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HEALTHY FAMILIES HEALTHY PLANET

working paper

Making Aid Effectiveness Work for Family Planning and Reproductive Health

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Population Action International uses research and advocacy to improve access to family planning and reproductive health care across the world so women and families can prosper and live in balance with the earth. By ensuring couples are able to determine the size of their families, poverty and the depletion of natural resources are reduced, improving the lives of millions across the world.

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CONTENTS

ACRONYMS

CSO	Civil Society Organization
ICPD	International Conference on Population and Development
IHP+	International Health Partnership Plus Related Initiatives
IMF	International Monetary Fund
MDG	Millennium Development Goal
MTEF	Medium-term Expenditure Framework
OECD	Organization of Economic Cooperation and Development
PRGF	Poverty Reduction Growth Facility (IMF)
PRS	Poverty Reduction Strategy
PRSC	Poverty Reduction Support Credit (World Bank)
SWAp	Sector-Wide Approach

EXECUTIVE SUMMARY

The global aid architecture has changed due to the implementation of the Paris Declaration on Aid Effectiveness. These changes present both opportunities and challenges for increasing access to quality family planning and reproductive health services and supplies.

This Population Action International Working Paper analyzes the five principles of aid effectiveness—country ownership, alignment, harmonization, managing for results, and mutual accountability—from a family planning and reproductive health perspective. It also describes how the Paris Declaration has changed the ways of managing and delivering aid; highlights entry points and obstacles for champions working to improve funding and policies; and makes recommendations for civil society organizations, governments and donors.

The most notable shift in the aid architecture is the move by many donors away from project funding toward budget and sector support. As a result, in some countries family planning and reproductive health are not getting the attention required to achieve universal access because they are not being prioritized by country policymakers. Similarly, many donors are moving away from providing in-kind contraceptive supplies and toward funding aid recipient governments who are increasingly in charge of their own contraceptive supply procurement, despite often limited government capacity. These shifts in priority-setting and supply management from donor headquarters to aid recipient countries makes strong country-level capacity, advocacy and domestic accountability more important than ever.

While acknowledging challenges that aid effectiveness presents, this paper recognizes the need for champions to adjust to evolving circumstances and take advantage of emerging opportunities. Entry points for civil society champions working within the new aid architecture include pressuring governments and donors to prioritize family planning and reproductive health within national and sectoral budgets, as well as Poverty Reduction Strategies and other national and sectoral development plans. Ensuring these documents include funding and indicators to monitor progress toward family planning and reproductive health goals increases the likelihood that programs will be implemented. Civil society organizations can also monitor budget expenditures and implementation of government and donor policies and commitments, and follow up with advocacy for improvements.

Champions within government bodies such as parliament and ministries of health should also ensure that family planning and reproductive health are priorities in budgets and that funding cannot be diverted. Governments and donors should create an enabling environment for civil society organizations and other nongovernmental stakeholders to influence policy-making, budgeting, and monitoring, for example, through ensuring access to information and meaningful participation in decision-making processes. Where necessary, governments should work to improve public financial management, procurement and logics systems to respond to demand. Government and donor efforts to improve public financial management must also address challenges tracking and reporting funding flows at the sub-sector level.

In cases of weak government capacity or political will, donors should use a mix of funding mechanisms including project support to ensure that commitments are met. Donors should also improve the predictability of their aid to allow longer-term planning to achieve universal access to family planning and reproductive health in aid-dependent countries.

SUMMARY OF ENTRY POINTS AND RECOMMENDATIONS

For civil society and other actors:

- Pressure governments and donors to prioritize family planning and reproductive health within national and sectoral budgets, as well as Poverty Reduction Strategies (PRSs) and other national and sectoral development plans. To ensure implementation, interventions outlined in these documents should include funding lines and indicators to monitor progress.
- Monitor budget expenditures and implementation of commitments to improve or expand family planning and reproductive health, and following up with advocacy for improvements.

For governments and donors:

- Prioritize family planning and reproductive health in strategy documents such as PRSs and sectoral plans, ensure that these items are budgeted, include relevant indicators, and transparently monitor progress toward achieving goals.
- Create an enabling environment for CSOs and other nongovernmental stakeholders to influence policy-making, budgeting, and tracking, for example through ensuring access to information and meaningful participation in decision-making processes.

For governments:

- For champions within government agencies such as parliament and ministries of health, ensure that family planning and reproductive health are priorities in budgets and that funding is "ring fenced."
- Where necessary, improve public financial management, procurement and logics systems to respond to national demand for supplies and foster greater domestic accountability.

For donors:

- Improve the predictability of aid to allow for longer-term planning to meet family planning and reproductive health needs in aid-dependent countries.
- During the transition from donor provision of reproductive health supplies to greater use of country systems, donors should be prepared to provide emergency supplies as needed.
- In cases of weak government capacity or political will, donors should use a mix of funding mechanisms including project support to ensure that commitments to achieve universal access to family planning and reproductive health are met.

INTRODUCTION

In 2005, 122 countries and 26 international agencies endorsed the **Paris Declaration on Aid Effectiveness**, a pledge for donors and aid recipient countries to improve the effectiveness of aid through: (1) strengthening aid recipient ownership of national development; (2) ensuring donor alignment with national development priorities; (3) bolstering donor harmonization; (4) increasing orientation toward outcomes and results; and (5) mutual accountability between donors and developing countries for achieving development results (see Box 1).[1] The Organization of Economic Cooperation and Development (OECD) assesses progress toward these goals by monitoring and reporting on 12 indicators and related targets to be achieved by 2010.[2]

BOX 1. PARIS DECLARATION PRINCIPLES

Country ownership: Aid recipient countries should take leadership over their development, improve their institutions, and address corruption.

Alignment: Donors are supposed to base their support on partner countries' priorities and use country systems.

Harmonization: Donors should coordinate their actions, simplify procedures and avoid duplication.

Managing for Results: Development programs should produce and measure results.

Mutual Accountability: Donors and aid recipient countries are accountable for development results.

In 2008, world leaders reconvened in Accra, Ghana to reflect on achievements toward the Paris Declaration goals and commit to actions that will accelerate progress to make achieving the 2010 goals possible. There was a strong civil society presence in Accra, with over 700 participants from around the world attending the CSO Parallel Forum on Aid Effectiveness days prior to the official events.[3] In the Accra Agenda for Action, the outcome document negotiated by donor and developing country delegations, governments and aid agencies commit to a number of measures relevant for family planning and reproductive health,[4] including: deepening engagement with civil society; strengthening implementation of agreed commitments on gender equality; bolstering the use of developing country institutions and systems, and; reducing donor conditionality ("Accra Agenda for Action" 2008). These leaders are set to come together again in 2011 in Beijing, China to review achievements toward the 2010 targets and negotiate a successor declaration to Paris and Accra. A large turn-out from civil society to influence the Beijing outcome document is likely.

While the Paris Declaration and Accra Agenda for Action echo many previous commitments to improve the effectiveness of aid,[5] they are important because they bring together a set of

1 Throughout the paper, we have bolded words included in Appendix 1: Glossary of Terms.

2 The Paris Declaration list of indicators and targets, as well as a lineup of signatories, is available from: http://www.oecd.org/dataoecd/11/41/34428351.pdf.

3 For more on Accra, see the author's blog: "Strong Civil Society Voices on Aid Effectiveness:" http://www.populationaction.org/blog/2008/10/strong-civil-society-voices-on.html.

4 This paper relies primarily on the terms family planning and reproductive health since most donors use them to categorize projects and track funding flows. Funding for family planning and reproductive health can advance sexual and reproductive health and rights, as understood in paragraphs 7.2 and 7.3 of the 1994 ICPD Program of Action and paragraph 96 of the 1995 Beijing Platform for Action.

5 Previous efforts include the World Bank's Comprehensive Development Framework that started in 1999, a precursor to country ownership, and the 2003 Rome Declaration on Aid Harmonization.

goals into a concrete pledge with targets, indicators for monitoring progress, and a timeline for implementation.[6] Since 2005, donor agencies and countries—including the US—have been aligning their aid with the Paris Declaration Principles to varying degrees.[7]

Aid effectiveness, or the process of reforming the management and delivery of aid through implementing the Paris Declaration and Accra Agenda for Action, has changed the rules and delivery of development assistance. There are compelling critiques of the Paris Declaration and Accra Agenda for Action, but it is clear that they both will remain relevant at least in the short term.[8] Therefore, it is important for champions working to increase access to family planning and reproductive health services to be aware of aid effectiveness and its repercussions. Throughout this paper, the term champions refers to people working to advance sexual and reproductive health and rights in central governments, parliaments, health ministries, donor agencies, Civil Society Organizations (CSOs), advocacy groups, health practitioners, and implementing agencies, among others.

World leaders have committed to achieve universal access to reproductive health including family planning by the year 2015. Achieving universal access was a key pledge at the 1994 International Conference on Population and Development (ICPD), which was reaffirmed at the 2007 United Nations General Assembly World Summit. At the World Summit, leaders added the Target 5B: Achieve universal access to reproductive health to **Millennium Development Goal** (MDG) 5: "Improve maternal health" (United Nations 2007). Progress toward these targets has been slow, and it is unlikely they will be achieved without a dramatic increase in government and donor support. With the MDG and ICPD goal year fast approaching, a renewed focus by both donors and developing countries is needed to build momentum toward 2015 and beyond. To effectively carry out this advocacy and programming, champions must navigate within the new **aid architecture**—or set of rules and institutions governing aid flows to developing countries (World Bank 2008)—both recognizing and overcoming obstacles, and taking advantages of entry points to prioritize family planning and reproductive health.

The Paris Declaration and Accra Agenda for Action have brought about both opportunities and challenges, and the ultimate impacts of many changes depend on the context in which they are implemented. Greater country ownership has opened up opportunities for civil society to influence development planning documents, although depending on the country context the process can be time consuming and success does not necessarily translate into government expenditures. Therefore, actors with limited capacity should focus directly on government budgets to have the greatest impact on funding levels for family planning and reproductive health.

One of the most significant changes resulting from the Paris Declaration implementation has been a shift in **aid modalities**, or the ways donors provide aid, by the majority of donors from directly funding contraceptive supplies or services through projects to providing **budget sup-**

6 The Paris Declaration list of indicators and targets, as well as a lineup of signatories, is available from: http://www.oecd.org/datao While the Paris Declaration is more monumental than the Accra Agenda for Action, the Accra agreement builds on and deepens the commitments made in Paris, therefore it is important to mention the two together.

7 While the extent to which the US government is implementing the Paris Declaration is unclear, USAID clearly states, "As a result of this commitment (to aid effectiveness), the major U.S. Government agencies that manage the bulk of U.S. foreign assistance have implemented significant policy and operational changes both centrally and in field offices to increase the effectiveness of their assistance" http://www.usaid.gov/about_usaid/dfa/accra.html.

8 While this paper covers many of the key critiques and debated issues, it is not intended to be a comprehensive critical review of the Paris Declaration or Accra Agenda for Action.

port or health **sector support**, or aid that is deposited into a government's bank account to be allocated according to nationally identified priorities. Under budget support, aid recipient governments and other policymakers must prioritize family planning and reproductive health or these programs risk being sidelined. Channeling aid through budget support encourages use of country systems, such as procurement and logistics systems, for example, to distribute reproductive health supplies. Increased use of country systems is a welcome development because it can build government capacity, but it can come at the expense of contraceptive supply security where country systems are weak. Budget support and **basket funds**, or common accounts that a number of donors jointly fund for development projects or programs, make it more difficult to track donor investments in family planning and reproductive health at the country and global levels.

The purpose of this PAI Working Paper is to provide the range of champions who are working to ensure that family planning and reproductive health are adequately funded with an understanding of aid effectiveness and its current implications for the field. While this paper does not provide a comprehensive critique of aid effectiveness, including from a family planning and reproductive health perspective, our analysis highlights a number of challenges that the changing funding landscape presents for achieving universal access to reproductive health. While fully acknowledging these challenges and suggesting ways to overcome them in the medium and long term, this paper also recognizes the need to adjust to evolving circumstances in the short term. It therefore identifies entry points to leverage attention to, and funding for, family planning and reproductive health within the existing aid architecture. This paper also examines opportunities and issues beyond the scope of the Paris Declaration and Accra Agenda for Action.

The remainder of this paper examines each Paris Declaration principle from a family planning and reproductive health perspective. Section 1 gives an overview of country ownership and examines opportunities and challenges for engagement in Poverty Reduction Strategies. Section 2 looks at alignment, in particular the use of country financial management and procurement systems. Section 3 examines donor harmonization and the implications of budget and sector support on funding for family planning and reproductive health. Section 4 looks at managing for results, focusing on performance-based aid. Section 5 examines issues and opportunities related to accountability. The last section offers concluding thoughts and summarizes the most notable entry points and challenges identified throughout the paper. All through the paper, we have bolded words included in Appendix 1: Glossary of Terms.

1. COUNTRY OWNERSHIP AND PRSs

Country ownership is the principle that aid recipient countries should take effective leadership over their development policies and strategies, co-ordinate development actions, improve country institutions and address corruption ("Paris Declaration" 2005). The origins of country ownership are found in the Comprehensive Development Framework developed by the World Bank in the late 1990s, which argued that for societies to truly transform, change had to come from within (Stiglitz 1999). The Comprehensive Development Framework principles of: Long-term, holistic vision; Country ownership; Country-led partnership; and Results focus (World Bank 2003) laid the groundwork current emphasis of country ownership, and to some extent aid effectiveness.

Country ownership has primarily been implemented through **Poverty Reduction Strategies** (PRSs), national plans prepared every three to five years that describe a country's macroeconomic and social policies and programs, as well as external financing requirements.[9] They are supposed to be prepared by governments through a participatory process involving parliamentarians, civil society groups, the private sector and donor agencies. PRSs began in the late 1990s as a requirement for accessing debt relief from the World Bank and International Monetary Fund (IMF), and grew to be a prerequisite for all **concessional loans** and **grants** from the World Bank and the IMF. Having a PRS also increasingly helps countries to qualify for bilateral aid and global funds such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). At least 65 countries are currently developing or have already implemented PRSs, and some are on to second and third generation PRSs (World Bank ND).

Although PRSs are not implementation documents, they can translate into spending. Governments are supposed to convert the priorities identified in PRSs through to budgets, sectoral and thematic strategies, and then into programs. **Medium-term Expenditure Frameworks** (MTEFs), or rolling, costed estimates of financial needs as well as public sector and donor resources available for spending, are used to link policy and planning documents such as in PRSs with budgets at the national and sectoral levels. Donors are supposed to align funding with MTEF and budget needs (Wilhelm and Krause 2008).

Thus far, most PRSs have identified population, family planning and reproductive health needs, but fail to develop clear follow-up actions. For example, a World Bank review of 21 PRSs found that most mention population and reproductive health, but few have even basic implementation arrangements such as identification of an institution responsible for execution, a timeline and budget allocations. The same study found that while PRS monitoring and evaluation generally includes at least one reproductive health target (generally maternal mortality), other indicators are starkly absent, particularly indicators related to adolescent health and development. PRSs' orientation toward the MDGs has a strong focus on maternal mortality, but only one-third of PRSs reviewed include related targets such as contraceptive prevalence rate and the number of births attended by skilled personnel or handled institutionally (World Bank 2004). An unpublished review of 45 PRSs found that while two-thirds of PRSs reviewed mention family planning, less than one-quarter include details related to financing, logistics and commodities (Borda 2005 cited in Bhuyan, Borda and Winfrey 2007).

9 Many governments had national development plans prior to PRSs, and some continue to use national strategies that are not part of the PRS process, as well as sector and theme-specific strategies such as a national AIDS or gender strategy.

1.1 Influencing the PRS

PRSs have become an important document driving government planning and donor funding in many countries (Bhuyan, Borda and Winfrey 2007; World Bank 2004). This has prompted calls for family planning and reproductive health champions to work to influence PRSs. However, there is often a disconnect between interventions discussed in PRSs and actual government spending, which limits the potential benefits of engagement and has led many organizations to focus directly on influencing government budgets.[10] There are also challenges to engaging in PRS processes that are time consuming and long in duration. Equally important, historical participation by civil society in PRS processes has often been more consultative than participatory, because of civil society's often limited ability to influence decision-making (Bhuyan, Borda and Winfrey 2007). Therefore, the decision for family planning and reproductive health champions such as parliamentarians, CSOs or donor agencies to engage in PRS

BOX 2. WHAT IS DRIVING THE MACROECONOMIC CONTENT OF PRSs?

Research shows that country ownership over PRS macroeconomic content is often constrained by government agreements with the IMF and World Bank that require macroeconomic and structural reforms. This has limited CSOs' ability to influence macroeconomic policies such as fiscal, monetary policies which determine a government's overall resource envelope and spending (Rowden and Irama 2004; Rowden 2005).

In 1999, the World Bank created the Poverty Reduction Support Credit (PRSC), a facility for low-income countries to support structural reforms in PRSs. As a complement, the IMF created the Poverty Reduction and Growth Facility (PRGF) to support PRS macroeconomic policy reforms. Like their predecessors, structural adjustment programs, both PRSCs and PRGFs are "policy based," meaning that the loan or grant is provided to the central government on the condition that the recipient undertakes specific policies and measures often designed to balance its international debt payments (Bhuyan, Borda and Winfrey 2007). Conditions often include keeping a government or sector budget below a spending ceiling, which often is set too low to allow for the significant increases in health and education spending necessary to address health needs and achieve the MDGs (Ooms and Philips 2008; Rowden 2005).

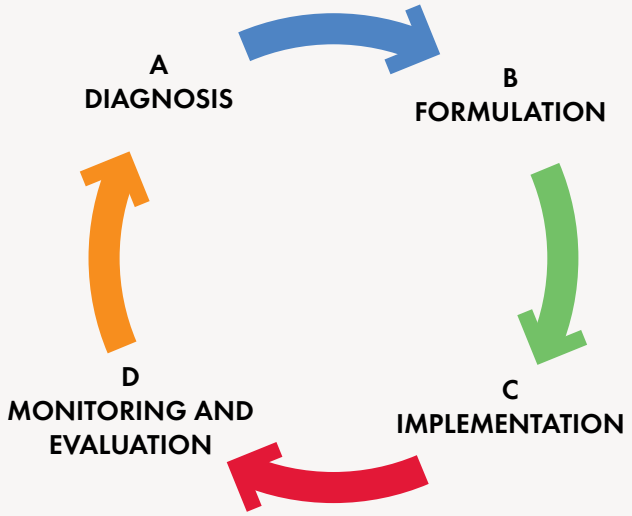
The World Bank and IMF often respond to these critiques by saying that the conditions in PRSCs and PRGFs are taken from PRSs and are therefore country owned. Since PRSs have to be approved by the World Bank and IMF for a country to access funds, it is likely that governments generally design PRS macroeconomic content to match World Bank and IMF priorities, draw on existing agreements to develop macro content and consult the World Bank and IMF during PRS drafting. However, it is difficult to verify what is actually happening from the outside because government negotiations with the World Bank and IMF are held behind closed doors.

10 For a good overview of budget work for reproductive health, see: Hofbauer, H and M Garza. 2009. The Missing Link: Applied Budget Work as a Tool to Hold Governments Accountable for Maternal Mortality Reduction Commitments." International Initiative on Maternal Mortality and Human Rights and Washington, DC: International Budget Project.

processes should weigh factors such as the probability that they will be able to meaningfully contribute to the process (see Box 2), the likely outcome given the county and political context, available time and resources needed to sustain engagement and opportunities to advance sexual and reproductive health and rights outside of the PRS process. Champions should also realize that PRS processes and outcomes depend heavily on the economic, social and political context of a country, and these factors can change over time.

Should a champion decide to take part in PRS processes, the remainder of this section identifies opportunities to integrate family planning and reproductive health priorities into PRSs, based on the work of Bhuyan, Borda and Winfrey (2007).

FIGURE 1. IMPORTANT STAGES IN THE PRS PROCESS AND OPPORTUNITIES FOR ACTION



Source: Bhuyan, Borda and Winfrey 2007

Opportunities for engagement will vary depending on the stage that a particular country's PRS is in its three to five year life-cycle. The PRS process has four major stages:

A) *Diagnosis* or analysis of poverty;
B) *Formulation* of policies to respond to issues identified in the diagnosis;
C) Policy *implementation*, and;
D) *Monitoring and evaluation* (Figure 1).

In order to integrate family planning and reproductive health into a PRS, individuals with expertise on population issues, health, development and family planning must be involved in the PRS process, particularly in the beginning, because subsequent phases build on one another.

Key actors and arrangements for drafting PRS documents vary from country-to-country. Generally, there are various thematic and stakeholder groups with representation from relevant government ministries and agencies involved in the process, as well as committees such as the all-important drafting group in charge of producing the final document. In many countries, the Ministry of Financeoften plays a large role in drafting the overall document, given its focus on macroeconomic policies. Governments are in charge of designing a participatory process that generally involves getting inputs from CSOs, the private sector and donor agencies (Bhuyan, Borda and Winfrey 2007). CSOs' access to the drafting group and other committees varies by country; donors may have better access to key government actors given their position as funders.

1.1a Diagnosis

It is important to highlight population, family planning and reproductive health concerns during the poverty diagnosis because all activities described in a country's PRS are supposed to

respond to needs identified at this stage. The main advocacy point of entry during the diagnosis phase is to prepare written material and meet with influential actors in order to emphasize the impact of rapid population growth and high fertility on development and poverty reduction goals, including economic growth, household income, education, food supply, security, and gender equality. The diagnosis phase is also a good opportunity to draw on assessments of unmet needs for family planning particularly of lower-income groups, and highlight linkages between meeting unmet need and achieving the MDGs.

1.1b Formulation

The formulation or drafting phase is closely connected to the poverty diagnosis phase, because the PRS is supposed to respond to issues directly identified in the diagnosis. Therefore, formulation is an opportunity to influence the PRS drafting team to ensure measures that address unmet needs and objectives related to family planning and reproductive health. Champions can also suggest appropriate policies and approaches at this time. These can be framed either as stand-alone interventions or to support related national goals such as improving maternal health and achieving the MDGs. To increase the likelihood that interventions are implemented, it is important that the PRS and MTEF formulation include budget lines for family planning and reproductive health, as well as strong monitoring and evaluation indicators to measure policy impact such as total fertility rate, contraceptive prevalence rate and unmet need for family planning.

Materials that can help make the case for family planning and reproductive health at this stage include fact sheets and issue briefs with policy recommendations, as well as analysis of resource needs to demonstrate the costs and benefits of family planning. CSOs and other champions that are not part of the PRS drafting team should explore informal channels to ensure that family planning and reproductive health needs are addressed.

1.1c Implementation

PRSs are a good indication of a country's commitment to specified priorities, but inclusion of a policy or program in a PRS does not guarantee that it will be implemented. As Bhuyan, Borda and Winfrey explain, "any proposal contained in the document must be supported by a sequence of actions, such as strengthening political will, adopting a national policy or law, appointing a group or agency to lead implementation, allocating and approving a budget for the activity, conducting the necessary capacity building and training to roll out the policy, and so on" (Bhuyan, Borda and Winfrey 2007, page 27). Supporters of family planning inside the government are essential to ensure implementation of activities outlined in the PRS. External pressure from CSOs, donor agencies and other champions can help allies within government implement their agenda and hold government and other implementers accountable to commitments made in the PRS.

1.1d Monitoring and Evaluation

Governments are required to submit annual progress reports to the World Bank and IMF during the 3-5 years that a PRS is in implementation. Although central governments are not required to include outside stakeholders in developing progress reports, parliamentarians, CSO

and other family planning champions can still be involved in PRS monitoring. Examples for influence at this point include collaboration with government entities in charge of monitoring PRS implementation, performing parallel monitoring and evaluation, providing analysis and policy advice to government committees and donor agencies, and interpreting and disseminating monitoring reports to the general public.

Because progress reports shape short-term activities to keep PRSs on-track, it is important to ensure that family planning priorities and outcomes are reflected in monitoring reports. Progress on family planning and reproductive health indicators—which were hopefully included in the PRS—should be reviewed and reported on and stakeholders should develop plans to address any unsatisfactory outcomes.

Monitoring spending on family planning and reproductive health is also essential to ensure full PRS implementation. Even countries with PRSs are having trouble linking strategy with budgets (OECD 2008). As one World Bank study of nine countries reported, "Budgets in the case study countries are rarely executed as planned in the annual budget or MTEF documents, breaking the link between approved budgets and actual spending. When budget execution is weak, the emphasis placed on the importance of the PRS-budget link can be called into question, because the budget cannot be considered a reliable instrument of policy implementation" (Wilhelm and Krause 2008, page 26).

Given persistent problems linking planning with spending, it is important to ensure that the PRS includes a **budget line** item for family planning and reproductive health (often supplies are included as a separate line item). It is then important to ensure that these budget lines make it into MTEFs or other mechanisms to link the national or sectoral plan to the budget. Once family planning and reproductive health budget lines make it into the national budget, it is also important to ensure that these items are **ring fenced**, or protected from being diverted to other needs to ensure execution of funds. It is important that governments accurately track and report spending to the public, in order to provide an accountability mechanism to help ensure that funds are spent as planned.

2. ALIGNMENT

Under the Paris Declaration and Accra Agenda for Action, donors commit to align their aid with country priorities, make aid more **predictable**, and channel more funding through strengthened aid recipient country systems such as public financial management and procurement systems. As discussed in the sections below, predictability has potential advantages for family planning and reproductive health but progress has been slow. Use of country systems has the potential to enhance sustainability of government provision of reproductive health supplies, but care is needed in implementation. Donors are supposed to be limiting and harmonizing conditionalities attached to loans and grants, but progress has been limited.

2.1 Predictability

Donors pledge to make their aid more predictable, by providing aid recipient governments with "regular and timely information on their rolling three- to five-year forward expenditure and/or implementation plans, with at least indicative resource allocations that developing countries can integrate in their medium_term planning and macroeconomic frameworks" ("Accra Agenda for Action" 2008). Were donors to fulfill their pledge to make aid more predictable, aid-dependent governments could better plan to meet long-term needs such as increasing access to contraceptives and improving health systems, both of which require sustained support. However, donor progress on predictability has been weak: in 2007 merely 46 percent of aid was disbursed on schedule, up from 41 percent in 2005 but far below the 71 percent target for 2010 (OECD 2008).

2.2 Country Systems

In order to meet donor standards, many aid recipient countries are reforming their **country systems**, or legal and institutional systems including public financial management spanning budget planning, execution, financial reporting, monitoring and auditing processes. There is also a focus on improving country **procurement** systems, or rules on government purchasing, leasing, or renting of goods and services.

Despite many countries' efforts to improve their systems, donors have been sluggish in responding to improvements: in 2007 only 45 percent of donor aid in support of the public sector relied on country public financial management systems and 43 percent used public procurement systems, up from 40 percent and 39 percent, respectively, from 2005 (OECD 2008). The 2010 target agreed to in the Paris Declaration is 80 percent for both indicators.

Increased budget support and the subsequent use of country systems has brought new challenges and opportunities for governments to provide quality family planning and reproductive health services and supplies. Evidence from Malawi and Tanzania suggests that the transition from in-kind donor contributions to budget or health sector support, where aid recipient countries are responsible for procurement of family planning and reproductive health supplies, can lead to delays in procurement and contraceptive supply stock-outs (Ortiz, Olson, McEuen and Dowling 2008). While Southern governments continue to build their capacity for procurement, logistics and distribution of quality reproductive health supplies, donors should protect from delays and stock-outs by using a mix of funding mechanisms including budget support,

sector support, pooled and project-specific funding for government, civil society and multilateral agencies depending on the country context and needs.[11]

2.2a Improved Country Systems for Domestic Accountability

Improving public financial management, procurement and logistics systems have great potential to benefit domestic accountability and service delivery. Instead of focusing on improving donor use of country systems, advocates can orient reform efforts toward strengthening domestic, or **downward accountability**, of governments to citizens, and enhancing the ability of government to meet the needs of people who rely on government services.

Strengthened public financial management can improve domestic accountability, for example, through increasing civil society's and parliaments' ability to access information about government expenditures. However, continued pressure is needed in many countries to ensure that data on public finance is publicly available, accurate, and includes data on government spending on sub-sectors such as family planning and reproductive health. Tracking and accountability is an important follow-up to budget development: many governments currently include budget lines for reproductive health supplies, which must be tracked to compare allocations to expenditures. Access to accurate information on family planning and reproductive health outcomes—such as contraceptive prevalence rate, unmet need for family planning, coverage of skilled attendance at birth, maternal mortality and morbidity, and rates of sexually transmitted diseases—is also important to enhance accountability over the use of government funds.

2.3 Conditionality

Another part of alignment under the Paris Declaration and Accra Agenda for Action is that **conditionality**, or measures that donors require aid recipients to undertake to receive funding, are supposed to be limited and derived from national development strategies like PRSs (Box 2). There are two primary types: **fiduciary conditionality** that requires measures of transparency, accountability and proper use of financial resources to sustain funding, and the more controversial **policy conditionality**, which mandates "the adoption and/or implementation of general or sector policies, but also macro-economic and fiscal objectives" (Antunes, Carrin and Evans 2008, page 6). Policy conditionalities are often tied to budget support (Section 3.1). Policy conditionalities historically promoted by the IMF such as wage bill caps limit the amount of money a government can spend on public sector workers like doctors and nurses, and can undermine efforts to strengthen health systems (Antunes, Carrin and Evans 2008).

While all donors are not expected to have the same conditions, under the Paris Declaration all donor funding is supposed to be linked to a **Performance Assessment Framework**, or "single framework of conditions and/or manageable set of indicators" based on a national strategy for each recipient country ("Paris Declaration" 2005). Donors are supposed to then make disbursement decisions based on a country's performance achieving the targets outlined in the framework (IDD and Associates 2006). However, instead of harmonizing and limiting conditions, performance assessment frameworks tend to be "a jumble of different types of conditions" reflecting competing donor priorities (Hayes and Pereira 2008, page 20). As an example, Malawi's framework resulted in 29 official indicators or conditions, which translates into

11 For more, see: Countdown 2015 Europe's Recommendations for EU Governments and Institutions in the Run Up to the High Level Forum on Aid Effectiveness in Accra, Ghana, September 2008: http://www.countdown2015europe.org/images/frontpage/countdown2015_aideff.pdf.

a much larger number of actions that a government must take: the first indicator requires that Malawi stay on track with its IMF program, which has multiple quantitative and structural policy conditions. Despite their growing importance, performance assessment frameworks are generally formulated by donors, then negotiated with a recipient country's executive branch and Ministry of Finance, all outside the purview of parliament and civil society (Hayes and Pereira 2008).

Policy dialogue and the establishment of benchmarks for performance assessment frameworks and other monitoring frameworks that determine donor disbursement are inherently weighted toward donors, and not the result of a true partnership. As a representative of Niger's Ministry of Finance explained, "We need the money; therefore we accept performance indicators even if we don't think we will be able to meet them. These negotiations are by their nature unequal as we need the money" (Hayes and Pereira 2008, page 20). Despite the focus on building mutual accountability, the continuation of policy conditionality under the Paris Declaration and Accra Agenda for Action continues to advantage the donors who can delay the release of funds unless countries follow their policy advice (see section 5.1 Accountability to Whom?).

3. HARMONIZATION

Improving harmonization between and within donors and governments in the health sector has important implications for family planning and reproductive health outcomes. Health is the most fragmented of all sectors. It has the largest number of major stakeholders in any sector, often with overlapping and unclear mandates. The sector has experienced a recent rise in funding levels, but much of that funding is from new organizations such as global funds and foundations targeting specific diseases. There is pressure for donors to fund "vertically"—or to a single health issue—in order to show direct results, which has led to a decline in funding for health systems.[12] When left uncoordinated, this fragmentation results in duplication of efforts and inefficient use of resources, wasted time and energy of Ministry of Health officials who have to coordinate with donors instead of addressing programmatic concerns, and incentives to focus on disease-specific interventions versus building health systems needed for comprehensive health services that include family planning and reproductive health (Dodd, Schieber, Cassels, Fleisher and Gottret 2007). While there is evidence suggesting that vertical funds undermine health systems by establishing parallel service delivery systems and attracting skilled staff away from public services (Marchal, Cavalli and Kegels 2009), the impacts of vertical funds on health systems is mixed (World Health Organization Maximizing Positive Synergies Collaborative Group 2009). For example, emerging evidence suggests that HIV/AIDS programs can have positive spillover effects into other areas of health including that of women and children (International AIDS Society 2009).

Harmonization is an approach in which the aid recipient country exercises leadership over a donor-supported program, and donors coordinate and streamline processes. Through this approach, ministry officials, including those who work on health, should be able to focus more on responding to the needs of their citizens as opposed to hosting donor missions and report-writing. The Paris Declaration and Accra Agenda for Action promote harmonization by encouraging donors to implement common arrangements for planning, impact assessments, funding, disbursement, monitoring, evaluation, and reporting to government (OECD 2008). Stakeholders in health sub-sectors such as HIV/AIDS have made efforts to harmonize approaches that family planning and reproductive health champions can learn from (Box 3).

Box 3. "Three Ones" in HIV/AIDS

Partly in response to criticism that the response to HIV/AIDS has been fragmented and not harmonized with country health systems, UNAIDs and other donors developed the "Three Ones" principles:

- *One* agreed HIV/AIDS strategy that serves as the basis for coordinating the work of all partners;
- *One* National AIDS Coordinating Authority; and
- *One* country-level Monitoring and Evaluation System.

12 In some contexts such as fragile states donors must rely on project specific vertical funding because existing systems are inadequate.

One way that the Paris process is promoting harmonization is through the use of **Program Based Aid**, or aid that is organized in support of a particular sector or activity such as a PRS or sector plan (OECD 2008). Nearly half of all aid is channeled through program-based approaches (OECD 2008). Program based aid can be funding for a project identified in a PRS or sector plan, but also includes budget and sector support that has implications on funding levels for family planning and reproductive health.

3.1 Budget Support

Budget support is a type of program-based aid that is deposited in a country's national treasury or Ministry of Finance account and is subject to all associated government budget-making, procurement, monitoring, evaluation and reporting systems. Budget support is typically used to support a PRS or other national strategy. Donors can also support specific health sector plans such as through **sector support**, which is deposited into a ministry account such as the Ministry of Health (see the next section on SWAps). According to the last Paris Declaration Monitoring Survey, budget support constitutes 20 percent of aid to 55 countries surveyed, which equals nearly US$10 billion (OECD 2008).[13]

World Bank and IMF structural adjustment operations were early forms of budget support, but now many other donors are using budget support as well. In fact, the European Commission has pledged to increase the share of aid that it channels through budget support from 20 to 50 percent (Michel 2008). Therefore, the need to ensure budget support funding benefits family planning and reproductive health and the importance of transparency and accountability in the use of budget support funds will continue to grow. Part of this aid will be channeled toward health through **MDG Contracting**, an initiative for predictable, longer-term budget support to select countries to allocate toward achieving the MDGs, including the health MDGs (DSW 2008; European Commission 2007). For more on MDG Contracting, see Box 4.

Budget and sector support can be contrasted with **parallel aid**, or dedicated funding for particular projects, which can be reflected in aid recipient budgets, but is not subject to country budget, public financial management or procurements systems. Some donors also provide **earmarked** budget support, which is funding channeled through the government's account (and subject to country systems) that is restricted to a specified type of activity. For example, in 2008 the Danish International Development Agency provided earmarked budget support for the Ghanaian government to procure condoms (Ortiz, Olson, McEuen and Dowling 2008).

Because budget support is often aligned with a national strategy, in many cases the best way to influence the allocation of budget support is to make certain that family planning and reproductive health are included in a country's PRS, are budgeted, implemented and effectively monitored.

3.1a Budget Support: A Double Edged Sword

Budget support is as good as the strategy it funds, and if family planning and reproductive health are low priorities in national and sector plans or are not included in government budgets, they will not benefit from budget support (DSW 2008). While the effects of budget support will depend on the implementation context, a review of budget support found that

13 It is not clear whether or not this figure includes sector budget support.

BOX 4. MDG CONTRACTING

In 2007, the European Commission unveiled plans to enhance their budget support to select countries through MDG Contracting: longer-term, more predictable budget support whose conditionalities focus on performance and achieving MDG targets. Countries with MDG Contracts will receive budget support for six years instead of the typical three years, and are virtually guaranteed 70 percent of committed funding. The 30 percent of funding that varies depending on country achievement of MDG-related indicators, and performance linked to the PRS, public finance management, and macroeconomic performance (Beynon 2008). The 10 countries eligible for MDG contracting have a good track record in governance, financial monitoring, macroeconomic stability and handling aid inflows (DSW 2008; European Commission 2007). In March 2009, the European Union and Zambia signed the first MDG contract for 225 million Euros (US$283.1 million) in grant funding (Reuters 2009) with more in the pipeline.

However, evidence suggests that while MDG Contracting is longer-term than normal budget support, it may not lead to greater outcomes for MDGs. And thus far, funding is not significantly tied to performance achieving family planning and reproductive health outcomes: Burkina Faso's MDG contract has one indicator related to reproductive health (the rate of deliveries where a skilled birth attendant is present), but performance on this target will influence merely 10 percent of a variable 20 percent of funding, or 2 percent of the total (Hoehn 2009).

while it can lead to a rapid expansion in basic services (in education in Uganda, for example), budget support is often accompanied by sharp declines in the quality of those services (IDD and Associates 2006).

Governments have committed to achieve universal access to family planning and reproductive health services. Assuming they are sufficiently prioritized, budget support has the potential to strengthen health systems by improving access to family planning and reproductive health where staffing is inadequate due to funding shortfalls. Governments can use budget support to pay for recurrent costs such as health worker salaries, whereas donors are reluctant to directly fund recurrent costs for fear of creating dependence on volatile donor funding. In countries such as Malawi, which has just 266 doctors to serve 13 million people, enhancing the government's ability to retain doctors and nurses by paying a fair wage can help avert a human resource crisis and meet the MDGs (Pereira and Hayes 2008). However, conditions such wage bill caps imposed by the IMF on low-income countries can restrict countries' ability to use funding to pay public sector salaries (Marphatia, Moussié, Ainger and Archer 2007; Working Group on IMF Programs and Health Spending 2007).[14]

Budget support is not a panacea. In many countries, particularly heavily indebted poor countries, Ministries of Finance end up not actually releasing large portions of budget support for use in development programs. Between 1999 and 2005, merely 27 cents of every dollar of foreign aid going to sub-Saharan countries actually made it to state budgets for spending on priorities like health. The rest was used by Ministries of Financeto build foreign exchange reserves and/or repay foreign debts (Antunes, Carrin and Evans 2008). To be effective in the long-term, budget support has to be predictable (European Commission 2007), transparent and accountable for results. Budget support is not appropriate in fragile states, or countries with weak governance and institutions, where one-sixth the population of the developing

14 For the IMF Executive Board response to this and other critiques related to spending and absorption of aid, see: http://www.imf.org/external/np/sec/pn/2007/pn0783.htm.

BOX 5. GLOBAL HEALTH PARTNERSHIPS

Over the last ten years an estimated 75 to 100 global health partnerships have gained prominence within the health sector. While global health partnerships can add to complexity of the aid architecture, they also bring increased attention and funding (Dodd, Schieber, Cassels, Fleisher and Gottret 2007). This box highlights global health partnerships with a focus on the International Health Partnership Plus Related Initiatives (IHP+).

In 2007 the United Kingdom launched the IHP+. The purpose of the IHP+ is to improve achievement of the health-related MDGs through increasing access to and quality of essential health services by ensuring increased, more predictable and sustainable funding and improved coordination and better delivery of services (IHP+ 2008). IHP+ relies on developing country compacts, or "close-to-binding" commitments by governments, national partners, and international development agencies to support national health plans. These compacts are supposed to improve harmonization, alignment and predictability of aid, and strengthen health systems to address neglected diseases and ailments instead of focusing on specific diseases. IHP+ is currently being rolled out in ten countries: Burundi, Cambodia, Ethiopia, Kenya, Madagascar, Mali, Mozambique, Nepal, Nigeria and Zambia. There are some opportunities for civil society to provide inputs into country compacts and the IHP+ global governance. But at this early stage, it is unclear whether the initiative will result in increased funding for the health sector, and the extent to which IHP+ country compacts will prioritize family planning and reproductive health.

IHP+ has the potential to benefit family planning and reproductive health because it aims to harmonize donor funds and fill gaps in country health financing needs to meet the MDGs. Because the MDGs now include Target 5B: Achieve universal access to reproductive health as part of the goal to improve maternal health, global health partnerships such as IHP+ could potentially be used to leverage funding for family planning and reproductive health. However, preliminary analysis suggests that global health partnerships to date have infrequently addressed reproductive health concerns or MDG Target 5B in their programming, and when MDG 5 is mentioned it is not budgeted (Fogstad and Bustreo in "MDG 5 Coordination and Information Sharing Meeting" 2009).

In 2008 leaders of donor agencies formed a High Level Taskforce on Innovative Financing for Health Systems chaired by UK Prime Minister Gordon Brown and World Bank President Robert Zoellick, to help mobilize resources to meet the health MDGs, including filling any financing shortfalls identified in the IHP+ country compacts. The Taskforce will help countries fill financing gaps through mobilizing additional resources and improving the use of existing funds for health (High Level Taskforce 2008). The Taskforce formed two working groups, and in June 2009, they released reports on: (1) Constraints to Scaling Up and Costs; and (2) Raising and Channeling Funds.[15]

15 Both reports are available from: http://www.internationalhealthpartnership.net/en/taskforce.

world reside (Dodd, Scheiber, Cassels, Fleisher and Gottret 2007).[16] In aid-dependent countries, the public may not have access to information needed to participate in the prioritization of and track the allocations of budget support: countries that perform poorly in terms of budget transparency also tend to be dependent on aid to finance public expenditures (Ramkumar and de Renzio 2009). Budget support is more volatile than other forms of aid because it relies on donor confidence in country systems; it tends to be withdrawn more rapidly than other aid modalities when political disagreements arise (IDD and Associates 2007). Also, budget and sector spending ceilings set in MTEFs and IMF agreements can constrain funding for staffing (Ooms and Philips 2008; Rowden 2005), negating the advantage of being able to use budget support for recurrent costs. Unless budget support is additive, it can lead to decreased donor support for CSOs that perform advocacy and watchdog functions to hold governments accountable to their commitments (UNIFEM 2006).

Weak government capacity can also be a challenge, as explained in section 2.2 Country Systems. Malawi experienced a worsening of reproductive health supply security after donors began pooling funds into a government-implemented SWAp. Health workers claim that shortages were never so common in the past when donors provided commodities directly to health facilities (Ortiz, Olson, McEuen and Dowling 2008).

The shift to budget support has aggravated problems tracking funding for family planning and reproductive health. Whereas donor funding for dedicated family planning and reproductive health projects is fairly simple to track, the share of budget support and SWAp funding allocated to these priorities is more difficult to assess. Weaknesses in most aid recipient countries' public financial management and reporting have led to a heavy reliance on donor aid reporting systems for accurate data on financing for family planning and reproductive health. While strengthened public financial management through aid effectiveness may improve this, it is not clear that family planning and reproductive health are enough of a priority among either donors or governments to warrant tracking these specific issues in new public financial management systems. For instance, two recent studies reveal that budget support provided by the European Commission fails to track the performance of budget support on gender equality and sexual and reproductive health (DSW 2008). More work is needed to overcome these tracking challenges to better evaluate the impacts of budget support on reproductive health outcomes.

3.2 Sector-Wide Approach

Another way that donors harmonize around country priorities is through funding **Sector-Wide Approaches** (SWAps), or single government-led sector programs supported by donors involved in the sector, and often involving common goals, monitoring, evaluation, reporting and procurement systems. SWAps can be funded through different mechanisms including sector budget support and basket funds (see below). The SWAp approach is based on the logic that when aid recipient governments play a leadership role defining priorities and goals, and donors align aid with these goals, funds can be used more effectively and have a longer-term development impact (Ortiz, Olson, McEuen and Dowling 2008).

SWAps can be a useful space for government officials and donors to ensure that family planning and reproductive health are priorities within the health sector. For example, stakehold-

16 For a list of countries that the World Bank categorizes as fragile states, see: http://go.worldbank.org/HCP9BFLFL0.

ers in Mozambique's SWAp—the Ministry of Health reproductive health program, the United States Agency for International Development, and the United Nations Population Fund—formed a SWAp Reproductive Health Working Group to advocate for prioritizing reproductive health in policies, guidelines, and documents including the national health sector strategic plan. This group effectively persuaded SWAp leadership to include contraceptive prevalence rate as an indicator in its monitoring and evaluation plan. While integrating language on family planning in SWAp policy documents has been successful, more work is needed to ensure that the national government translates these priorities into sufficient funding for reproductive health (Ortiz, Olson, McEuen and Dowling 2008). CSOs and other stakeholders can influence SWAps by advocating to donors and the government through informal channels and pushing for a seat at the table in SWAp governance mechanisms.

SWAp **donor coordination mechanisms** are an opportunity for donors to advance family planning and reproductive health interests by ensuring that family planning and reproductive health priority interventions are costed out in the sector-specific MTEF, and pushing for relevant indicators to monitor SWAp performance.[17] Other donor coordination mechanisms at the country level present similar opportunities.

BOX 6. BUDGET SUPPORT, SECTOR BUDGET SUPPORT, SWAP AND BASKET FUNDS

The aid modalities and approaches discussed in this section are often similar and interrelated, which can be confusing. To recap:

Budget support is funding a donor lends or grants to a Ministry of Finance, and therefore gives a government greater discretion over the use of funding than aid for a specific project.

Sector Support is budget support lent or granted to a specific line ministry such as health. Similar to budget support, sector support gives ministries greater control over the prioritization of funds than project aid.

A **SWAp** is an approach that brings together stakeholders in a particular sector such as health around a government led sector plan. Activities funded through a SWAp can be financed through sector support, a basket fund, project specific aid, or another source of funding.

A **Basket Fund** is an account where a number of donors "pool" funding for a development project or program. A basket fund can be used to fund a wide range of activities, from a specific project to a SWAp.

3.3 Basket Funds

Another modality that harmonizes donor aid is a basket fund, or an account where a group of donors place their funds for a particular project or program. Basket funds can be used for project or program-based aid, including sector support to benefit a SWAp. While basket funds are only as sensitive to family planning and reproductive health as the project or program that they support, they can make tracking funding in specific areas difficult unless the basket only targets one sub-sector such as reproductive health. A 2002 UNFPA report states because of tracking challenges, none of its country offices in countries with health and/or education sector SWAps opted to use a common-basket fund. Instead, country offices tended to use parallel funding mechanisms, which "enabled better tracking of resources and outputs, and better reporting and monitoring of support for reproductive health" (Executive Board of the United Nations Development Program and of the United Nations Population Fund 2002).

17 Although USAID does not participate in pooled funding schemes such basket funds, it often takes part in SWAps by aligning project funding with SWAp priorities (Ortiz, Olson, McEuen and Dowling 2008).

4. MANAGING FOR RESULTS

Managing for results is defined as "a management strategy focusing on performance and the achievement of outputs, outcomes, and impact" ("Joint Marrakech Memorandum" 2004). A results orientation implies designing development interventions by focusing on the desired outcomes and impacts (such as universal access to contraceptive supplies and services), and then identifying the inputs and actions needed to achieve these goals ("Managing for Development Results" 2004). This is more desirable than an approach that starts with planned actions and estimates their likely impacts or outcomes.

Assuming family planning and reproductive health are a priority for policymakers and practitioners, a results orientation could help ensure that interventions are designed to have the greatest impact on outcomes such as achieving universal access to reproductive health. Bolstering monitoring systems could have great potential to benefit family planning and reproductive health through improved availability of data on family planning and reproductive health outcomes and increased transparency and reporting on financial flows to these sectors. However, pressure on countries and donors is needed to ensure that family planning and reproductive health are priorities.

Performance-based aid, also known as output-based aid or performance-based funding, is an approach that links funding to progress achieving agreed performance indicators. Performance-based aid ranges from the country level, for example through a policy-based loan or budget support operation where disbursement is conditioned upon a government maintaining good standing with the IMF, to the project level, with assistance conditioned upon achieving agreed outcomes or outputs such as a number of patients treated. There are many ways to set up a performance-based operation. A donor disburses funding in portions or tranches and withholds funding if a certain criterion is not met (as is common with World Bank and IMF policy-based loans and grants). MDG contracts are a hybrid: they guarantee a portion of the funding committed and base a portion on performance. Other institutions that rely on performance-based funding include the Global Fund to Fight AIDS, TB and Malaria; the Millennium Challenge Corporation and the GAVI Alliance (Eichler and Glassman 2008). As part of performance-based funding, these organizations are creating tools to assess the quality of the data collected to measure performance (Measure Evaluation 2008).

The focus on results is related to an evolution within monitoring from simply measuring the outputs of development projects (such as the number of women receiving routine reproductive health care) to also assessing outcomes (like improved reproductive or maternal health). When evaluating outcomes in reproductive health, it is important to keep in mind that the long-term benefits of investments in many social sectors are often not fully realized within the 1-3 year typical project life cycle. Therefore the benefits of investments in these sectors can be underestimated or not show up in results-type monitoring. Hopefully the anticipated longer-term planning enabled by more predictable aid flows can prevent this mismatch.

The net impacts of performance-based aid on family planning and reproductive health are not clear. Potentially, the results framework could reward countries or projects with a good track record promoting family planning and reproductive health with scaled-up donor funds. The increases in contraceptive prevalence rates since donor funding for family planning became available is one of development industry's success stories (see, for example, (USAID ND) and

can be used to justify increased investments in the sector. Similarly, aid could be aligned with demonstrated commitment toward achieving the MDGs and other reproductive health goals. A UNIFEM paper suggests that progress meeting commitments to build gender equality could be an element to determine eligibility for new types and levels of aid (UNIFEM 2006).

However, there is potential for concern. Similar to other forms of aid, MDG Contracts (a kind of performance-based aid) must place a greater emphasis on reproductive health indicators in to have an impact (Hoehn 2009). Aid cut-offs if performance conditions are not met could result in shortfalls in government funding, and cutbacks for family planning and reproductive health services and supplies. At the project level, performance-based aid could exacerbate inequalities in service delivery: poor performing clinics or projects could be further neglected and the people who rely on their services could be cut off, while funds are redirected to good performers. Performance based aid may not be sufficiently flexible to encourage learning: If projects produce positive outcomes that were not their original targets, they may not be rewarded with continued funding despite their contribution.

5. MUTUAL ACCOUNTABILITY

Accountability can be understood as a duty or willingness to accept responsibility for one's actions. The Paris Declaration envisions **mutual accountability** as enhancing donor and aid recipient country accountability and transparency in the use of development resources. Country commitments include strengthening parliaments' role in national development strategies and budgets, and reinforcing participatory approaches by "systematically involving a broad range of development partners when formulating and assessing progress in implementing national development strategies" ("Paris Declaration" 2005, page 8). Donors' responsibility is to provide timely, transparent information to aid recipient governments to help their budget processes. Both sets of parties agree to undertake "mutual assessments of progress" in implementing aid effectiveness commitments ("Paris Declaration" 2005, page 8).

Progress toward this target has been slow. As of 2007, only 14 out of 55 countries had country-level mechanisms for assessing mutual progress toward achieving aid effectiveness, up from 12 in 2005. These mechanisms generally consist of a forum for government officials and donors providing budget support to review progress around an agreed action plan.[18] In Mozambique, each year independent consultants assess the performance of donors who provide budget support against a matrix of targets drawn from the Paris Declaration and informed by the Performance Assessment Framework of the country's PRS. Vietnam has a Partnership Group on Aid Effectiveness, which includes representatives from civil society, to implement both the Paris Declaration and other partnership commitments (OECD 2008).

Family planning and reproductive health champions should explore mutual accountability mechanisms, and utilize the range of existing structures as a possible point of entry. It is not clear whether these mechanisms have historically focused on sub-sectors such as reproductive health, but they are a potential forum for donors and governments to hold each other accountable to their commitments to aid effectiveness related to reproductive health. For example, if a donor agreed to provide more predictable support to fund government-provided family planning services and supplies as part of implementing the Paris Declaration and Accra Agenda for Action, the mutual accountability mechanism could be used to review progress and adjust accordingly.

Other structures for donors and governments to hold one another accountable to commitments made in family planning and reproductive health include health round tables and health sector SWAp coordinating groups. Donors and governments can set out their mutual commitments in Memoranda of Understanding, an emerging best practice. PRSs, MTEFs and annual budget review processes are also opportunities for governments and donors to review progress on commitments ("Donor and Mutual Accountability in Scaling Up For Better Health" 2007). Where there is little space for civil society groups within existing accountability structures, submitting shadow reports to accountability structures and the public can be a good way to hold donors and government agencies accountable to family planning and reproductive health commitments. Responses by donors and governments to shortcomings brought out in accountability structures will depend on political factors and the design of the mechanism.

18 According to the 2008 Survey on Monitoring the Paris Declaration, Rwanda is the only country with a mutual assessment mechanism that extends beyond donors providing budget support.

5.1 Accountability to Whom?

The reliance of aid-dependent countries on donors to finance their health sector budgets skews government accountability heavily in favor of donors who hold the purse strings, and erodes government accountability to citizens, for example in meeting family planning and reproductive health commitments. The aid effectiveness framework focuses on accountability between donors and aid recipient governments, with an emphasis on so-called **upward accountability** of governments to donors. More work is needed to equalize accountability between donors and aid recipients. For example, recommendations from the High Level Forum in Accra suggest that accountability should move from a donor-driven focus on conditionality to commonly agreed results, with a clear statement of which actors—including donors—are responsible for what deliverables ("Round Table 8 Summary" 2008).

Ultimately, governments should fulfill their commitments to meet contraceptive needs in response to citizen demands and a desire to improve the health of women and families. For this to happen, governments need adequate resources and political will to support family planning and reproductive health. An enabling environment for CSOs to participate in policymaking, priority setting, monitoring, and evaluation can foster political will. Ensuring transparency and access to information are key components of this enabling environment. Enhancing CSOs' budget literacy and advocacy skills are an important part of this process.

BOX 7. CSO INVOLVEMENT IN GLOBAL FUND GOVERNANCE

The Global Fund to Fight AIDS, Tuberculosis and Malaria has made special efforts to create an enabling environment for CSOs, which have been part of the fund since its establishment:

(1) CSOs are part of the Global Fund Board, and have equal voting rights with donor and recipient governments;

(2) CSOs represent the needs of vulnerable and marginalized groups on Country Coordinating Mechanisms, and;

(3) The Global Fund facilitates CSOs as implementers by allowing them to access funding as Principal Recipients without going through governments to get grants (The Global Fund ND).

More discussion is needed to establish best practices for donors in fostering domestic, or downward accountability of governments to citizens. The World Bank and IMF have required governments to allow CSO participation in developing PRSs, with mixed results (section 1.1 Influencing the PRS). Other donors, such as the Global Fund, have tried to create an enabling environment for CSOs by including them in governance structures and as funding recipients (Box 7), although there can still be challenges for CSOs to access timely information about processes particularly at the country level. At a minimum, donors should review their conditionalities and eliminate those that undermine domestic accountability.

In the long term, to balance conflicts between downward accountability of governments to domestic constituencies and upward accountability of governments to donors, aid-dependent governments should explore ways to reduce their reliance on donor funds, for example through revisiting revenue generation policy such as tax breaks for large businesses. However, the current financial crisis has undermined prospects of aid independence for most countries in the near future.

CONCLUSIONS AND KEY RECOMMENDATIONS

As this paper has shown, implementation of the aid effectiveness principles has changed the global aid architecture, including for family planning and reproductive health. While recognizing and addressing the shortcomings of aid effectiveness, PAI believes it is important that champions working to increase the availability of family planning and reproductive health services and supplies understand and are able to navigate within this changing funding landscape in order to achieve the ICPD goals.

Country ownership and the shift in development priority-setting from donor headquarters increasingly to the country level is one of the most dramatic changes relevant for family planning and reproductive health, elevating the importance of country-level advocacy and capacity-building.

Institutionalized processes must be in place to ensure the participation of a wide range of government actors including health ministries and parliamentarians and non-state actors such as civil society in developing, implementing, and monitoring national development plans (Mas de Xaxás and Gibb Vogel 2007). For aid effectiveness to be successful, governments need to increase transparency, strengthen institutions of accountability, and foster participation and responsiveness to local demands.

Many of the changes in aid modalities can have either positive or negative impacts on family planning and reproductive health, depending largely on the context in which they are implemented. For example, budget and sector support has enhanced opportunities for governments to direct aid to where it is needed most, but family planning and reproductive health may not be getting the attention required to achieve universal access because they are not prioritized. In countries with low commitments to family planning and reproductive health or with weak country systems, donors should use a mix of aid modalities, including targeted project funding, to help meet the needs of women and families (DSW 2008). During the transition from donor to country procurement and logistics systems, donors need to be flexible and respond to commodity security crises as needed.

With budget support and basket funds, tracking donor and government funding levels for family planning and reproductive health is more difficult. It is important that efforts to improve global aid transparency and public financial management address tracking issues at the sub-sector level so all champions have information on funding flows for family planning and reproductive health, which is essential to hold all actors accountable to their commitments.

There are opportunities for champions to work toward achieving universal access to reproductive health including family planning—an important global commitment reinforced with the addition of MDG Target 5B—within the current aid architecture. For example, to ensure that donor funding channeled through government budgets reaches family planning and reproductive health programs, in-country champions can push for the addition of these priorities in a country's PRS and other national and sectoral plans. Following the inclusion of family planning and reproductive health in PRSs, champions must then ensure that family planning and reproductive health are given priority within the country's MTEF and the annual budget, and that the government adheres to the budget allocation. Including family planning and repro-

SUMMARY OF ENTRY POINTS AND RECOMMENDATIONS

For civil society and other actors:

- Pressure governments and donors to prioritize family planning and reproductive health within national and sectoral budgets, as well as Poverty Reduction Strategies (PRSs) and other national and sectoral development plans. To ensure implementation, interventions outlined in these documents should include funding lines and indicators to monitor progress.
- Monitor budget expenditures and implementation of commitments to improve or expand family planning and reproductive health, and following up with advocacy for improvements.

For governments and donors:

- Prioritize family planning and reproductive health in strategy documents such as PRSs and sectoral plans, ensure that these items are budgeted, include relevant indicators, and transparently monitor progress toward achieving goals.
- Create an enabling environment for CSOs and other nongovernmental stakeholders to influence policy-making, budgeting, and tracking, for example through ensuring access to information and meaningful participation in decision-making processes.

For governments:

- For champions within government agencies such as parliament and ministries of health, ensure that family planning and reproductive health are priorities in budgets and that funding is "ring fenced."
- Where necessary, improve public financial management, procurement and logics systems to respond to national demand for supplies and foster greater domestic accountability.

For donors:

- Improve the predictability of aid to allow for longer-term planning to meet family planning and reproductive health needs in aid-dependent countries.
- During the transition from donor provision of reproductive health supplies to greater use of country systems, donors should be prepared to provide emergency supplies as needed.
- In cases of weak government capacity or political will, donors should use a mix of funding mechanisms including project support to ensure that commitments to achieve universal access to family planning and reproductive health are met.

ductive health targets such as contraceptive prevalence rate in PRS and SWAp monitoring and evaluation frameworks can help ensure that programs and projects are implemented.

There are several outstanding issues that merit further attention: Which aid modalities are most effective at improving family planning and reproductive health, and under which circumstances? What are entry points for champions to improve country systems to ensure that governments prioritize family planning and reproductive health needs? How do champions make aid for family planning and reproductive health more predictable? How effective are Global Health Partnerships at improving family planning and reproductive health outcomes? How can champions make performance-based aid work to enhance access to family planning and reproductive health services? How can governments, donors and CSOs improve domestic accountability in aid-dependent settings?

While the full implications of the Paris Declaration and Accra Agenda for Action may not be clear for years to come, family planning and reproductive health champions—inside government, among donors and CSOs—need to understand the new aid principles and funding mechanisms as they emerge. And they must have a seat at the negotiating table to ensure that universal access to reproductive health including family planning is a priority.

APPENDIX 1. GLOSSARY

TERM	DEFINITION
Accountability	A duty or willingness to accept responsibility for one's actions. Downward accountability refers to domestic accountability of governments to civil society and other domestic constituencies, and upward accountability is accountability of governments to donors.
Aid	Grants, concessional loans, or technical assistance from a donor agency to a recipient government or organization. Aid is often used synonymously with Official Development Assistance.
Aid Architecture	The set of rules and institutions governing aid flows to developing countries.
Aid Effectiveness	The process of reforming the management and delivery of aid through five principles: (1) aid recipient country ownership of development; (2) donor alignment with national development priorities; (3) increased donor harmonization; (4) increasing orientation towards outcomes and results; and (5) mutual accountability between donors and developing countries for achieving development results. The process of reforming the management and delivery of aid through five principles: (1) aid recipient country ownership of development; (2) donor alignment with national development priorities; (3) increased donor harmonization; (4) increasing orientation toward outcomes and results; and (5) mutual accountability between donors and developing countries for achieving development results.
Aid Modality	The way donor aid is channeled to recipient. Types of aid modalities include: (1) Funding for a specific project; (2) In-kind support of goods or services, for example of reproductive health supplies; (3) Budget support which is integrated into the budget of the recipient country; and (4) Parallel aid which is kept out of the national resources.
Alignment	Under this Paris Declaration principle, donors commit to align their aid with country priorities, make aid more predictable, and channel more funding through strengthened aid recipient country systems such as public financial management and procurement systems.
Basket Fund	A common account that a number of donors jointly fund for a development project or program. A basket can be earmarked to a narrow or a wider set of activities. The term “basket fund” is often used interchangeably with “pooled funding.”

TERM	DEFINITION
Bilateral Aid	Aid from the government of one country to a recipient government or organization in another country.
Budget Line	An item in a country's budget with a dedicated funding amount, such as reproductive health supplies.
Budget Support	Aid to governments which is not earmarked to specific projects or expenditure items. Budget support is integrated into the national budget of the recipient country and used according to national public expenditure management rules and procedures. Budget support gives countries discretion over the use of aid, and makes it difficult to track how much of a specific donor's funding is going toward family planning and reproductive health.
Concessional Loan	A low interest loan that has a grant element of at least 25 percent. Also known as a "soft" loan.
Conditionality	Measures that donors require aid recipients to undertake in order to receive funding. Funding is often disbursed in tranches based on achievement toward agreed indicators or performance criterion. There are two primary types of conditionality: (1) fiduciary conditionality where sustained funding requires measures of transparency, accountability and good governance in the use of financial resources; and the more contentious (2) policy conditionality where donors requires recipient governments to adopt and/or implement general or sector policies, as well as macroeconomic and fiscal objectives to obtain funding.
Country Ownership	The Paris Declaration principle that aid recipient countries should take effective leadership over their development policies and strategies, co-ordinate development actions, improve country institutions and address corruption.
Country Systems	A country's legal and institutional framework, consisting of its institutions and applicable laws, regulations, rules, and procedures at all levels of government. Country systems include local procurement and logistics systems often responsible for supplying and distributing reproductive health supplies.
Donor Coordination Mechanism	A forum for donors to coordinate actions at the country level, often used in Sector-Wide Approaches.
Downward Accountability	See accountability.

TERM	DEFINITION
Earmarked Funds	Aid that a donor requires a country or recipient to use in a specified way. This can range from very narrow earmarking that targets specific budget items such as reproductive health supplies, to broad earmarking of a specific sector or sub-sector.
Fiduciary Conditionality	See conditionality.
Grant	A transfer of money, goods, or services which is not repaid.
Harmonization	A Paris Declaration principle defined as an approach in which the partner country exercises leadership over a donor-supported program, and donors coordinate and streamline processes.
Loan	A transfer of money, goods, or services which must be repaid.
Managing for Results	A Paris Declaration principle defined as a strategy focusing on performance and the achievement of outputs, outcomes, and impact.
MDG Contracting	A program introduced by the European Commission in 2007 to enhance budget support to a few countries through longer-term, more predictable budget support whose conditionalities focus on performance and achieving MDG targets.
Medium-term Expenditure Framework (MTEF)	Rolling, costed estimates of financial needs as well as public sector and donor resources available for spending, used to link policy, planning, and budgeting processes both at the national and sectoral levels. MTEFs are supposed to link planning documents such as PRSs to annual budgets.
Millennium Development Goals (MDGs)	Eight international development goals that the majority of United Nations member states and international organizations agreed to achieve by the year 2015. They are: (1) Eradicate extreme poverty and hunger; (2) Achieve universal primary education; (3) Promote gender equality and empower women; (4) Reduce child mortality; (5) Improve maternal health; (6) Combat HIV/AIDS, malaria, and other diseases; (7) Ensure environmental sustainability, and; (8) Develop a global partnership for development. Each goal has a set of targets used for monitoring progress. In 2007, member states agreed to add Target 5B: Achieve universal access to reproductive health in order to improve maternal health.
Multilateral Aid	Aid from an organization made up of more than one member country, such as the World Bank.

TERM	DEFINITION
Mutual Accountability	The Paris Declaration principle defined as enhancing donor and aid recipient country accountability and transparency in the use of development resources.
Performance Assessment Framework	A single framework of indicators and conditions used to monitor performance implementing the Paris Declaration. It is supposed to be based on a national strategy such as a PRS.
Parallel Aid	Aid which is kept separate from the general resources in the national budget. Parallel aid may be reflected on the national budget, but is not necessarily subject to the rules and procedures in the public expenditure management system.
Paris Declaration on Aid Effectiveness	A 2005 pledge by donors and aid recipient countries to improve the effectiveness of aid through implementing the principles of aid effectiveness by 2010.
Performance-Based Aid	An approach that links funding to progress achieving agreed performance indicators.
Policy-Based Operation	A loan or grant provided by a donor to the central government on the condition that the recipient undertake specific policy reforms.
Policy Conditionality	See conditionality.
Poverty Reduction Strategy (PRS)	Developed during the late 1990s as a prerequisite for accessing debt relief from the World Bank and International Monetary Fund, PRSs are national plans prepared by central governments with inputs from parliamentarians, civil society, donors, and the private sector every three to five years that describe a country's macroeconomic and social policies and programs, as well as external financing requirements.
Predictability	Defined by the Paris Declaration as regular and timely information on donors' rolling three to five year forward expenditure and implementation plans, with at least indicative resource allocations that developing countries can integrate in their medium_term planning and macroeconomic frameworks.
Procurement	The acquisition of goods or services.
Program Based Aid	Aid that is organized in support of a particular sector or activity such as a PRS or sector plan.
Public Financial Management	A government's rules and institutions governing budget planning, execution, financial reporting, monitoring and auditing.

TERM	DEFINITION
Ring-fenced	A budget line item that is protected from being diverted to other priorities, and can only be used for a particular purpose.
Sector (Budget) Support	Budget support to a line ministry such as the ministry of health, often used to fund a Sector-Wide Approach.
Sector-Wide Approach (SWAp)	An organizational method in which all stakeholders involved in a sector such as health collaborate in support of a government-led sector plan, often adopting common donor approaches and streamlining reporting, accounting, and procurement systems.
Upward Accountability	See accountability.

REFERENCES

"Accra Agenda for Action." 2008. Presented at Third High Level Forum on Aid Effectiveness, Accra, 25 July. http://www.oecd.org/dataoecd/58/16/41202012.pdf. Accessed 3 August 2009.

Action for Global Health. 2007. "MDG Contracting." *Briefing #01.* http://www.actionforglobalhealth.eu/content/download/7250/37695/file/Briefing%201%20-%20MDG%20Contracting.pdf. Accessed 12 August 2008.

Antunes, A F, G Carrin and D Evans. 2008. *General Budget Support in Developing Countries: Ensuring the Health Sector's Interest.* Geneva: World Health Organization. http://www.who.int/health_financing/documents/cov-pb_e_08_2-budget_support/en/index.html. Accessed 27 July 2009.

Beynon, J. 2008. "MDG Contract: An Approach for Longer Term, More Predictable General Budget Support." Presented at the AIDCO Info Point Seminar, Brussels, 24 June. http://ec.europa.eu/europeaid/infopoint/documents/presentations/presentation_24_06_2008_(2)_en.pdf. Accessed 27 January 2009.

Bhuyan, A, M Borda and W Winfrey. 2007. *Making Family Planning Part of the PRSP Process: A Guide for Incorporating Family Planning Programs Into Poverty Reduction Strategy Papers.* Washington: USAID. http://population.developmentgateway.org/uploads/media/population/257_1_PRSP_paper_final.pdf. Accessed 9 February 2009.

Dodd, R, G Schieber, A Cassels, L Fleisher and P Gottret. 2007. "Aid Effectiveness and Health." *Making Health Systems Work: Working Paper No. 9.* Geneva: WHO. http://www.searo.who.int/LinkFiles/Health_Systems_Aid_Effect_and_Health_WP-9.pdf. Accessed 27 May 2009.

"Donor and Mutual Accountability in Scaling Up For Better Health." 2007. Presented at the Multi-donor Secretariat of the High-Level Forum on the Health MDGs, Paris, 25-26 September 2006. http://www.hlfhealthmdgs.org/Documents/070605IsenmannMutualAccountabilityFINAL.pdf. Accessed 15 May 2009.

DSW (*Deutsche Stiftung Weltbevölkerung* [German Foundation for World Population]). 2008. "Budget Support Consequences for Sexual and Reproductive Health." *DSW Fast Facts.* Hannover: DSW. http://www.weltbevoelkerung.de/en/Fast_fact_Budget_Support_26_june_2008.pdf. Accessed 4 August 2008.

Eichler, R and A Glassman. 2008. "Health Systems Strengthening Via Performance-Based Aid: Creating Incentives to Perform and Measure Results." *Global Health Financing Initiative Working Paper 3.* http://www.brookings.edu/~/media/Files/rc/papers/2008/09_global_health_glassman/09_global_health_glassman.pdf. Accessed 28 January 2009.

European Commission. 2007. *Technical Discussion Paper on a "MDG Contract:" A Proposal for Longer Term and More Predictable General Budget Support.* Brussels: European Commission. http://doku.cac.at/eudiscussionpaper070619.pdf. Accessed 27 January 2009.

Executive Board of the United Nations Development Program and of the United Nations Population Fund. 2002. "UNFPA and Sector-Wide Approaches: Follow-up to Decision 2000/8." Geneva: United Nations. http://www.unfpa.org/exbrd/2002/annualsession/dpfpa20026.doc. Accessed 9 January 2009.

GAVI (Global Alliance for Vaccine Initiative). ND. *Data Quality Audits.* http://www.gavialliance.org/performance/country_results/dqas/index.php. Accessed: 1 February 2009.

Global Fund to Fight AIDS, Tuberculosis and Malaria, The. ND. *NGOs and Civil Society.* Global Fund. http://www.theglobalfund.org/en/civilsociety/. Accessed 15 May 2009.

Hayes, L and J Pereira. 2008. *Turning the Tables: Aid and Accountability Under the Paris Framework (A Civil Society Report)*. Brussels: EURODAD. http://www.eurodad.org/uploadedFiles/Whats_New/Reports/Turning_the_Tables.pdf. Accessed 4 August 2008.

High Level Taskforce on Innovative International Financing for Health Systems. 2008. *Terms of Reference and Management Arrangements*. http://www.internationalhealthpartnership.net/pdf/Proposal%20for%20a%20taskforce%20on%20health%20financing%20v2.pdf. Accessed 27 January 2009.

Hoehn, K. 2009. "Changing Aid Modalities for Health." Presented at the Countdown 2015-Europe Meeting, 8 June. Hannover: DSW. http://www.euroresources.org/fileadmin/user_upload/Other/DSW_Presentation_BudgetSupport_CountdownWorkshop_8June2009.PPT. Accessed 28 July 2009.

IDD and Associates. 2006. *Evaluation of General Budget Support: Synthesis Report*. Birmingham, U.K.: International Development Department, School of Public Policy, University of Birmingham with DFID. http://www.oecd.org/dataoecd/25/43/37426676.pdf. Accessed 9 February 2009.

—. 2007. "6. General Budget Support: General Questions and Answers." *The Joint Evaluation of General Budget Support 1994-2004: Thematic Briefing Papers*. Birmingham, U.K.: International Development Department, School of Public Policy, University of Birmingham with DFID. http://www.oecd.org/dataoecd/13/55/38339341.pdf. Accessed 4 August 2008.

IHP+ (International Health Partnership + Related Initiatives). 2008. *Scaling up for Better Health: Work Plan for the International Health Partnership and related initiatives (IHP+) For September 2007 to March 2009*. Geneva and Washington, DC: IHP+. http://www.internationalhealthpartnership.net/pdf/02_IHP_Workplan_EN_Feb20_2008_FINAL.pdf. Accessed 27 January 2009.

International AIDS Society. 2009. "At Conclusion of Major International Scientific Meeting on AIDS, Researchers Highlight Evidence of Important Benefits from HIV Investments for Other Health Conditions, Including Those Affecting Women and Children." *Media Statement*. Geneva: International AIDS Society. http://www.iasociety.org/Web/WebContent/File/Leveraging%20HIV%20Investments%20for%20Health%20Women%20and%20Kids%20(22%20July%20FINAL).pdf. Accessed 28 July 2009.

"Joint Marrakech Memorandum." 2004. Presented at Managing for Development Results; Second International Roundtable, Marrakech, 4-5 February. http://www.mfdr.org/2ndRoundtable.html. Accessed 27 January 2009.

Managing for Development Results. 2004. "Annex 1: Promoting a Harmonized Approach to Managing for Results: Core Principles for Development Agencies." Presented at Managing for Development Results; Second International Roundtable, Marrakech, 4-5 February. http://www.mfdr.org/documents/2CorePrinciples05Feb04.pdf. Accessed 30 July 2008.

Marchal, B, A Cavalli and G Kegels . 2009. "Global Health Actors Claim To Support Health System Strengthening—Is This Reality or Rhetoric?" *PLoS Med* 6(4): e1000059. http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1000059. Accessed 28 July 2009.

Marphatia, A, R Moussié, A Ainger and D Archer. 2007. *Confronting the Contradictions: The IMF, wage bill Caps and the Case for Teachers*. Johannesburg: ActionAid International. http://www.actionaid.org/assets/pdf/1%20%20CONFRONTING%20THE%20CONTRADICTIONS%20E-VERSION.pdf. Accessed 28 July 2009.

Mas de Xaxás, M and C Gibb Vogel. 2007. "Making Country Ownership a Reality: An NGO Perspective." *PAI Research Commentary* 2(3). Washington, DC: PAI. http://www.populationaction.org/Publications/Working_Papers/July_2007/Summary.shtml. Accessed 27 May 2009.

"MDG 5 Coordination and Information Sharing Meeting" (Unpublished meeting notes). 2009. Co-organized by Sida and Norad Stockholm, February 10-11, 20.

Measure Evaluation (on behalf of the Global Fund to Fight AIDS, TB and Malaria and multiple organizations). 2008. *Data Quality Audit Tool: Guidelines for Implementation.* Chapel Hill, NC: The MEASURE Evaluation Project. http://www.cpc.unc.edu/measure/tools/monitoring-evaluation-systems/data-quality-assurance-tools/dqa-auditing-tool-implentation-guidelines.pdf. Accessed: 1 February 2009.

Michel, Louis. 2008. *Budget support: A Question of Mutual Trust*. Luxembourg: European Commission. http://ec.europa.eu/development/icenter/repository/LM_budget_support_en.pdf. Accessed 27 July 2009.

OECD (Organisation for Economic Co-operation and Development). 2008. *2008 Survey on Monitoring the Paris Declaration: Making Aid More Effective by 2010.* Paris: OECD: Paris. http://www.oecd.org/document/0/0,3343,en_2649_15577209_41203264_1_1_1_1,00.html. Accessed 20 August 2008.

Ooms, G and M Philips. 2008. "Fiscal space for health expenditure in Mozambique: blocking effectiveness of international funds through budget support." Presented at the XVII International AIDS Conference Mexico City, 3-8 August. http://www.aids2008.org/Pag/ppt/MOAE0206.ppt. Accessed 5 May 2009.

Ortiz, C, N Olson, M McEuen, P Dowling. 2008. *Primer: Ensuring Reproductive Health Commodity Security within a Sector Wide Approach*. Arlington, VA: John Snow, Inc., DELIVER Project, for the U.S. Agency for International Development. http://deliver.jsi.com/dhome/countries/countrypubs?p_persp=PERSP_DLVR_CNTRY_BD. Accessed 10 January 2009.

"Paris Declaration on Aid Effectiveness: Ownership, Harmonization, Alignment, Results, and Mutual Accountability." 2005. Presented at the High Level Forum in Paris, February 28-March 2. http://www.oecd.org/document/18/0,2340,en_2649_3236398_35401554_1_1_1_1,00.html. Accessed 20 August 2008.

Ramkumar, V and P de Renzio 2009. "Improving Budget Transparency and Accountability in Aid Dependent Countries: How Can Donors Help?" Budget Brief 02(7). Washington, DC: International Budget Partnership. http://www.internationalbudget.org/resources/briefs/brief7.pdf.

Reuters. 2009. "EU Agrees Zambia Financing Package to Fight Poverty." Reuters.com. http://www.reuters.com/article/latestCrisis/idUSL5929027. Accessed 27 May 2009.

Rowden, R and J Irama. 2004. "Rethinking Participation: Questions for Civil Society about the Limits of Participation in the PRSPs." *An ActionAid USA/ActionAid Uganda Discussion Paper.* Washington, DC: ActionAid International USA. http://siteresources.worldbank.org/CSO/Resources/AA_Rethinking_Participation_by_Action_Aid.pdf. Accessed: 12 May 2009.

Rowden, R. 2005. *Changing Course: Alternative Approaches to Achieve the Millennium Development Goals and Fight HIV/AIDS.* Washington, DC: ActionAid International USA. http://www.actionaid.org.uk/doc_lib/131_1_changing_course.pdf. Accessed: 8 August 2008.

"Round Table 8 Summary." 2008. Outcome Document of the Third High Level Forum on Aid Effectiveness in Accra, September 2-4. http://siteresources.worldbank.org/ACCRAEXT/Resources/4700790-1210008992554/4968817-1227556355024/RT8-Sectors.pdf. Accessed 21 July 2009.

Stiglitz, J. 1999. *Participation and Development: Perspectives from the Comprehensive Development Paradigm*. Washington, DC: World Bank. http://siteresources.worldbank.org/CDF/Resources/stiglitzparticipation1999.pdf. Accessed: 22 January 2009.

United Nations (UN). 2007. Report of the Secretary-General on the work of the Organization. Official Records, Sixty-second session, Report A/62/1. New York: UN. http://www.un.org/millenniumgoals/sgreport2007.pdf?OpenElement. Accessed 29 July 2009.

UNIFEM (United Nations Development Fund for Women). 2006. *Promoting Gender Equality in New Aid Modalities and Partnerships*. New York: UNIFEM. http://www.idrc.ca/uploads/user-S/11429447581 PromotingGenderEqualityInNewAidModalities_eng.pdf. Accessed 15 July 2008.

USAID. ND. *Impact of Family Planning Programs*. http://www.usaid.gov/our_work/global_health/pop/success.html. Accessed 15 May 2009.

Wilhelm, V and P Krause (Eds). 2008. *Minding the Gaps: Integrating Poverty Reduction Strategies and Budgets for Domestic Accountability.* Washington, DC: World Bank. http://go.worldbank.org/O0AD1SDZX0. Accessed 27 May 2009.

World Health Organization Maximizing Positive Synergies Collaborative Group, B Samb, T Evans, M Dybul, R Atun, J P Moatti, S Nishtar, A Wright, F Celletti, J Hsu, J Y Kim, R Brugha, A Russell, C Etienne. 2009. "An Assessment of Interactions Between Global Health Initiatives and Country Health Systems." *The Lancet* Jun 20;373(9681):2137-69. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60919-3. Accessed 30 July 2009.

Working Group on IMF Programs and Health Spending. 2007. *Does the IMF Constrain Health Spending in Poor Countries? Evidence and an Agenda for Action*. Washington, DC: Center for Global Development. http://www.cgdev.org/doc/IMF/IMF_Report.pdf. Accessed 28 July 2009.

World Bank. ND. *Poverty Reduction Strategies*. http://go.worldbank.org/FXXJK3VEW0. Accessed 23 May 2009.

—. 2003. *Toward Country-led Development: A Multi-Partner Evaluation of the Comprehensive Development Framework (Synthesis Report)*. Washington, DC: World Bank. http://www.worldbank.org/evaluation/cdf/#download. Accessed 30 July 2008.

—. 2004. *A Review of Population, Reproductive Health, and Adolescent Health & Development in Poverty Reduction Strategies*. Washington, DC: World Bank. http://siteresources.worldbank.org/INTPRH/Publications/20262402/PRSP%20report%20-%20Aug%2031%202004.pdf. Accessed July 2008.

—. 2008. *Aid Architecture: An Overview of the Main Trends in Official Development Assistance Flows*. Washington, DC: World Bank. http://siteresources.worldbank.org/IDA/Resources/Aid_Architecture-May2008.pdf. Accessed 18 May 2009.

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