only 19 resident missions with limited authority, staff and skills. • Finance institution • Concessional lending for the poorest countries – Asian Development Fund.
Mandate, mission, aims and objectives	The overarching goal of the AsDB is poverty reduction and the strategy rests on three pillars: pro-poor sustainable economic growth, social development and good governance.
Strategic priorities and health priorities	According to the Policy for the Health Sector (1999), ADB's overall approach to the health sector will be to Assist Developing Member Country (DMC) governments in ensuring their citizens have broad access to basic preventive, promotive, and curative services that are efficacious, cost-effective, and affordable. ADB's activities in the health sector will be guided by these strategic considerations: • there will be continued focus on improving the health of the poor, women, children, and indigenous peoples • investments will focus on achieving tangible and measurable results • ADB will actively support rigorous testing of innovative approaches to the management and financing of the health sector, and assist with the timely deployment of effective new technologies • ADB will play a significant role in policy reform by encouraging DMC governments to take an appropriate and activist role in the health sector that includes increasing public investment in PHC, facilitating private sector involvement in health, and increasing the focus on public goods • ADB will increase the efficiency of its investments in the sector by assisting DMC governments to strengthen their managerial capacity, improve economic and sector work, and strengthen linkages with other sectors.
Links with MDGs 4, 5 and 6 (see note)	AsDB: • Recognizes the links between sustainable economic

	growth and poverty. • Committed to assisting the DMCs in achieving the MDGs. • Timid and low key approach to combating HIV/AIDS in Asia. No policy or strategic approach. • Has contributed significantly to expand publicly provided health services (PHC). • Women's health is a priority area in the Health Sector Policy and priority interventions to reduce maternal mortality are outlined. •
Role, functions and activities	• Recent health sector loans increased attention to public goods such as health education of the general public, and regulation and reform. • Few health sector loans and technical assistance projects in its present portfolio. • Insufficient attention to the health needs of the priority groups. • Few HIV/AIDS projects mainly in the Greater Mekong Region. •
Comparative advantages	• Regional character, influential and trusted partner by DMCs. • Leadership role in regional cooperation.
Budget	• Administrative budget 2002: USD 239.7 millions. • Authorized loans in 2002 amounted to USD 5.5 billion, comprising USD 3.9 billion from ordinary capital resources and USD 1.6 billion from the ADF. • 29% of the lending volume in 2001 was directed to poverty interventions.
Monitoring and evaluation, performance measurement systems	• Performance based allocations for concessional loans (ADF) introduced in 2001. • New loan classification system (LCS) introduced in 2001. LCS set a target of at least 40% of lending volume for poverty interventions. • New Comprehensive Project Performance Report system in 2001 to improve individual project performance –includes assessment of development objectives using targets and indicators specified in the logical framework during project preparation. • The Evaluation Unit upgraded to the Operations Evaluation Department and a Board Development Effectiveness Committee has been established.