An Index of the Quality of Official Development Assistance in Health

Denizhan Duran and Amanda Glassman

Abstract

Health is one of the largest and most complex aid sectors: 16 percent of all aid went to the health sector in 2009. While many stress the importance of aid effectiveness, there are limited quantitative analyses of the quality of health aid. In this paper, we apply Birdsall and Kharas's Quality of Official Development Assistance (QuODA) methodology to rank donors across 23 indicators of aid effectiveness in health. We present our results, track progress from 2008 to 2009, compare health to overall aid, discuss our limitations, and call for more transparent and relevant aid data in the sector level as well as the need to focus on impact and results.

JEL Codes: F35, I15

Keywords: official development assistance, health.

Center for Global Development
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Working Paper 287
February 2012

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CGD is grateful for contributions from the UK Department for International Development in support of this work.

Denizhan Duran and Amanda Glassman. 2012. "An Index of the Quality of Official Development Assistance in Health." CGD Working Paper 287. Washington, D.C.: Center for Global Development.
http://www.cgdev.org/content/publications/detail/1425926

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Table of Contents

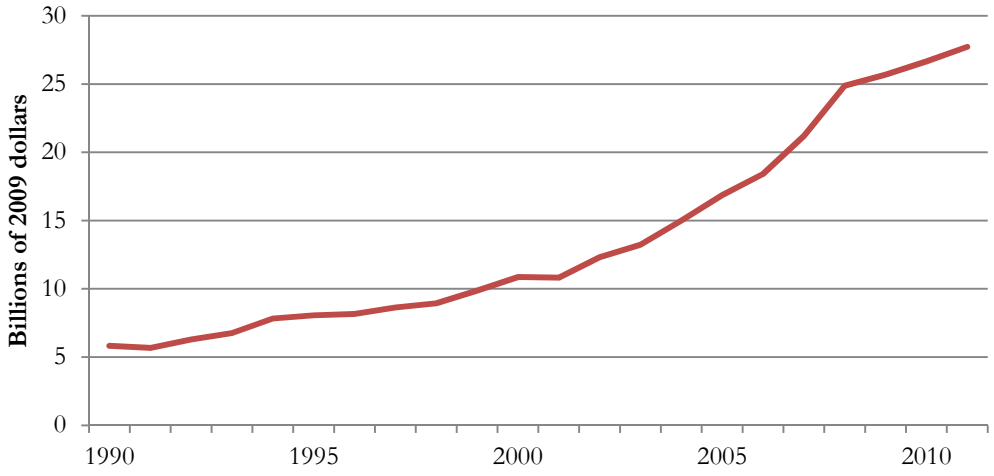
Aid Effectiveness in Health 1
The QuODA Methodology 9
Data and Terminology 11
Dimensions and Results 12
Dimension 1: Maximizing Efficiency 13
Dimension 2: Fostering Institutions 16
Dimension 3: Reducing Burden 18
Dimension 4: Transparency and Learning 20
Discussion of Results 21
2008 versus 2009, across health indicators 21
Overall QuODA versus Health QuODA, 2009 26
Recipient-level analysis for aid dependent countries 30
Recommendations and conclusion 31
Recommendation 1: Need for continued progress across indicators 31
Recommendation 2: Need for more and better aid effectiveness data 31
Recommendation 3: Need for more policy impact evaluations 32
Conclusion: Going Forward 32
References 34
Appendix 1: Descriptions of Indicators 38
Dimension 1: Maximizing Efficiency 38
Dimension 2: Fostering Institutions 44
Dimension 3: Reducing Burden 45
Dimension 4: Transparency and Learning 49
Appendix 2: Tables 54
Appendix 3. Aid Effectiveness in Health: A List of Country-Specific Cases 69

Aid Effectiveness in Health

Effective health aid has saved lives: the health outcomes of the poorest have steadily improved in the past century, some of which is likely due to official development assistance in health (Kenny, 2011). Over the years, health aid has progressively grown larger, more complex, and more fragmented. According to the Institute of Health Metrics and Evaluation, health aid has been increasing dramatically since 1990: from $5.66 billion 1990 to $27.73 billion in 2011 (see figure 1), mostly due to the entrance of non-state actors such as the Bill and Melinda Gates Foundation, as well as new multilaterals such as the Global Fund and GAVI Alliance (IHME 2012). Bilateral commitments to health went up from 5.3% of total aid in 1980-1984 to 7.8% in 2006 (OECD 2011b). Official Development Aid in Health (DAH), coming from Development Assistance Committee (DAC) countries, also increased, totaling $13.40 billion in 2009 (CRS 2009)[1] and representing almost 16% of all aid.

Health aid is as complex an industry as overall aid when it comes to the number of players: thirty donors have given aid through 27,900 activities – a 77% increase from 2008 (see figure 2 and table 1), to 137 recipients. Donors differ in size and scope; the largest donor, the United States, gave health aid through 6,699 projects to 122 countries, amounting to $4.2b. The smallest donor, Portugal, gave health aid through 68 projects to 10 countries, amounting to $9.3m.

Figure 1: Total Health Aid Disbursements, 1990-2011

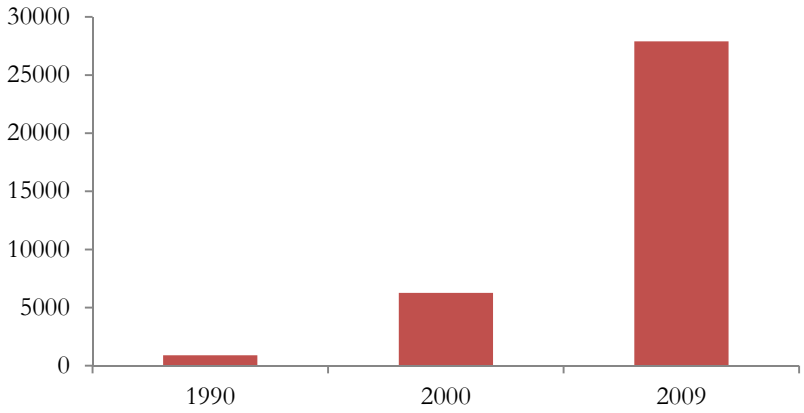


Source: IHME DAH Database, 2011

[1] IHME's DAH estimates cover non-DAC donors such as private foundations, multilaterals and NGOs, such as the World Health Organization and the Bill and Melinda Gates Foundation, and rely on certain estimations, especially for multilaterals. Given this methodology, they calculate the total DAH in 2009 to be $25.23 billion, but the total in the Credit Recording System is $13.37b. IHME looks at private citizens, corporations and foundations, which make up 27% of DAH in 2007; CRS does not have data for these. [See definitions, section 2]

While the effect of the current economic downturn will not immediately materialize given that multi-year commitments are lagged by a couple of years, it is likely that donors will decrease their commitments in the coming years (IHME 2012). Further, funding commitments that have increased are under enormous pressure to improve performance and demonstrate value for money.

Figure 2: Number of Health Aid Activities as Reported in CRS



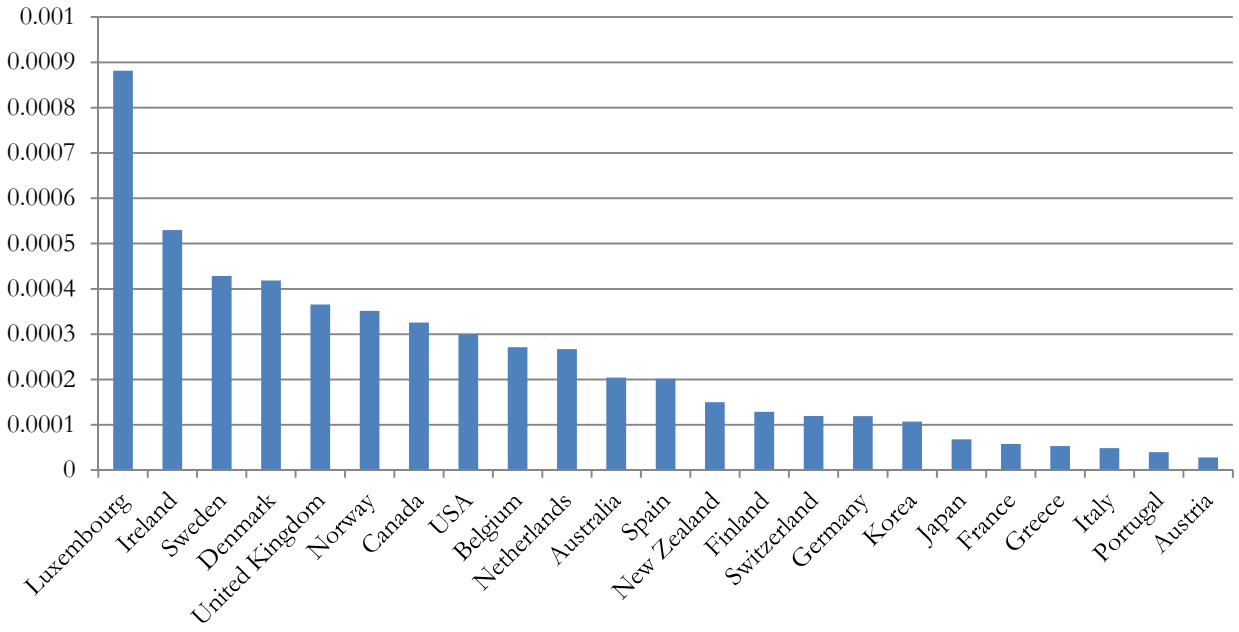
Source: OECD CRS 2009

Potential declines in health aid can be detrimental given the concentration of aid spending on recurrent costs (80% according to Action for Global Health, 2011) such as vaccines or drugs. This need to shift towards predictable and stable health aid flows has spurred innovation in the health sector, especially with the creation of special purpose funding vehicles such as the GAVI Alliance and the Global Fund. However, these institutions are not immune to current aid trends: the Global Fund recently cancelled its Round 11 grants, which would cover 2011 to 2013, due to a shortage of money.[2]

It is also important to note that health aid, as a percentage of GDP, is very small (see figure 3): Luxembourg gives the highest share to health; almost 0.001% of its GDP.

[2] Sarah Abelow, "Crisis looms as Global Fund forced to cut back on AIDS, malaria and TB grants." http://www.guardian.co.uk/society/sarah-boseley-global-health/2011/nov/23/aids-tuberculosis November 23, 2011

Figure 3: Health Aid as a Percentage of GDP, 2009



Source: OECD CRS, 2009

Consequently, beyond funding constraints, it is important to consider the gap between money flows and results. Even before the cuts in global health aid, many were pointing out the difficulty of governance and achieving results in the field. Garrett (2007) highlights the importance of establishing sustainable health systems in partner countries, as well as the need for an efficient tracking mechanism of funds: even when funding is adequate, inefficiency can impede effectiveness; a 2006 World Bank report showed that about half of all health funds in certain sub-Saharan African countries never make it to frontline clinics and hospitals. Such issues increase the stakes involved in ensuring health aid effectiveness. Esser (2009) highlights the political reasons impeding aid effectiveness: priorities in global health are often set without evidence, and are threatened by inaction and financing problems even if they are. While it is impossible to quantify political obstacles that emerge in both donor and recipient countries, it is important to think of them as we discuss aid effectiveness in health and how certain issues can be overcome.

The size, complexity and use of health aid to fund recurrent costs in recipient country health systems, past experiences with inefficiency, and the looming reductions in aid spending in donor countries all point to the exceptional importance of assuring that aid to the health sector is used as efficiently as possible. Agreed in 2005 by over 100 donor and partner countries, and further endorsed in Accra in 2008, improved aid effectiveness is defined by the five principles of the "Paris Declaration" (OECD 2011a), which are intended to be the means to the end that is aid effectiveness:

- **Ownership** by partner countries on coordinating development actions
- **Alignment** between donor and partner countries on national development priorities and institutions
- **Harmonization** between donors
- **Managing** for results and improving decision-making based on results
- **Mutual accountability** for both donors and partners for development results

Within this framework, the OECD has identified "health [as] a litmus test for broader aid effectiveness efforts," choosing health as a "tracer sector" to track progress and obstacles (OECD 2011b). Each Paris principle is associated with one or several performance measures and targets; however, in 2010, only one of fifteen general aid effectiveness targets was met, namely coordinated support between donors (OECD 2011a). Donors have not met other commitments, including having an operational development strategy, reliable procurement systems or mutual accountability frameworks.

The recently released OECD report on health as a tracer sector finds that –unlike overall aid performance- there have been significant achievements. The sector has created the Health Systems Funding Platform to harmonize assessments and coordinate activities and funding in focus countries (see Glassman and Savedoff 2011) and has launched a non-governmental effort to track implementation of the Paris agenda called IHP+ Results (see Box 1). Similarly, the "Harmonization for Health in Africa" initiative, involving AfDF, UNAIDS, UNFPA, UNICEF, WHO and the World Bank, provides technical support and capacity building to various African countries, working with existing instruments such as budget support and SWAPs (Dodd et al 2007). Some of the innovative financing mechanisms used in the sector, such as the International Finance Facility for Immunization and the Advanced Market Commitment, have increased the predictability of funding for the GAVI Alliance.

Box 1. IHP+ Results

The closest evaluation of aid effectiveness in health sector that goes beyond disbursement amounts is the International Health Partnership Results Survey (IHP+ Results). We include IHP+ membership as an indicator in our index, but IHP+ Results goes beyond membership into IHP+ by surveying donor and partner government practices and tracking their progress on aid effectiveness. Fifteen bilateral/multilateral donors and ten partner countries participate in the IHP+ Results process, which hopes to streamline the health aid process by rating donor performance in each recipient country setting. The questionnaire includes questions on technical cooperation, usage of program-based approaches, avoidance of parallel project implementation units, the presence of a single national performance assessment framework, support to civil

box 1 continued

society organizations, dialogue between recipients and donors, as well as predictability of aid and amount of general budget support. The principal goal of this process is to strengthen mutual accountability between donor and partner governments. Donors answer this question based on their operations at partner countries which have signed the compact; which limits the scope of this survey.

The following are measured in the IHP+ Results survey:

- Partner has signed IHP+ country compact
- Aid recorded on national health budgets
- Health systems strengthening support
- Program-based approaches
- Aid that is provided through multi-year commitments
- Aid that is disbursed in adherence to schedule
- Aid that uses country procurement systems

Yet aside from these global initiatives, to date, the evidence on progress is limited, case-based and qualitative. Building on the IHP+ Results survey of 15 donors and 10 recipients, the OECD report finds that "aid effectiveness appears to be correlated with increased coverage and utilization of essential services, improved service delivery and health outcomes in some countries." Various case studies conducted in Malawi, Nepal and Tanzania, sector-wide approaches (SWAp) to coordinate donors are said to have contributed to an increase in the quality and quantity of service providers. Mozambique, Rwanda, South Africa, Tanzania and Mali have all seen improvements attributed in part to more coordinated and holistic approaches, which are thought to decrease the deadweight loss of aid and increase public expenditure within recipient countries, as well as improved sector coordination and oversight. In Mali, for example, there has been increased dialogue between government and donors on country systems, and Mali has strengthened its policy, budget planning capacities, and strengthened its institutions (Dickinson 2011). Use of a health sector SWAp was concurrent with a 31% decline in infant mortality in Tanzania from 1999-2005 (Zinnen 2011). In addition to SWAps, joint assistance strategies are said to improve harmonization and coordination in Tanzania, Zambia and Uganda (DANIDA 2005).[3] It is important to note that these case studies – and many others we have reviewed in the appendix – merely point out to correlations, and it is harder to define a cause-effect relationship between aid effectiveness and results in health.

Case-based information from the OECD suggests persistent problems in aid predictability, heavy bureaucracy and excessive dependence on process with a lack of focus on impact. More worrying, at the macro level, Wilson (2011) and Williamson (2008) find, with the exception of aid for infectious diseases, that even after controlling for income and

[3] For a list and summary of relevant health aid effectiveness literature, see Appendix 3.

governance quality, overall health aid actually has no effect on reducing mortality. Health aid tends to follow improvements in health outcomes instead of contributing to them. This is partly due to the lack of allocative efficiency: Esser and Bench (2011) point out to the gap between the distribution of disease burden and health aid, finding that there is weak correlation between the responsiveness of DAH to national disease burdens.

Results-based financing methods, such as cash-on-delivery or performance-based funding, where funding is contingent on the achievement of certain goals, are increasingly gaining prominence, although are far from being the norm. Cash on Delivery (COD) Aid, which is a method of results-based financing as defined by Savedoff and Martel (2011), incorporates paying for outcomes, hands-off funders, transparency through public dissemination, and independent verification of results. Implementing COD Aid in health would be feasible towards certain indicators, given the possibility of setting benchmarks, such as decreases in child/maternal mortality, reducing low birth weight and sustained HIV/AIDS treatment.

Another way to improve allocative efficiency would be to increase partner country ownership: as locals would have a better perspective of how to allocate global health funding as opposed to top-down directives from donors. In 2008, The Accra Agenda for Action has introduced country ownership as a crucial component of aid effectiveness efforts, and various studies (Sridhar 2009) have pointed out to how country ownership can increase aid effectiveness; through mechanisms that hold donors accountable, strengthening national leadership in health and fostering South-South collaboration. Yet, to date, there has not been much progress in the area, highlighting both the difficulty of changing aid practices as well as increasing donor accountability.

Box 2. Fungibility in Health Aid

Fungibility is one of the most discussed issues in aid: donors want their spending to leverage, not displace, public expenditure. A study by Lu et al (2010) finds that while health financing by the government in developing countries has increased by 100%, on average, from 1995-2006, it actually decreased in many sub-Saharan African countries that are aid dependent. DAH was shown to reduce domestic government health spending by $0.43 to $1.14 for every $1 of DAH – implying that fungibility might indeed be decreasing aid effectiveness, and that there should be more monitoring of such expenditures. In the Abuja Declaration of 2001, African leaders pledged to spend 15% of their annual budget on health, although currently many African countries are far from achieving this target both in terms of per capita spending and the percentage of (IHP+ Results 2011), which shows the importance of this problem.

While we wanted to measure or track fungibility in health aid, we did not choose to do so for various reasons. First, fungibility is not necessarily a good or bad thing; if the partner country is receiving funds to allocate to combating infectious disease, for example, it makes sense that they allocate fewer resources to this area, which would decrease health spending financed by the government. Second, the opposite of

box 2 continued

fungibility, which is defined as additionality, might be taking place: health aid received by governments might be leveraging further investment in health. Third, if recipient countries reach the optimal level of funding from donors, they could possibly invest in other sectors, such as infrastructure or education.

The issue of fungibility makes the issue of capacity strengthening even more important – since governments are not spending the money on where they are "supposed to," strengthening the absorptive capacity of national health systems would be crucial. This also ties into the issue of "leverage", such that the marginal benefit introduced by $1 of aid could be higher than $1 (Lane and Glassman, 2007).

The absence of systematic, quantitative analysis of existing OECD data on aid effectiveness is a limitation of the tracer sector effort. While it will not help to establish the relationship between many aid effectiveness measures and health impact, in this paper, we address the absence of quantitative, comparable analyses of internationally accepted principles of principles of aid effectiveness (such as the Paris survey indicators), adapting and expanding the Quality of Official Development Assistance (QuODA) index (Birdsall and Kharas 2010) to health aid. Basing our analysis on the OECD's 2008 and 2009 Creditor Reporting System (CRS), we measure aid effectiveness in health across 4 dimensions and 23 indicators, and rank donors in each dimension. We compare our results with the overall QuODA, and look at changes from 2008 to 2009.

The paper is organized in four sections. After this introductory section, a second section discusses the QuODA methodology, defines key terms as well as the scope of the data used to rank donors on each measure. Section 3 describes each dimension, indicator and overall results.

Table 1: Donors included in our analysis, by size and scope: 2008 and 2009

Donor	2008 Health ODA (Current US$ millions)	2009 Health ODA (Current US$ millions)	Change (%)	Number of projects (2008)	Number of projects (2009)	Number of Health Aid Recipients (2008)	Number of Health Aid Recipients (2009)	Number of Agencies that Distribute Health ODA(2009)
Austria	13.55176	10.7514	-0.207	183	190	59	70	9
Belgium	120.3199	128.0485	0.064	314	354	53	53	6
Denmark	95.65341	129.3263	0.352	108	114	39	37	1
France	120.7014	153.2671	0.270	277	383	83	85	5
Germany	382.7183	397.6625	0.039	852	896	93	90	5
Italy	121.02	103.042	-0.149	653	546	100	91	4
Netherlands	272.851	212.8524	-0.220	168	133	44	31	1
Norway	143.3354	133.1082	-0.071	372	376	69	69	4
Portugal	7.948526	9.268216	0.166	30	68	8	10	3
Sweden	236.8573	172.9392	-0.270	803	699	110	104	2
Switzerland	52.7184	58.71447	0.114	262	248	48	67	4
United Kingdom	851.6644	798.2772	-0.063	324	338	56	56	3
Finland	33.83836	30.71009	-0.092	192	198	58	59	1
Ireland	146.9715	117.7925	-0.199	572	376	64	51	1
Luxembourg	56.86786	46.71642	-0.179	221	211	50	47	1
Greece	13.39914	17.36406	0.296	54	79	35	40	5
Spain	362.2661	296.0273	-0.183	1121	1258	92	89	8
Canada	370.8005	435.2789	0.174	438	3613	77	134	3
USA	3683.507	4227.646	0.148	6112	6699	116	122	11
Japan	338.3695	341.7561	0.010	591	1040	137	130	5
Korea	56.57429	89.29179	0.578	529	462	66	60	4
Australia	202.6612	201.8319	-0.004	666	1198	41	68	1
New Zealand	19.08959	17.67763	-0.074	72	67	18	19	1
IDA	993.1146	1214.4	0.223	1678	1673	86	85	1
IDB Special	0	22.22131	N/A	0	56	0	20	1
AfDF	111.8177	104.3238	-0.067	56	41	27	26	1
EC	618.0073	559.8665	-0.094	601	795	111	109	2
GAVI	623.7839	367.4021	-0.411	465	409	70	72	1
GFATM	2171.631	2336.844	0.076	471	442	110	99	1
UN (Select Agencies)	475.1813	637.1831	0.341	4585	4938	133	137	5
TOTAL	12,697	13,372	0.053	22,770	27,900			

Source: OECD CRS (2008,2009)

The QuODA Methodology

Many analysts have worked to quantify aid effectiveness. CGD's Commitment to Development Index (Roodman 2010) includes measures of aid quantity and quality (share of tied aid, allocation to poorly governed states, fragmentation, among others) that is combined with other measures of donor country policy that affect well-being in low- and middle-income countries. Knack, Rogers and Eubank (2011) create an index that measures donor selectivity, alignment, harmonization and specialization. Before these recent efforts, Easterly and Pfutze (2008) characterized the ideal four dimensions of an aid agency, and Collier and Dollar (2002) looked at how aid could maximize poverty reduction.

Using 2008 OECD data, Birdsall and Kharas built on these earlier efforts and created QuODA in 2010, an index composed of four dimensions (efficiency, institutions, burden, transparency/learning) which correspond to the Paris Declaration principles. In this paper, we adapt these dimensions to the health sector.

The **Maximizing Efficiency (ME)** dimension corresponds to the "results" principle of the Paris Declaration, conceptually measuring the "development bang for the buck" of donors. More efficient allocation and spending could increase the value of aid; Collier and Dollar (2002) show that if aid were allocated more efficiently, it would lift 80 million people out of poverty instead 30 million. Similarly, as noted in Part 1, efficient health aid –funding the "right things" efficiently and at scale –has been shown to make a significant difference for health status.

The **Fostering Institutions (FI)** dimension attempts to measure donor support to strengthened institutions in partner countries, corresponding with the "ownership" dimension of the Paris Declaration. Birdsall and Kharas argue that stronger recipient country institutions may increase ownership, defined by the OECD as "effective leadership over development policies and strategies." This perspective is borne out, albeit by a sparse literature; Acemoglu, Johnson and Robinson (2001), for example, find that differences in institutional quality account for a significant portion of developmental differences between countries. Further, there is evidence that aid can weaken institutions; Knack and Rahman (2004) find that higher aid levels reduce institutional quality.

The **Reducing Burden (RB)** dimension rewards donors that minimize bureaucratic requirements for partner countries. In 2009, there were 27,900 health projects, each associated with transaction costs. The OECD states that the deadweight losses associated with various redundant aid missions may be as high as $5 billion (Killen and Rogerson 2010). This is particularly important in health; aid recipient countries tend to have low technical and administrative capacity, and excessive fragmentation further leads to the deterioration and overstretching of these resources. Consolidation of administrative processes would make health aid more efficient, and divert resources from bureaucracy to improving health outcomes.

Finally, the **Transparency and Learning (TL)** dimension measures the possibility of "mutual accountability" by assessing whether the data and analysis necessary to determine whether commitments and results are genuine is publicly available. Transparency can be a cost-efficient way of increasing the value of aid indirectly: both donors and recipients often lack access to complete information, and are forced to allocate their budgets in this context. Increased transparency can reduce unpredictability, improve coordination, increase public support, increase accountability, and reduce diversion of resources to other uses; all of which can make aid more effective (Moon and Williamson 2010; Collin et al 2009). Despite evidence of the benefits of transparency, data are scarce; while progress on transparency and evaluation is hard to quantify, we try to make best usage of data available to us. Initiatives such as International Aid Transparency Initiative (IATI) and Publish What You Fund have signed up donors to standardize and publish more of their data, regarding aid delivery, while the International Initiative for Impact Evaluations (3iE) promotes and facilitates the rigorous evaluation of development results.

Within each dimension, Birdsall and Kharas (2010) use three criteria to select indicators that express performance in that dimension of aid effectiveness: indicators that are intrinsic goods, indicators that are proxies for important factors but that are not directly observable, and indicators that are inputs into a desirable outcome. All of these indicators aim to measure the *quality* rather than the quantity of aid. In the application of QuODA to health, we maintain as many of the original indicators as possible, while omitting some for lack of sector-specific data and including others in order to better reflect aid effectiveness in the sector itself. A description and justification of each dimension is provided in the following section, and detailed methodology for each indicator is provided in the appendix, as well as relevant literature justifying the inclusion of each indicator.

QuODA calculates a "raw score" for each indicator for each donor country/organization, and then transforms these raw scores into a standardized normal variable with the mean equal to zero and the variance equal to one.[4] The average of these standardized scores across all indicators within that dimension generates the score of that donor in that dimension. The score measures how many standard deviations the country or agency is from the mean value: hence, the relative success (or failure) of each donor. We adopt this approach without modification in health: looking at rankings through different dimensions underlines the relative strengths and weakness of each donor.

QuODA weights all indicators equally within each dimension. There are various reasons for this: first, the relative "importance" of the different dimensions is not evident; making it impossible to, for example, value maximizing efficiency indicators higher than reducing burden indicators, or vice versa. Second, correlations between individual indicators are fairly low, implying that there is no "double counting", or using indicators that measure the same thing. We maintain this approach in the application to health.

[4] The methodology for the calculation of each raw score is described in Appendix 1.

Finally, we calculate an overall rank for every donor using equal weights, but we advise donors and readers to pay more attention to rankings within every dimension instead of this overall rank, given reasons discussed in the results section.

Data and Terminology

With a few exceptions mentioned in the appendix, data sources for indicators are drawn mainly from the 2009 Creditor Reporting System (CRS) aggregated by the OECD Development Assistance Committee (DAC). The CRS includes data on commitments and disbursements for DAC member countries, as well as multilaterals such as the GAVI, Global Fund, United Nations agencies, Development Banks, and the European Commission. In our analyses, we further aggregate five United Nations agencies: UNDP, UNICEF, WFP, UNAIDS and UNFPA, and analyze them together, given the fact that these agencies have small sizes and scopes by themselves, and often collaborate together in different health projects.

Grepin et al (2011) outline the various challenges and difficulties in tracking DAH. While it is possible to look into aggregate flows for non-DAC donors and private foundations, it is not possible to look into further detail of these flows, which makes it impossible for us to include in our analysis. IHME (2011) has one of the most comprehensive DAH databases, and they calculate DAH in 2009 to be $25.69b. Excluding private foundations, as well as dropping projects with insufficient reporting, we obtain the values in table 1.

For the context of this paper, Official Development Assistance (ODA) is defined as "flows to countries and territories on the DAC List of ODA Recipients and to multilateral development institutions which are provided by official agencies, including state and local governments, or by their executive agencies, and each transaction of which is administered with the promotion of the economic development and welfare of developing countries as its main objectives; and is concessional in character and conveys a grant element of at least 25%; calculated at a rate of discount of 10%." (OECD 2008) This definition of ODA implies that the large philanthropic and private contributions to global health described in the IHME report are not included for the purposes of this analysis, and their absence represents an important shortcoming. Based on this definition of general ODA, Official Development Assistance in Health (DAH) is the portion of ODA with the purposes described in table 2.

Another key concept is Gross Country Programmable Aid (CPA). CPA is the component of ODA that goes directly into specific country programs – thus, it is ODA minus contributions to multilateral organizations, emergency nonfood humanitarian aid, development food aid and debt relief (OECD 2008). The CPA is what QuODA's authors describe as "what remains for development programs." However, for health aid purposes, all ODA is classified as CPA, since ODA that falls under health purposes does not include aid

to multilateral organizations, development food aid, humanitarian aid (nonfood) or debt relief.

For several indicators, following Birdsall and Kharas (2010), we use an even stricter definition of CPA (sCPA) that further subtracts technical cooperation and donor interest received from CPA (OECD 2008). This stricter definition best reflects the budgetary contribution available to the recipient (Roodman 2006; Kharas 2007).

All analyses were performed using Stata 12, and our data and program files can be downloaded from our website. We report standard errors for each indicator, and post our raw scores online.

Table 2: Health Aid Projects Divided by Purpose, 2008-2009

Purpose Code	Purpose Name	2008	2009	Change
12110	Health policy & administrative management	2,062	2,969	0.44
12181	Medical education/training	315	364	0.16
12182	Medical research	235	509	1.17
12191	Medical services	823	864	0.05
12220	Basic health care	3,105	3,755	0.21
12230	Basic health infrastructure	713	787	0.10
12240	Basic nutrition	804	1,344	0.67
12250	Infectious disease control	1312	1,575	0.20
12261	Health education	342	626	0.83
12262	Malaria control	857	946	0.10
12263	Tuberculosis control	565	647	0.15
12281	Health personnel development	501	591	0.18
13010	Population policy & administrative management	1660	1,724	0.04
13020	Reproductive health care	2,569	2,979	0.16
13030	Family planning	797	1,069	0.34
13040	STD control including HIV/AIDS	5,634	6,538	0.16
13081	Personnel development: population & reproductive health	41	127	2.10
16064	Social mitigation of HIV/AIDS	435	486	0.12
	Total number of health projects	22,770	27,900	0.23

Source: CRS (2008, 2009)

Dimensions and Results

Although every effort was made to remain consistent with overall QuODA to permit comparisons between donors across indicators, the availability of health-specific data has limited the number of common indicators. As a result, while the Original QuODA has 31 indicators, the effort as applied to health includes 23 (see table 3). In this section, we

describe our dimensions and talk about overall results – best and worst performers within each indicator can be found in Appendix 1, as well as relevant tables posted online.

Table 3: Indicators, overall QuODA versus health QuODA

	Overall QuODA	Health QuODA
Maximizing Efficiency	Share of allocation to poor countries	Share of allocation to poor countries
	Share of allocation to well-governed countries	Share of allocation to countries with high disease burden
	Low administrative unit costs	Share of allocation to well-governed countries
	High country programmable aid share	High strict country programmable aid share
	Focus/Specialization by recipient country	Focus/Specialization by recipient country
	Focus/Specialization by sector	Support of select global public good facilities
	Support of select global public good facilities	Share of untied aid
	Share of untied aid	
Fostering Institutions	Share of aid to recipients' top development priorities	Share of allocation to countries with National Health Plans
	Avoidance of Project Implementation Units	Support to essential health metrics
	Share of aid recorded in recipient budgets	
	Share of aid to partners with good operational strategies	
	Use of recipient country systems	
	Coordination of technical cooperation	
	Share of scheduled aid recorded as received by recipients	
	Coverage of forward spending plans/Aid predictability	
Reducing Burden	Significance of aid relationships	Significance of aid relationships
	Fragmentation across donor agencies	Fragmentation across donor agencies
	Median Project Size	Median Project Size
	Contribution to multilaterals	Member of IHP+
	Coordinated missions	Share of aid through multilateral channels
	Coordinated analytical work	
	Use of programmatic aid	
Transparency and Learning	Member of IATI	Member of IATI
	Implementation of international data reporting standards	Implementation of international data reporting standards
	Recording of project title and descriptions	Member of 3iE
	Detail of project description (log)	Recording of project title and descriptions
	Reporting of aid delivery channel	Detail of project description (log)
	Completeness of project-level commitment data	Reporting of aid delivery channel
	Quality of Evaluation policy	Completeness of project-level commitment data
	Aid to partners with good M&E frameworks	Quality of Evaluation policy
		Aid to partners with good M&E frameworks

Dimension 1: Maximizing Efficiency

Within the ME dimension, we include seven indicators that measure three different perspectives on health aid efficiency – allocative efficiency, transaction costs and global public goods.

Indicators 1-4 are focused on allocative efficiency issues – the extent to which health aid is allocated so as to –conceptually – maximize impact on health: share of allocation to poor countries, share of allocation to countries with high disease burdens, focus and specialization by recipient country and share of allocation to well-governed countries. The main goal of aid is to increase outcomes in developing countries; it is, however, not possible to link health outcomes directly to aid given data constraints: various studies (Esser and Bench 2011; IHME 2011) demonstrate the gap between need and the flow of money towards specific diseases. The gap between the two, as well as data constraints, makes it impossible to track

how a dollar of aid translates into health outcomes: hence, this indicator does not determine an optimally health maximizing allocation (and how far each donor is from that allocation). Rather, this indicator tracks the extent to which aid tracks need, or potential gains.

There are many reasons why aid might not or should not track need or potential gains; for example, because aid is allocated based on political, military or other rationale, because a funding agency may be restricted to working in regions with a large number of small countries (the Caribbean, see Acharya et al 2006) or because average needs may obscure important inequalities in less needy countries. Further, to some extent, these simplistic allocation rules used by most global health funders fail to acknowledge the complex set of factors that transforms efficiency into effectiveness. It is not only that funds are invested in the "right" countries, but also that they come in the "right" amounts with the "right" incentives. Another factor possibly decreasing the bang for the buck of health aid is working in countries with poor governance (fragile states), on which there is conflicting evidence (see appendix, ME4).

Indicators 5-6 are focused on measuring the extent to which donor provide health by minimizing transaction costs: through increasing portions actually available to country budgets and through untied funding. Finally, indicator 7 measures the extent of donor support to global public goods.

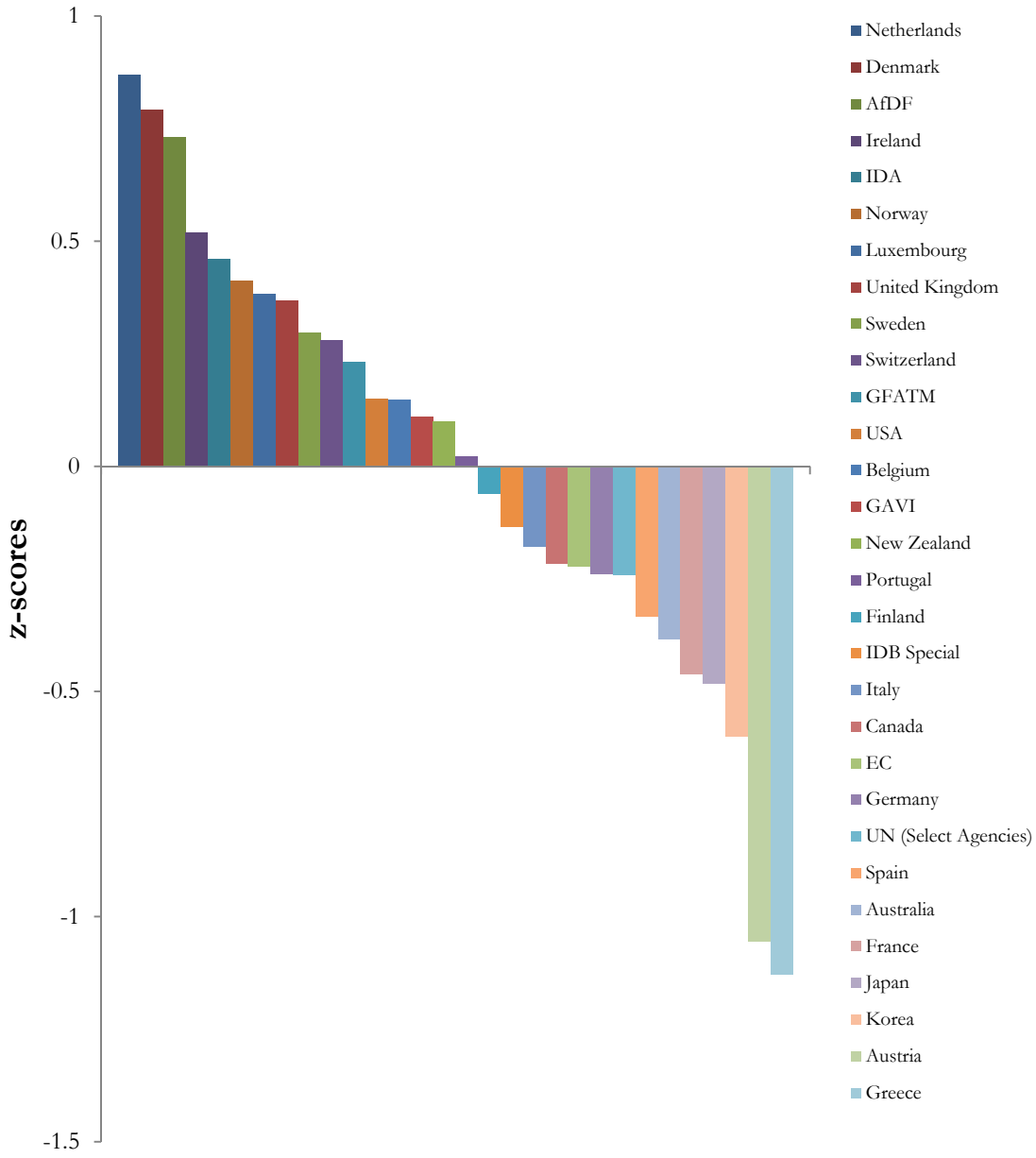
As described in part 2, the indicators are combined in an unweighted average index and donor countries are ranked in figure 4.

Our indicators for the Maximizing Efficiency dimension are:

1. Share of allocation to poor countries
2. Share of allocation to countries with high disease burden
3. Share of allocation to well-governed countries
4. High strict country programmable aid share
5. Focus/Specialization by recipient country
6. Share of untied aid
7. Support of select global public good facilities

We find that the Netherlands, Denmark and AfDF fare best in this category. Korea, Austria and Greece rank last.

Figure 4: Rankings on maximizing efficiency



Box 3: Share of aid that has gender equality as an objective

Many of the world's developing countries face with a tremendous inequality between men and women, and this manifests itself in health outcomes. There have been many to address this issue by various international organizations, and certain countries have implemented policies that seek to close the gap in health outcomes between men and women. In 2009, the Center for Global Development published a report on "Start with a Girl," which focused on the risks faced by adolescent girls and the feasibility of investing in their health: girls' health outcomes have tremendous implications on their access to education and employment, and they translate on the next generation's well-being.

Certain challenges remain, such as maternal health, prevention of HIV, child marriage/early childbearing, exploitation and barriers in access to healthcare. Some of these have been surmountable with policy reforms such as demand-side incentives or strengthening health systems, whereas some have been very hard to overcome, which further necessitates the concentration of health aid to sustain gender equality: service delivery and institutional quality is still a major problem, and many countries with high HIV prevalence rates are seeing disproportionally higher increased mortality for women (World Bank 2011). Furthermore, it is not only a question of increased income translating to better health outcomes: a World Bank report on gender points out that in low- and middle-income countries between 1990 and 2008, income growth did not reduce excess female mortality, which is largely due to girls who go missing in India and China every year, as well as access to health institutions which disproportionately affect women and translate as excess female mortality in early childhood.

Given this, we have developed an indicator that looks into share of a donor's allocation to health projects that explicitly state gender equality as an objective. Multilaterals such as IDA, UN, AfDF, GAVI and Global Fund are excluded from this category due to incomplete data. We find that Sweden, Germany and Belgium perform well in this category, with 98% of Sweden's health aid going into projects that explicitly state gender equality as a priority. On average, 41% of aid projects target gender equality, up from 35% in 2008 (see table A.12 in appendix). We do not include this indicator in any of our dimensions, although it fits in with the discussion of maximizing efficiency given purposes of need, as well as equity.

Analysis based on: (Aid with reported gender objective)$_d$ / grossCPA$_d$

Dimension 2: Fostering Institutions

In this dimension, we have no overlap between the overall QuODA and health QuODA, due to the lack of data availability. Ideally, we would have preferred to include variables that track civil society organizations, budget support by each donor, avoidance of project implementation units, coordination of technical cooperation, as well as predictability: yet the Paris Declaration survey, which tracks these measures, does not have sector-specific data.

In our re-population of the FI dimension, we include measures that reflect donor support to national institutions that are thought to improve country ownership, including support to countries with WHO-recommended national health plans and support to essential health metrics. The small number of indicators in this dimension perhaps unfairly under-emphasizes the importance of institutions to development effectiveness in health, but maintaining the dimension will allow for additional and improved indicators to be developed in subsequent estimations.

Our Fostering Institutions dimension consists of two indicators:

1. Share of aid to countries with national health plans

2. Support to essential health metrics

IDB, Norway and Finland fare best in this category, while the Netherlands, Spain and Korea rank in the bottom.

Box 4. Volatility in health aid: Can we quantify it?

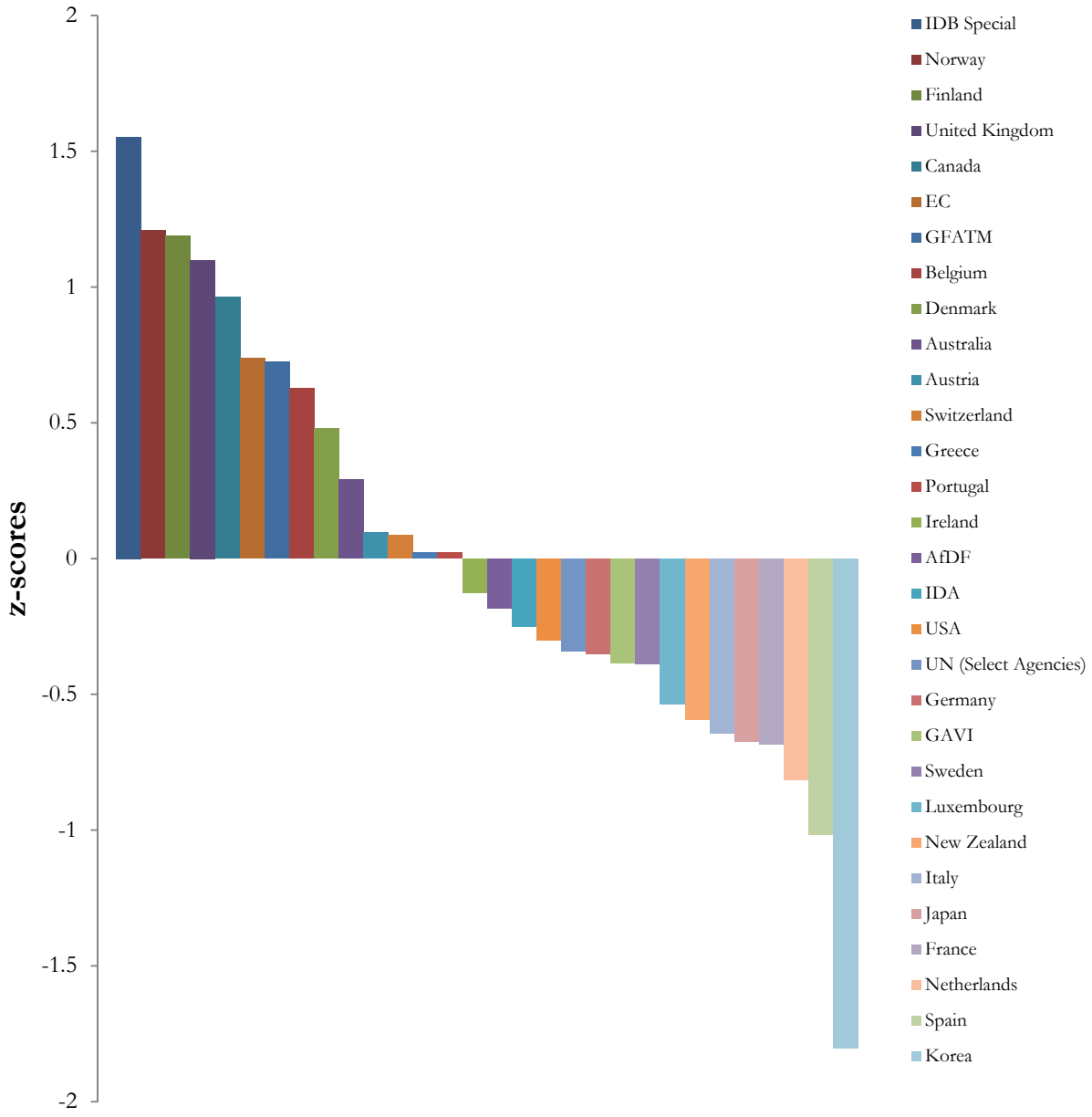
Another possible measure of support to fostering institutions and/or improved efficiency in health aid is the volatility of health aid disbursements.

Aid is increasingly becoming an important source of health funding in low-income countries: in 2000, aid constituted 12% of health expenditures, whereas in 2006 it constituted 17% (Lane and Glassman 2007). Volatile aid, according to Kharas, "worsens public financing, shifts government expenditures from investment to consumption and exacerbates business cycles, among other things." Aid volatility is the principal contributor to the damage current foreign aid system has generated, which, since 1970, generated the same income shock to developing countries that two world wars and the Great Depression, combined, did to richer countries (Kharas 2008).

Homi Kharas at Brookings estimates the cost of volatility to be US$16 billion, which amounts to 15-20% of total global aid, and translates to a 1.9% potential GDP loss to recipients. An analysis by Lane and Glassman shows that volatility of health aid is high in most aid-dependent countries, and the fact that aid is more volatile than government spending on health is a problem, especially in fragile states. Hence, decreased volatility would ideally contribute to fostering institutions in recipient countries.

In our analysis of health aid data from 2005 to 2009, where we use a Hodrick-Prescott Filter, we find that almost all donors have scaled up their health aid in this period for every recipient, resulting in mainly positive shocks. We therefore omit volatility as a contributor to poor quality. However, as aid plateaus or declines in coming years, volatility should be revisited.

Figure 5: Rankings on fostering institutions



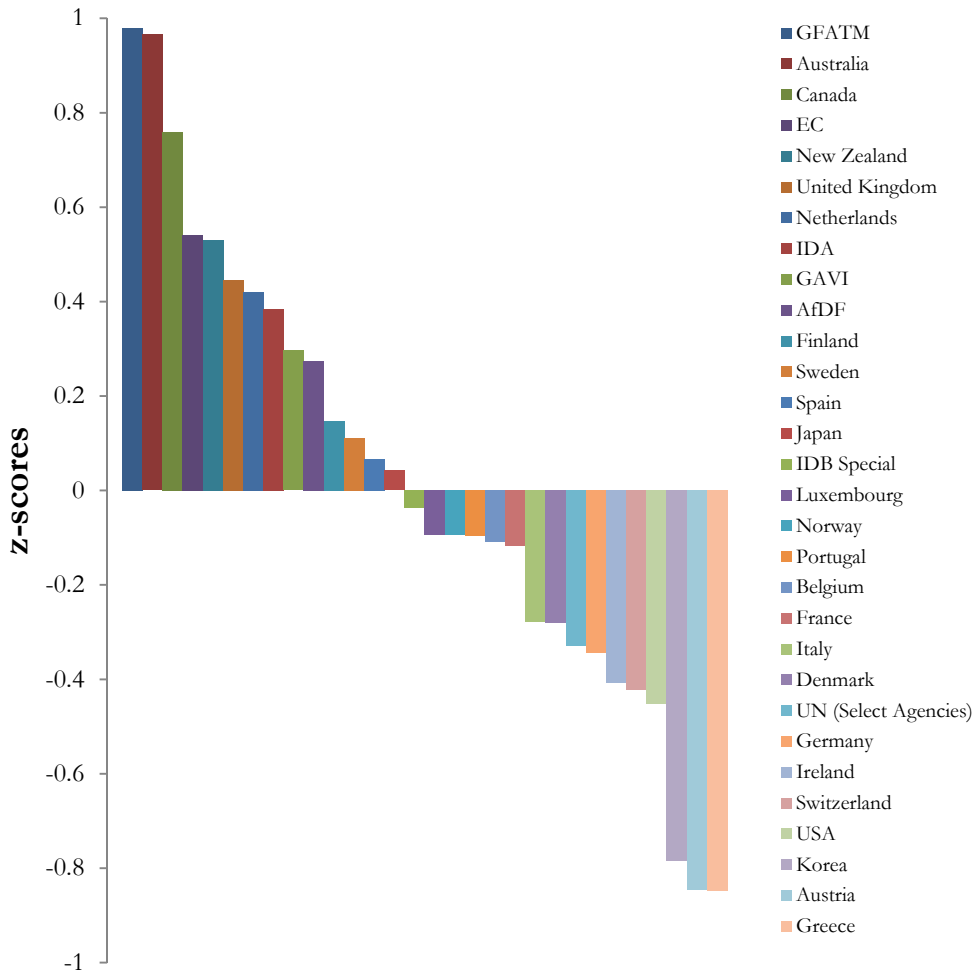
Dimension 3: Reducing Burden

This dimension uses four indicators from original QuODA that measure the significance of aid relationships, fragmentation associated with multiple same-country donor agencies in a single recipient country, median project size and share of aid through multilateral channels. We add an indicator reflecting donor country membership in the International Health Partnership Plus, an initiative intended to harmonize planning and funding in aid-dependent countries. Our Reducing Burden dimension has 5 indicators:

1. Significance of aid relationships
2. Fragmentation across donor agencies
3. Median project size
4. Member of IHP+
5. Share of aid through multilateral channels

Overall, we find that the Global Fund, Australia and Canada perform best in this indicator. South Korea, Austria and Greece rank last. It is important to note that GAVI and the Global Fund, both multilaterals with the main goal of reducing burden on recipients, fare above average in this category.

Figure 6: Rankings on reducing burden



Dimension 4: Transparency and Learning

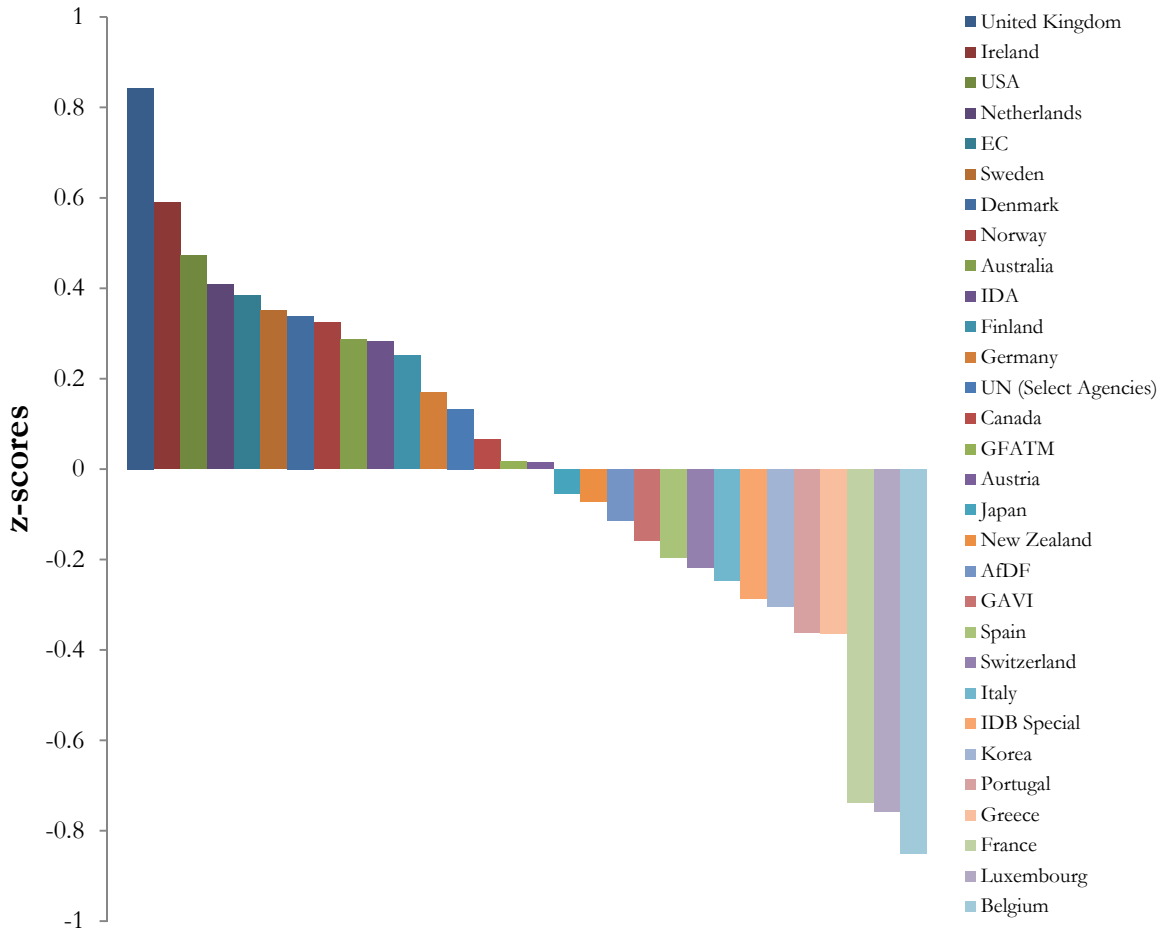
In this dimension, we evaluate how open donors are in their reporting to the CRS, as well as their commitment to various other international initiatives on expenditure transparency, such as the International Aid Transparency Initiative (IATI). We keep all the indicators from original QuODA, and add membership to the International Initiative for Impact Evaluations (3iE) as a measure of donor commitments to rigorous impact evaluations, which are crucial in health.

We find that the United Kingdom, Ireland and the United States perform best in this category. France, Luxembourg and Belgium are the most opaque in their reporting to the OECD Credit Reporting System database.

Our indicators in the Transparency and Learning indicator are:

1. Member of IATI
2. Implementation of international data reporting standards
3. Member of 3iE
4. Recording of project title and descriptions
5. Detail of project description
6. Reporting of aid delivery channel
7. Completeness of project-level commitment data
8. Quality of evaluation policy
9. Aid to partners with good M&E frameworks

Figure 7: Rankings on transparency and learning



Discussion of Results

In the previous section, we outlined our indicators and best/worst performers within each dimension. Here, we discuss changes from 2008 to 2009, compare health aid effectiveness to overall aid effectiveness, and introduce a brief discussion of health aid effectiveness in aid-dependent countries.

2008 versus 2009, across health indicators

While our analysis above has focused on 2009 numbers, we also calculated 2008 values for each of our indicators to see how rankings have changed from 2008 to 2009 (see table A9 for 2008 rankings, table A10 for 2009 rankings, and see table A11 for change between 2008 and 2009). We also report means for both 2008 and 2009 for every indicator (see table A2). It is important here to note that if a donor's ranking went down, it could be because their performance got worse, or, others' performance improved relatively. For overall trends, we compare the averages of our raw scores.

A summary of the changes are below:

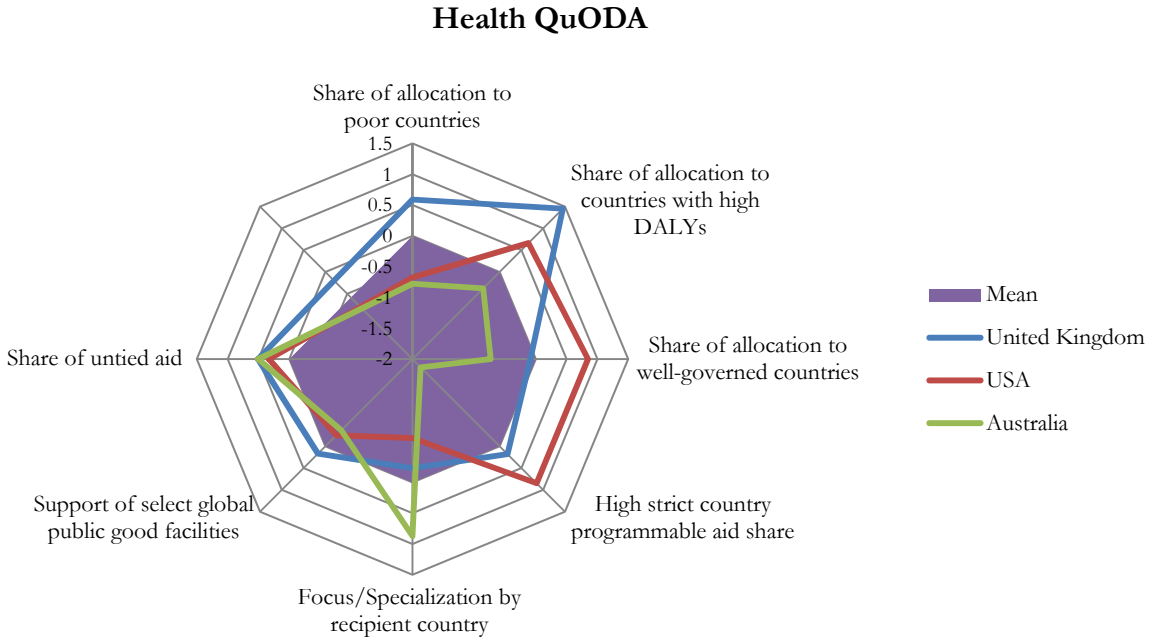
- Maximizing Efficiency: Compared to 2008, allocative efficiency indicators (ME1-2-3) have worsened in 2009 as donors, on average, have regressed in their share of allocation to poor countries, share of allocation to countries with high DALYs and share of allocation to well-governed countries. There were modest improvements in donors' share of strict country programmable aid, focus by recipient country, support of select global public good facilities and share of untied aid.
- Fostering Institutions: In 2009, donors allocated more to countries with stronger national health plans, and supported more projects that seek to gather essential health metrics.
- Reducing Burden: Aid relationships became more significant from 2008 to 2009, but fragmentation across donor agencies increased. This was further followed by a decrease in median project size. All of this point out to the fact that as health aid is becoming more complex and fragmented, as many qualitative case studies point to: decreased alignment and donor proliferation seems to have an adverse effect as health aid continues to increase.
- Transparency and Learning: While donors have reported more project titles, descriptions and channels, they gave less aid to partners with good M&E frameworks, and did a worse job reporting their commitments to the DAC website. The details of project descriptions also decreased from 2008 to 2009.

When we look at overall rankings, calculated by taking the average of every indicator, we see that there haven't been many changes in rankings from 2008 to 2009, except for Belgium, which has dropped down 10 places, and Australia, which went up 11 places (see table 4).[5]

However, we believe it is better to look at rankings within every dimension instead of the overall ranking while comparing 2008 to 2009 as well as rankings within individual years: different rankings for each dimension lets us demonstrate the relative strengths and weakness of each donor.

[5] As we have discussed before, we present an overall ranking as opposed to original QuODA, and the main reason is what due to data constraints, we have less balanced dimensions then original QuODA does: our fostering institutions dimension, for example, only contains two indicators, and except for transparency and learning, all our dimensions have less indicators then original QuODA. While dimension rankings are useful in highlighting the various strengths and weaknesses of donors, we believe combining all indicators provides a holistic view of aid effectiveness in health. Readers can download our spreadsheet and construct averages with the weights they specify.

Figure 8. United Kingdom, USA and Australia across Maximizing Efficiency indicators

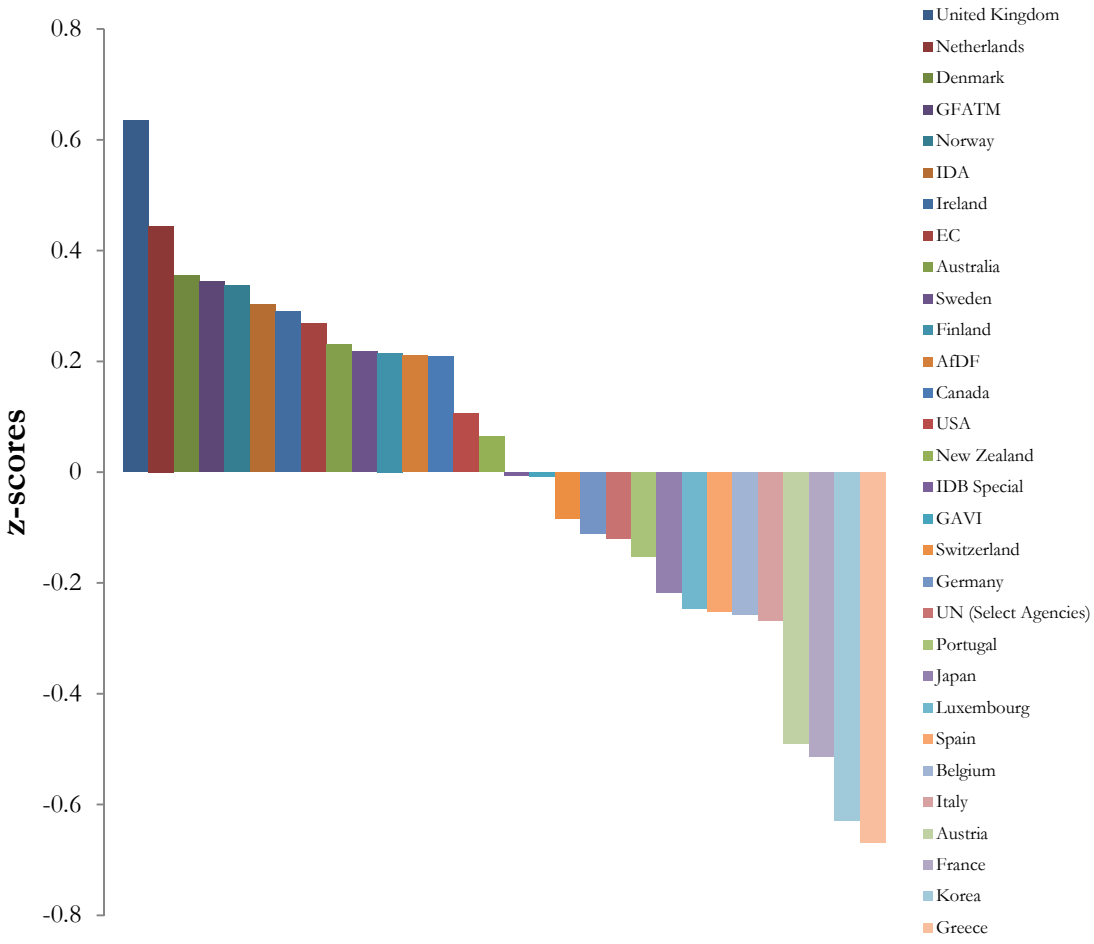


In figure 8, we look into the donor which ranks first in overall rankings (United Kingdom), largest donor (USA), and a donor with a rapidly growing aid program (Australia). We find that Australia scores below the mean in many indicators, but is focused by recipient country, and unties a majority of its aid. The United Kingdom performs above average in allocating according to need, untying aid and giving to global public goods. The United States is above average in terms of allocating according to disease burden, having a high strict CPA share, as well as untying its aid, but fares worse in terms of allocating to poor countries and focusing by recipient country.

Table 4. Overall Rankings, 2008-2009

	2008 z-score	2009 z-score	2008 Rank	2009 Rank	Change
Austria	-0.61183894	-0.49088	28	27	1
Belgium	0.015842391	-0.25662	15	25	-10
Denmark	0.277324894	0.354549	7	3	4
France	-0.4100727	-0.51376	26	28	-2
Germany	0.037573927	-0.11136	13	19	-6
Italy	-0.24041614	-0.26778	24	26	-2
Netherlands	0.516096033	0.444154	2	2	0
Norway	0.491405305	0.336577	3	5	-2
Portugal	-0.14762269	-0.15301	22	21	1
Sweden	0.14070407	0.218086	9	10	-1
Switzerland	-0.00169966	-0.08416	16	18	-2
United Kingdom	0.571281586	0.634368	1	1	0
Finland	0.078370597	0.214904	12	11	1
Ireland	0.293240218	0.289329	6	7	-1
Luxembourg	-0.10927453	-0.24675	19	23	-4
Greece	-0.31575803	-0.66831	25	30	-5
Spain	-0.02086698	-0.25215	17	24	-7
Canada	0.102491928	0.208154	11	13	-2
USA	-0.06405693	0.105603	18	14	4
Japan	-0.53963487	-0.21794	27	22	5
Korea	-0.64979185	-0.62946	29	29	0
Australia	-0.14384029	0.230298	20	9	11
New Zealand	-0.14965797	0.064921	23	15	8
IDA	0.435717856	0.303249	4	6	-2
IDB Special		-0.00732		16	
AfDF	0.128078683	0.209923	10	12	-2
EC	0.017875259	0.268779	14	8	6
GFATM	0.376800282	0.344303	5	4	1
GAVI	0.213205015	-0.00902	8	17	-9
UN (Select Agencies)	-0.14477654	-0.11959	21	20	1

Figure 9: Overall rankings, 2009



Overall QuODA versus Health QuODA, 2009

Table 5: Comparing donors across common indicators, overall versus health QuODA[6]

	QuODA	Rank	QuODAH	Rank	Change
Maximizing Efficiency, 2009					
Austria	-0.2647	23	-1.07439	30	-7
Belgium	-0.1475	19	0.078388	14	5
Denmark	0.1972	7	0.797818	2	5
France	0.069	10	-0.31681	21	-11
Germany	-0.8554	29	-0.47782	26	3
Italy	-0.0367	14	-0.22218	19	-5
Netherlands	-0.1057	17	0.943481	1	16
Norway	-0.2713	24	0.458066	6	18
Portugal	0.0391	11	0.334144	9	2
Sweden	-0.0396	15	0.31965	10	5
Switzerland	-0.1353	18	0.357566	8	10
United Kingdom	0.1791	8	0.18788	12	-4
Finland	-0.0192	13	-0.12642	18	-5
Ireland	0.342	5	0.506243	5	0
Luxembourg	0.1134	9	0.563188	4	5
Greece	-0.5621	26	-0.81851	29	-3
Spain	-0.3097	25	-0.32485	22	3
Canada	-0.2621	22	-0.33921	23	-1
USA	-0.7103	28	0.063729	16	12
Japan	0.0214	12	-0.63241	27	-15
Korea	-0.6455	27	-0.73004	28	-1
Australia	-0.2515	21	-0.38579	25	-4
New Zealand	0.2017	6	0.363273	7	-1
IDA	0.5277	4	0.307994	11	-7
IDB Special	0.5479	3	0.070886	15	-12
AfDF	1.1519	1	0.739097	3	-2
EC	-0.0723	16	-0.23805	20	-4
GFATM	0.5774	2	0.104035	13	-11
GAVI			-0.03537	17	
UN (Select Agencies)	-0.1776	20	-0.37858	24	-4

[6] Rankings in this section rely on average scores across indicators/dimensions that are only common in both original and health QuODA indexes.

	QuODA	Rank	QuODAH	Rank	Change
Reducing Burden, 2009					
Austria	0.0946	10	-0.75849	29	-19
Belgium	-0.1832	20	-0.3422	23	-3
Denmark	-0.0563	16	-0.04994	15	1
France	-0.1724	19	-0.35294	24	-5
Germany	-0.3458	22	-0.63476	27	-5
Italy	0.1718	8	-0.55281	25	-17
Netherlands	0.0019	13	0.318654	10	3
Norway	-0.5533	25	-0.32441	21	4
Portugal	0.3322	6	-0.32507	22	-16
Sweden	-0.0315	14	-0.06602	16	-2
Switzerland	-0.7013	27	-0.2272	19	8
United Kingdom	0.0583	11	0.350489	9	2
Finland	0.0087	12	-0.0214	14	-2
Ireland	-0.1594	18	-0.20862	18	0
Luxembourg	-0.0559	15	0.182752	11	4
Greece	-0.4828	23	-0.76142	30	-7
Spain	-0.4868	24	-0.12138	17	7
Canada	-0.2223	21	0.742858	5	16
USA	-0.7105	28	-0.26469	20	8
Japan	-0.1382	17	0.353239	7	10
Korea	-0.6551	26	-0.68132	28	-2
Australia	0.1639	9	1.001409	2	7
New Zealand	1.0037	1	0.962454	3	-2
IDA	0.9802	2	0.912352	4	-2
IDB Special	0.2428	7	0.351292	8	-1
AfDF	0.8463	3	0.091233	13	-10
EC	0.346	5	0.447319	6	-1
GFATM	0.5938	4	1.030607	1	3
GAVI			0.121235	12	
UN (Select Agencies)	-0.766	29	-0.57962	26	3
Transparency and Learning, 2009					
Austria	-0.3432	22	0.110229	15	7
Belgium	-0.9749	29	-0.86291	30	-1
Denmark	-0.1014	20	0.21956	11	9
France	-0.525	26	-0.73571	28	-2
Germany	0.0404	15	0.285035	8	7
Italy	-0.726	27	-0.18532	22	5
Netherlands	0.0107	16	0.297106	7	9
Norway	0.2065	10	0.202386	12	-2

	QuODA	Rank	QuODAH	Rank	Change
Portugal	-0.4994	25	-0.31218	24	1
Sweden	0.408	8	0.233639	10	-2
Switzerland	-0.0906	19	-0.15188	21	-2
United Kingdom	0.5659	5	0.787005	1	4
Finland	0.5816	4	0.375666	5	-1
Ireland	0.4541	7	0.50217	3	4
Luxembourg	-0.8712	28	-0.75882	29	-1
Greece	-0.3699	23	-0.31549	26	-3
Spain	-0.1146	21	-0.12744	20	1
Canada	0.0422	14	-0.08797	19	-5
USA	0.1505	12	0.369038	6	6
Japan	0.1191	13	0.031313	16	-3
Korea	-0.0356	18	-0.24913	23	-5
Australia	0.2232	9	0.160472	13	-4
New Zealand	0.1904	11	0.011375	17	-6
IDA	1.0215	1	0.430432	4	-3
IDB Special	-0.426	24	-0.51306	27	-3
AfDF	0.5481	6	-0.31495	25	-19
EC	0.6343	3	0.545457	2	1
GFATM	0.7966	2	0.126635	14	-12
GAVI			-0.07296	18	
UN (Select Agencies)	-0.0001	17	0.258846	9	8

We compare overall QuODA and health QuODA across common indicators, by looking at the means of raw indicators. We also correlate common indicators between overall and health QuODA 2009, finding that the highest correlation is between the transparency and learning indicators (0.7732), and the lowest correlation is between the maximizing and efficiency indicators (0.5491). (See correlation matrices, table A7.)

- **Maximizing Efficiency:** Health aid fares worse in allocating to poor countries compared to overall aid. Health aid also goes to less well-governed countries. More of health aid makes it to recipients' budgets than other sectors; as 79% of it is strict CPA, compared to 41% of all aid. It is also more focused, and less tied, than overall aid: countries that give overall aid through a multitude of agencies, such as the United States, fare better in this indicator than they do in overall QuODA because they channel health aid through few large agencies – such as USAID/PEPFAR in the case of the United States.

- **Reducing Burden:** Health aid has more significant relationships compared to overall aid, but it's more fragmented across donor agencies. It also has a smaller median project size, and less of it goes through multilateral channels.

- **Transparency and Learning**: We find that health aid is less transparent than overall aid – sector-level data tends to be less consistent and detailed compared to overall data. While health aid is better in terms of the reporting of commitments to the DAC database, project descriptions are less detailed. Health aid also goes to partners with worse M&E frameworks, which is a problem given the need for tracking for results and impact.

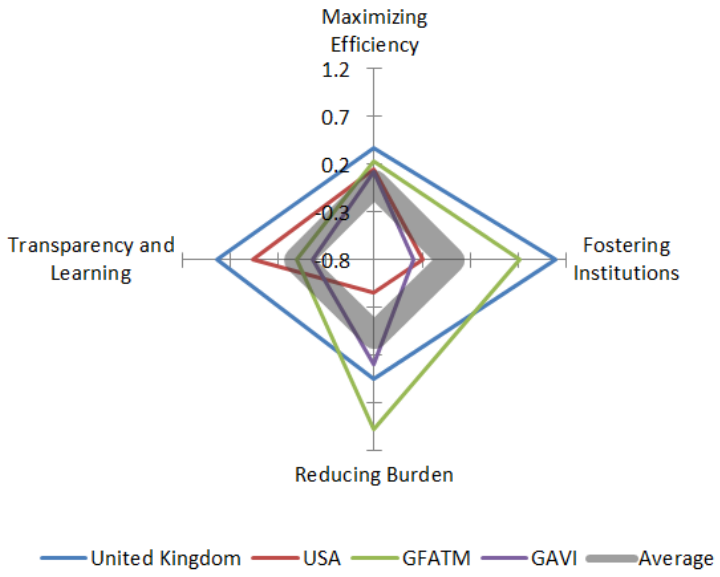
Box 5. Multilaterals, innovative financing and health aid

The scaling of health aid corresponded with the establishment of two international financing mechanisms: GAVI Alliance for immunization, and the Global Fund to fight HIV/AIDS, TB and Malaria. These funders differ from traditional donors in the sense that they are public-private partnerships which are financial instruments and not implementers. Both of these organizations defend transparency and accountability as their primary principles, and seek to mitigate volatility through innovative, specialized longer-term funding windows. GAVI, for example, features Advance Market Commitments for pneumonia, as well as the International Finance Facility for Immunization (IFFIm), both of which have accelerated the introduction and uptake of new and underutilized vaccines.

These differences from traditional donors should work in favor or aid effectiveness, thus, it is important to see how they perform in our indicators. Overall, we see that while the Global Fund is ranked above average in the 4th place, and GAVI is below average at 17th. In maximizing efficiency, the Global Fund is ranked 11th and GAVI is ranked 14th – again, both are above average. GAVI performs particularly worse in fostering institutions, due to the fact that they work with countries which lack health plans. Both organizations do well in the reducing burden category, with the Global Fund ranking first and GAVI ranking 9th – a promising result, showing that such multilateral initiatives with innovative financing mechanisms do indeed reduce the burden on recipient countries. A rather disturbing result is in the transparency and learning category: while both organizations espouse principles of transparency and accountability, they both rank below average.

Given these results, both organizations need to be more rigorous about holding themselves up to their commitments on transparency and learning; focusing on the effectiveness of results instead of inputs. This proves to be more important given the funding cuts looming for the Global Fund.

box 5 continued



Recipient-level analysis for aid dependent countries

There are many countries that rely on external financing for a high share of their public health budget. We have identified the countries that finance more than 20% of their health budget through aid, and ran 6 of our aid effectiveness measures for these countries – we omitted the transparency and learning indicators from this analysis, and looked instead at maximizing efficiency and reducing burden measures.[7]

Our results are somewhat encouraging (see table A8): We find that the sample of aid-dependent recipients receive more untied aid, more strict CPA, and suffer from less fragmented aid. The median project size in these countries is also larger. However, aid relationships are less significant between aid-dependent nations, and these nations receive much less through multilateral channels (11% for aid-dependent, versus 18% overall average).

[7] The countries included in this analysis are: Democratic Republic of the Congo, Malawi, Mozambique, Eritrea, Tanzania, Rwanda, Liberia, Burundi, Guinea-Bissau, Central African Republic, Ethiopia, Zambia, Haiti, Kenya, Niger, Sudan, Lesotho, Djibouti, Madagascar, Gambia, Mali, Mauritania, Benin, Burkina Faso, Uganda and Sierra Leone.

Recommendations and conclusion

Recommendation 1: Need for continued progress across indicators

In the previous section – as well as in appendix 2 – we analyzed how donors fare within each indicator and dimension. Our analysis is based on the inherent assumption that effective health aid can save lives, and the 23 indicators in this index constitute a proxy for tracking aid effectiveness. Given this, we believe that it is possible to track and compare progress across different periods using our indicators; as we did between 2008 and 2009. Through this exercise, we also highlight the relevant strengths and weaknesses of each donor.

Here, however, it is important to discuss a crucial point: the indicators are scored relative to the average, as for almost all indicators it is not possible to declare a best-practice level. This relies on the assumption that the donors below average can increase their aid effectiveness if they go above average. Similarly, maximizing overall performance as opposed to individual performance would be more relevant: currently, our only way to determine if overall efficiency (or burden on recipients, or transparency) goes up or down is to compare raw scores across years, which we do on table A2. It is, again, not possible to establish an optimal level of aggregate performance.

Despite these limitations, the indicators forming our index have one point in common: performing better in them would translate into better aid, which, ideally, translates into better development results, and those who perform worse should improve their performance, as measured in raw scores, across these indicators. Donors could also use these rankings to capitalize on their comparative advantages, as for most donors, their rankings are very different across every dimension.

Recommendation 2: Need for more and better aid effectiveness data

Our biggest difficulty while constructing this index was the lack of health sector specific data pertaining to aid effectiveness. Information on many initiatives, such as sector wide approaches and budget support, remain on the qualitative side; hence it was not possible for us to quantify these efforts. Similarly, we were not able to look into harmonization and predictability, measures which were tracked through the Paris Declaration Monitoring Survey. Hence, the results we present here are only a part of the aid effectiveness in health: if we had the chance, we would have included data on the following categories, which are at least as important as the measures we have included:

- Aid predictability and volatility
- Harmonization and coordination: avoidance of parallel project implementation units
- Budget support and fungibility
- Results-based financing

- Investment in health systems strengthening

Including sector-level questions in the Paris Declaration Monitoring Survey would be an efficient and beneficial way of tracking donor performance on health aid effectiveness. Further, it is important to transition from aid effectiveness to development effectiveness, and connecting aid practices with results achieved on the field: certain studies we cite in our first section point out to the correlation between aid and results, but donors do not track, or quantify, the impact of their aid dollars on improving various measurable health outcomes such as mortality, vaccination rates or deaths averted. Thus, measurement, monitoring and evaluation practices should be improved across the board.

Recommendation 3: Need for more policy impact evaluations

A major difficulty in constructing a valid indicator of health aid quality is that the relationship between each indicator and/or dimension and the outcomes is unclear and unproven empirically. If aid effectiveness measures matter -if they are more than common sense- we should be able to show that they matter for program results. However, such evaluations would require heroic and convoluted assumptions; for example, it is difficult to assess how a small aid-funded technical assistance program provided in five countries can be compared to a large aid-funded commodity procurement. Both are inputs into a production function of a given health service that has both a supply and demand-side. As a result, while we believe that it is useful to continue to track aid effectiveness goals just because world leaders agreed that these measures were important, ultimately more attention should be paid to impact evaluation that would allow country governments and donors to assess best technical assistance modalities, best procurement mechanisms and best health coverage and outcomes.

Conclusion: Going Forward

In this paper, we build an index that quantifies aid effectiveness in health, an exercise that should be useful given the increase (and potential decrease) in both the scale and scope of health aid. We replicate Birdsall and Kharas' QuODA where possible, and add various indicators of our own.

There is mixed progress from 2008 to 2009: while progress has been made in some dimensions, such as untying aid, supporting global public good facilities, and establishing more significant aid relationships, donors fared worse in certain very important categories such as allocation according to disease burden and fragmentation across agencies. We also see mixed results as we compare overall aid effectiveness to health aid effectiveness: while the health aid sector seems more focused and concentrated, it does less well in allocating to poor or well-governed countries.

It is, once again, very important to stress the caveats involved in our analysis: while we rank donors in four dimensions, and an overall dimension, these rankings should be taken with a grain of salt. We are publishing all of our data, code and results, so our readers can implement the weights they want or omit certain indicators and re-rank donors.

In the end, we see that what we leave out is as significant as what we include: every index, or ranking, omits crucial indicators, but in our case it could be debated that what we leave out is even more significant than what we include. Yet, given all these caveats, our principal aim is to generate a discussion over quantitative sector-level aid effectiveness measures, and let recipients hold donor agencies accountable.

The Busan High Level Forum on Aid Effectiveness, held in November 2011, addressed certain issues such as transparency, aid in fragile states and the emergence of new donors, yet failed to address others such as the shift from aid effectiveness to development effectiveness (results). Effective health aid, as we have pointed out repeatedly in this paper, saves lives, and as donor funding flat lines and decreases, commitment to better outcomes must be reaffirmed. We hope the findings of this index nudge donors in the right way.

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Appendix 1: Descriptions of Indicators

Dimension 1: Maximizing Efficiency

ME1. Share of allocation to poor countries

Generally, poorer countries spend least on health per capita, yet higher spending levels are closely connected with health improvements worldwide. A study in the United States finds that mortality fell by between 1.1 and 6.9% for every 10% increase in public spending (Mays and Smith 2011), while a cross-country study in developing countries found that increased health expenditures are associated with better outcomes in Africa, especially on infant and child mortality (Anyanwu and Erhijakpor 2007). Similarly, a WHO review (2002) found a positive relationship between health-adjusted life expectancy and health spending (Pouillier et al 2002). This literature –while far from definitive- suggests that countries with less capacity to spend on health should receive more health aid. By including the indicator "share of donor allocation to poor countries", we reward donors that direct more of their resources to poorer countries, thus creating the conditions for "better bang-for-the-buck" for health aid.

We use per capita national income as a measure of poverty instead of per capita public spending on health, since we believe that per capita income is a more objective measure of the funding and administrative capacity of countries given concerns that health aid might be fungible. In addition, GDP per capita and public spending on health are highly correlated, essentially measuring the same thing.

As in QuODA (2010), we took the logarithm of per capita GDP adjusted for purchasing power parity (*CGDP*) to emphasize changes at the lower end of the spectrum. We weigh net CPA with the logarithm of CGDP. Hence, we measure the true orientation of donors with respect to need.

The donors that allocate most consistently with income per capita are Belgium, Ireland, AfDF, Norway and GAVI. The countries that fare worst in this category are France, Portugal, Korea, IDB and Spain. Allocation rules and eligibility requirements play a clear role in donor performance on this measure. For example, only countries with per capita incomes below US$1,500 per year are eligible for GAVI assistance. Similarly, the IDB –as a demand-based lending institution, limited to funding in Latin America and the Caribbean- will be unlikely to preferentially allocate to the globally worst-off.

Analysis based on: $$\sum_r \left(\frac{netCPA_{d,r}}{netCPA_d} * \log CGDP \right)$$

Source: OECD CRS Database (2009); IMF World Economic Outlook (2011)

ME2. Share of allocation to countries with high burden of disease

The most basic objective of health aid is to improve health. Yet a 2007 study finds that 90% of the global disease burden in developing countries receives only 12% of global health spending (Dodd et al 2007). Non-communicable diseases, for example, constituted 0.5% of all health aid in 2008, while representing over two-thirds of global disease burden (WHO 2010). A study by the Institute for Health Metrics and Evaluation (IHME) shows that –in the aggregate- development assistance for health is negatively correlated with total burden of disease (measured as disability-adjusted life years – DALY). The lack of correlation overall results in very different allocation amounts per case of disease; for example, Eastern European countries, such as Bulgaria and Serbia, receive more than $100 per case of tuberculosis, whereas countries with higher burden such as Uganda and Zimbabwe receive less than $5 per case (IHME 2011)

We calculate this indicator using the same methodology as ME1, looking to see whether countries allocate aid preferentially to countries with the largest disease burdens. We define disease burden as DALYs, disability adjusted life years, which measures the number of years lost due to disability, early death, or poor health; measuring years of healthy life lost (WHO 2008). The latest figures for this measure are from the World Health Organization's 2008 report, using data from 2004.

Donors which perform best on this measure are the United Kingdom, IDA, Germany, Global Fund and GAVI, and those which perform worst are IDB, France, New Zealand, Portugal and Greece.

Analysis based on: $$\sum_r \left(\frac{grossCPA_{d,r}}{grossCPA_d} * \log CDALY \right)$$

Source: OECD CRS Database (2009); IHME DAH Disease Burden Database (2010)[8]

ME3. Focus/specialization by recipient country

Many studies suggest that donor proliferation –donor agencies that disperse their aid budget among a portfolio of potential recipients in lieu of concentrating more significant resources in a few countries- dilutes the impact of aid. There are currently over 100 partnerships in health, and many donors have small aid programs in a multitude of countries (Dodd et al 2007). Roodman (2006) shows that there are economies of scale in the provision of aid that could be exploited given the sunk costs associated with each project as well as the scarcity of resources and institutions in the recipient countries. Knack and Rahman (2004) analyze trends of donor proliferation in recipient countries, showing that proliferation has increased since 1975. An analysis by Kharas (2009) shows that smaller and poorer countries tend to

[8] CDALY: Per capita DALY. DALY data comes from latest available data; from 2004.

suffer from higher fragmentation, and countries with high aid per capita are less fragmented. Social sectors, such as health, tend to suffer from higher fragmentation and less significant aid relationships: 51% of partnerships tend to be significant, and 88% of aid goes to significant recipients (OECD 2010).[9]

Donors could enhance their impact by establishing more significant relationships with fewer countries. We use the same methodology to calculate ME3 as was used in the original QuODA; by calculating each donor's revealed comparative advantage (RCA) defined as the concentration of that donor's aid in a recipient country. We compare the ratio of a donor's health aid in a partner country relative to the cumulative aid to that partner, and the donor's total aid flows to all its partner countries relative to total global health aid. When this indicator exceeds 1, the donor is considered to have an RCA in the recipient country. When donors provide small amounts of aid to many countries, or to countries which receive high amounts of aid, their RCA decreases.

Donors which give the majority of their aid to a smaller number of countries fare better in this category, such as IDB, Portugal and New Zealand. Countries that have less significant aid relationships, such as Norway, Japan and the UN Agencies fare worst in this category.

Analysis based on: $\sum_r \left[\left(\frac{CPA_{d,r,RCA>1}}{CPA_d} \right) + \left(\frac{CPA_{d,r,RCA>1}}{CPA_d} \right) \right]$ with

$$RCA = \frac{\left(CPA_{d,r} \middle/ CPA_r \right)}{\left(CPA_d \middle/ CPA_{world} \right)}$$

Where CPA is gross CPA.

Source: OECD CRS Database (2009)

ME4. Share of allocation to well-governed countries

The relationship between effective aid and good governance is well documented, to the extent that aid organizations such as the Millennium Challenge Corporation (MCC) integrate governance as a selection criterion. Many articles point to a strong relationship between aid effectiveness and governance quality (see Burnside & Dollar 2000, Bearce 2009). The original QuODA includes a share of allocation to well-governed countries, as a function of country programmable aid weighted by the Kaufmann and Penciakova (2010) quality of governance index, finding that smaller donors have a good governance orientation. Similarly,

[9] Significant relationships are defined as the number of donors who are involved in the group of donors that together disburse 90% of total aid to the recipient (OECD 2010)

an analysis by Fielding (2011) finds that health aid effectiveness is sensitive to corruption, governance quality and political rights.

However, there is also evidence that the same relationship does not necessarily hold for health aid: Dietrich (2011) finds that countries such as Bangladesh and Mali, which are not necessarily well-governed, have efficiently managed the DAH they receive. Dietrich attributes this efficiency to donors behaving differently in weak governance countries, anticipating weak institutions and focusing on sector-specific programs. Immunization coverage in weak governance countries from 1990-2004 supports this argument; corrupt governments may not seek rents in the health sector, and use the assistance to provide minimal coverage. Dietrich posits that corrupt countries use health aid efficiently as to please donors and show them progress, so that they can seek rents in more profitable sectors such as infrastructure.

Another argument for not including governance as a determinant of aid effectiveness in health comes from the experience of GAVI and the Global Fund, which are evaluated in this index: these countries work in both low- and middle-income countries with low governance quality, and yet they have managed to be efficient in these settings. The Global Fund has invested ~US$5 billion from 2002-2009 in 41 fragile states, and most of these grants have been evaluated to perform well (Bornemisza et al 2010).

We include an indicator that captures the correlation of aid with good governance in recipient countries, but given the mixed evidence, this measure's significance should be taken with a grain of salt. We weight the strict CPA of each donor with the quality of governance of its partner countries. GAVI performs the worst in this category, not surprising given that GAVI gives to countries with an average income below $1,500, most of which are also fragile, weak governance countries. The Netherlands, Portugal and Denmark perform best in this category.

Analysis based on: $$\sum_r \left(\frac{sCPA_{d,r}}{sCPA_d} * GVI_r \right)$$

Source: OECD CRS Database (2009); Kaufmann, Kraay and Mastruzzi 2009

ME5. Share of strict country programmable aid

As discussed in part 2, the Development Assistance Committee defines country programmable aid as ODA minus debt relief, humanitarian aid, food aid, administrative costs and imputed student costs. CPA is useful in the sense that it excludes spending that is inherently unpredictable, entails no flows to the recipient country or is not discussed between the main donor agency and recipient governments (Benn and Steensen 2010). Strict CPA constituted 79% of cumulative health CPA in 2008. CPA is particularly useful for comparing in-country financial impact across donors, as well as concentration across and

within countries and agencies: it captures programmable development projects by excluding emergency situations.

Since all health ODA is automatically CPA, we use ODA to calculate the indicators throughout this report. However, not all health CPA is strict CPA, which subtracts free standing technical cooperation (FTC) and interest payments from ODA. FTC is defined as the provision of resources for building up general national capacity without reference to the implementation of specific investment projects. We believe that taking out FTC and interest payments, which do not include actual transfers of funds into partner countries, gives an accurate representation of the share of aid donors allocate to support programs and projects directly.[10]

Thus, we calculate the share of strict health sector CPA over gross CPA. We see that multilaterals, such as IDB Special, GAVI, Global Fund and UN Agencies perform best in this category, and donor countries such as Australia, Greece and Canada perform worst.

Analysis based on: $sCPA_d$/ $grossCPA_d$

Source: OECD CRS Database (2009)

ME6. Share of untied aid

The practice of tying aid – conditioning it to the procurement of goods and services from suppliers in the donor country – has long been condemned, and the share of tied aid has steadily been going down. Untying aid is efficient for various reasons: it sustains resource transfer efficiency, greater flexibility within agency programming, as well as greater responsibility and ownership for recipient partner countries. A comprehensive survey of five donors who were untying aid after 2001 (Australia, Canada, Denmark, Norway and Switzerland) shows favorable results for untying aid, as it brings support to country institutions and passes responsibility for disbursement from donors to country partners and civil society organizations (Clay et al 2008). About 84% of total health aid in 2006 was untied; in 2009, this went up to 89% (CRS 2009).

CRS reports untied aid in two different categories: partially untied, and untied. We give untied aid a weight of 1, and partially untied aid a weight of 0.5. We see that many of the larger donors have almost 100% untied aid: Norway, Netherlands and United Kingdom untied all their health aid; 97% of United States' health is untied. On the other hand, smaller aid programs fared worse, with Austria untying 21% of its aid and Korea untying only 8%.

Analysis based on: (Untied aid_d) + 0.5*(Partially tied aid_d) / Total bilateral aid_d

Source: OECD CRS Database (2009)

[10] FTC's definition: http://stats.oecd.org/glossary/detail.asp?ID=6023

ME7. Support of selected global public good facilities (WHO, GAVI, UNICEF, Global Fund, PAHO)

Many issues in health, such as communicable disease control and prevention, are beyond a single country's reach, and require cooperation regionally and globally to achieve results. Global public goods in health refer to programs, policies and services that have a global impact on health, although the distribution of benefits may be unevenly perceived across countries; they are non-excludable and depend on the contribution of many states. In today's globalizing world, borders are becoming increasingly porous and many global public bads – especially in health – are moving beyond one single country's realm (Kaul and Faust 2001). Drug resistance, disease elimination, disease surveillance, research and development, and standardized data are examples of global public good issues in health. Humanitarian concerns have been the main basis for international collaboration in health in the past, yet countries can benefit from working together to resolve the major global health challenges of the day. As the world becomes more integrated and interdependent, countries are exposed to health problems originating beyond their borders. Furthermore, it is easier to benefit from economies of scale in aspects such as research, public-private partnerships for vaccine and drug creation, as well as disease elimination/eradication: efficiency gains are immense.

The agencies that support GPG in health include the standard-setting and epidemiological surveillance agencies such as WHO and PAHO, as well as funding agencies that directly support the control and prevention of communicable diseases such as the GAVI Alliance for vaccine preventable diseases and the Global Fund for HIV/AIDS, tuberculosis and malaria. In the context of sustaining lower prices and encouraging bulk purchasing, PAHO and GAVI have been very effective in increasing immunization rates in the low-income and lower-middle income countries. Similarly, through its grants and loans, the Global Fund was able to increase prevention and treatment of HIV/AIDS, TB and malaria in both low-income and middle-income contexts.

We include support to five institutions that provide or fund global public goods as a share of total donor ODA. We reward donors which give the highest share of their total ODA – including all sectors – to these donors, as contributions to global public good facilities come out of donors' total aid budget.

We find that Norway, Italy and the Netherlands contribute most as a share of total ODA to global public good facilities. Portugal, Greece and Austria give a very small share of their total ODA to these facilities.

Analysis based on: (total contributions to 5 facilities$_d$)/totalODA

Source: OECD CRS Database (2009); annual financial reports for each of the organizations included in the measurement

Dimension 2: Fostering Institutions

FI1. Share of aid to countries with national health plans

As recipient governments identify their priorities through national health plans, donors should be able to provide support more aligned with national priorities. The World Health Organization actively supports the development of National Health Policies, Strategies and Plans (NHP) through technical cooperation and international policy frameworks (WHO 2010). A framework approved by the WHO in early 2011 outlines certain elements for NHP, such as focusing on MDGs, public health, including primary health care reforms as well as equity and universal coverage. In emphasizing NHP as the epicenter of policy dialogue, the WHO hopes that countries achieve coherence between aid agencies as well as recipient countries. Similarly, UNICEF has called for the improvement of national health plans in Africa, and together with the World Health Organization established "Harmonization for Health in Africa" in order to invest in them.

In this indicator, we look at the World Health Organization's data on all countries regarding health plans: an overall National Health Plan, a Country Multi Year Plan for Immunization, and plans for TB, HIV/AIDS, Reproductive Health, Maternal Health and Child Health. We give 1 point to each plan, and in the end develop a score out of seven. We reward donors that give to countries with "more" health plans (higher scores) by weighing their CPA by the log of the number of health plans.

While recognizing the absurdity of counting the number of plans as a measure of support to institutions, given the uncertain relationship between plans, their quality and actual budgets and implementation, the presence or not of NHP has thus far been the main means of tracking progress in the development of national ownership in the health sector (WHO, 2011b). Within the International Health Partnership and the Health Systems Funding Platform countries, the WHO is carrying out join assessments of the quality of National Health Plans and their monitoring and evaluation arrangements (Glassman and Savedoff 2011); results of these assessments have not been made public.

The IDB Special Fund outperforms all donors in this measure, since it concentrates its aid in Latin American countries, all of which have multiple health plans. Norway and Finland also fare well in this category. Spain, New Zealand and Korea rank last.

Analysis based on: $$\sum_r \left(\frac{netCPA_{d,r}}{netCPA_d} * \log NHP \right)$$

Source: OECD CRS Database (2009); WHO National Health Plans Database (2011)

FI2. Support to essential health metrics

Effective health spending and by extension health aid can only be measured and managed effectively if complete, high quality data for health decision-making is available. Vital statistics, household health surveys, census data, birth and death registration, disease surveillance, utilization and spending data, are essential building blocks of the health system. However, developing countries frequently lack such data, which makes management, improvement and accountability of health systems insurmountably difficult. Recently, numerous global health agencies have made calls to ensure data availability (Chan et al 2010). Eight agencies working in global health, including the WHO, GAVI, Global Fund, World Bank and UNICEF, have suggested the development of common data architecture, the strengthening of performance monitoring and evaluation, as well as increased data access and use. The Director-General of the World Health Organization deemed the availability of vital statistics to be "badly needed," and that "the United Nations Commission on Information and Accountability for Women's and Children's Health have given "high priority to the establishment of badly needed information systems for the registration of births, deaths and cause of deaths" (WHO 2011).

Parallel to this, the WHO has established the Health Metrics Network, a partnership supporting the availability of vital statistics and minimum health information systems in developing countries. Similarly, PARIS21 (The Partnership in Statistics for Development in the 21st Century), is a global partnership of statisticians aiming to promote, influence and facilitate statistical capacity development. In this indicator, we look to see if a donor agency contributes actively to statistical capacity-building. Our data sources are PARIS21 members, Health Metrics Network members, and donor agency websites. We find that most countries have at least one project supporting essential health metrics.

Analysis based on

Presence of keywords "health metrics, demographics, statistics, capacity, surveillance, accounts, surveys" in the long description field of OECD CRS database; agency websites used to cross-check. Dummy variable; 1 if keywords present, 0 if not.

Source: OECD CRS Database (2009); donor agency websites

Dimension 3: Reducing Burden

RB1. Significance of aid relationships

As described in ME3, aid proliferation significantly increases the burden on recipients, as administrative costs associated with each development program reduce the received value of aid to recipients. Roodman (2006) describes the high costs of managing many small aid projects that lead to diminishing marginal effectiveness. Knack and Rahman (2007) find that these costs also lead to the poaching of highly qualified civil servants and that fragmentation

is associated with decreased bureaucratic quality of recipients. An OECD report (2010) on fragmentation in sectoral aid finds that 51% of partnerships are significant, and 88% of aid goes to significant recipients in health. The same report highlights data from 2007, which shows that smaller donors fare worse than larger donors: Austria, Finland, Greece and UNDP had the least significant relationships (Frot and Santiso 2010). Fragmentation is more common in social sectors, such as health, where smaller scales of investment are needed as opposed to infrastructure projects, which makes coordination among donors harder. About 46% of donors collectively represented less than 10% of sectoral aid in 2007, which leads to a very high level of fragmentation in the health sector (Frot and Santiso 2010)

As in original QuODA, we measure the significance of aid relationships by estimating the marginal contribution of each donor to its partner countries' administrative costs. Recipient countries must deal with multiple donors, so it stands to reason that the administrative cost per dollar received is inversely proportional to the concentration of aid across all donors in a given recipient country. We then take a weighted average of the donor's contribution to all recipients. The smaller the contribution, the higher the donor's score on this measure, thus rewarding the significance of a donor's aid relationship in a given country.

The concentration of aid is defined as the Herfindahl-Hirschman Index (HHI) – usually used to measure competition in a given market by looking at firms' market shares – and the marginal contribution of donors to recipients' HHI is the sum across partners of the squared share of donor aid to a partner weighted by the donor's total gross ODA.

Donors who have significant aid relationships with their partners fare better in this category such as Portugal, Australia and New Zealand. Donors with less significant aid relationships, such as Denmark, AfDF and Ireland, fare worse.

Analysis based on $\sum_r \left(\frac{2 * grossCPA_{d,r}^2}{grossCPA_d * grossCPA_r^2} \right)$

Source: OECD CRS Database (2009)

RB2. Fragmentation across donor agencies

Many of the larger donors deliver aid through many agencies, and reducing the number of donor-partner relationships as well as the administrative burdens associated with them would make aid more effective: instead of interacting with a single donor agency providing a single service, recipients often have to interact with multiple agencies for the same service. An OECD report shows that there are 3,700 aid relationships between 151 aid recipients & 46 largest donors, resulting in "too little aid from too many donors" (OECD 2009). Some donors deliver aid through multiple agencies affiliated with their governments, which increases the administrative burden for both donors and recipients. The United States, for example, delivers aid through more than 50 bureaucratic organizations, 11 of which give health aid (Brainard 2007). Over the past decade, the number of delivery mechanisms and

donors in global health has expanded rapidly: there are now more than 100 global partnerships in health sector alone, with 80% of donors providing only 10% of total assistance (Action for Global Health 2011).

We calculate the concentration of aid delivery using the HHI constructed in RB1. In this case, if a donor delivered aid through one agency, its HHI is equal to one, and as the number of agencies increase, the share of each individual agency decreases & HHI approaches zero. We also did not treat aid delivered through multilateral donors as an additional channel – so aid channeled through a multilateral but coming through different agencies would be counted as being disbursed through a single agency channel.

Donors that disburse aid through few agencies, such as Denmark, Netherlands and Finland, fare better in this category; as opposed to the UN Agencies, France and Greece, which deliver smaller amounts of aid through individual agencies.

Analysis based on: $\sum_{agency}\left(\frac{grossCPA_{d,agency}}{grossCPA_{d}}\right)^{2}$

Source: OECD CRS Database (2009)

RB3. Median project size

Since every aid project has high fixed costs, the multitude of small projects decreases the value of aid. Literature shows that funding larger projects increases aid effectiveness; the burden per dollar is larger for the smaller project (Roodman 2006). Further, health aid suffers from extreme fragmentation: there were 18.654 projects and 27,900 activities in 2009, with the average size of $496,000.[11]

In this indicator, we look at the median health aid project size. We use the median rather than the mean to control for the multitude of small projects in the CRS database. The Global Fund, IDA and the European Commission have the highest median project sizes, as opposed to Austria, Portugal and Sweden, which have the lowest.

Analysis based on log[median commitment size of projects]

Source: OECD CRS Database (2009)

RB4. Share of aid that goes through multilateral channels

The Paris Declaration encourages donors to reduce transaction costs by delegating aid to donors which have expertise in partner countries. Using multilateral channels decreases

[11] The number here refers to activities, which is the unit of measurement in the CRS. An activity is a one line item, but a project can consist of many activities. In this indicator, however, our unit of measurement is projects, and we have tried to collapse activities into projects.

coordination and harmonization costs, thus reducing the burden on recipient countries and making aid more effective. Multilateral channels are also less affected by political issues that affect health aid.

In this indicator, we measure the share of CPA by each donor that is channeled through multilateral channels; which mostly includes NGOs and public-private partnerships. Here, we exclude core aid to multilaterals, which, by definition, is not sectoral. It is important to note that many activities do not indicate their channel type, which reduces the significance of this indicator.

We find that Canada, Japan and Australia channel the highest share of their aid through multilaterals. France and Portugal fare worst in this indicator, as they do not channel any of their aid through multilaterals.

Analysis based on Multilateral CPA_d / Total CPA_d

Source: OECD CRS Database (2009)

RB5. IHP+ membership

The International Health Partnership (IHP+) is a group of partners who seek to implement Paris and Accra principles on aid effectiveness in the context of improving health services and outcomes. It was established to combat with the major problems of global health agenda: inadequate progress towards MDGs, unaddressed health system constraints, insufficient investment in health, unpredictable international funding, and inefficient support to countries (IHP+ 2009).

IHP+ seeks to reduce burden on developing countries by encouraging them to focus on implementing the national health strategy, as well as helping them sustain a better use of existing funds through improved coordination and increased investment in national health strategies, and increasing government leadership in sector coordination. IHP+ encourages increased support for a national health plan through support to national sector planning processes, encouraging joint assessment of strengths and weaknesses of national plans, tracking plan implementation and monitoring progress against commitments. IHP+'s main toolkit is the Joint Assessment of National Strategies (JANS), which is a shared approach to assessing the strengths and weaknesses of a national strategy. By early 2011 give developing countries (Nepal, Ethiopia, Uganda, Ghana and Vietnam) have completed this process, and other countries are increasingly using this process to streamline their national health plans.

Launched in September 2007, IHP+ has 52 members, including donor/partner countries, civil society organizations and multilateral organizations. 25 members of IHP+ (15 of which are donor organizations) are also participants to the IHP+ Results process, which hopes to streamline the health aid process by rating donor performance in each recipient country setting.

We include membership to IHP+ as a proxy for harmonization and coordination efforts (See Box 1).

Analysis based on: IHP+ Membership: YES or NO

Source: IHP+ Website

Dimension 4: Transparency and Learning

TL1a & TL1b. IATI membership / Implementation of IATI data reporting standards

IATI helps donors implement the transparency commitments made at the Accra Agenda for Action. Its members commit to "the IATI standard," which seeks to streamline and facilitate data availability. By streamlining data reporting and availability as well as facilitating access to data, IATI increases the quality of public information on aid, in turn increasing the accountability of donors.

An estimate shows that while IATI would cost a total of $6m to signatories, it would end up saving $7m due to decreasing the duplicate manual reporting of aid information, as well as other benefits that would come with increasing aid transparency: increased predictability, by itself, could lead to the equivalent of a $1.6b increase in aid, and if the IATI standard were to be implemented by all DAC donors this would increase global aid by 2.3% (Collin et al 2009).

While IATI currently has 20 signatories, not all donors have implemented these standards yet, which is why we include an additional indicator measuring if donors have reported their data according to IATI standards or not.

Analysis based on: IATI membership: yes or no [2009] / Data reported in IATI standard: yes or no [2009]

Source: International Aid Transparency Initiative Website

TL2. 3ie membership

Both donor and recipient countries often do not conduct impact evaluations: while billions of dollars are spent by donors, few programs benefit from ex post evaluations and empirical evidence that would help reallocate funds more efficiently, as well as improve accountability. A World Bank report of evaluations in 2000 states that "Despite the billions of dollars spent on development assistance each year, there is still very little known about the actual impact of projects on the poor," highlighting the importance of evaluations for accountable and efficient aid (Easterly 2006).

An example to benefits of ex post evaluations can be conditional cash transfer programs, which have been rigorously evaluated thanks to the availability of survey data: initially started

in Mexico, these programs have sprawled to almost all Latin American countries when it was found that they were effective (Bourguignon and Sunderberg 2006).

A working group convened by the Center for Global Development in 2006 resulted in the establishment of the International Initiative for Impact Evaluation, 3ie. 3ie sponsors in-depth impact evaluations which rely on the construction of a credible counterfactual, and seeks to generate evidence of what works in development, as well as developing both the capacity and the culture of producing and using impact evaluations.

3ie currently has 24 members, most of which are multilateral donors; although various countries such as United States, Australia, United Kingdom, Norway and Sweden also participate in this initiative.

Analysis based on: Response of YES or NO

Source: 3ie website

TL3. Recording of project titles and descriptions

DAC members commit to providing information about each of their aid projects to the CRS database, and they should provide complete records of information regarding the descriptions and titles of these projects. The CRS database has fields on sectors, countries, regions to which the aid project is targeted, as well as the descriptions of the purpose of these projects: the availability of this information would greatly benefit academics, civil society organizations, as well as the media, thus increasing accountability.

We looked at the CRS database to see the average percentage of populated fields by each donor: project title, short description and long description. Fourteen donors completed all three key fields in health projects: including Austria, USA, Germany and the Global Fund. Three donors completed the smallest share, filling out 2/3 of the fields: Belgium, AfDF and GAVI.

Analysis based on: Populated key field entries$_d$ / Total key field entries$_d$

Source: OECD CRS (2009)

TL4. Detail of project descriptions

Similar to the project titles and descriptions, the detail of project descriptions empowers policymakers and civil society organizations by offering more insight into the details of each aid project. In the "long description" field of CRS, donors can provide details on the purpose and components of each project. We look at the length of these descriptions as a proxy for each donor's project-level activities: some donors simply repeat the project name in the long description field, thus longer fields imply more project-level data.

We take the logarithm of the average character count, which emphasizes changes at the lower level. Although this indicator does not take into account the "quality" of the responses, it is the best available replacement for how much information is made available by the donors.

The best performing organizations in this category are IDA, Ireland and the United States. AfDF and Korea provided no long descriptions to the CRS.

Analysis based on: Log (Number of characters in long description entries$_d$ / Number of long description entries$_d$)

Source: OECD CRS (2009)

TL5. Reporting of aid delivery channel

Donors have various channels through which they can disburse aid, and by specifying how they channel their support, they enable better tracking of the movement of donor aid flows.

We use the same methodology used in QuODA, which was borrowed from Development Initiatives' analysis of donor reporting, which constructs a measurement based on the information reported by donors to the CRS. Donors report the channel of their support for each of their aid projects, and we look at whether they "sufficiently" fill this field or not. On average, 83% of projects have reported their channel. Five donors (Portugal, Greece, Korea, AfDF and GAVI) reported all their channels, and two donors (IDA and IDB) have not reported any of their channels.

Analysis based on: CRS flows with sufficient reporting$_d$ / Total CRS flows$_d$

TL6. Completeness of project-level commitment data

The sector-level DAC database includes aggregate aid flows from donor to partner countries, whereas the CRS database tracks project-level spending. In this indicator, we look into the discrepancy between the two, as donor countries should accurately report their project-level aid. We subtract the ratio of total CPA by donors reported in the project level to the total CPA they report in the aggregate level, which scores them on how they report their project-level commitment data.

IDB, Denmark and AfDF perform the best in this category, whereas Sweden and the Global Fund have the highest discrepancy between their reporting to the DAC sector-level database and the Credit Reporting System.

Analysis based on: $\left| 1 - \frac{CPA_{d,proj}}{CPA_{d,aggr}} \right|$

Source: OECD DAC database; OECD CRS (2009)

TL7. Quality of evaluation policy

As we discussed in our 3iE indicator, impact evaluations are crucial for health aid effectiveness. In this indicator, we are using a methodology developed by the original QuODA team to rank countries' evaluation policies, by evaluating them across 5 indicators and seeing if the principal aid agency in each country has the following:

- 0.5 points for having a single policy document
- 0.5 points for describing measures to maximize the independence of evaluations; this includes stating that evaluation units report separately from line management or that evaluations are primarily led by external researchers
- 0.5 points for stating that all evaluations will be publicly available (as an indication of openness/transparency)
- 0.5 points for describing mechanisms to ensure that evaluation findings and recommendations will be considered in future planning (as an indication of how evaluation contributes to evaluation and learning)
- 0.5 points for clarifying what gets evaluated

Austria and the United States get all of the possible 2.5 points, while Italy, Luxembourg, Greece and Belgium get 0 points.

Analysis based on: Agency websites; QuODA team scoring of each agency's evaluation policies over an index of 2.5

Source: Agency websites; evaluation policy documents

TL8. Aid to partners with good monitoring and evaluation frameworks

Monitoring and evaluation is especially crucial in allocating health aid more efficiently, as it establishes an evidence base for budget and policy decisions. All policy decisions in health imply a tradeoff, and the strength of monitoring and evaluation institutions in partner countries improves the probability that this money will be allocated more efficiently. In order to underline the importance of strengthening M&E frameworks, we looked at the most recent World Bank AER (2007), which ranks the M&E frameworks of 62 low and lower-middle income countries on a scale of 1 to 5. We define a solid M&E framework as one which receives one of the two highest scores in the World Bank rating, and look at the share of allocation to countries with good M&E frameworks. We give full credit to top 2 ratings and partial credit to those with the 3rd highest rating.

Analysis based on: $\sum_r \left(\frac{CPA_{d,r,M\&E=1}}{CPA_d} \right)$

Source: OECD CRS (2009); World Bank (2007)

Appendix 2: Tables

Table A1. Gross ODA, CPA and Strict CPA by Country, Overall and Health

	2008 Overall			2009 Overall			2008 Health				2009 Health			
Donor name	**Gross ODA**	**Gross CPA**	**Gross sCPA**	**Gross ODA**	**Gross CPA**	**Gross sCPA**	**Gross ODA**	**Gross CPA**	**Gross sCPA**	**Health/Overall**	**Gross ODA**	**Gross CPA**	**Gross sCPA**	**Health/Overall**
Austria	1,759.4	218.5	137.7	1,151.9	202.0	111.3	13.6	13.6	7.1	6.20%	10.8	10.8	6.1	5.32%
Belgium	2,437.1	721.5	312.0	2,658.2	774.9	371.2	120.3	120.3	48.2	16.68%	128.0	128.0	64.1	16.52%
Denmark	2,866.6	914.9	867.6	2,845.7	996.5	975.4	95.7	95.7	89.5	10.46%	129.3	129.3	124.2	12.98%
France	12,539.8	3,846.2	2,576.5	14,113.8	3,607.6	2,154.2	120.7	120.7	75.4	3.14%	153.3	153.3	91.5	4.25%
Germany	15,961.2	4,748.7	1,992.1	13,342.3	5,171.6	2,231.7	382.7	382.7	223.9	8.06%	397.7	397.7	240.7	7.69%
Italy	5,096.6	840.4	727.9	3,475.8	595.7	513.0	121.0	121.0	98.8	14.40%	103.0	103.0	87.4	17.30%
Netherlands	7,111.1	2,223.1	2,063.9	6,542.0	1,825.1	1,689.4	272.9	272.9	265.1	12.27%	212.9	212.9	207.6	11.66%
Norway	4,005.8	1,504.0	1,207.2	4,085.9	1,419.1	1,212.6	143.3	143.3	125.2	9.53%	133.1	133.1	117.5	9.38%
Portugal	627.2	298.2	189.8	548.3	234.8	131.6	7.9	7.9	5.4	2.67%	9.3	9.3	7.5	3.95%
Sweden	4,731.7	1,620.1	1,509.2	4,548.3	1,418.4	1,374.4	236.9	236.9	232.8	14.62%	172.9	172.9	169.6	12.19%
Switzerland	2,049.3	626.3	531.0	2,320.1	644.1	600.4	52.7	52.7	51.8	8.42%	58.7	58.7	57.0	9.12%
United Kingdom	11,976.6	4,185.0	3,432.1	11,490.2	4,111.4	3,588.0	851.7	851.7	704.0	20.35%	798.3	798.3	664.5	19.42%
Finland	1,167.7	352.2	181.9	1,290.2	409.8	180.7	33.8	33.8	19.9	9.61%	30.7	30.7	14.6	7.49%
Ireland	1,327.8	558.1	545.4	1,005.9	464.5	460.7	147.0	147.0	143.8	26.33%	117.8	117.8	117.0	25.36%
Luxembourg	414.9	193.6	191.0	414.7	180.0	175.4	56.9	56.9	56.8	29.38%	46.7	46.7	46.6	25.95%
Greece	703.2	143.1	38.1	607.3	141.3	41.7	13.4	13.4	3.2	9.36%	17.4	17.4	4.7	12.29%
Spain	7,477.4	3,276.9	2,431.9	6,984.2	3,062.6	2,278.0	362.3	362.3	289.8	11.06%	296.0	296.0	187.0	9.67%
Canada	4,833.7	1,776.9	1,013.0	4,041.2	1,993.1	461.9	370.8	370.8	248.6	20.87%	435.3	435.3	97.6	21.84%
USA	27,414.3	14,426.9	13,746.7	29,659.2	15,672.5	14,955.4	3,683.5	3,683.5	3,658.0	25.53%	4,227.6	4,227.6	4,205.1	26.97%
Japan	17,474.6	9,157.2	7,724.2	16,440.4	10,152.3	6,756.5	338.4	338.4	206.9	3.70%	341.8	341.8	198.0	3.37%
Korea	841.8	460.2	296.3	850.8	511.4	390.0	56.6	56.6	30.5	12.29%	89.3	89.3	71.8	17.46%
Australia	2,954.1	1,536.1	823.3	2,761.6	1,507.0	609.7	202.7	202.7	65.2	13.19%	201.8	201.8	70.3	13.39%
New Zealand	348.0	161.1	138.8	309.2	126.9	102.2	19.1	19.1	18.5	11.85%	17.7	17.7	17.1	13.93%
IDA	9,291.3	8,874.3	8,009.3	12,639.2	10,919.2	10,335.7	993.1	993.1	925.5	11.19%	1,214.4	1,214.4	1,152.2	11.12%
IDB Special	551.6	159.0	159.0	1,024.7	587.2	587.2					22.2	22.2	13.4	3.78%
AfDF	1,755.1	1,787.6	1,754.4	3,008.2	2,666.0	2,626.8	111.8	111.8	108.3	6.26%	104.3	104.3	101.1	3.91%
EC	13,197.0	8,965.5	7,783.3	13,445.7	9,392.2	8,097.6	618.0	618.0	570.4	6.89%	559.9	559.9	519.0	5.96%
GAVI	623.8	623.8	623.8	559.9	559.9	559.9	623.8	623.8	623.8	100.00%	367.4	367.4	367.4	100.00%
GFATM	2,167.6	2,171.6	2,171.6	2,336.9	2,336.8	2,336.8	2,171.6	2,171.6	2,171.6	100.00%	2,336.8	2,336.8	2,336.8	100.00%
UN (Select Agencies)	2,278.2	1,477.0	1,477.0	2,596.6	1,667.8	1,667.8	475.2	475.2	475.2	32.17%	637.2	637.2	637.2	38.21%
TOTAL	165,984.3	77,847.8	64,655.8	167,098.1	83,351.9	67,576.9	12,697.2	12,697.2	11,543.4	**16.31%**	13,371.6	13,371.6	11,994.7	**16.04%**

Source: Authors' calculations, CRS database

Table A2. Summary statistics by indicator

	Maximizing Efficiency						
	Share of allocation to poor countries	Share of allocation to countries with high DALYs	Share of allocation to well-governed countries	High strict country programmable aid share	Focus/Specialization by recipient country	Support of select global public good facilities	Share of untied aid
	ME1	ME2	ME3	ME4	ME 5	ME6	ME7
Mean, 2009	7.565865633	20.615974	70.79709	0.788762	0.85278	0.102517	0.894073
Mean, 2008	6.941324103	20.67949034	69.77504	0.784216	0.851981	0.088633	0.88523
QuODA mean, 2009	7.061108355		68.34433	0.414103	0.832182	0.186153	0.865392
QuODA mean, 2008	7.130891645		67.89825	0.398995	0.845062	0.056209	0.861323
Is more better?	**N**	Y	**N**	Y	Y	Y	Y
Maximum, 2009	8.09095	22.9257	81.27035	1	0.996741	0.244922	1
Minimum, 2009	7.003544	15.86137	60.04883	0.224138	0.617926	0.020104	0.134661
Standard Deviation, 2009	0.282575966	1.592115493	5.097714	0.243119	0.090198	0.059859	0.209832
Number of Donors	30	30	30	30	30	23	30

	Fostering Institutions	
	Share of allocation to countries with NHP	Support to essential health metrics
	FI1	FI2
Mean, 2009	1.308947367	0.366666667
Mean, 2008	1.29773731	0.275862069
Is more better?	Y	Y
Maximum, 2009	1.532181	1
Minimum, 2009	0.957581	0
Standard Deviation, 2009	0.123004457	0.490132518
Number of Donors	30	30

	Reducing Burden				
	Significance of aid relationships (log)	Fragmentation across donor agencies	Median Project Size (log)	Member of IHP+	Share of aid through multilateral channels
	RB1	RB2	RB3	RB4	RB5
Mean, 2009	2.142208363	0.757671607	-1.56764	0.593333	0.142048
Mean, 2008	2.055326452	0.774148093	-1.30234	0.613793	0.13484
QuODA mean, 2009	0.620054513	0.73227619	1.063447		0.332908
QuODA mean, 2008	0.555249955	0.7147432	1.106524		0.309226
Is more better?	Y	Y	Y		Y
Maximum, 2009	4.713614	1	2.314197	1	0.459246
Minimum, 2009	0.7092393	0.2294538	-4.72581	0	0
Standard Deviation, 2009	1.056861094	0.268389173	1.723232	0.481194	0.122904
Number of Donors	30	30	30	30	23

	Transparency and Learning								
	Member of IATI	Implementation of international data reporting standards	Member of 3iE	Recording of project title and descriptions	Detail of project description (log)	Reporting of aid delivery channel	Completeness of project-level commitment data	Quality of Evaluation policy	Aid to partners with good M&E frameworks
	TL1a	TL1b	TL2	TL3	TL4	TL5	TL6	TL7	TL8
Mean, 2009	0.573333333	0.44	0.366667	0.923439	3.813212	0.893	0.22308	1.283333	0.5391
Mean, 2008	0.55862069		0.344828	0.911002	4.058977	0.839484	0.207455		0.557387
QuODA mean, 2009	0.55483871	0.361290323		0.905063	4.655973	0.869791	0.373235	1.387097	0.567347
QuODA mean, 2008	0.490322581			0.895291	4.84379	0.814543	0.386715		0.38771
Is more better?	Y	Y		Y	Y	Y	**N**	Y	Y
Maximum, 2009	1	1	1	1	5.497168	1	0.783392	2.5	0.717398
Minimum, 2009	0	0	0	0.666667	0	0.208	0	0	0.003523
Standard Deviation, 2009	0.497534149	0.499378925	0.490133	0.126828	1.853486	0.169753	0.229816	0.795281	0.156983
Number of Donors	30	30	30	30	30	23	30	30	30

Table A3. Donor standardized scores in Maximizing Efficiency, 2008 versus 2009

	2008 Health QuODA							2009 Health QuODA						
	Share of allocation to poor countries	Share of allocation to countries with high DALYs	Share of allocation to well-governed countries	High strict country programmable aid share	Focus/Specialization by recipient country	Support of select global public good facilities	Share of untied aid	Share of allocation to poor countries	Share of allocation to countries with high DALYs	Share of allocation to well-governed countries	High strict country programmable aid share	Focus/Specialization by recipient country	Support of select global public good facilities	Share of untied aid
	ME1	ME2	ME3	ME4	ME 5	ME6	ME7	ME1	ME2	ME3	ME4	ME 5	ME6	ME7
Austria	-0.21663	-2.2066	-0.96456	-1.14234	0.40199	-1.57576	-2.83424	-0.68257	-0.93369	-0.104	-0.90747	0.243649	-1.37679	-3.61914
Belgium	1.182865	0.511966	-0.45687	-1.67663	0.206234	-0.83676	0.483908	1.989985	0.568562	-0.67229	-1.18518	0.272741	-0.27297	0.33804
Denmark	1.218516	0.74829	1.523679	0.664413	0.655492	0.58124	0.483908	1.083532	0.761251	1.544149	0.706746	0.683736	0.263926	0.50482
France	-1.69276	-2.30284	-0.13105	-0.69806	0.902735	-0.06063	0.483908	-1.04181	-1.32557	0.265751	-0.78744	0.681477	-0.43723	-0.58158
Germany	0.1596	1.248866	0.178114	-0.87104	-0.86848	-0.89059	-0.11867	-0.48225	1.190349	-0.39643	-0.75449	-0.49733	-0.71849	-0.01793
Italy	-0.79048	-0.30928	-0.9036	0.140327	-0.82542	1.276103	-0.95738	-0.19096	0.081719	-0.53394	0.243879	-0.87106	1.903926	-1.88495
Netherlan	0.144347	0.610042	1.477435	0.819789	1.018104	1.529853	0.214263	-0.32006	0.419138	2.108448	0.767273	0.96862	1.631789	0.50482
Norway	1.186544	0.559889	0.547578	0.390444	-0.68676	1.830329	0.483908	1.337428	0.137928	-0.58719	0.385245	-1.27092	2.379016	0.50482
Portugal	-1.43384	-1.87876	2.163923	-0.43906	1.655887	-1.15452	0.483908	-1.05865	-1.84575	2.073731	0.08975	1.475728	-1.08052	0.50482
Sweden	0.407814	0.157536	-0.25009	0.869964	0.148332	1.894209	0.483908	0.418741	0.154962	-0.36244	0.78959	-0.40765	0.974841	0.50482
Switzerlar	0.576182	-0.49818	0.648962	0.866217	1.356394	-0.63546	0.483908	0.499831	-0.18178	0.419657	0.751234	0.711359	-0.74151	0.50482
United Kir	0.765036	1.52923	-0.38151	0.185334	-0.35824	-0.27817	0.483908	0.589936	1.450728	-0.08677	0.179698	-0.23027	0.169866	0.50482
Finland	0.366497	0.306131	0.62384	-0.85584	-0.78546	0.67448	0.318075	0.626619	0.32855	1.023914	-1.29398	-0.7941	0.157221	-0.47822
Ireland	1.42996	0.633167	0.710103	0.850318	0.191077	0.108407	0.483908	1.765199	0.59792	0.716779	0.840742	-0.28857	-0.50151	0.50482
Luxembou	-0.05602	-0.95223	0.623563	0.941529	0.726073	0.989379	0.483908	0.092259	-0.69386	0.631558	0.854609	0.864482	0.4314	0.50482
Greece	-2.28337	-0.99724	1.284939	-2.3712	1.387196	-1.09023	0.356509	0.130463	-2.98634	-1.76778	-2.12735	1.40204	-1.09641	-1.45202
Spain	-1.31682	-0.2082	0.222784	0.06907	-0.09646	-0.20109	-0.66145	-1.85821	-0.38526	0.350375	-0.64578	0.184104	0.020183	0.000215
Canada	1.087396	0.846795	-1.81475	-0.49788	-0.50404	0.550643	-0.14384	0.491645	0.515512	-0.4255	-2.32242	-1.15388	0.951135	0.423777
USA	-0.39641	0.566301	0.740479	0.913781	-1.2855	-0.35772	0.331478	-0.67457	0.661857	0.848491	0.84697	-0.71729	-0.25081	0.329586
Japan	-0.82911	-0.03865	-1.03811	-0.75544	-1.21637	-1.02879	0.483908	-0.13007	0.419013	-1.07012	-0.86092	-1.29505	-0.94314	0.50482
Korea	-0.85302	0.046645	-0.79862	-1.07372	0.035301	-0.27047	-3.39303	-1.51762	0.174729	-0.39021	0.06372	-0.22879	-0.12967	-2.17765
Australia	-0.81076	-0.44588	-0.26602	-2.02257	0.678851	-0.2376	0.375569	-0.7758	-0.37704	-0.73216	-1.812	0.869699	-0.36704	0.502555
New Zeal	-0.63762	-1.49125	-0.43113	0.80273	1.378415	-0.81685	0.394447	-0.73863	-1.48875	1.306774	0.73466	1.411869	-0.96722	0.432184
IDA	0.8614	0.926392	0.133696	0.646079	0.284387		0.483908	0.344316	1.227931	-0.46644	0.658231	0.499039		0.50482
IDB Special								-1.60865	-1.16157	-1.00667	0.868867	1.596063		0.50482
AfDF	1.176849	0.550528	0.066312	0.804511	0.434994		0.483908	1.50106	0.686322	0.31028	0.740459	0.638867		0.50482
AsDF														
EC	-0.75407	0.129426	-0.07752	0.607013	-0.33362		-1.62426	-0.81389	-0.14381	-0.0061	0.568754	-1.04705		0.108026
IFAD														
GFATM	0.184276	0.632626	0.108762	0.944093	-1.56712		0.483908	-0.41892	0.865888	0.077075	0.868867	-0.51167		0.50482
GAVI	1.126026	0.948913	-2.39292	0.944093	-0.26877		0.483908	1.090041	0.841098	-2.0545	0.868867	-0.58609		0.50482
UN (Selec	0.197623	0.376352	-1.14741	0.944093	-2.66522		0.483908	0.351602	0.439964	-1.01445	0.868867	-2.60376		0.50482

Table A4. Donor standardized scores in Fostering Institutions, 2008 versus 2009

	2008 Health QuODA		2009 Health QuODA	
	Share of allocation to countries with NHP	Support to vital statistics	Share of allocation to countries with NHP	Support to vital statistics
	FI1	FI2	FI1	FI2
Austria	1.545155	-0.60648	0.9390262	-0.748097
Belgium	0.318682	1.592006	-0.0361685	1.2921675
Denmark	-0.12407	1.592006	-0.3336519	1.2921675
France	-0.9519	-0.60648	-0.6196256	-0.748097
Germany	0.401604	-0.60648	0.0471528	-0.748097
Italy	-0.95204	-0.60648	-0.5407643	-0.748097
Netherlands	-0.39865	-0.60648	-0.8831384	-0.748097
Norway	1.743798	-0.60648	1.126044	1.2921675
Portugal	0.718459	-0.60648	0.7924641	-0.748097
Sweden	0.277221	-0.60648	-0.029119	-0.748097
Switzerland	1.460422	-0.60648	0.9217288	-0.748097
United Kingdom	1.001099	1.592006	0.9070027	1.2921675
Finland	1.226661	-0.60648	1.085894	1.2921675
Ireland	0.724463	-0.60648	0.4931549	-0.748097
Luxembourg	-0.76193	-0.60648	-0.3237743	-0.748097
Greece	-0.09835	-0.60648	0.7929051	-0.748097
Spain	-0.68675	-0.60648	-1.28702	-0.748097
Canada	1.179848	1.592006	0.6321111	1.2921675
USA	0.226201	-0.60648	0.147947	-0.748097
Japan	-1.0037	-0.60648	-0.6034612	-0.748097
Korea	-1.4336	1.592006	-2.856534	-0.748097
Australia	-1.02466	1.592006	-0.7082317	1.2921675
New Zealand	-2.05283	1.592006	-2.481659	1.2921675
IDA	0.541766	-0.60648	0.2441406	-0.748097
IDB Special			1.814846	1.2921675
AfDF	-0.44686	-0.60648	0.3804384	-0.748097
AsDF				
EC	-1.69969	-0.60648	0.1823003	1.2921675
IFAD				
GFATM	0.550318	-0.60648	0.1545498	1.2921675
GAVI	-0.20489	-0.60648	-0.0245194	-0.748097
UN (Select Agencies)	-0.07578	1.592006	0.0659611	-0.748097

Table A5. Donor standardized scores in Reducing Burden, 2008 versus 2009

	2008 Health QuODA					2009 Health QuODA				
	Significance of aid relationships (log)	Fragmentation across donor agencies	Median Project Size (log)	Member of IHP+	Share of aid through multilateral channels	Significance of aid relationships (log)	Fragmentation across donor agencies	Median Project Size (log)	Member of IHP+	Share of aid through multilateral channels
	RB1	RB2	RB3	RB4	RB5	RB1	RB2	RB3	RB4	RB5
Austria	-0.97345	-0.97189	-1.21447	-1.25341	-0.285406	-0.21487	-1.36001	-1.14088	-1.20094	-0.31821
Belgium	-0.96231	0.273819	-0.32618	0.788665	-0.8821213	-0.43964	0.299475	-0.64624	0.823118	-0.58241
Denmark	-1.45121	-1.02171	0.659416	-1.25341	-1.047663	-1.31789	0.872639	1.116736	-1.20094	-0.87125
France	1.542367	-1.19326	-0.76837	0.788665	-1.175257	1.743846	-1.6452	-0.3574	0.823118	-1.15298
Germany	-0.55935	0.233864	-0.38904	0.788665	-0.9719216	-1.06543	-0.14171	-0.29973	0.823118	-1.03216
Italy	0.25376	-1.35052	-0.91614	0.788665	-0.559897	-0.4326	-1.04318	-0.91111	0.823118	0.175645
Netherlands	0.086976	0.907011	1.105509	0.788665	-0.1993084	-0.17872	0.872639	1.027669	0.823118	-0.44698
Norway	-0.93491	-0.54983	-0.3363	0.788665	0.9708406	-0.89106	-0.50798	-0.29119	0.823118	0.392599
Portugal	1.070434	0.907011	-0.72136	0.788665	-1.175257	2.431056	-1.00554	-1.57283	0.823118	-1.15298
Sweden	-0.89781	0.907011	-1.2142	0.788665	1.019761	-0.43333	0.871619	-1.7897	0.823118	1.087342
Switzerland	-0.6204	0.547395	0.706697	-1.25341	-0.6325009	-1.08276	0.672972	0.361133	-1.20094	-0.86015
United Kingdom	-0.05468	0.873529	0.433064	0.788665	-0.1818143	-0.17761	0.838211	0.233387	0.823118	0.507965
Finland	-0.34496	0.907011	-0.43648	0.788665	-0.7216645	-0.45023	0.872639	0.203285	0.823118	-0.71131
Ireland	-1.1749	0.907011	-1.03533	-1.25341	-0.7229312	-1.35476	0.872639	0.060773	-1.20094	-0.41311
Luxembourg	-0.59115	0.907011	-0.46399	-1.25341	1.411176	-0.24474	0.872639	-0.35528	-1.20094	0.458393
Greece	0.730532	-1.87385	-0.53381	-1.25341	0.1199859	0.08173	-1.90214	-1.00054	-1.20094	-0.22472
Spain	0.402317	-1.3556	-0.34319	0.788665	1.916707	0.643485	-1.21515	-0.40223	0.823118	0.488362
Canada	-0.49476	0.675041	-0.02884	0.788665	0.8587604	0.678263	0.675504	-0.95699	0.823118	2.574656
USA	-0.01766	-1.10833	0.538007	-1.25341	-0.7136465	-0.11124	-0.86527	0.686238	-1.20094	-0.76847
Japan	0.872751	-1.11289	0.060658	-1.25341	1.108527	0.140943	-0.9397	0.788855	-1.20094	1.422861
Korea	-0.61453	-0.71532	-1.23628	-1.25341	-0.6992591	0.133725	-0.88911	-0.94347	-1.20094	-1.02643
Australia	1.463782	0.907011	-0.20698	0.788665	0.7359278	1.979143	0.872639	-0.19265	0.823118	1.346503
New Zealand	2.904602	0.902846	-0.39348	-1.25341	1.826963	1.930175	0.872639	-0.05984	-1.20094	1.10684
IDA	0.228041	0.907011	1.714982	-1.25341		-0.07642	0.872639	1.940834	-1.20094	
IDB Special						-0.02485	0.872639	0.206084	-1.20094	
AfDF	-1.04202	0.907011	2.419594	0.788665		-1.33981	0.872639	0.740869	0.823118	
AsDF										
EC	0.988593	-0.85638	1.49805	0.788665		0.372869	-0.78864	1.757728	0.823118	
IFAD										
GFATM	0.197519	0.907011	1.876904	0.788665		0.019394	0.872639	2.199789	0.823118	
GAVI	-0.83459	0.907011	0.730353	0.788665		-1.12618	0.872639	0.617245	0.823118	
UN (Select Agencies)	0.827001	-1.37404	-1.17878	0.380249		0.807504	-1.52582	-1.02055	0.418306	

Table A6. Donor standardized scores in Transparency and Learning, 2008 versus 2009

	2008 Health QuODA							2009 Health QuODA								
	Member of IATI	Member of 3iE	Recording of project title and descriptions	Detail of project description (log)	Reporting of aid delivery channel	Completeness of project-level commitment data	Aid to partners with good M&E frameworks	Member of IATI	Implementation of international data reporting standards	Member of 3iE	Recording of project title and descriptions	Detail of project description (log)	Reporting of aid delivery channel	Completeness of project-level commitment data	Quality of Evaluation policy	Aid to partners with good M&E frameworks
	TL1	TL2	TL3	TL4	TL5	TL6	TL7	TL1a	TL1b	TL2	TL3	TL4	TL5	TL6	TL7	TL8
Austria	-1.11801	-0.71286	0.71411	0.250106	0.023336	0.625361	-0.33258	-1.15235	-0.88109	-0.7481	0.603661	0.325368	-0.12931	0.827002	1.529858	-0.2413
Belgium	-1.11801	-0.71286	0.71411	0.792048	0.861424	-0.0824	-0.33889	-1.15235	-0.88109	-0.7481	-2.02456	-2.05732	0.575791	0.413247	-1.61369	-0.16331
Denmark	0.883368	1.354431	0.56552	0.684463	-1.72401	0.033482	0.79767	0.857563	1.121393	1.292168	0.419224	0.64115	-4.03528	0.966615	0.901149	0.884662
France	-1.11801	-0.71286	0.588587	-0.40513	-0.88621	0.202743	-0.41771	-1.15235	-0.88109	-0.7481	-1.31776	0.175877	-0.00039	-1.39067	-0.98498	-0.33432
Germany	0.883368	-0.71286	0.71411	0.229927	0.646168	0.471388	0.821815	0.857563	-0.88109	-0.7481	0.603661	0.337631	0.60658	0.571143	-0.35627	0.541065
Italy	-1.11801	-0.71286	0.628096	0.417131	-0.08178	0.6457	0.885358	-1.15235	-0.88109	-0.7481	-0.14726	0.375466	0.041196	0.930523	-1.61369	0.964632
Netherlands	0.883368	1.354431	0.69819	0.042911	0.274198	-0.35869	0.446046	0.857563	1.121393	1.292168	0.5839	0.190818	0.198989	-0.29994	-0.98498	0.709102
Norway	0.883368	1.354431	0.71411	0.66297	0.758573	-0.08163	0.639978	0.857563	-0.88109	1.292168	0.603661	0.729894	0.566081	-1.87452	0.901149	0.716347
Portugal	-1.11801	-0.71286	-0.80151	0.063336	0.783747	0.558404	-2.25219	-1.15235	-0.88109	-0.7481	0.603661	0.212315	0.630327	0.951159	-0.98498	-1.87645
Sweden	0.883368	1.354431	-1.62077	-0.54933	-0.32935	-0.61384	-0.15557	0.857563	1.121393	1.292168	0.393102	0.591382	-0.24175	-1.95895	0.901149	0.205222
Switzerland	0.883368	-0.71286	-1.91967	-1.99582	0.582747	0.199948	0.526847	0.857563	1.121393	-0.7481	-1.98217	-1.33822	-0.74817	-0.79384	0.901149	0.767238
United Kingdom	0.883368	1.354431	0.71411	0.561625	0.861424	0.224667	0.999834	0.857563	1.121393	1.292168	0.595885	0.589323	0.624252	0.911349	0.901149	0.695129
Finland	0.883368	-0.71286	0.71411	0.680452	-0.68565	-0.18474	-0.50937	0.857563	1.121393	-0.7481	0.603661	0.719556	-0.61956	-0.31798	0.901149	-0.26046
Ireland	0.883368	1.354431	0.358741	0.864732	0.451449	0.452961	0.547005	0.857563	-0.88109	1.292168	0.603661	0.905453	0.133128	0.839994	0.901149	0.657506
Luxembourg	-1.11801	-0.71286	-1.67005	-1.20213	0.857034	0.657322	-0.50349	-1.15235	-0.88109	-0.7481	-1.99965	-1.63237	0.629793	0.909634	-1.61369	-0.33084
Greece	-1.11801	-0.71286	0.71411	0.351381	0.861424	0.617326	-0.11551	-1.15235	-0.88109	-0.7481	0.603661	0.13959	0.630327	0.140182	-1.61369	-0.39054
Spain	0.883368	-0.71286	0.46836	0.480664	0.617587	0.08745	-0.18627	0.857563	-0.88109	-0.7481	0.390562	0.453008	0.307329	-1.31878	-0.98498	0.156853
Canada	-1.11801	1.354431	-0.78807	0.490002	-2.55955	0.482994	0.195503	-1.15235	-0.88109	1.292168	-0.45621	0.750372	0.301254	0.942179	-0.35627	0.148397
USA	-1.11801	1.354431	0.71411	0.809581	-1.18289	-0.2881	0.788599	-1.15235	1.121393	1.292168	0.603661	0.825545	-0.61122	-0.32115	1.529858	0.956567
Japan	-1.11801	-0.71286	-1.95146	-0.66316	0.014685	-0.45868	-0.08573	-1.15235	-0.88109	-0.7481	0.603661	-0.28006	0.617667	0.807637	0.272441	0.262604
Korea	-1.11801	-0.71286	-1.192	-2.71512	0.861424	0.590676	1.307585	-1.15235	-0.88109	-0.7481	0.603661	-2.05732	0.630327	0.712915	-0.98498	1.135779
Australia	0.883368	1.354431	-0.42642	0.170781	-1.705	-2.61068	-2.21448	0.857563	1.121393	1.292168	0.478612	0.662687	-0.64297	-0.00991	0.272441	-1.45604
New Zealand	0.883368	-0.71286	-0.14028	0.41301	0.699215	-3.97109	-3.03962	0.857563	1.121393	-0.7481	0.132934	0.537338	0.535592	-0.83638	-0.35627	-1.90117
IDA	0.883368	-0.71286	0.639195	0.944122		0.659676	0.561649	0.857563	1.121393	-0.7481	0.603661	0.908534		-0.41535	-0.35627	0.293492
IDB Special								-1.15235	-0.88109	1.292168	0.603661	0.006907		0.970689	0.272441	-3.41169
AfDF	-1.11801	1.354431	-1.96051	-2.71512		0.659676	0.547937	0.857563	-0.88109	1.292168	-2.02456	-2.05732		0.965927	0.901149	0.033672
AsDF																
EC	0.883368	-0.71286	0.70966	0.69356		0.386307	0.301981	0.857563	1.121393	-0.7481	0.603661	0.496962		0.192204	0.272441	0.273978
IFAD																
GFATM	0.883368	-0.71286	0.71411	0.463733		0.563878	0.369696	0.857563	1.121393	-0.7481	0.603661	0.902498		-2.43809	-0.35627	0.195687
GAVI	0.883368	-0.71286	0.71411	0.59561		0.203345	0.532792	0.857563	1.121393	-0.7481	-2.02456	-2.05732		-0.00439	0.901149	0.695447
UN (Select Agencies)	-0.71774	-0.71286	0.673276	-0.41632		0.32654	-0.11888	0.857563	-0.4806	-0.7481	0.531276	0.002256		-0.07247	0.901149	0.072748

Table A7. Correlations

Correlation Matrix - Health QuODA	Maximizing efficiency	Fostering institutions	Reducing burden	Transparency and learning
Maximizing efficiency	1.0000	0.1421	0.3546	0.3320
Fostering institutions		1.0000	0.3132	0.2615
Reducing burden			1.0000	0.2583
Transparency and learning				1.0000

		Health QuODA		
		Maximizing efficiency	Reducing burden	Transparency and learning
QuODA	Maximizing efficiency	**0.5491**	0.4959	-0.0697
	Reducing burden	0.3208	**0.6416**	0.0591
	Transparency and learning	0.1736	0.5127	**0.7732**

Correlations across common indicators

Source: Authors' calculations

Table A8. Selected indicators for aid-dependent countries

	Share of untied aid				Share of strict CPA				Significance of aid relationships				Fragmentation across donor agencies			
	2008	2008 z	2009	2009 z	2008	2008 z	2009	2009 z	2008	2008 z	2009	2009 z	2008	2008 z	2009	2009 z
Austria	0.891	-0.249	0.765	-1.206	0.360	-2.260	0.444	-1.677	0.012	-0.997	0.008	-1.104	0.809	-0.051	0.513	-1.239
Belgium	1.000	0.403	1.000	0.458	0.435	-1.893	0.613	-0.922	0.418	-0.303	0.325	-0.547	0.699	-0.532	0.798	-0.040
Denmark	1.000	0.403	1.000	0.458	0.961	0.688	0.971	0.681	0.177	-0.715	0.171	-0.818	0.501	-1.402	1.000	0.809
France	1.000	0.403	0.928	-0.052	0.779	-0.206	0.617	-0.902	0.940	0.591	1.096	0.808	0.505	-1.385	0.305	-2.114
Germany	0.807	-0.753	0.887	-0.341	0.462	-1.760	0.531	-1.291	0.202	-0.672	0.252	-0.674	0.998	0.781	0.993	0.781
Italy	0.604	-1.964	0.616	-2.257	0.714	-0.524	0.769	-0.224	0.130	-0.795	1.373	1.295	0.585	-1.031	0.758	-0.210
Netherlands	1.000	0.403	1.000	0.458	0.977	0.766	0.983	0.735	0.385	-0.358	0.416	-0.386	1.000	0.788	1.000	0.809
Norway	1.000	0.403	1.000	0.458	0.892	0.349	0.857	0.172	0.411	-0.315	0.560	-0.133	0.635	-0.812	0.572	-0.992
Portugal	1.000	0.403	1.000	0.458	0.684	-0.671	0.847	0.128	2.446	3.171	1.900	2.221	1.000	0.788	0.577	-0.968
Sweden	1.000	0.403	1.000	0.458	0.997	0.864	0.966	0.658	0.306	-0.494	0.160	-0.837	1.000	0.788	1.000	0.809
Switzerland	1.000	0.403	1.000	0.458	0.976	0.760	0.966	0.659	0.198	-0.678	0.133	-0.884	1.000	0.788	1.000	0.809
United Kingdom	1.000	0.403	1.000	0.458	0.858	0.179	0.912	0.415	0.643	0.083	0.878	0.425	0.963	0.626	0.968	0.676
Finland	1.000	0.403	1.000	0.458	0.605	-1.060	0.587	-1.037	0.059	-0.916	0.072	-0.992	1.000	0.788	1.000	0.809
Ireland	1.000	0.403	1.000	0.458	0.985	0.805	1.000	0.811	0.750	0.267	0.706	0.122	1.000	0.788	1.000	0.809
Luxembourg	1.000	0.403	1.000	0.458	0.998	0.867	1.000	0.811	0.398	-0.336	0.257	-0.667	1.000	0.788	1.000	0.809
Greece	1.000	0.403	0.772	-1.157	0.587	-1.150	0.223	-2.670	0.014	-0.994	0.010	-1.101	0.845	0.107	0.587	-0.926
Spain	0.627	-1.828	0.792	-1.017	0.664	-0.770	0.479	-1.522	1.405	1.389	1.822	2.085	0.463	-1.565	0.552	-1.074
Canada	0.865	-0.405	0.972	0.259	0.807	-0.068	0.449	-1.657	0.606	0.019	0.712	0.133	0.968	0.646	0.963	0.654
USA	0.996	0.376	0.996	0.427	0.994	0.850	0.996	0.793	1.270	1.157	1.358	1.269	0.462	-1.573	0.505	-1.274
Japan	1.000	0.403	1.000	0.458	0.549	-1.336	0.707	-0.501	0.458	-0.234	0.877	0.423	0.504	-1.387	0.586	-0.934
Korea	0.257	-4.037	0.396	-3.811	0.647	-0.853	0.764	-0.245	0.009	-1.002	0.016	-1.090	0.955	0.590	0.691	-0.489
Australia	1.000	0.403	1.000	0.458	0.982	0.790	0.998	0.801	0.015	-0.993	0.105	-0.934	1.000	0.788	1.000	0.809
New Zealand	1.000	0.403			1.000	0.877	1.000	0.811	0.008	-1.005	0.019	-1.084	1.000	0.788	1.000	0.809
IDA	1.000	0.403	1.000	0.458	0.984	0.798	0.982	0.732	1.221	1.073	1.192	0.978	1.000	0.788	1.000	0.809
IDB Special			1.000	0.458			1.000	0.811			0.373	-0.462			1.000	0.809

AfDF	1.000	0.403	1.000	0.458	0.970	0.728	0.967	0.665	0.887	0.501	0.639	0.004	1.000	0.788	1.000	0.809
EC	1.000	0.403	1.000	0.458	0.943	0.598	0.937	0.529	0.434	-0.275	0.431	-0.361	0.503	-1.392	0.558	-1.051
GFATM	1.000	0.403	1.000	0.458	1.000	0.877	1.000	0.811	1.688	1.874	1.675	1.827	1.000	0.788	1.000	0.809
GAVI	1.000	0.403	1.000	0.458	1.000	0.877	1.000	0.811	0.690	0.164	0.501	-0.238	1.000	0.788	1.000	0.809
UN (Select Agencies)	1.000	0.403	1.000	0.458	1.000	0.877	1.000	0.811	1.056	0.791	1.046	0.721	0.395	-1.864	0.302	-2.126
Mean	0.933	0.000	0.935	0.000	0.821	0.000	0.819	0.000	0.594	0.000	0.636	0.000	0.820	0.000	0.808	0.000
Standard deviation	0.167	1.000	0.141	1.000	0.204	1.000	0.223	1.000	0.584	1.000	0.569	1.000	0.228	1.000	0.238	1.000
Mean for all countries	0.885		0.894		0.784		0.789		2.055		2.142		0.774		0.758	

Selected indicators for aid-dependent countries

	Median project size (log)				Share of aid through multilateral channels			
	2008	2008 z	2009	2009 z	2008	2008 z	2009	2009 z
Austria	-3.833	-1.348	-3.603	-0.989	0.089	-0.324	0.134	0.110
Belgium	-1.728	-0.304	-2.753	-0.598	0.026	-0.589	0.022	-0.527
Denmark	0.242	0.672	0.626	0.954	0.013	-0.644	0.000	-0.653
France	-2.300	-0.588	-1.734	-0.130	0.000	-0.698	0.000	-0.653
Germany	-2.329	-0.602	-2.293	-0.386	0.000	-0.698	0.000	-0.653
Italy	-2.853	-0.862	-2.888	-0.660	0.000	-0.698	0.318	1.162
Netherlands	1.402	1.248	-0.760	0.318	0.034	-0.554	0.056	-0.332
Norway	-2.396	-0.636	-2.129	-0.312	0.135	-0.132	0.093	-0.123
Portugal	-2.629	-0.752	-4.967	-1.615	0.000	-0.698	0.000	-0.653
Sweden	-3.614	-1.240	-5.141	-1.695	0.039	-0.536	0.026	-0.503
Switzerland	0.090	0.597	-2.383	-0.428	0.000	-0.698	0.000	-0.653
United Kingdom	-1.037	0.038	-0.705	0.343	0.102	-0.270	0.150	0.203
Finland	-1.445	-0.164	-0.954	0.228	0.000	-0.698	0.000	-0.653
Ireland	-3.263	-1.066	-1.057	0.181	0.058	-0.457	0.091	-0.135
Luxembourg	-2.083	-0.481	-1.937	-0.223	0.370	0.849	0.151	0.205
Greece	-2.494	-0.685	-5.318	-1.776	0.587	1.753	0.000	-0.653
Spain	-1.554	-0.218	-2.033	-0.267	0.293	0.527	0.144	0.166
Canada	-0.768	0.172	-2.874	-0.654	0.339	0.720	0.318	1.158
USA	-0.057	0.524	0.291	0.801	0.025	-0.591	0.026	-0.504
Japan	-0.042	0.532	0.423	0.861	0.202	0.145	0.382	1.525
Korea	-3.479	-1.173	-3.107	-0.761	0.042	-0.522	0.000	-0.653
Australia			-2.370	-0.422	0.623	1.905	0.725	3.477
New Zealand	0.825	0.962			0.863	2.908	0.000	-0.653
IDA	1.617	1.355	1.609	1.406				
IDB Special			1.705	1.450				
AfDF			-0.260	0.547				
EC	3.848	2.461	2.635	1.877				
GFATM	2.576	1.830	2.926	2.011				
GAVI	0.461	0.781	0.239	0.777				
UN (Select Agencies)	-3.239	-1.054	-3.276	-0.838				
Mean	-1.114	0.000	-1.451	0.000	0.167	0.000	0.115	0.000
Standard deviation	2.016	1.000	2.177	1.000	0.239	1.000	0.175	1.000
Mean for all countries	-1.302		-1.568		0.135		0.142	

Missing calculations due to lack of commitment data

Table A9. 2008 Rankings on Health QuODA for Each Donor

Rankings, 2008	Maximizing efficiency	Fostering institutions	Reducing burden	Transparency and learning
Austria	29	7	29	17
Belgium	16	3	20	16
Denmark	1	5	27	9
France	25	26	18	22
Germany	19	16	19	6
Italy	22	27	23	13
Netherlands	2	22	6	5
Norway	4	6	16	2
Portugal	17	13	12	24
Sweden	7	17	13	18
Switzerland	8	8	21	21
United Kingdom	10	2	9	1
Finland	13	9	14	15
Ireland	3	12	26	3
Luxembourg	9	25	15	25
Greece	26	20	25	14
Spain	21	24	11	11
Canada	15	1	10	20
USA	14	18	24	12
Japan	27	28	17	28
Korea	28	11	28	23
Australia	24	10	4	27
New Zealand	18	19	2	29
IDA	6	15	7	4
IDB Special*				
AfDF	5	23	3	26
EC	23	29	5	8
GFATM	12	14	1	7
GAVI	11	21	8	10
UN (Select Agencies)	20	4	22	19

*IDB does not have any health projects for 2008.

Table A10. 2009 Rankings on Health QuODA for Each Donor

Rankings, 2009	Maximizing efficiency	Fostering institutions	Reducing burden	Transparency and learning
Austria	29	11	29	16
Belgium	13	8	19	30
Denmark	2	9	22	7
France	26	27	20	28
Germany	22	20	24	12
Italy	19	25	21	23
Netherlands	1	28	7	4
Norway	6	2	17	8
Portugal	16	14	18	26
Sweden	9	22	12	6
Switzerland	10	12	26	22
United Kingdom	8	4	6	1
Finland	17	3	11	11
Ireland	4	15	25	2
Luxembourg	7	23	16	29
Greece	30	13	30	27
Spain	24	29	13	21
Canada	20	5	3	14
USA	12	18	27	3
Japan	27	26	14	17
Korea	28	30	28	25
Australia	25	10	2	9
New Zealand	15	24	5	18
IDA	5	17	8	10
IDB Special	18	1	15	24
AfDF	3	16	10	19
EC	21	6	4	5
GFATM	11	7	1	15
GAVI	14	21	9	20
UN (Select Agencies)	23	19	23	13

Table A11. Change from 2008 to 2009	Maximizing efficiency	Fostering institutions	Reducing burden	Transparency and learning
Austria	0	-4	0	1
Belgium	3	-5	1	-14
Denmark	-1	-4	5	2
France	-1	-1	-2	-6
Germany	-3	-4	-5	-6
Italy	3	2	2	-10
Netherlands	1	-6	-1	1
Norway	-2	4	-1	-6
Portugal	1	-1	-6	-2
Sweden	-2	-5	1	12
Switzerland	-2	-4	-5	-1
United Kingdom	2	-2	3	0
Finland	-4	6	3	4
Ireland	-1	-3	1	1
Luxembourg	2	2	-1	-4
Greece	-4	7	-5	-13
Spain	-3	-5	-2	-10
Canada	-5	-4	7	6
USA	2	0	-3	9
Japan	0	2	3	11
Korea	0	-19	0	-2
Australia	-1	0	2	18
New Zealand	3	-5	-3	11
IDA	1	-2	-1	-6
IDB Special				
AfDF	2	7	-7	7
EC	2	23	1	3
GFATM	1	7	0	-8
GAVI	-3	0	-1	-10
UN (Select Agencies)	-3	-15	-1	6

Table A12. Share of health aid with the objective of decreasing gender inequality.

	2008, %	2009, %
Austria	0.6615404	0.5517077
Belgium	0.5234019	0.7919376
Denmark	0.2849143	0.4750341
France	0.0799658	0.1501861
Germany	0.8945448	0.8791162
Italy	0.1603719	0.2047571
Netherlands	0.4263462	0.4926361
Norway	0.6872964	0.6834884
Portugal	0.1489179	0.1439132
Sweden	0.9586947	0.9758974
Switzerland	0.2313055	0.4705623
United Kingdom	0.4085909	0.7679721
Finland	0.6723127	0.7098302
Ireland	0.565768	0.6986479
Luxembourg	0.1680894	0.2465381
Greece	0.351023	0.3230859
Spain	0.3276288	0.4193304
Canada	0.3810595	0.4590606
USA	0	0.4356206
Japan	0.1307142	0.4277683
Korea	0.2614827	0.1931211
Australia	0.5349767	0.4161304
New Zealand	0.7549482	0.786755
IDA	0.1175495	0.0912478
IDB Special	N/A	0
AfDF	0	0
EC	0.3097992	0.3314569
GAVI	0	0
GFATM	0	0
UN (Select Agencies)	0.0597209	0.0573238
AVERAGE	0.348309086	0.406104177

Appendix 3. Aid Effectiveness in Health: A List of Country-Specific Cases

Aid Effectiveness in Health: A List of Country-Specific Cases (Google/Medline/Econlit search using combinations of following keywords: aid, assistance, effectiveness, health, governance, harmonization, coordination, JANS, SWAp, ownership, case study, country specific)

Country	Paper Name
(Main findings)	
Nepal	**Harmonization of Donor Assistance in Nepal**
Harmonization of donors deemed to be inefficient; aid integration plan did not work.	
Uganda	**Joint Assessment of Uganda's Health Sector Strategic & Investment Plan**
Uganda has led the Public Financial Management (PFM) reports in Africa; Adequate national regulations; Orderly budget process; Fiduciary and financial problems come from the lack of sanctions/remedies/training/shortage of qualified staff; No clear prioritization plan	
Tanzania	**Health Spending in Tanzania: The Impact of Current Aid Structures and Aid Effectiveness**
Need for sustained policy dialogue; Need for more transparent consultation processes; outreach to CSOs; CSO capacity and partnership should be built; increased coordination under JAST helped increase efficiency, but non-state actors were excluded; SWAp program in effect; Possible conflicts between IHP+ and EU - too many parallel structures?	
Uganda	**Can donor aid for health be effective in a poor country? Assessment of prerequisites for aid effectiveness in Uganda.**
Between 2004-2007, the level of aid increased from US$6 per capita to US$11. Aid was found to be unpredictable with expenditure varying between 174-360 percent from budgets. More than 50% of aid was found to be off budget and unavailable for comprehensive planning. There was disproportionate funding for some items such as drugs. Key health system elements such as human resources and infrastructure have not been given due attention in investment. The government's health funding from domestic sources grew only modestly which did not guarantee fiscal sustainability.	

Uganda **Global Health Initiatives and aid effectiveness: insights from a Ugandan case study.**

Results: The Ugandan government had a stated preference for donor funding to be channelled through the general or sectoral budgets. Despite this preference, two large GHIs opted to allocate resources and deliver activities through projects with a disease-specific approach. The mixed motives of contributor country governments, recipient country governments and GHI executives produced incentive regimes in conflict between different aid mechanisms.

Kenya **A Case Study of Aid Effectiveness in Kenya, with a focus on Health**

Very volatile aid; health aid volatility higher than overall aid; Very fragmented compared to other countries; Efforts to align sectoral distribution of external resources with priorities

Vietnam **Player or referee? Aid effectiveness and the governance of health policy development: Lessons from Vietnam**

Qualitative analysis; Principles of aid effectiveness have political ramifications

Lao PDR **Paris on the Mekong: Using the aid effectiveness agenda to support human resources for health in the Lao PDR**

Research shows pathways where aid effectiveness is promoting an integrated response. 1) efforts to improve governance and accountability, 2) budget support is the best method to implement, 3) Harmonization is crucial, donor support should be increased to support systems

Zambia **Stakeholder perceptions of aid coordination implementation in the Zambian health sector**

In order to achieve the aims of the Paris Declaration; to increase harmonization, alignment and ownership--resources from donors must be better coordinated in the health sector planning process; This requires careful consideration of contextual constraints surrounding each donor.

Uganda **Health spending in Uganda: the impact of current aid structures and aid effectiveness**

Recommendations include donors advocating Uganda to reach the Abuja target of 15% More ownership through CSOs. Study finds that 21% of EU aid in Uganda relies on budget support. SWAp support accounts for 40% of Uganda's health sector resources. Need USD 40 per capita - currently have USD 10 per capita - to sustain the minimum healthcare package

Botswana, Ethiopia, Mali, Mozambique, Tanzania and Uganda The pooling of technical assistance: an overview based on field experience in six African countries

Reviewed technical assistance pooling procedures in six countries. Found that there were serious capacity shortages - SWAps exacerbate such shortages, which lead to additional requirements for TA to address capacity gaps. Mixed assessment of efficiency gains from TA. In some cases, TA pooling highlights the comparative advantages and costs of different providers, and thus increases transparency. There is some evidence of a correlation between the use of TA pooling and the crafting of better sector strategies and policies. TA pooling is affected by: policies/organizational context, behavior within international funding community, structure and management of the broader aid relationship between government/IDA community, design and management of sector programme support

Malawi Impact evaluation of the SWAp in Malawi.

There are some suggestions that the rate of improvement is declining (suggesting that perhaps easier gains have been made, that the SWAp is performing less than ideally or that external factors are responsible).While far from achieving MDGs, progress has been made under SWAps.. Aid dependency increased during the period. The SWAp has enabled two broad systems issues – the delivery of a prioritised essential health package and human resources – to be addressed in ways which would almost certainly not have been possible under earlier vertical approaches. Increase in resources due to SWAp. Health outcomes have been improving at more rapid rate than comparable countries – and though the health status of poorer groups has generally been improving, equity in health outcomes does seem to have been declining. The increased role of public financing of health care and the corresponding decline in the share of private funding and the fact that the resources appear reasonably welltargeted should have afforded the population – and especially the poor – greater protection against health care costs.

Ethiopia A Case Study on Aid Effectiveness in Ethiopia - Analysis of the Health Sector Aid Architecture

Coordination, fragmentation and unpredictability key problems. Small projects. SWAp, for instance, has not been effectively exploited by either the government or donors to improve aid predictability or harmonize funding arrangement. Progress made when transaction costs are reduced. Governance and rule of law overarching problems. Parallel mechanisms should be reduced

Uganda Global Health Initiatives and aid effectiveness: insights from a Ugandan case study

The Ugandan government wants donor funding to be channeled through general or sectoral budgets, but two large GHIs allocate proejcts through a disease-specific approach: budget support still not deemed feasible by donors.

El Salvador Health spending in El Salvador the impact of current aid structures and aid effectiveness

"International cooperation needs to become more needs-based, specifically in the health sector, where European and other donors are still concentrating a disproportionately high amount of financial resources towards the fight against specific diseases and health infrastructure financing. The government of El Salvador will need to overcome inequities in terms of per capita distribution of financial resources to health by reforming the health sector's currently fragmented structure. Donors could support the government in this aim, for instance by providing technical assistance and advice."

Mozambique Health spending in Mozambique the impact of current aid structures and aid effectiveness

Pooled donor funding made available for CSO capacity-building is seen as a positive mechanism by civil society in Mozambique. General Budget Support (GBS): at least 15% of such funding should be targeted at supporting non-state actors, national parliaments and local authorities. Vertical funds should complement HSS. In the light of the new donor landscape in Mozambique, European donors should advocate for the recognition, by the country government, of health as an investment and highlight the need to jointly re-commit to a post-2015 MDG frameworkNeed for a results focus

Ethiopia Aid effectiveness in the health sector: case study

Political disagreement: Donors are reluctant to start delivering on their commitments because of their political differences. In addition, the IHP+ does not include Ethiopia's largest donors, the Global Fund and the US President's Emergency Plan for AIDS Relief (PEPFAR), which constrains the initiative and its outcomes. Major vertical donors in Ethiopia are showing positive signs of change. PEPFAR and GF are increasing alignment. Democratic ownership is missing in Ethiopia

Zambia Aid effectiveness in the health sector: case study

"The IHP+ Compact did not include vertical donors, such as PEPFAR and the Global Fund. These organisations are currently Zambia's largest donors to the health sector. Internal regulations do not allow both these donors to provide aid through local financial management systems, preventing them from aligning their aid flows. As a consequence, project aid tends to dominate the activities of vertical funds. These problems and the amount of resources mobilised by vertical funds, transform them into a major obstacle in the implementation of the aid effectiveness agenda. "

Mozambique The Global Fund operating in SWAp through a common fund: issues and lessons from Mozambique

GF coordination with national development strategies is essential for aid effectiveness. Coordination in the sector level

Uganda The Uganda health SWAp: new approaches for a more balanced aid architecture?

The evidence points to the need for a more balanced architecture of development assistance for health which: promotes the active participation from global financing partnerships with other donors acting within the framework of common co-ordination structures; enables effective use of non-financial resources; and is informed by financial planning frameworks. [adapted from authors]

India, Sierra Leone, Uganda Assessing the impact of global health partnerships: country case study report (India, Sierra Leone, Uganda)

Global Health Partnership brought more funds, but not always predictable and problematic at times. Donors should invest more in HSS; complement resources brought in by HSPs