Private Financial Assistance for Health and Principles of Aid Effectiveness: Development Partner Perceptions in Chad, Ghana, Mozambique, and Tanzania, 2019

Ashley Warren[1, 2*], Stephen Browne[3], Roberto Cordon[4], Raymond Saner[5], Lichia Yiu[5], Shufang Zhang[6] , Michaela Told[6] , Don de Savigny[1, 2] , Ilona Kickbusch[6] , Marcel Tanner[1, 2]

(Working Draft, unpublished, outcome of a research project for SNIS (Swiss Network for International Studies, 31st September 2012 to 30th April 2015), lead authors Ashley Warren, Don de Savigny with support from Raymond Saner and other members of research consortium.)

[1] Department of Epidemiology and Public Health, Swiss Tropical and Public Health Institute, Socinstrasse 57, 4002, Basel, Switzerland

[2] University of Basel, Petersplatz 1, 4003, Basel, Switzerland

[3] Ralph Bunche Institute, Graduate Center, City University of New York

[4] Franklin University Switzerland, Via Ponte Tresa 29, 6924 Lugano-Sorengo, Switzerland

[5] Centre for Socio-Eco-Nomic Development, CP 1498, Mont Blanc, 1211 Geneva 1, Switzerland

[6] Graduate Institute of International and Development Studies, Maison de la Paix, Chemin Eugène-Rigot 2, 1202 Geneva, Switzerland

Abstract

Background: Development assistance for health (DAH) has increased substantially since 2000, and the global health landscape continues to evolve into an increasingly complex network of actors, institutions, and funding arrangements. The influence of this increasing plurality in the global health financing system on the coherence, efficiency, and effectiveness of health development programmes requires on-going investigation. In this paper we report results of the a study of perceptions and experiences of conventional DAH country-level stakeholders with regard to private donors (corporations and philanthropic foundations) as partners in health development efforts in Chad, Ghana, Mozambique, and Tanzania - four countries that span the donor-darling / donor-orphan spectrum.

Methods: We conducted face-to-face semi-structured in-depth interviews with 93 key informants from government ministries, bilateral and multilateral agencies, local research institutions, and independent consultants. We examined these discussions and perspectives on private donors through the comprehensive framework of the Paris Declaration, i.e. the five pillars of alignment, harmonization, mutual accountability, managing for results, and ownership.

Results: Major observations include that small-scale engagement makes harmonization both more difficult and more necessary, but private actors are absent from coordination groups at the country-level. Therefore conventional development partners know little of how private actors are engaged in the local health sector.

Conclusions: Private finance for health is not necessarily aligned with country priorities or strengthening country health systems. This type of assistance supplements conventional bi- and multi-lateral assistance, but in order to limit further fragmentation, such emerging private funders should be informed of, and included in, development partner group discussions.

Keywords: Development Assistance for Health; Philanthropy; Corporate Social Responsibility; Paris Declaration; Aid Effectiveness

Key Messages:

Implications for policy makers

At the international level-

- There should be designated fora at high-level aid effectiveness discussions for feedback from actors leading in-country operations.

- Philanthropic foundations and corporations that are active in health development should be present at such fora and included in in-country discussions.

- Members of the Organization for Economic Cooperation and Development's Global Network of Foundations Working for Development (netFWD) should advocate their principles to extend awareness among non-members.

At country-level –

- Coordination groups should be inclusive when they become aware of emerging donors in-country.

- Governments should increase transparency of the nature of engagement with all partners.

At the organizational level –

- Corporations and philanthropic foundations should develop policies for engaging national governments and coordinating with other in-country development partners at the central level.

Implications for Public Health

Through the Paris Declaration on Aid Effectiveness, international experts agreed on principles to maximize benefits from international aid. This research seeks to highlight how government officials and health development stakeholders in different countries think private donors contribute based on those principles. The stakeholders that we interviewed think that corporations and organizations funded by wealthy individuals could make improvements. If these private donors communicate with the recipient government more effectively, they will better understand the country's priorities. They can then decide together what resources are required to assist where it is most needed. If they communicate more with other aid agencies, they all will have a better idea of what services are available in different communities and how gaps can be filled. Donors want to be effective, and most professionals agree that sharing information and making decisions together is important for reaching this goal.

Introduction

Development assistance for health (DAH) has increased substantially over the last 15 years, and the global health landscape continues to evolve into an increasingly complex system of actors and approaches [1]. More than 100 well-endowed global health initiatives, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, have been established [2] since 2000. Across all sectors, private capital flows including corporate social responsibility have become the largest portion of financial flows from developed countries to developing countries [3,4].

This study is part of a larger investigation of private finance in the health sector in Africa. The objective of the present study is to illuminate country level development partner perspectives on private finance in the health sector from private corporations and philanthropy by applying the Paris Declaration principles as a reference frame. This research was conducted to answer the following two research questions: What are country-level perspectives on philanthropic foundations' and corporations' engagement in financing for the health sector? And, how do health development experts perceive these actors' models of development cooperation?

In 2005 more than 100 developed and developing countries agreed upon five principles of aid effectiveness in the Paris Declaration. These are ownership of development policies and strategies, alignment of aid with country priorities and systems, harmonization of donor practices, managing for results, and mutual accountability [5]. In 2011, at the Fourth High Level Forum on Aid Effectiveness, in Busan, South Korea, development partners agreed to update the five aid effectiveness principles. Analogs of the Paris Declaration pillars of ownership, managing for results, and mutual accountability were carried forward, but alignment and harmonization were collapsed into "inclusive development partnerships". The most noticeable deletion is language about alignment of resources with national strategies [6].

The 2014 Global Partnership on Effective Development Cooperation High-Level meeting in Mexico was the first high-level discussion on aid effectiveness that included private stakeholders [7]. In the report for the Third International Conference for Financing for Development in July 2015, participants acknowledged the contributions from philanthropists but called for increased

transparency, accountability, and alignment with country strategies and systems [8]. There was no mention of coordinating efforts with other private actors such as corporations.

With the 2009 global financial crisis, many began to question the effects of a long-term recession on development and identified potential corrective actions [9-12]. Others insisted the global recession would not affect bilateral levels of DAH [13]. Years later the discussion persists while some treatment programmes have been discontinued and aid revenue has decreased [14-17]. Likely the overall ratio of private to public spending will continue changing at a noteworthy rate.

In 2014, corporations provided $662 million (1.9%) for DAH. Other private sources amounted to $2.7 billion (7.4%) of DAH; this figure includes charitable giving and philanthropy excluding the Bill and Melinda Gates Foundation [18]. 74.8% was provided to NGOs in 2014 ($2.5 billion); UN agencies and the Global Fund also received shares. The Bill and Melinda Gates Foundation (BMGF) is the largest single source of private finance for global health. In 2014 alone, the BMGF accounted for 8.1% of total DAH and 46.6% of private funding flows for global health ($2.9 billion USD) [18]. Overall, private philanthropy has grown more substantially than corporate donations over the last decade [18]. Despite the inclusion of private actors in recent aid effectiveness discussions, few philanthropic actors appear to be aware of the principles first outlined in 2005 [5]. BMGF is the only foundation that currently adheres to the principles outlined by the 2011 Busan Partnership for Effective Development Cooperation [19].

From 2003 onwards, sub-Saharan Africa consistently received the largest share of DAH. On average, it accounted for more than 24.5% of total international expenditure on health from 2000 to 2012. The vast majority of its support comes from governments, multilateral agencies, and large funding partnerships such as the Global Fund and the GAVI Alliance [18] (which mix public and private finance). It is difficult to tease out how much support comes from exclusively private sources as they may enter recipient countries through other channels, e.g. NGOs. The majority of money coming from private foundations and corporations is deemed un-allocatable. The only private foundation that was tracked from source to recipient was the BMGF which allocated 25.3% of its funds to sub-Saharan Africa in 2012 [18].

Shared roles and responsibilities blur the division between the private and public sectors' aims and responsibilities [20]. This raises concerns about legitimacy, accountability, and international cooperation [21] as well as concerns over potential conflicts of interest [22], divergence from national strategies, and lack of harmonization among donors [23]. The influence of increasing plurality of the

global health financing system on the coherence, efficiency, and effectiveness of health development programmes requires further investigation [24].

The scope of this study is confined to four countries, Chad, Ghana, Mozambique and Tanzania. These countries were selected to span the donor-darling / donor-orphan spectrum[25]. The scope is also restricted to conventional DAH development partner views on private corporations and private philanthropy investments in the health sector. In this scope, we do not include remittances, publically funded global health initiatives, private international or national non-governmental or faith-based organizations.

Private sources of finance addressed in this study were defined as philanthropic foundations and corporate social responsibility programmes (CSR). Philanthropic foundations and corporations, rather than faith-based organizations or charities, were selected due to their recognition and participation at the international level through the Fourth High-Level Forum on Aid Effectiveness in 2011. Philanthropic foundations, along with the OECD, have developed guidelines for effective engagement[8] and many corporations have signed the UN Global Compact[26]. Such examples signify that these actors, in turn, recognize the need for global perspective and international cooperation.

Methods

Country selection

Chad, Ghana, Mozambique and Tanzania were selected according to the following considerations. We chose countries at the extreme ends and in the middle of the DAH "donor-orphan / donor-darling" spectrum on the assumption that emerging private finance might have more visible influence and partnership in a DAH "donor-orphan" country. Chad is classified as a "donor-orphan"; it is ranked in the lowest ten countries in terms of commitments and disbursements of DAH based on the OECD's Development Assistance Committee's credit reporting system (DAC CRS) and the Global Health Expenditure Database. Using the same indicators, Mozambique and Tanzania are classified as "donor-darlings". Ghana falls between a donor-darling and a donor-orphan across all classifications [25]. There are other countries in each of these categories but the choice of these four as being emblematic of the donor-darling or donor-orphan categories was arbitrary.

Primary data collection

In 2014-15 we conducted face-to-face semi-structured in-depth interviews with 88 key informants from the Ministry of Health, Ministry of Finance, health or development attachés of bi- and multilateral agencies, local research institutions, the African Development Bank, and independent consultants. Interviews were held in the offices of key informants in N'Djamena, Chad; Accra, Ghana; Maputo, Mozambique; and Dar es Salaam, Tanzania. One in-depth interview was conducted by telephone. Interviews lasted approximately one hour but ranged from 45 minutes to three hours. Interviewers held an additional five brief discussions with relevant experts for country and/or development context bringing the total number of interactions to 93 (See Table 2). In N'Djamena investigators were invited to, and attended, a meeting hosted by the Washington, D.C.-based Grant Management Solutions (a USAID-funded technical body founded to support Global Fund principle recipients [27]).

Table 1. Interviewees by institution

We targeted agencies that the WHO reported to be prominent sources of DAH in the case-study countries (Table 2 and Figures 1 and 2). Interviewees were selected as the most senior, cognizant and available representatives for the issues from each respective agency. We then used the 'snowball' approach whereby each interviewee suggested colleagues in partner organizations and the government who had insight into our research interests. We contacted prospective interviewees via emails that contained a brief description of the research team, overall research questions and objectives, and methods.

Table 2. Top five sources of disbursements for health, case-study countries (2009-2010) [28-31]

Figure 1a. Multilateral representation; number of interviewees

Figure 1b. OECD partner representation; number of interviewees

Interviews in Ghana and Tanzania were conducted in English. In Chad, ten interviews were conducted in French and six in English. The meeting of the Country Coordinating Mechanism was

held in French. One investigator is a Francophone and the other an Anglophone (accompanied by a local translator). In Mozambique discussions were held primarily in English with periodic clarifications in Portuguese as one investigator speaks Portuguese fluently. Investigators took detailed notes during the discussion. When more than one investigator was present for an interview, notes were compared after transcription.

We used a semi-structured interview guide (see Annex 1). Discussions included questions about interviewees' perspectives and experiences of overall changes in development assistance for health and resulting influences at country-level. Interviewers sought perceptions about who were the most influential private sources of finance and knowledge of actors' activities in-country. We asked open-ended questions about private actors' engagement with other donors, the recipient government, and their prospective roles in the country's health development landscape.

Analysis

The corresponding author combined interviewers' notes into one Microsoft Word document per interviewee and organized the material into fundamental themes- type of donor, aid management, health system, country context, etc. These were uploaded into MAXQDA 11 (UdoKuckartz; Berlin, Germany) and read each at least three times by the corresponding author. Each successive reading was accompanied by descriptive, analytic, and thematic coding, respectively. Interview notes were indexed using the five pillars of the Paris Declaration (Annex 2) as an organizing reference framework and included sub-themes as determined by the initial analytic coding [32].

To preserve respondents' anonymity, each interviewee was given a label: two letter country code, professional affiliation, and number (based on chronological order of interviews of people with same professional affiliation). For example, "TDConsultant2" the second consultant interviewed in Chad.

Results

Overview in case-study countries

Despite the marked increase in private finance for health, discussions with health ministry officials and development partners at the country-level painted a different picture. Many interviewees concluded that although private actors work in these countries, their contributions are not visibly influential in the health sector. For example, government interviewees had heard of private financiers acting in Chad but had "*never seen any outcome"* of their activities (TDGovernment2). Respondents in all four countries perceive foundations and CSR programmes to have a narrow

scope and provide one-off project assistance. In Chad and Ghana, interviewees commented that support from private actors has been increasing and that this trend will likely continue. One interviewee from Chad drew from his experience in other contexts and suggested that economic transitions present openings for non-traditional financiers (TDConsultant1). This could apply to Ghana, which has recently been reclassified from a low-income to a lower-middle income economy. Likewise, in Mozambique, foreign direct investment, government revenue, and lending have all increased, changing the balance and influence of traditional donors.

Private financiers are seen to be supplementary sources of finance. Their contributions are welcome due to financial challenges, but they contribute to fragmentation and do not feed their experience back into their aid approaches.

Interviewees' observations and concerns about the influence of private assistance were consistent with the themes outlined in the Paris Declaration, i.e. the five pillars of ownership, alignment, harmonization, managing for results, and mutual accountability. Discussions focused on alignment and harmonization of assistance, in particular.

Alignment

Alignment refers to coherence of support with recipient countries' development strategies and policies, as well as strengthening country systems [33]. Overall, respondents largely agreed that private sources of assistance do not adhere to the principles of alignment in their respective countries. "*Like the larger funders, these sources tend to want to impose their own agendas"* (TZAcademic1).

Overall, interviewees agreed that resources coming from philanthropic sources are supplementary to traditional development assistance, but replacement isn't feasible due to the narrowly-focused approach. Respondents in Tanzania highlighted the pros and cons of philanthropic foundations' lack of alignment with national strategies. One interviewee implied that foundations' agendas are ideological rather than needs-based, e.g. Kaiser Foundation (USA), "*…because of the sensitivity of donors,* [some] *private sources are reluctant to channel funds to the critical HIV-infected groups"* (TZMultilateral5). On the other hand, when the donor is more liberal than the government and doesn't need to worry about political diplomacy, it can fill gaps. "*The Diana Foundation (UK-based) provides funding for HIV/AIDS to fill gaps left by government due to systemic stigma (e.g. criminalization of certain behaviors that result in increased risk for AIDS – sex workers, men-who-have-sex-with-men*" (TZMultilateral5).

Systems support was a prominent theme of discussions in Chad and Tanzania. In both countries there were discordant views on systems support from the BMGF. In Chad one respondent recounted that along with polio eradication, BMGF also strengthens routine immunization (TDConsultant1). TDConsultant2 stated that BMGF, "*understands there is need for a fully functioning health system"*. In contrast, a third respondent spontaneously implied that BMGF provides no system-level support, "*Gates should do minimum of training and capacity development. Without adequate health systems, even if funded by Gates, medication will not be used efficiently; there will be losses due to mismanagement"* (TDMultilateral9). In Tanzania the debate centered upon the Clinton Health Access Initiative which is under the umbrella of the Clinton Foundation. Its projects are included in the Health Sector Strategic Plan, and to that extent are approved by the government (TZMultilateral3). Likewise, "*they are involved in collaborations for the pay-for-performance scheme, innovative financing mechanisms, and systems strengthening"* (TZOECDPartner4). Another respondent addressed the same area of support but with a different opinion. They are "*very active in terms of money and technical input, but they are following their own agenda. They set up a pay-for-performance scheme over the past two years and trying to influence policy although the government is not ready to commit to a certain type of payment scheme"* (TZOECDPartner3). This intervention was a source of conflict within the development partners group for health [34].

Discussions with TDMultilaterals 9 and 10 highlighted the role of alignment with country systems to increase results. Likewise, in Tanzania, TZMultilaterals 1 and 2 were under the impression that because private sources don't have a local base, they "*are not feeding back their experience into their aid approaches"*. Other respondents in Tanzania suggested that a key to producing results had more to do with scale rather than alignment or evidence-based decision-making. "*Private financing sources like Clinton Foundation and Gates' Foundation support projects which can show results rather than larger programmes"* (TZMultilateral3).

In Chad, Mozambique, and Tanzania CSR contributions are small-scale projects with limited reach. Interviewees identified the extractive industries, namely oil and gas, as the most visible contributors through CSR. In general, these programmes are not focused on the long-term, are localized, and target personal interests. Due to lack of evaluation, it is difficult to gauge how much

they provide in the short-term (MZGovernment1). As one respondent said, "*The private sector is better suited for one-off commitments rather than sustained contributions"* (MZNGO2).

Ghana has a unique example of a CSR programme that has been incorporated into a national strategy. Presently, AngloGold Ashanti is a Principle Recipient of a Global Fund grant for a malaria control programme in 40 districts. It was replicated on AngloGold's integrated malaria programme for employees in Obuasi town and villages of the Obuasi Municipal district. Some respondents were not particularly supportive of the programme - though they have experience and success in a small locality, they do not necessarily have the technical capacity to scale-up to national level. Overall, CSR programmes have contributed minimally. "*AngloGold Ashanti Malaria Control Ltd is an exceptional case, and its formation and level of involvement is due to Global Fund support"* (GHGovernment3).

Harmonization

Harmonization has three principles - coordinated donor actions; simplified procedures; and shared information to avoid duplication (4). All four case-study countries have active country-level coordinating bodies. Interviews highlighted a distinct absence of private actors in these mechanisms.

In Chad, new partners are expected to enter the health sector in the established partnership framework, but so far it is unclear with whom private actors engage. They lack structured policies and focus areas. TDGovernment4 stated that "*[t]here are difficulties in coordinating both conventional and unconventional donors, but it is essential for all to coordinate"* (TDGovernment4). The government convenes meetings once per month to promote dialog with donors. Private partners have not been included in coordination bodies led by traditional development partners, but

> *"The partners group is very formalized and technically open to all, but to-date there is no clear criteria for representation. The group of development partners has acted somewhat exclusively by not extending the invitation to join to interested, potential partners. So the dialog has been stymied. Involvement of non-traditional partners is weak perhaps because they are not well-informed or perhaps because they are not pro-active"* (TDMultilateral1).

In terms of CSR specifically, one respondent reported that "*the results of their efforts are unclear, there are no observers, and there is no cooperation"* (TDCoordination1).

In Ghana, respondents were more likely to mention *channels* for private contributions such as the Global Fund or the One Million Community Health Workers Initiative[1] rather than philanthropic actors. Such partnerships can obfuscate the contributions of different actors from the recipient's perspective. There was a remarkable increase in resources coming from CSR programmes in 2012, but perhaps the data are being captured more effectively rather than an actual increase (GHGovernment4). Respondents discussed a diverse group of corporate actors in Ghana - banks, the Cocoa Board, mining companies, oil and gas companies, and telecommunications providers. Ghana's lack of policy for integrating CSR funds has resulted in uncoordinated activities and, ultimately, waste. "*The Central Medical Stores currently has medicines that will not be distributed but must be disposed of. These medicines were likely purchased without regard to context or need"* (GHGovernment2). The Ministry of Health is working towards a policy for including the private sector because of these coordination challenges.

One development partner in Tanzania argued that participation in coordination activities through the Development Partners Group is not always for the sake of coordination. "*Clinton is the only private foundation participating regularly, albeit opportunistically, in the sector-wide approach. They contribute to discussions only to push their agenda rather than moving forward together as a group"* (TZOECDPartner3). With regard to harmonization of actual funds, private actors do not provide finance to the sector-wide approach basket because of the lack of visibility and lack of "branding" (TZOECDPartner3).

One interviewee in Mozambique summarized coordination with corporations in the health sector as follows. "*So far this type of support is uncoordinated, and there is no real model. It is actually Corporate Social (Ir)responsibility"* (MZMultilateral2). Respondents often spontaneously listed philanthropic donors, but not corporations, working in project implementation. This suggests that philanthropic donors are more likely to partner with implementing agencies - either out of necessity or by choice.

[1] http://1millionhealthworkers.org/ "The 1mCHW Campaign, which has a partnership base of over 150 organizations from United Nations agencies, civil society, the private sector, and academia, was launched in January 2013 at the World Economic Forum in Davos. Since its launch, the Campaign has been actively supporting African governments and partners who are dedicated to increasing the number and quality of lay health workers in the region."

Overall, respondents' comments in Chad and Mozambique reflect that the lack of harmonization with CSR programmes leaves respondents without much to say about whether and how they measure up to the managing for results pillar:

> *"It is difficult to predict how important corporate social responsibility programmes will be for health development over the coming years because the results of their efforts are unclear, there are no observers, and there is no cooperation"* (TDCoordination1).

> *"In general, these programmes are not focused on the long-term, they are very localized, and it is difficult to gauge how much they actually provide in the short-term"* (MZGovernment1).

Respondents largely agreed that the small scale at which these donors operate makes it even more important for them to coordinate their efforts with established donors to maximize and leverage their assistance. This could be especially important for philanthropic donors who work in multiple locations. In theory, this makes philanthropic foundations perfect candidates for utilizing and supporting national systems (and therefore avoiding duplication). CSR programmes are quite localized, so perhaps they do not feel the need to use more country systems.

Mutual accountability

Models of 'mutual accountability' between donors and recipients inherently vary between countries as recipient mechanisms for aid delivery are fundamentally different. For example, respondents in Chad reported that no donor funds go through the government. In Tanzania official development assistance always goes through the Ministry of Finance. Ghana and Mozambique both have more mixed models; their governments do receive funds from donors, but these funds can enter at any level (central, regional/provincial, or district), and many actors act outside of government channels altogether [35]. In Chad, BMGF is the largest philanthropic donor and communicates with the Ministry of Health through either UNICEF, WHO, or the Chadian Comité de Coordination Inter-agences. The Ministry of Health is uninformed of BMGF activities in Chad, unless "*Bill Gates himself comes to Chad for a meeting"* (TDGovernment4). The Ministry of Health and development partners disagreed about who private actors were coordinating with. The ministry said that they had little to no contact with foundations and corporations. In contradiction,

interviewees from development agencies reported that, so far, these newer actors only coordinated with the ministry.

Despite private actors' absence in coordination bodies, in Tanzania development partners seemed very aware of private actors and partnerships between organizations. Most would spontaneously offer a litany of health development projects, all organizations involved, and where they were located. All interviewees were involved and actively engaged in the Development Partners Group, and it was clear that there was continuous communication among the OECD Partners. Tanzania's operations are decentralized, but unlike Ghana health is governed at the national level, and all external actors must act under the auspices of the Ministry of Health [35].

> *"There is an overall sense of uncertainty of volume of funding from different sources outside the Development Partners Group for health. This is not communicated openly. Submitting reports to the Ministry of Finance is mandatory for conventional donors, but is voluntary for unconventional sources"* (TZOECDPartner5).

TZOECDPartner1 shared that it is not uncommon to arrive at the launch of a project only to discover a previously unknown organization doing similar work in the same location - all sanctioned by the government. Additionally, the Ministry of Health reported that support from extractive industry goes directly to health facilities and hospitals. This indicates a different standard to which industry is held. All official development assistance for health is required to be channelled through the Ministry of Finance.

In Mozambique, there is no reported coordination between corporations and the Ministry of Health, and it was suggested that they actually contribute to brain drain as they hire people from the ministry. These discussions rarely included direct commentary on who should be held accountable in preventing brain drain. Only one respondent was quick to state that "*it is the onus of the government to regulate the extractive industry"* (MZMultilateral2). The government has proposed innovative health financing strategy for 2019, but there is a gap in rhetoric versus reality for integrating private resources. Multiple interviewees converged on the idea that "*the best thing that the private sector could do, including the extractive industry, is pay taxes. The revenue generated through fair taxing would far outweigh any contribution they would make through a corporate social responsibility programme"* (MZOECDPartner7).

One respondent, MZMultilateral6, highlighted another gap in progress towards satisfactory accountability of both donors and recipient governments- transparency. Until transparency extends to civil society, it will be difficult to gauge whether or not decision-makers on either side of a partnership are being held truly mutually accountable.

Managing for results

Managing for results refers to a management strategy for increasing efficiency and effectiveness with an emphasis on shared values and leadership while promoting results-based decision-making. It is an approach that includes strategic planning, monitoring and evaluating performance, reporting, and incorporating lessons learned for improvement [20].

Overall respondents discussed "managing for results" very minimally with regard to private donors, and when they did it was interwoven in discussions that centered more heavily upon other pillars.

Ownership

National ownership under the Paris Declaration refers to developing countries setting their own development strategies, improving their institutions, and tackling corruption [33].

Respondents in all four case-study countries commented on their respective country's lack of policy for including emerging donors, but the governments are actively discussing developing such policies and more inclusive health financing strategies. Interviewees often commented on perceived weaknesses in the health system but not specifically in the context of external private finance. Therefore these comments were deemed irrelevant in this analysis. The theme of country ownership was most often woven into interviewees' opinions about the future of private finance for health in Ghana and Mozambique.

Each of the case-study countries has a unique relationship with philanthropic foundations and corporations who support health development, but they also share experiences in terms of adherence to the Paris Declaration (see Table 2). Respondents expressed similar concerns and hopes for future collaboration with private donors.

Table 2. Summary of private donors' adherence to the five Paris Declaration pillars

Prospective views

A few respondents, particularly in Ghana and Mozambique, spontaneously gave insights into how they predict private donors will engage in the coming years and, furthermore, how they *should* engage. These comments most often overlapped with the theme of country ownership. One comment made by a respondent in Chad hinted at why country ownership is integral to the future of private sector engagement in health. He witnessed in Southeast Asia that "*as the country transitioned economically, it was easier to get unconventional funding"* (TDConsultant1). This observation is consistent with perspectives in Ghana and Mozambique.

In 2010 Ghana rebased its gross domestic product (GDP) calculations [36] and transitioned overnight from a low-income economy to a lower-middle-income economy [37]. This has changed its relationship with donors. Most importantly, Ghana is excluded from concessional loans from the World Bank's International Development Association, its predominant creditor for 30 years [38]. Although this change prevents it from receiving finance from poverty-targeted aid programmes of bilateral donors, it does signal a need for increased access to private investment, international capital markets, and lending from the World Bank's International Bank for Reconstruction and Development [38]. It may also open opportunities for emerging donors.

Respondents shared that there is an expected increase in the volume of assistance coming from external private financiers (GHNGO1). For example, the Global Fund's Country Coordinating Mechanism (the in-country multi-stakeholder group responsible for overseeing grant application and implementation) "*has a new role in securing private funding as part of the national resource mobilization strategy"* (GHCoordination2). EcoBank has committed $3 million USD to West Africa with a deal that the Global Fund uses EcoBank as an intermediary (GHGovernment3).

The majority of comments made about the future of the private sector in health were not about assistance but rather about foreign direct investment. Ghana is anticipating a partnership in pharmaceutical manufacturing, namely with investors from China and India. GHMultilateral4 shared that the government provided a stimulus package to spur private or international investment for two to five new manufacturing plants. Three Indian companies have applied for a license. Additionally, there was a joint venture company between China and Ghana. This first China-Ghana pharmaceutical joint venture was inaugurated in 2005, with Danpong Pharmaceuticals Ghana Ltd. as the Ghanaian partner. Eventually the Chinese partner pulled out, supposedly due to non-compliance with the joint venture contract.

In Mozambique, as the consultant in Chad suggested, "*[foreign direct investment, government revenue, and lending have all increased which changes the balance and the influence of traditional donors"* (MZOECDPartner10). A number of interviewees (MZNGO2 and MZOECDPartners 7, 8, and 9) agreed that tax regulation is important for harnessing the wealth of the private sector. Additionally, MZOECDPartners 7, 8, and 9 suggested that there is room to pilot a Development Impact Bond. MZOECDPartner4 elaborated on the perceived benefits, "*It would result in a longer-term commitment, guaranteed results, and risk-sharing".* It would require cooperation of government, NGOs, and private actors who "*have the flexibility to innovate and take higher risks. … Also, it is more an outcome-based approach rather than an output-based approach"*.

A follow-up discussion with MZOECDPartners 7, 8, and 9 revealed that the Ministry of Health says that they are open to Development Impact Bonds but view this approach as a purely donor-funded endeavor. In order for it to work, the Ministry of Health must have a clearly defined role as overseer and service provider. They must define what services they would be willing to out-source and set clear targets. Such a mechanism should be an integrated component of the national strategy. Ultimately, it is an approach to harmonization, but in theory, it addresses all five pillars of the Paris Declaration.

Discussion

This study (as part of a larger study on the influence of emerging private finance in health development [39]) focussed on the perceptions of conventional DAH stakeholders at country level on private finance in the health sector and on the model of development cooperation applied by private finance, either by philanthropy or corporate social responsibility. It used the comprehensive principles of the Paris Declaration on Aid Effectiveness as an organizing framework to catalogue the issues raised and discuss the issues raised.

Despite very different base scenarios of DAH support across the four countries, the perspectives of DAH stakeholders were remarkably similar. Most issues raised were with regard to the alignment and harmonization principles in the Paris Declaration, and to a lesser extent, lack of mutual accountability. Most of the ideas for better engagement of private finance were aimed at the ownership principle and the need for more engagement. Philanthropic foundations' priorities and strategies differ from bilateral donors because they are determined more by internal factors

than external factors. The interests of the benefactors, donors, or Board members dictate the priorities and therefore the themes of funding [3].

The Paris Declaration and the World Bank, for instance, emphasize harmonization with key stakeholders in order to organize aid initiatives and finances for the health sector [40]. In-country coordinating bodies are a response to the Paris Declaration. They are comprised of bilateral and multilateral agencies that work with the host government and domestic non-governmental stakeholders for increased coordination and health development effectiveness.

In 2014, the OECD Global Network of Foundations Working for Development (netFWD) developed the "Guidelines for Effective Philanthropic Engagement" [8]. The three pillars- dialogue, data / knowledge sharing, and partnering - aim to foster "mutual recognition between philanthropic actors, governments and development agencies on the basis of their respective comparative advantages" [2]. Essentially, this document reflects the recognition of the Paris Declaration's harmonization pillar as the foundation of effective engagement. One could assume that all organizations associated with netFWD would abide by this pillar, if none other. Therefore it is surprising that the only foundation adhering to the 2011 Busan Partnership for Effective Development Cooperation principles was BMGF [3]. Although the Busan Agreement does not explicitly address harmonization, foundations' adherence would symbolize their commitment to internationally recognized principles. Currently many philanthropic foundations neglect systematic reporting of interactions with governmental institutions and other donors operating in-country [41].

Therefore, although the underlying principles of mutual accountability should remain consistent across the countries, the means for achieving this goal will naturally vary. At the time of the interviews all four case-study countries lacked policies for integrating resources from private donors but recognized the need to formalize guidelines. Additionally countries experience a lack of mutual transparency, whether it was on the part of the government(s) or the private actors. This has direct implications for mutual accountability.

As private actors' lack of alignment and harmonization were the most pervasive themes, it is not surprising that respondents did not spontaneously discuss the emerging donors' results or management thereof. Both traditional development partners and government officials were largely unaware of the nature of these actors' engagement (as compared to awareness of traditional

partners' efforts), so it is unlikely that they should speak of organizational policies on results management.

These non-traditional donors are not held to the same standards as conventional DAH donors in terms of regulation and policies (e.g. in Tanzania submitting reports to the Ministry of Finance is mandatory for official development assistance, but is voluntary for non-traditional sources). Corporate Social Responsibility aside, perhaps the greatest contribution that could come from the corporate sector is to pay fair corporate tax, provided the host country has an effective anti-corruption mechanism in place. Responsibility must be taken all along the value chain, and the governance of this extends beyond the health sector.

Over ten years later, health development stakeholders at country-level are still talking about Paris Declaration principles and are calling for emerging donors to adhere to the five pillars, in particular alignment, harmonization, and mutual accountability. Based on our interviews with key stakeholders, philanthropic foundations and corporations are not responding to these in-country demands. Currently, in the four case-study countries, there are no policies, there is little information available, and, therefore, there are limited means for accountability. This type of assistance is supplementary to traditional bi- and multi-lateral assistance, but in order to prevent further fragmentation, emerging private sector donors should be informed of, and included in, development partner group discussions

Limitations of the study

In this study we were interested in the perception of emerging actors' influence, hence we did not engage directly with representatives from philanthropic, corporate social responsibility, or the emerging economies. This was planned in a separate study.

A major limitation is that the study was conducted in only four countries, albeit selected to represent the extremes of highest, moderate and lowest DAH support. The countries selected from these three categories were selected arbitrarily. We expected to see much more prominence in the additional availability of private finance in the "donor orphan" country, however DAH partner perspectives and experiences were remarkably similar across the four countries. This may not have been the case if more countries could have been included.

We expected to obtain quantitative data on financial flows for the four case-study countries to supplement the wealth of qualitative data gathered in interviews. No interviewees, including those from the Ministries of Health, could, or would, provide figures of financial flows from private donors. Chad's Ministry of Finance was the only governing body that provided budgetary data; unfortunately, no donor funds go through the public sector, so it was not useful in our study. This unexpected result illuminates the lack of transparency, or country-level awareness, of newer sources of external finance.

There were also limitations to the interviews themselves. There was one interview lead who was present for all in-depth interviews, though not all short contextual discussions. A different co-interviewer accompanied the lead in each case-study country. The four co-interviewers are development professionals with different backgrounds (trade, etc.). The interview guide provided structure and topics that needed to be covered, but the interviews were conducted with different lenses and potentially steered by differing expertise. Additionally, the interviewees at times appeared to use the interviews as a chance to vent their frustrations on the state of development assistance for health in-country. This frustration might have restricted the range of the perspective communicated to interviewers. The interview lead did all thematic coding which could introduce a bias, however results were discussed among co-interviewers and all authors.

Finally, there are limitations of conducting research and reporting results on the rapidly changing landscape of development assistance for health. This research was conducted during the transition from the Millennium Development Goals to the Sustainable Development Goals, in the aftermath of the largest global recession in recent history, and during volatile political climates in donor and recipient nations. The nature and influence of development assistance for health is itself guided by these rapidly changing spheres of power. The snapshot captured in 2013-2014 could be dramatically different from a snapshot captured at the time of publication.

Conclusions

This four-country study of DAH partner perceptions revealed that there is currently little coordination among private donors and conventional development assistance for health partners. Development partners know little about how private actors, specifically corporations and philanthropic foundations, are engaged in the health sector. Due to the scale of their engagement, private donors are only supplementary to assistance coming from large bi- and multi-lateral agencies. They currently contribute to fragmentation due to their narrow focus. They are not

necessarily aligned with country priorities or strengthening country health systems. Realistically, donors can only provide coherent and cohesive support if governments are clear about what they want, spell out their policies, and forge meaningful strategies to act as a framework for all domestic and donor resources. Governments must also ensure compliance with their own strategies and hold the private sector to the same alignment standards used for official development assistance for health.

To redress this at country level, philanthropic foundations and corporations that are active in health development should be included in appropriate country level fora and discussions for feedback from actors leading in-country operations. Governments should increase transparency of the nature of engagement with all partners. Corporations and philanthropic foundations should develop policies for engaging national governments and coordinating with other in-country development partners. At the global level, members of the Organization for Economic Cooperation and Development's Global Network of Foundations Working for Development (netFWD) should advocate their principles to extend awareness among non-members. Donors need and want to be effective. Sharing information and making decisions together is important for reaching this goal.

List of Abbreviations

BMGF : the Bill & Melinda Gates Foundation ; **CHE :** Switzerland ; **CSR :** corporate social responsibility ; **DAC CRS :** the OECD Development Assistance Committee credit reporting system ; **DAH :** development assistance for health ; **DEU :** Germany ; **DNK :** Denmark ; **EC :** European Commission ; **FRA :** France ; **GBR :** United Kingdom ; **GDP :** gross domestic product ; **GH :** Ghana ; **MZ :** Mozambique ; **NLD :** the Netherlands ; **netFWD :** OECD Global Network of Foundations Working for Development ; **OECD :** the Organisation for Economic Cooperation and Development ; **TD :** Chad ; **TZ :** Tanzania ; **UNAIDS :** Joint United Nations Programme on HIV/AIDS ; **UNDP :** United Nations Development Programme ; **UNFPA :** United Nations Population Fund ; **UNICEF :** the United Nations Children's Fund ; **UNIDO :** United Nations Industrial Development Organization ; **USA :** United States of America ; **WHO :** World Health Organization

Reference List

1. Kickbusch I, Szabo MM. A new governance space for health. *Global health action.* 2014;7:23507.
2. Samb B, Evans T, Dybul M, et al. An assessment of interactions between global health initiatives and country health systems. *Lancet.* 2009;373(9681):2137-2169.
3. Adelman C, Norris J, Spantchak Y, Marano K. *The Index of Global Philanthropy and Remittances.* Washington, D.C.: Hudson Institute Center for Global Prosperity;2011.
4. Stoianova V. *Private Funding: An emerging trend in humanitarian donorship.* Somerset, U.K.: Global Humanitarian Assistance, ;2012.
5. OECD. *Paris Declaration on Aid Effectiveness.* Paris, France: Organization for Economic Co-operation and Development (OECD);2005.
6. Sheikh K, Gilson L, Agyepong IA, Hanson K, Ssengooba F, Bennett S. Building the field of health policy and systems research: framing the questions. *PLoS Med.* 2011;8.
7. Partnership for Effective Development Cooperation. *First High-Level Meeting of the Global Partnership for Effective Development Cooperation: Building Towards an Inclusive Post-2015 Development Agenda.* Mexico City, Mexico: Government of Mexico, Ministry of Foreign Affairs;2014.
8. OECD NetFWD. *Guidelines for Effective Philanthropic Engagement.* Paris, France: Organization for Economic Cooperation and Development (OECD);2014.
9. Over M. How Will the Financial Crisis Affect Aid to the Health Sector? 2009; http://blogs.cgdev.org/globalhealth/2009/06/how-will-the-financial-crisis-affect-aid-to-the-health-sector.php. Accessed 30 September, 2016.
10. Batniji R, Woods N. *Averting a Crisis in Global Health: 3 Actions for the G20.* Oxford, U.K.: University of Oxford;2009.
11. Garrett L. The Future of Foreign Assistance Amid Global Economic and Financial Crisis. *Council on Foreign Relations* 2009; CFR.org. Accessed 20 June, 2012.
12. USAID. *How Will the Global Economic Crisis Impact the Health of the World's Poor?* Washington, D.C.: United States Agency for International Development (USAID);2009.
13. Stuckler D, Basu S, Wang SW, McKee M. Does recession reduce global health aid? Evidence from 15 high-income countries, 1975-2007. *Bulletin of the World Health Organization.* 2011;89(4):252-257.
14. Bennett S. Financial Crisis May Kill in Congo as Global Health Aid Stalls. 2012; http://www.businessweek.com/news/2012-01-18/financial-crisis-may-kill-in-congo-as-global-health-aid-stalls.html. Accessed 30 September, 2015.
15. Gravier-Rymaszewska J. *How Aid Supply Responds to Economic Crisis.* Helsinki, Finland: United Nations University, World Institute for Development Economics (UNU-WIDER);2012.
16. IHME. *Financing Global Health 2011: Continued Growth as MDG Deadline Approaches.* Seattle, WA: Institute for Health Metrics and Evaluation (IHME), University of Washington;2011.
17. Dieleman JL, Schneider MT, Haakenstad A, et al. Development assistance for health: past trends, associations, and the future of international financial flows for health. *The Lancet.* 2016;387:2536-2544.
18. IHME. *Financing Global Health 2014: Shifts in Funding as the MDG Era Closes.* Seattle, WA: Institute for Health Metrics and Evaluation (IHME);2015.
19. UNDP. *Philanthropy as an Emerging Contributor to Development Cooperation.* New York, NY: UNDP;2014.
20. Buse K, Walt G. Global public-private partnerships: Part I--A new development in health? *Bulletin of the World Health Organization.* 2000;78(4):549-561.
21. Hein W, Kickbusch I. *Global Health, Aid Effectiveness and the Changing Role of the WHO.* Hamburg, Germany: German Institute for Global and Area Studies (GIGA);2010.
22. Stuckler D, Basu S, McKee M. Global health philanthropy and institutional relationships: how should conflicts of interest be addressed? *PLoS Med.* 2011;8(4):e1001020.

23. Piva P, Dodd R. 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.* 2009;87(12):930-939.
24. McCoy D. *Aidspan Review of a Study by Y. Akachi and R. Atun on the Effect of Investment in Malaria Control on Child Mortality.* Nairobi, Kenya: Aidspan;2012.
25. Van de Maele N, Evans DB, Tan-Torres T. Development assistance for health in Africa: are we telling the right story? *Bulletin of the World Health Organization.* 2013;91(7):483-490.
26. UN. United Nations Global Compact. https://www.unglobalcompact.org/. Accessed 25 Jan 2017.
27. GMS. Grant Management Solutions. 2016; http://www.gmsproject.org/gmswebsite/. Accessed 10 November, 2016.
28. WHO. *Official Development Assistance (ODA) for Health to Chad.* Geneva, Switzerland: World Health Organization (WHO);2012.
29. WHO. *Official Development Assistance (ODA) for Health to Ghana.* Geneva, Switzerland: World Health Organization (WHO);2012.
30. WHO. *Official Development Assistance (ODA) for Health to Mozambique.* Geneva, Switzerland: World Health Organization (WHO);2012.
31. WHO. *Official Development Assistance (ODA) for Health to Tanzania.* Geneva, Switzerland: World Health Organization (WHO);2012.
32. Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC medical research methodology.* 2013;13:117.
33. OECD-DAC. *Measuring Aid to Health.* Pairs, France: Organization for Economic Co-operation and Development - Development Assistance Committee;2009.
34. Chimhutu V, Tjomsland M, Songstad NG, Mrisho M, Moland KM. Introducing payment for performance in the health sector of Tanzania- the policy process. *Globalization and health.* 2015;11(38).
35. de Savigny D, Webster J, Akua Agyepong I, et al. Introducing vouchers for malaria prevention in Ghana and Tanzania: context and adoption of innovation in health systems. *Health Policy and Planning.* 2012;27:iv32-iv43.
36. Ghana Statistical Service. *News Brief: New Series of the Gross Domestic Product (GDP) Estimates.* Accra, Ghana: Ghana Statistical Service;2010.
37. Jerven M, Duncan ME. Revising GDP estimates in Sub-Saharan Africa: Lessons from Ghana. *The African Statistical Journal.* 2012;15:13-22.
38. Moss T, Majerowicz S. *No Longer Poor: Ghana's New Income Status and Implications of Graduation from IDA.* Washington, D.C.: Center for Global Development;2012.
39. SNIS. Trends and Influence of Private Finance on Global Health Initiatives and Development Goals in Resource-constrained Countries. 2012; http://www.snis.ch/project_trends-and-influence-private-finance-global-health-initiatives-and-development-goals. Accessed 10 October, 2016.
40. Yiu L, Saner R. Poverty Reduction Strategy Papers (PRSP) and the Health Sector. *Journal of Poverty Alleviation and International Development.* 2011;1(2):135-180.
41. Nam S, Obeng Ampofo F, Shields L, Sosa Altamirano E, Toure MS. *Enhancing Learning in Monitoring and Evaluation: Six Cases from Philanthropic Organizations Working in the Health Sector.* Geneva, Switzerland: Centre for Socio-Eco-nomic Development;2013.

Table 1. Interviewees by institution

	Academic Institutions	Consultants	Coordination Bodies	Government Officials	Multilateral Institutions	NGOs	OECD partners	Total
Chad	0	4	2	4	9	1	4	24
Ghana	1	1	2	4	6	3	0	17
Mozambique	0	2	2	2	6	2	11	25
Tanzania	3	2	0	5	7	0	10	27
Total	**4**	**9**	**6**	**15**	**28**	**6**	**25**	**93**

*includes face-to-face interviews, telephone call, and four respondents added in follow-up emails with MZ and T

Table 2. Top five sources of disbursements for health, case-study countries (2009-2010)

Chad		**Ghana**		**Mozambique**		**Tanzania**	
Source	**%**	**Source**	**%**	**Source**	**%**	**Source**	**%**
Global Fund	37.8	the Global Fund	27.5	United States	43.4	United States	41.0
UNFPA	12.6	United States	17.5	Global Fund	10.0	Global Fund	19.3
UNICEF	9.1	United Kingdom	12.1	Ireland	5.6	IDA	9.3
GAVI	7.7	Netherlands	10.9	United Kingdom	4.8	Germany	4.8
EU Institutions	6.1	Denmark	10.1	Canada	4.7	Denmark	4.4

Table 3. Summary of private donors' adherence to the five Paris Declaration pillars

	Alignment	Harmonization	Mutual accountability	Ownership	Managing for results
Chad	• discordant views on degree of systems support • CSR based on location of industry and personal interests • not focused on long-term; lacking evaluation	• lack structured policies and focus areas	• government largely uninformed of activities • opposing accounts of who donors are communicating with in-country		• alignment required to increase results
Ghana	• private company integrated into national strategy • overall CSR contributing minimally	• working on policy for integrating CSR funds • difficulty tracking funds • lack of coordination results in waste	• lack of policy affects decreases accountability	• associated with discussions about private donors and effective engagement	
Mozambique	• CSR based on location of industry and personal interests • not focused on long-term; lacking evaluation	• foundations more likely to coordinate than corporations	• disagreement about responsibility for brain-drain • lack of transparency	• associated with discussions about private donors and effective engagement	
Tanzania	• foundations' agendas are ideological • fill gaps left by other donors • discordant views on degree of systems support • CSR based on location of industry and personal interests • not focused on long-term; lacking evaluation	• lack of awareness • using coordination efforts to push own agenda	• government not clearly communicating with development partners about private donors' engagement • government has different standards for private donors		• private donors not using evidence-based decision-making • positive outcomes result of small-scale projects

Shared amongst all four countries	• philanthropy supplementary to traditional development assistance; replacement isn't feasible due to the narrowly-focussed project approach • follow own agenda • there are good examples that could provide a model for future	• all countries have established country-level coordinating bodies • private donors are largely absent from coordination efforts • small scale makes harmonization more difficult AND more necessary	• models vary by country • lacking transparency • lacking policy	• governments actively discuss developing policies to integrate private donors and more inclusive health financing strategies • need for health systems strengthening	• discussions tied in themes of other pillars for increasing results (specifically alignment and harmonization) • results unclear due to lack of coordination / communication

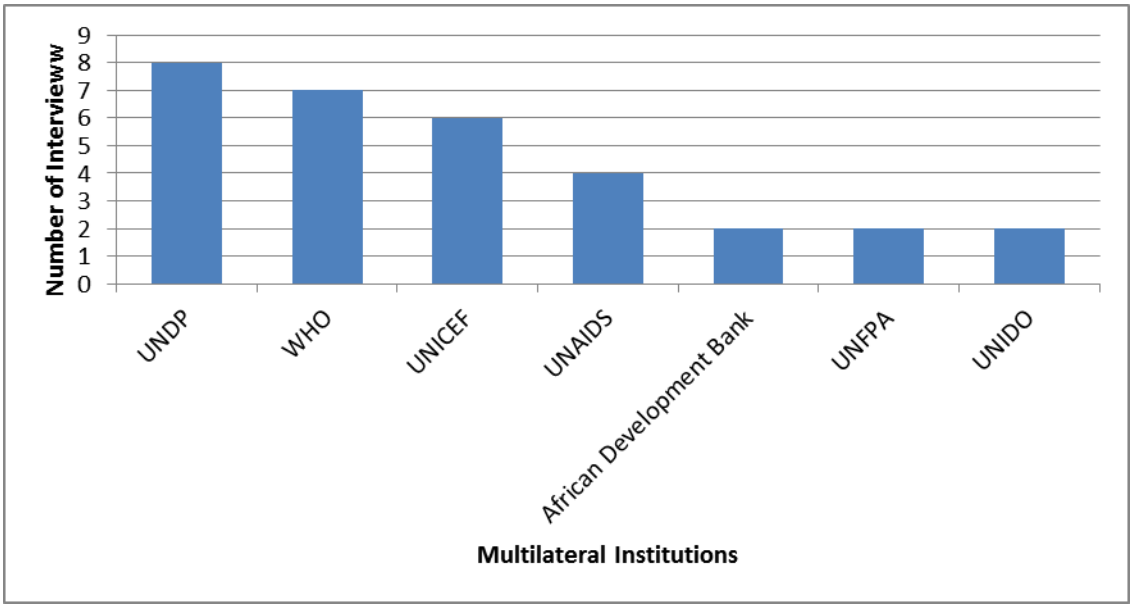

Figure 1a. Multilateral representation; number of interviewees

UNDP : United Nations Development Programme; WHO : World Health Organization; UNICEF : United Nations Children's's Fund; UNAIDS : Joint United Nations Programme on HIV/AIDS; UNFPA : United Nations Population Fund; UNIDO : United Nations Industrial Development Organization

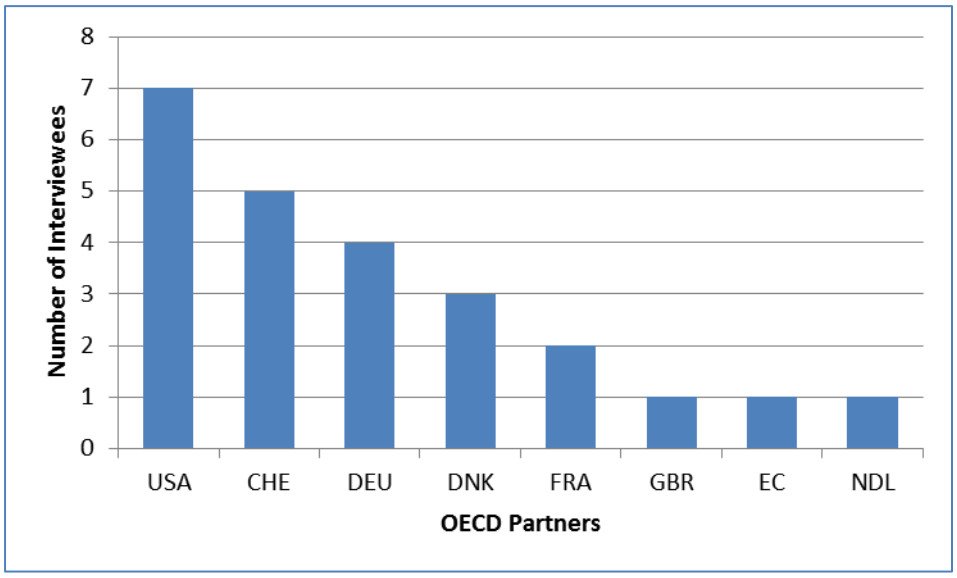

Figure 1b. OECD partner representation; number of interviewees

USA : United States of America; CHE : Switzerland; DEU : Germany; DNK : Denmark; FRA : France; GBR : United Kingdom; EC : European Commission; NLD : the Netherlands

Annex 1. Semi-structured interview guide (for health ministry officials)

Overview

What have been the most influential shifts of external finance for health channelled through your Ministry (in terms of source and magnitude)?

How have these affected resource allocation and the budget for health at the national level?

Were the increases in assistance for health added to the budget or did the funds acts as a substitute? If yes, in which area?

Have changes in development assistance for health led to an increase in interaction and coordination between the Ministries of Health, Finance, and Foreign Affairs in terms of communication and/or resource flows? If yes, please describe. (Follow-up: who initiates such coordination? Is the coordination formalized? What are the mechanisms? Results?)

Private finance

Could you comment on how your Ministry experiences private and/or philanthropic partners for health in terms of the following:

a) Partnership;
b) Avoiding policy conditionality in governance, economic policy, or institutional reform;
c) Structuring assistance to compliment direct investment;
d) Emphasizing individual project feasibility rather than long-term debt sustainability;
e) Applying domestic development lessons?

What are the most notable differences in your Ministry's experience of private and/or philanthropic partners for health when compared to traditional bilateral or multilateral partners?

What are the key influences of this finance channel on national health governance?

International Organizations

Could you comment on how your Ministry experiences public and/or private partners- such as the Global Fund, the GAVI Alliance, Medicines for Malaria Venture, and the World Health Organization- in terms of the following:

a) Partnership;
b) Avoiding policy conditionality in governance, economic policy, or institutional reform;
c) Emphasizing individual project feasibility rather than long-term debt sustainability;
d) Applying domestic development lessons?

What are the most notable differences in your Ministry's experience of public and/or private institutions when compared to traditional bilateral or multilateral partners?

What are the key influences of this finance channel on national health governance?

Concluding

How does your Ministry record in-kind assistance for health in the mid-term expenditure framework?

Are there structural/institutional changes needed within your Ministry for effective harmonization of these diverse assistance channels?

Are there any other key points or concerns related to our project that you would like to share?

Annex 2. Pillars of aid effectiveness (Paris Declaration, 2005)

Alignment

- donors align with recipient strategies
- donors use local systems

Harmonization

- donors coordinate actions
- donors simplify procedures
- donors share information to avoid duplication

Mutual accountability

- partners are accountable for development results

Managing for results

- partners focus on producing results
- partners focus on measuring results

Ownership

- recipients set their own development strategy
- recipients improve their institutions
- recipients tackle corruption