3. FOR MORE EFFECTIVE HEALTH AID IN AFRICA

Atef El Maghraby, MD, MA HMPP, and Feng Zhao, MD, PhD, MPH

CHALLENGES TO HEALTH AID EFFECTIVENESS

For decades, official development aid (ODA) has helped Africa to reduce poverty, build local capacity, reduce inequality, and improve the health and well-being of the population (AfGH 2008; Hollway et al. 2011; OECD 2012a). It is widely believed that aid for health has saved millions of lives and improved the livelihood of families (Nikolov 2006).

Nevertheless, despite the aid and the remarkable developments over recent years, 350 million Africans still lack access to clean water sources and basic sanitation. Africa still has the heaviest burden of communicable and noncommunicable diseases, especially from HIV/AIDS, TB, and malaria, and child and maternal mortality (WHO 2010b). More than 48 percent of all Africans live on less than US$1.25 a day (UNECA and AU 2012). Development health aid has been seen as arguably less successful than desired in delivering the intended results for a variety of reasons. These include dysfunctional and rudimentary local systems, complex donor bureaucracies, poor inter- and intradonor coordination, and failure of stand-alone health projects to deliver the expected tangible results (Easterly 2002; Oomman, Bernstein, and Rosenzweig 2007; Wood et al. 2008). In many cases, lack of coherent strategic planning by donors and differences in donor approaches have limited the effectiveness of aid (Easterly 2002; Hollway et al. 2011). Also, high transaction costs associated with ODA and irregular and unpredictable funding add to the challenges (Vandeninden 2012).

The purpose of this paper is to contribute to the mounting call to improve the impact and value of health aid in Africa and increase the understanding of the related obstacles that confound achieving the desired health outcomes. The paper examines key aspects of official foreign aid dynamics and management for health in Africa and identifies approaches that have potential to improve the effectiveness of ODA in terms of its impact on health and sustainable improvements in health systems.

What Is Aid Effectiveness?

Since the 2003 Rome Declaration, development aid has been increasingly on the agenda of donor agencies and national governments (OECD 2003a, 2003b). This focus grew out of the mounting concern over aid effectiveness in recent decades and pressures to improve the return on investments of donor funding.

The World Bank defines aid effectiveness thus: “It is about improving the delivery and management of aid so partner countries can more easily achieve their development objectives” (World Bank. 2012). Aid Effectiveness addresses a variety of modalities and principles for delivering and managing aid to achieve agreed development objectives cost-effectively. To realize these objectives the full engagement of both development partners and partner countries is

deemed critical and mandatory. While development needs far more than aid to be successful and sustainable, aid nonetheless still plays an important catalytic role for development in many countries and communities (World Bank 2011b).

The Fourth High Level Forum on Aid Effectiveness (HLF4) has a more tailored definition that links aid with the Millennium Development Goals (MDGs) for a more tangible and measurable approach. It states, "Aid effectiveness is about ensuring maximum impact of development aid to improve lives, cut poverty and help achieve the Millennium Development Goals" (Busan HLF4 2011).

HEALTH AID IN AFRICA

Africa benefits from a great proportion of the total amount of global foreign aid. It received an estimated US$76.3 billion between 1960 and 1979, US$715.9 billion from 1980 to 2004, and US$40.1 billion in 2008 alone (Ilorah 2011). In particular, sub-Saharan Africa received the largest share of global health aid compared with any other region when it received 31.9 percent and 47.4 percent of all global health aid in 2002 and 2010, respectively (Wexler, Valentine, and Kates 2013). Yet, critics argue that the impact of these huge amounts of resources is unsatisfactory. This funding, according to many analysts, has not adequately reduced poverty, resolved major health challenges in terms of essential infrastructure, advanced sector regulatory institutions and operational systems, or secured essential health care services for the poor and vulnerable (Easterly 2002; World Bank 2007).

Unable to fully finance needed health care for their citizens, the majority of African countries are dependent on foreign aid. In fact, two-thirds of the forty-seven fragile and low-income sub-Saharan governments spend less than the US$34 per capita per year on health recommended by WHO, which is the minimum amount required to provide basic health care services (WHO 2011a). Table 1 provides data for a selected sample of least-developed African countries and the amount of ODA they received for health.

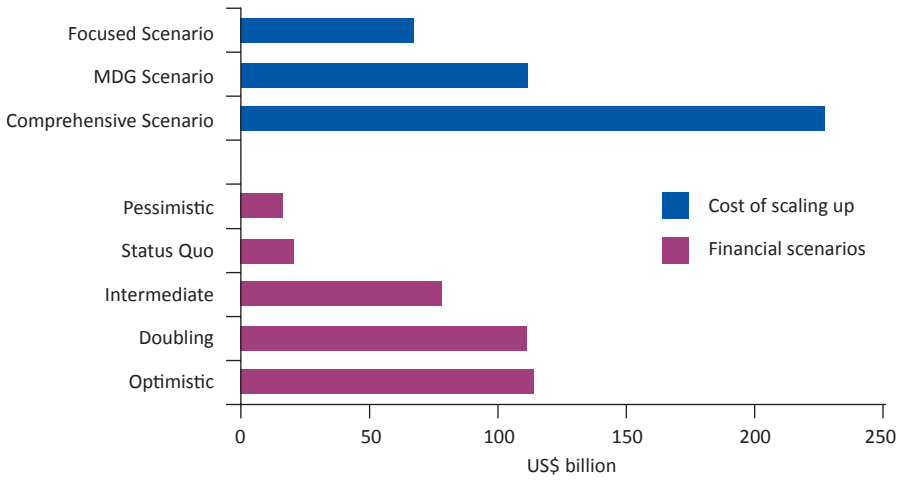
TABLE 1. HEALTH AID IN SELECT AFRICAN COUNTRIES

Country	Population (millions) 2005*	Health ODA per Capita (US$) 2002–2006**	ODA (percent of GDP) 2005*	% GDP on Health 2008***
Ethiopia	79.0	2.9	17.3	4.3
Mozambique	20.5	9.9	19.4	4.7
Niger	13.3	3.4	15.1	5.9
Zambia	11.5	20.0	13.1	4.8

Sources: *UNDP 2007; **WHO 2008; ***WHO 2011c.

Additional resources are needed in the African region to achieve health targets. Soucat (2010) analyzed different financial scenarios to attain better health for Africans and demonstrated the substantial funding gap that needs to be filled to enable African countries to attain MDGs. Figure 1 shows that the most ambitious "comprehensive scenario" scale-up exceeds even the most optimistic financial scenario. On the other hand, the most realistic "focused scenario" scale-up is feasible under three out of five financial scenarios (World Bank et al. 2009).

FIGURE 1. FINANCIAL SCENARIOS TO ATTAIN MDGS



Source: Soucat, A. 2010. Health Financing in Africa: Buying More Health for the Money? Presentation of the African Development Bank at the Harmonizing Health for Africa (HHA) Directors Meeting, December 13, Dakar, Senegal. Reprinted with permission.

Health is a labor-intensive sector, and the health workforce crisis remains a major continental bottleneck despite global health aid (WHO 2006). Experts note that the potential benefits of aid are not fully realized due to the underperformance of service delivery (Berman and Ahuja 2008), which includes the lack of qualified health care workers. The shortage of a skilled health workforce and poorly functioning health systems limit access to quality health care services and adversely impact the health status of Africans. For aid to deliver more value for the money, countries in the region need to strategically and sustainably improve equitable access to and the quality of health care services. With pressure to deliver more for less, donors and recipient countries alike need to demonstrate results and best practices.

GLOBAL AID ARCHITECTURE IN HEALTH

Although there are more donors to health than to any other sector (WHO 2007a), the health sector is fraught with complex challenges and inefficiencies. Health is inherently complex and the structure of aid assistance and collaborations between donors and countries is critical. The proliferation of new donors such as the Global Fund, GAVI, and others, along with changing

approaches for delivering and managing aid, have precipitated a new and more diverse aid architecture that challenges donors and recipient countries as they work to improve aid effectiveness and impact (OECD 2011b). Whilst diverse aid approaches can bring benefits, they often challenge country ownership and alignment and can lead to duplicate and fragmented approaches at global and national levels (AfDB 2010; DFID 2011; OECD 2012a). Aid can also challenge (1) achieving complementarity across national, regional, and global development priorities and programs and (2) strengthening recipient countries' ability to make effective use of potentially scaled-up, rapidly disbursed health ODA.

Project-Based Aid

Project-based aid dominated development assistance for several decades. Often, planning and implementation problems can coexist in donor-driven projects. These include poorly defined project goals, inadequate local participation in planning, failure to align programs with existing structures, and lack of integration with domestic systems and norms (Dickinson 2011; WHO 2010a). In addition, recipient countries are calling for a greater voice in defining the focus of ODA so it serves their national priorities as well as respects their sovereign choices and leadership.

With many international organizations involved in health projects, frequently there are overlapping and unclear mandates that require robust coordinating mechanisms. To illustrate, during the past decade alone, the majority of health donor organizations that emerged (The Global Fund, GAVI, Bill & Melinda Gates Foundation) are disease-focused and rely on vertical programs. While these programs have achieved remarkable progress in terms of infectious disease interventions, critics of disease-specific program funding assert that such models overlook opportunities for sustainable systems strengthening. Vertically funded programs are thought to have weakened health systems (Ram 2004), created double standards within countries (Hansen and Tarp 2000), and offered incentives that other parts of the health system do not provide. Vertical donor-funded projects that run parallel to national health systems are seen by some as contributing to the distortion of an already weakened health system as they increase the loss of skilled health workers from the public sector (ibid.).

USAID, one of the largest global development programs, heavily relies on tailor-made project assistance to help countries. It uses aid and partnerships as its strategic approach in long-term development programs. USAID funding for HIV/AIDS alone was doubled between 2000 and 2004 when the US President's Emergency Plan for AIDS Relief (PEPFAR) was created to address the global HIV crisis especially in low-income countries and fragile states. Sturchio and Cohen (2012) argue that PEPFAR is an example of a successful bilateral program and that good governance can make aid projects deliver results. They conclude that setting ambitious goals and creating a culture of partnerships, collaboration, planning, monitoring, and evaluation are key to effective

aid programs. Others argue that PEPFAR support has not been adequately coordinated and can undermine national policies (Oomman, Bernstein, and Rosenzweig 2007). A 2007 review found that PEPFAR funding was channeled largely outside government systems and that host government involvement in the oversight of PEPFAR programs was limited. The review also noted that most PEPFAR funding was awarded to international—mainly US nongovernmental—entities, and while some funding is awarded to recipient governments, the major portion of funding is managed and overseen by US government personnel (ibid.). Earmarking support to HIV alone created a situation in which lots of resources were pooled to HIV programs while the rest of the country's health systems and services were in severe shortage of resources. For example, in 2006, when Zambia's entire Ministry of Health budget was only US$136 million, PEPFAR provided the country with an HIV-targeted budget of US$150 million. This unbalanced distribution of health funding occurs across sub-Saharan Africa (De Maeseneer et al. 2008).

In contrast to the doubling of HIV funding, between 2000 and 2004 the funding of primary health care was reduced by half (Schneider and Garrett 2009). The emergence of new global health threats like SARS and avian and swine flu has drawn attention to the need for concerted global action to potential pandemics using a more integrated and sustainable approach with responsive regional mechanisms in place.

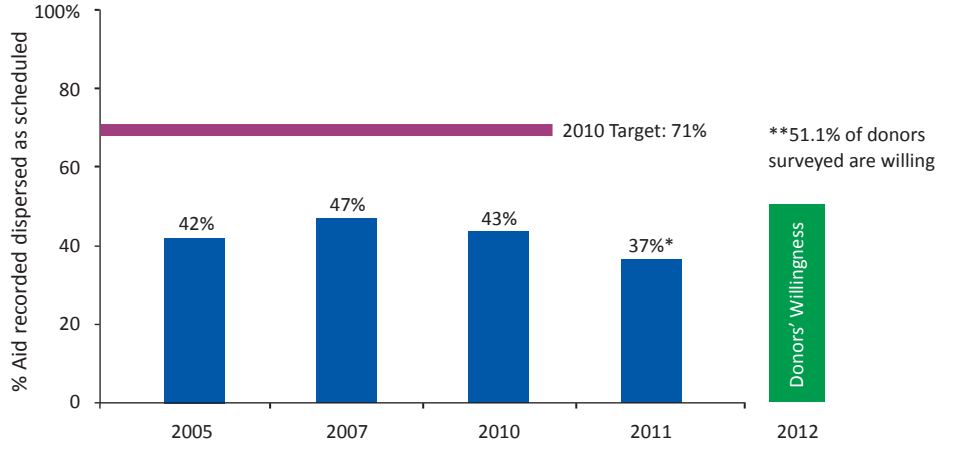
Aid Uncertainty

Historically, aid has often been short-term and unpredictable (AfGH 2008; OECD 2011a). In 2007, the level of OECD aid funding fell by 8.4 percent, and most donors did not fulfill their stated commitments to scale up aid to 0.7 percent GDP (OECD 2011a). Especially worrisome is the decline of aid to the health sector in many countries (AfGH 2008; Wexler, Valentine, and Kates 2013). The aid promised is not necessarily delivered (Abbott and Rwirahira 2012). An analysis of aid commitments and disbursements for the period from 2004 to 2006 found that average disbursements of ODA exceeded 80 percent of annual commitments (OECD 2011a). Although the differences between the committed and actual aid disbursed are not large, these data do not reveal delayed payments, which can cause serious disruption, especially for the least developed countries that have limited flexibility. Figure 2 shows that, on average between 2005 and 2010, only 44 percent of aid to thirty-two countries surveyed was disbursed in the year for which it was scheduled and recorded as such in partner government accounts (OECD 2011a). When all seventy-eight countries that participated in the 2011 survey are considered, this figure falls to 37 percent (ibid.). Figure 2 also shows the outcome of a more recent survey in 2012 where just over half the donors surveyed declared they were willing to share future spending plans (OECD 2012b).

In Accra in 2008 and in Busan in 2011, donors renewed their commitment to improve the availability of information on aid flows to support medium-term planning and increase the

transparency around conditions attached to aid. Making aid more predictable requires most donors to address structural constraints in their own planning and budgeting systems in order for them to be able to provide reliable indications of future expenditures (OECD 2011a). In addition, an article from the WHO *Bulletin* indicated that relatively small proportions of aid for health were paid in line with national fiscal cycles and administrative norms (Piva and Dodd 2009). Between 2002 and 2006, direct budget support commitments were only 6.4 percent of the total ODA, excluding debt relief (ibid.).

FIGURE 2. ODA PREDICTABILITY AND DONORS' WILLINGNESS TO SHARE FUTURE SPENDING PLANS



Sources: Adapted from *OECD 2011a; **OECD 2012b.

International Technical Assistance

The report from the Third High Level Forum on Aid Effectiveness (HLF3) held in Accra noted that in the period from 2004 to 2006, 41.7 percent of all health ODA was spent on technical assistance (World Bank, OECD, and WHO 2008). This included salaries for national staff and international short- and long-term experts, training, and related activities aimed at building human capital and strengthening local health systems. From this, a seemingly large proportion of aid then returns to donor countries in the form of remittances that international staff transfer home from the high fees they are paid.

South-to-South Aid: A New Paradigm?

New donors have emerged over the past decade, which brings exciting dynamics and a new landscape of ODA. China, India, and other mid-income countries (MICs) are now major world economic and political powers and play an increasingly important role in international cooperation. Those new MIC donors are investing in Africa through partnership agreements rather than the traditional aid modality. BRIC countries (Brazil, Russia, India, China, and South Africa) channel their support through knowledge exchange, investments, technology transfers, trade, and financial support (World Bank 2011b). China's foreign direct investment in Africa represented US$900 million of the continent's US$15 billion total in 2004. China is now the continent's third most important trading partner, behind the United States and France and ahead of Britain (Kohli 2009). Brazil, India, and others are also investing heavily in Africa through partnerships and expanding the paradigm of south-to-south collaboration.

BRIC countries increasingly support health and education sectors. Further, Brazil, Cuba, and Venezuela are prominent providers of teachers and doctors to other developing countries (ECOSOC 2008). By the end of 2009, China had helped to build fifty-four hospitals, set up thirty malaria prevention and treatment centers, and provided anti-malarial drugs to thirty-five African countries (AfDB 2010).

EFFORTS TOWARD HARMONIZATION

Since the 2000 Millennium Development Summit, work to improve aid effectiveness has intensified. The 2003 Rome High Level Forum on Harmonization gathered leaders of bi- and multilateral development institutions, funders, and national leaders who committed to work to this end (OECD 2003a). In the same year, findings of a study of donor missions in Vietnam reported that Vietnam received four hundred separate donor missions in one year, of which just 2 percent were jointly coordinated (Piron and Evans 2004).

The March 2005 Paris Declaration on Aid Effectiveness (box 1) aimed to achieve far-reaching reform of aid delivery and management. It emphasized that aid volume and effectiveness must increase significantly to support recipient countries' efforts to strengthen governance and systems and improve overall development performance.

The Paris Declaration put in place a framework of specific implementation measures and established a road map to harmonize plans, coordinate resource mobilization, assess progress, and ensure that donors and recipients hold each other accountable for their commitments.

BOX 1. 2005 PARIS DECLARATION

The 2005 Paris Declaration identified five main principles for improved aid outcomes:

1. Ownership: Developing countries should exercise effective leadership over their development policies and strategies and effectively coordinate development actions.
2. Alignment: Donors should base their overall support on countries' national strategies, institutions, and systems.
3. Harmonization: Donors' actions should be coordinated, transparent, and collectively effective.
4. Managing for results: Aid should be managed focusing on desired results and promoting effective decision making.
5. Mutual accountability: Donors and recipient governments should enhance mutual accountability and transparency in the use of aid resources.

Sources: OECD 2010; Roberts 2010.

Despite the limitations of the principles as defined in the Paris Declaration and the absence of reliable indicators to assess progress, the declaration increased global awareness and interest to coordinate aid and align processes and procedures at the country level to improve effectiveness and overall development outcomes. The declaration established a global consensus on placing aid effectiveness high among global priorities so that mutual donor-recipient accountability for greater outcomes is realized.

Strengthening the Paris Framework

The momentum created by the Paris Declaration prompted analysts to suggest the following improvements for aid effectiveness (Roberts 2010; WHO 2011b):

1. Improve clarity and comprehensiveness of the indicators and monitoring process in a coherent sector policy framework.
2. Accept and manage the risk of using country and other partners' systems instead of insisting on using donor-specific systems.
3. Strengthen transparency and mutual accountability.
4. Involve all stakeholders from the donor community, civil society, and NGOs in the process.
5. Provide the political will and government leadership to ensure delivery of inclusive results.
6. Avoid bureaucracy and the incurred transaction costs for more efficiency and effectiveness.

7. Minimize long-term foreign technical assistance while strengthening domestic technical and management capacity.

Although the MDGs include an indicator to monitor reductions in tied aid, in 2009 about 15 percent of bilateral aid remained tied (Clay, Geddes, and Natali 2009). The report, produced by the Danish Institute for International Studies, found that the proportion of fully untied bilateral aid rose progressively from 46 percent in 1999–2001 to 76 percent in 2007, and for the least developed countries it has increased from 57 percent to 86 percent. Taking into account multilateral aid, the proportion of untied ODA has risen to 83 percent overall (ibid.). Untying aid is essential to reduce transaction costs and bring more value, more ownership, more competitiveness, and greater development outcomes to recipient countries.

Aligning Aid with Local Systems

Since 2005, aid instruments have slowly but steadily become more adapted to the local country systems and norms. On one hand, local systems are generally weak or rudimentary so that they are likely to slow project progress and impose hurdles on the planning and implementation teams. On the other hand, working within local systems provides the foundation for real ownership, systems strengthening, and sustainable development (InterAction 2011).

Sector-Wide Approach (SWAp), General Budget Support (GBS), and Sector Budget Support (SBS) programs significantly increased country ownership (ICAI 2012; Bakoup 2012). These instruments, which represent 30 percent of all global foreign aid (World Bank 2011b), have increased country ownership and have improved quality of planning, resource allocation, and implementation. And, they have been noted to reduce transaction costs and hence improve efficiency (Vandeninden 2012). Donors argue that General Budget Support, however small, has been influential in catalyzing and sustaining reform and has a positive impact on growth (WHO 2010a).

Notably, health programs are influenced by and delivered through other sectors like education, water resources, civil work, and environment that are largely out of the direct control of the health sector. Therefore, collaboration and coalition building across those sectors is instrumental. Bringing on board those sectors not only through government but also through the private sector and civil society is prudent in order to influence strategies and activities related to key determinants of health and to support healthy public policies. It is vital to keep the different parts connected (WHO 2007b).

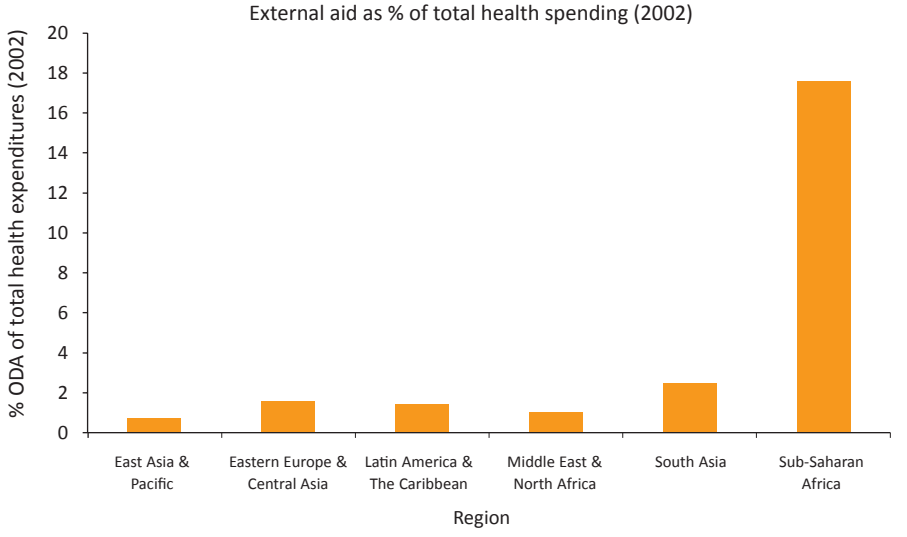
HEALTH AID FOR RESULTS

A cardinal objective of the aid effectiveness agenda is to improve the lives and well-being of people and, in particular, the most vulnerable in society. (—Kwabena Duffour, Minister of Finance and Economic Planning, Ghana, AfGH 2011)

Health care systems and services in sub-Saharan African countries remain dependent on external aid compared with other regions in the world (figure 3). Between 1990 and 2010, health sector aid to Africa increased more than sixfold, from US$4.4 billion to more than US$26.8 billion (AfGH 2011). Nevertheless, the unfilled gap in health remains large at an estimated US$20–30 billion a year (WHO 2010b). At a conservative estimate, WHO noted that 20 to 40 percent of health resources are wasted.

Reducing waste and inefficiencies would greatly improve the ability of health systems especially in low-income countries and fragile states to provide quality services and improve health. Furthermore, improved efficiency often makes it easier for the Ministry of Health to make a case for obtaining additional funding from the Ministry of Finance (WHO 2010b).

FIGURE 3. HEALTH AID BY REGION



Source: Soucat, A. 2010. Health Financing in Africa: Buying More Health for the Money? Presentation of the African Development Bank at the Harmonizing Health for Africa (HHA) Directors Meeting, December 13, Dakar, Senegal. Reprinted with permission.

A recent WHO report estimated that only seven African countries are on track to reach the target for MDG 4 and only two are on track to achieve MDG 5 by 2015 (WHO 2011b). Good governance, leadership, skilled health workforce, effective health management information systems, and adequate financing are deemed crucial for health sector performance. Strengthening infrastructure is critical for health improvement. Infrastructure development in terms of health centers, essential laboratory equipment, diagnostics, communication technology, roads, water, and sanitation are fundamental for health improvement (OECD 2012a). The former head of Interim National Government, Chief Ernest Shonekan, estimated that sub-Saharan Africa needs to spend approximately US$93 billion per year over the next decade to bridge its infrastructure gap despite Africa's increased investments in infrastructure from US$17 billion to US$35 billion between 2001 and 2009 (Ofose 2011). The focus on strengthening infrastructure, including information and communication technology (ICT), in sub-Saharan Africa is a key strategy for achieving MDGs (WHO 2011a).

REALIZING AID EFFECTIVENESS

Donor funding represents a major component of the global financial response for health in low-income countries and fragile states (Wexler, Valentine, and Kates 2013). The grim economic climate portends a continued financial crisis that inevitably impacts ODA and health aid. As such, the importance of making health aid more effective increases.

There is strong evidence that the principles of the Paris Declaration could lead to more effective aid. Increasingly, aid instruments that are driven by national leadership, harmonization, and mutual accountability have greater potential to deliver more value for the money (Bakoup 2012; European Commission 2008; Mutalemwa 2009; OECD 2012a; Roberts 2010; World Bank 2011b). Sector Wide Approach (SWAp), Sector Budget Support, and General Budget Support are widely considered superior to project-based models as they are better coordinated with country needs and aligned with national policies and strategies and local systems for sustainable development. Because the health workforce plays such a critical role in African health systems, major attention should be directed to its transformation to enable it to deliver quality health care services sustainably at lower cost.

The Global Monitoring Report 2011 by the World Bank set three policy directions to boost the impact of international support in human development: (1) enable low-income countries to sustain economic growth through repairing fiscal imbalances and macroeconomic policy reforms supported by the donor community over an extended period of time; (2) help low-income countries improve their infrastructure so that more rapid economic growth can be achieved and sustained, as donor countries can provide policy, technical, and financial

assistance; and (3) support fragile states to build institutions and accelerate development outcomes assisted through enabling an environment of peace and security (World Bank 2011a).

Additional resources are needed to help Africa attain the health-related MDGs by 2015. However, better health outcomes could be realized from the current limited resources (AfGH 2008). For health aid to be more effective, governments and donor agencies need to address the challenges described here and to incorporate the lessons learned into their systems and plans of action. Health expenditures are now increasingly monitored in order to help countries effectively address their health priorities. Health aid can better contribute to measurable health improvements expressed in a set of agreed-on plans and reliable indicators in an environment of increased institutional transparency, accountability, and national leadership. Health aid to Africa should no longer focus on only the amount of money disbursed but also on the achieved health gains expressed in quantitative and qualitative measures.

The Paris Declaration laid down the principles and foundations for aid effectiveness and greater health outcomes for the money. Robust donor coordination mechanisms and alignment with country systems, processes, and procedures will help accelerate achieving national health plans. A concerted approach to strengthening local health systems in consistent and incremental ways is paramount for sustainable, systemic progress and more health for the money. To this end, Direct and Sector Budget Support, Sector-Wide Approach, and the like are believed to be the financing mechanisms of choice to strengthen country ownership and effective leadership that could improve the health of populations in Africa. Managing for results is the key to the best value and health for the money.

REFERENCES

Abbott, P., and J. Rwirahira. 2012. *Aid Effectiveness in Rwanda: Who Benefits?* Kigali, Rwanda: ActionAid Rwanda. Available at http://reliefweb.int/sites/reliefweb.int/files/resources/Aid%20effectiness%20in%20Rwanda%202012.pdf.

AfDB (African Development Bank). 2010. *A Roadmap for Improving Performance on Aid Effectiveness and Promoting Effective Development: Turning Commitments into Action*. Tunis, Tunisia: African Development Bank. Available at http://www.afdb.org/fileadmin/uploads/afdb/Documents/Publications/Rev%20-%20Roadmap%20Aid%20Effectiveness.pdf.

AfGH (Action for Global Health). 2008. *Report Two: Healthy Aid: Why Europe Must Deliver More Aid, Better Spent to Save the Health Millennium Development Goals*. London: Action for Global Health. Available at http://www.actionforglobalhealth.eu/fileadmin/AfGH_Intranet/AFGH/Publications/2008_Policy_Report_-_Healthy_Aid/AFGH_ENGL_2008_web_01.pdf.

AfGH (Action for Global Health). 2011. *Aid Effectiveness for Health: Towards the Fourth High-Level Forum, Busan 2011; Making Health Aid Work Better*. London: Action for Global Health. Available at http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Key_Issues/Civil_Society_Engagement/ActionforGlobalHealth_health_aid2011.pdf.

Bakoup, F. 2012. *Budget Aid and Economic Reform in Developing Countries* (draft). Tunis, Tunisia: African Development Bank.

Berman, P., and R. Ahuja. 2008. Government Health Spending in India. *Economic and Political Weekly* 43 (26/27):209–16.

Busan HLF4. 2011. Fourth High Level Forum on Aid Effectiveness. November 29–December 1, Busan, Korea.

Clay, E.J., M. Geddes, and L. Natali. 2009. *Untying Aid: Is it Working?* An Evaluation of the Implementation of the Paris Declaration and of the 2001 DAC Recommendation of Untying ODA to the LDCs. Copenhagen: Danish Institute of International Studies. Available at http://www.oecd.org/development/evaluationofdevelopmentprogrammes/dcdndep/44375975.pdf.

De Maeseneer, J., C. Van Weel, D. Egliman, K. Mfenyana, A. Kaufman, N. Sewankambo, and M. Flinkenflögel. 2008. Funding for Primary Health Care in Developing Countries; Money from Disease Specific Projects Could Be Used to Strengthen Primary Care. *British Medical Journal* 336:518–19.

DFID (Department for International Development). 2011. *Multilateral Aid Review: Ensuring Maximum Value for Money for UK Aid Through Multilateral Organisations*. London: DFID. Available at http://www.dfid.gov.uk/Documents/publications1/mar/multilateral_aid_review.pdf.

Dickinson, C. 2011. *Is Aid Effectiveness Giving Us Better Health Results?* London: Health and Life Sciences Partnership (HLSP) Institute. Available at http://www.hlsp.org/LinkClick.aspx?fileticket=EzzFbskQILE%3D&tabid=1570.

Easterly, W. 2002. The Cartel of Good Intentions: Bureaucracy Versus Markets in Foreign Aid. Working Paper No. 4. Washington, DC: Center for Global Development. Available at http://www.cgdev.org/files/2786_file_cgd_wp004_rev.pdf.

ECOSOC. 2008. *Background Study for the Development Cooperation Forum: Trends in South-South and Triangular Development Cooperation*. New York: United Nations. Available at http://www.un.org/en/ecosoc/docs/pdfs/south-south_cooperation.pdf.

European Commission. 2008. *Budget Support: The Effective Way to Finance Development?* Brussels: European Commission. Available at http://ec.europa.eu/europeaid/infopoint/publications/europeaid/documents/budgetsupport08_en.pdf.

Hansen, H., and F. Tarp. 2000. Aid Effectiveness Disputed. *Journal of International Development* 12:375–98.

Hollway, S., S. Howes, M. Reid, B. Farmer, and J. Denton. 2011. *Independent Review of Aid Effectiveness*. Canberra: Australian Government. Available at http://www.aidreview.gov.au/publications/aidreview.pdf.

ICAI (Independent Commission for Aid Impact). 2012. *DFID's Oversight of the EU's Aid to Low-Income Countries.* London: Independent Commission for Aid Impact. Available at http://icai.independent.gov.uk/wp-content/uploads/2012/12/ICAI-EU-report-061212-FINAL.pdf.

Ilorah, R. 2011. *Africa's Endemic Dependency on Foreign Aid: A Dilemma for the Continent*. Available at http://sites.uom.ac.mu/wtochair/Conference%20Proceedings/50.pdf.

InterAction. 2011. *Aid Effectiveness in Fragile and Conflict-Affected States*. Policy Paper. Washington, DC: InterAction. Available at http://www.cso-effectiveness.org/IMG/pdf/interaction_policy_paper_aid_effectiveness_in_fragile_states.pdf.

Kohli, J.S. 2009. *The Dragon on Safari: China's Africa Policy*. IPCS Special Report No. 86. New Delhi: Institute of Peace and Conflict Studies. Available at http://www.ipcs.org/pdf_file/issue/SR86-China-Kohli-Final.pdf.

Mutalemwa, D. 2009. *Aid Effectiveness and General Budget Support in Tanzania: The Potential, the Problem, the Promise*. Dar es Salaam, Tanzania: Policy Forum. Available at http://www.policyforum-tz.org/files/GeneralBudgetSupport.01.pdf.

Nikolov, P. 2006. Justice and Allocation in International Health Aid: Is the Economic Justification Rational? *Perspectives*. Available at http://www.people.fas.harvard.edu/~pnikolov/JusticeEconomicsHealth.pdf.

OECD (Organisation for Economic Co-operation and Development). 2003a. First High Level Forum on Aid Effectiveness, Rome. Available at http://www.oecd.org/dac/aideffectiveness/hlf-1thefirsthighlevelforumonaideffectivenessrome.htm.

OECD (Organisation for Economic Co-operation and Development). 2003b. *Harmonising Donor Practices for Effective Aid Delivery*. Paris: OECD. Available at http://www.oecd.org /dac/aideffectiveness/hlf-1thefirsthighlevelforumonaideffectivenessrome.htm.

OECD (Organisation for Economic Co-operation and Development). 2010. Annex: Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, in OECD, *Development Co-operation Report 2010*. Paris: OECD. doi: 10.1787/dcr-2010-39-en.

OECD (Organisation for Economic Co-operation and Development). 2011a. *Aid Effectiveness 2005–10: Progress in Implementing the Paris Declaration*. Paris: OECD. Available at http://www.oecd.org/dac/aideffectiveness/48742718.pdf.

OECD (Organisation for Economic Co-operation and Development). 2011b. Fourth High Level Forum on Aid Effectiveness (HLF4). Available at http://www.oecd.org/dac/aideffectiveness/fourthhighlevelforumonaideffectiveness.htm.

OECD (Organisation for Economic Co-operation and Development). 2012a. *Aid Effectiveness in the Health Sector: Progress and Lessons*. Paris: OECD. Available at http://www.keepeek.com/Digital-Asset-Management/oecd/development/progress-and-challenges-in-aid-effectiveness_9789264178014-en.

OECD (Organisation for Economic Co-operation and Development). 2012b. *Aid Quality and Architecture: Outlook on Aid; Survey on Donors' Forward Spending Plans, 2012–2015*. Paris: OECD. Available at http://www.oecd.org/development/aideffectiveness/50056866.pdf.

Ofose, G. 2011. Africa Needs U.S. $480 Billion to Fix Infrastructure, Says International Consultancy. *All Africa*. May 22. Available at http://allafrica.com/stories/201105231328.html.

Oomman, N., M. Bernstein, and S. Rosenzweig. 2007. *Following the Funding for HIV/AIDS: A Comparative Analysis of the Funding Practices of PEPFAR, the Global Fund and World Bank MAP in Mozambique, Uganda and Zambia*. Washington, DC: Center for Global Development. Available at http://www.cgdev.org/files/14569_file_FollowingFunding.pdf.

Piron, L.H., and A. Evans. 2004. Politics and the PRSP Approach: Synthesis Paper. Working Paper No. 237. London: Overseas Development Institute. Available at http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/2011.pdf.

Piva, P., and R. Dodd. 2009. Where Did All the Aid Go? An In-Depth Analysis of Increased Health Aid Flows over the Past 10 Years. *Bulletin of the World Health Organization* 87(12):930–39. Available at http://www.who.int/bulletin/volumes/87/12/08-058677/en/.

Ram, R. 2004. Recipient Country's "Policies" and the Effect of Foreign Aid on Economic Growth in Developing Countries: Additional Evidence. *Journal of International Development* 16:201–11.

Roberts, R. 2010. *Reflections on the Paris Declaration and Aid Effectiveness in Afghanistan*. Afghanistan Research and Evaluation Unit: Policy Notes Series. Kabul: Afghanistan Research and Evaluation Unit. Available at http://www.areu.org.af/Uploads/EditionPdfs/1013E-Reflections%20on%20the%20Paris%20Declaration%20and%20Aid%20Effectiveness%20in%20Afghanistan.pdf.

Schneider K., and L. Garrett. 2009. The End of the Era of Generosity? Global Health amid Economic Crisis. *Philosophy, Ethics, and Humanities in Medicine* 4:1. Available at http://www.peh-med.com/content/4/1/1.

Soucat, A. 2010. Health Financing in Africa: Buying More Health for the Money? Presentation of the African Development Bank at the Harmonizing Health for Africa (HHA) Directors Meeting, December 13, Dakar, Senegal.

Sturchio, J., and G. Cohen. 2012. How PEPFAR's Public-Private Partnerships Achieved Ambitious Goals, from Improving Labs to Strengthening Supply Chains. *Health Affairs* 31, no. 7 (2012):1450–58.

UNDP (United Nations Development Programme). 2007. *Human Development Report 2007/2008: Fighting Climate Change: Human Solidarity in a Divided World*. New York: Palgrave Macmillan. Available at http://hdr.undp.org/en/media/HDR_20072008_EN_Complete.pdf.

UNECA and AU (United Nations Economic Commission for Africa and African Union). 2012. *Economic Report on Africa, 2012: Unleashing Africa's Potential as a Pole of Global Growth*. Addis Ababa, Ethiopia: Economic Commission for Africa. Available at http://new.uneca.org/Portals/era/2012/ERA2012_ENG_FIN.pdf.

Vandeninden, F. 2012. Foreign Aid Transaction Costs. UNU-MERIT Working Paper No. 2012-007. New York: United Nations University. Available at http://www.merit.unu.edu/publications/wppdf/2012/wp2012-007.pdf.

Wexler, A., A. Valentine, and J. Kates. 2013. *Donor Funding for Health in Low- and Middle-Income Countries, 2002–2010.* Menlo Park, CA: Kaiser Family Foundation. Available at http://globalhealth.kff.org/Daily-Reports/2013/January/10/GH-011013-RR-KFF-Donor-Report.aspx.

WHO (World Health Organization). 2006. *World Health Report 2006: Working Together for Health*. Geneva: WHO.

WHO (World Health Organization). 2007a. *Aid Effectiveness and Health*. Working Paper No. 9. Geneva: WHO.

WHO (World Health Organization). 2007b. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes—WHO'S Framework for Action*. Geneva: WHO. Available at http://www.who.int/healthsystems/strategy/everybodys_business.pdf.

WHO (World Health Organization). 2008. *Effective Aid, Better Health: Report Prepared for the Accra High Level Forum on Aid Effectiveness*. Geneva: WHO. Available at http://www.who.int/hdp/publications/effectiveaid_betterhealth_en.pdf.

WHO (World Health Organization). 2010a. External Aid for Health in Viet Nam: Additional or Fungible. Background Paper No. 40. Geneva: WHO. Available at http://www.who.int/healthsystems/topics/financing/healthreport/VietNamGBSNo40FINAL.pdf.

WHO (World Health Organization). 2010b. *World Health Report 2010: Health Systems Financing—The Path to Universal Coverage*. Geneva: WHO.

WHO (World Health Organization). 2011a. Efficiency and Effectiveness of Aid Flows Towards Health Workforce Development. *Human Resources for Health Observer*, no. 7. Available at http://www.who.int/hrh/resources/observer7/en/index.html.

WHO (World Health Organization). 2011b. *Monitoring the Implementation of Millennium Development Goals*. Geneva: WHO.

WHO (World Health Organization). 2011c. *World Health Statistics 2011*. Geneva: WHO. Available at http://www.who.int/whosis/whostat/EN_WHS2011_Full.pdf.

Wood, B., D. Kabell, N. Muwanga, and F. Sagasti. 2008. *Evaluation of the Paris Declaration* (Phase 1). Copenhagen: Kabell Konsulting.

World Bank. 2007. *Development and Aid Effectiveness: What Have We Learned, What Are We Doing, Where Are We Going?* Knowledge in Development Notes. Washington, DC: World Bank. Available at http://siteresources.worldbank.org/INTRES/Resources/469232-1127252519956/Overview_Note_Dev_and_Aid_Effect_06.23.05.pdf.

World Bank. 2011a. *The Global Monitoring Report 2011: Improving the Odds of Achieving the MDGs*. Washington, DC: World Bank. Available at http://siteresources.worldbank.org/DEVCOMMINT/Documentation/22891372/DC2011-0004(E)GMR2011Overview.pdf.

World Bank. 2011b. *The World Bank and Aid Effectiveness: Performance to Date and Agenda Ahead*. Washington, DC: World Bank. Available at http://www1.worldbank.org/operations/aideffectiveness/documents/WorldBank&AidEffectiveness2011Final.pdf.

World Bank. 2012. *Aid Effectiveness Issues Brief*, April. Washington, DC: World Bank. Available at http://www1.worldbank.org/operations/aideffectiveness/documents/OPCS_Aideffectivenes_IssuesBrief.pdf.

World Bank, OECD, and WHO. 2008. *Effective Aid: Better Health*. Available at http://www.who.int/hdp/publications/effectiveaid_betterhealth_en.pdf.

World Bank, UNICEF, UNFPA, and the Partnership for Maternal, Newborn and Child Health. 2009. *Health Systems for the Millennium Development Goals: Country Needs and Funding Gaps*. Available at http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Results___Evidence/HAE__results___lessons/Working%20Group%201%20Technical%20Background%20Report%20(World%20Bank%20UNICEF%20UNFPA%20PMNCH).pdf.

ABOUT THE AUTHORS

Atef El Maghraby, chief health analyst (HRH), African Development Bank, is an expert in global health with emphasis on human resources for health, service delivery, and systems strengthening. His focus is on promoting greater value for the money through investments in medical education, institutional capacity, and health policy development. He has a strong profile designing and managing health programs and technical assistance on a large scale in more than twenty-five countries in Africa, the Middle East, and South Asia. Before joining the African Development Bank, Maghraby worked for the United Nations Population Fund, the World Health Organization, and the European Commission. He holds an MD and an MA HMPP.

Feng Zhao, health division manager, African Development Bank, has more than twenty years of experience in public health, medicine, economics, and demography in Africa and Asia. He has worked extensively on service delivery, public-private partnership, eHealth, Sector-Wide Approach, health care financing, public expenditure analysis, strategy development, planning, and implementation. Before he joined the AfDB, Zhao worked for a range of organizations, including the World Bank, academia, and government agencies. His last position was as senior health specialist at the World Bank, responsible for operations and economic and sector work in a number of African countries. He holds an MD, a PhD, and an MPH.

Address correspondence to Atef El Maghraby at a.elmaghraby@afdb.org and atefhrm@yahoo.com

AUTHOR CONTRIBUTIONS

Atef El Maghraby is the lead author. He formulated the concept of the paper and researched health aid and its effectiveness. He drew on a number of health development reports that he produced focused on health workforce, value for money health results, and systems within donor dynamics that evolved after the Paris Declaration.

Feng Zhao provided the conceptual framework of how aid architecture evolution can be harnessed in Africa and deliver more health outcomes and sustainable health systems development. His experience at the World Bank and African Development Bank together with strategic partnerships and policy dialogues with global health donors helped to inform his input into this manuscript and the need for improved aid outcomes in the African region.

CITATION

Please cite as El Maghraby, A., and F. Zhao. 2013. For More Effective Health Aid in Africa (http://www.archive.nyu.edu/handle/2451/31739). In *Transforming the Global Health Workforce*, Marilyn A. DeLuca and Agnes Soucat, eds., 2013. New York: New York University, College of Nursing. Available at http://www.archive.nyu.edu/handle/2451/31736.

ACKNOWLEDGMENTS

The authors acknowledge with great appreciation the significant contribution and relentless support of Dr. Marilyn DeLuca, consultant, global health-health systems-philanthropy, adjunct associate professor, College of Nursing, and assistant professor, School of Medicine, New York University; and Dr. Agnes Soucat, director of the Human Development Department, African Development Bank. Recognition and thanks also go to all of the experts who provided comments and suggestions, especially Giles Dussault, coordinator, WHO Collaborating Center for Health Workforce Policy and Planning, University of Lisbon; Dr. Maha El Rabbat, head of the Public Health Department and professor of medicine, Cairo University; and Christophe Lemiere, senior health specialist, World Bank.