Een rapport over resultaten van Belgische financiering voor Ontwikkelingssamenwerking in de Gezondheidssector van 2009-2017

Executive Summary

Why a knowledge document?

Present report documents the determination of the Belgian development cooperation for transparency, effectiveness and impact. The report covers a decade of development cooperation: starting with the year 2009 up to 2017 and even beyond. The report examines results of ODA for Health and deals extensively with the Directorate General for Development Cooperation's (DGD) role.

Scrutinize what kind of Health donor Belgium is

DGD spent nearly € 1.5 billion in health from 2009 until 2017, thus financing a total of 764 interventions, governmental and non-governmental cooperation altogether. For the Belgian Development Cooperation, supporting health in developing countries means, developing a functional healthcare system. Increasing universal access to essential, good quality healthcare services, is a clear-cut priority.

Belgium allocates 60% of aid for health to specific countries of which 99% are 11 African countries in fragile situations. Aid allocation is managed in short programming cycles of 3, 4 or 5 years. Though the report points to a *de facto* long-term presence in the health sector. Multilateral organizations focusing health were allocated 31.1% of the funding, the EU 12%, the governmental development cooperation 28.9% and the non-governmental cooperation 27.2%. Of all multilateral organizations, the Global Fund to combat AIDS tuberculosis and malaria (GFATM), received most (40%) of the multilateral funding for health. The World Health Organization (WHO) comes second, (18%).

Scope

The research question is twofold: (1) the achievements of DGD investments during the period 2009-2017 and (2) lessons that DGD can draw in view of taking better decisions in the future. Present report is expected to be contributing to the improvement of DGD knowledge management systems. The report is not pretending to be a scientific (impact) study nor an evaluation but rather a learning exercise by and for DGD.

Approach

To assess the effectiveness of governmental interventions, we relied partly on the output of the *More-results* system from Enabel, sole implementer of Belgian governmental aid. For non-governmental spending, the report relies on available documentation and transcribed oral exchanges with some

important Belgian non-governmental actors. To understand how Belgium “influences” decisions in multilateral organizations and the EU, colleagues responsible in DGD as well as a number of supporting documents such as the DGD *multi-fiches* and evaluation reports from the multilateral organizations were consulted.

A document study including 23 governmental health projects in 5 African countries, Benin, Burundi, DRC, Rwanda and Uganda, completed in the period 2009-2017, guarantees sufficient representativeness. However it was impossible to make general statements for multilateral, non-governmental and EU development cooperation. A case study on social protection in health attempted to "confront" and connect activities of different Belgian actors and other donors in Senegal.

Context

The health sector of the 11 partner countries of Belgian development cooperation is characterized by a structural shortage of resources. The out-of-the-pocket costs for patients are too high which results in less than 50% of Africans consulting a health worker. These countries, do not yet spend enough per capita to guarantee minimal care, even if figures take into account external (e.g. donor funds) and private resources (insurance or domestic contributions). External resources usually exceed domestic and private resources. However, development cooperation seems not to discourage the governments of the 11 selected countries to use domestic resources for the health sector. The health sector is above all a crowded sector with donors shaping their activities based on at times contrasting assumptions. Despite all efforts, these countries will not reach the Health SDGs. It will be long before these countries will have sufficient resources to guarantee a reasonable level of health care for their population.

What the ministry might learn from the report on its development cooperation for health

The study found that Belgian governmental cooperation for health is globally effective. Partner countries show gradually improving health indicators. Government-to-government projects resulted in improved referral systems and accessibility of health care to the population in project areas. However, "access" to healthcare is not a regular and common indicator used by Belgian health actors to assess their projects. Raison why it was impossible to draw general conclusions. Enabel translates the assiduous focus on strengthening health care systems, into what they call a *double anchorage*. It appears to be a functional model for health support. The report is also positive about how Enabel adapted the modality of Performance-Based Financing and the Belgian contribution in Rwanda to sectoral budget support were the embassy plays an apparent role in political dialogue.

Belgium makes a major effort to align with policy choices of partner countries. As a result, dependency on government policy makes governmental cooperation extremely vulnerable to political decisions as well as to the quality of policies of assisted countries. This dependency is multiplied by opting for pilot projects that, upon successful completion, rely on the willingness of the supported Government to upscale the pilot experience. Sustainability of the achievements are therefore always uncertain. The study questions the pilot approach for an extreme fragile situation as is the case in the DRC. But even in Benin the longstanding investments in a system of performance based finance, are finally not taken up by the actual government.

In the health sector the study describes the approach of a number of strong Belgian NGAs and notices that they seem to act in accordance with the Belgian health strategy paper. More recently NGA's became implementers for other donors. However, the report cannot make statements about results of non-governmental actors. Firstly, because DGD collects insufficient information for that purpose. Secondly, because the Knowledge Document has only collected in-depth information on a few NGAs. It is still uncertain whether, DGD will be able to do so and whether the reform of 2015 has created enough incentives and clarity for NGA's in order to get sufficient results information in the future to justify money spent.

Effectiveness of EU activities in health is as well difficult to assess and remains anecdotal. Evaluations used for the Knowledge Document allow a number of positive conclusions: for example, joint programming adds value to development cooperation of EU and its Member States, but potential of cooperation has not yet been fully exploited. An evaluation of budget support shows that public finance management is a crucial issue for the health sector by linking it to improvement of the infant mortality rate of assisted countries. Results-oriented management of EU can still be improved. We found that a large donor like EU, with an extensive portfolio and programs on an ambitous scale, is well placed to make relevant judgments in the sector via its evaluations. EU has the potential to deliver useful lessons for all health actors, including Belgian actors. The report details how an EU health evaluation in the DRC has learning potential for other actors.

Observations in embassy reports on WHO show a mixed picture about the organization. Statements about GFATM are consistently critical, notwithstanding the large amount of Belgian funding. MOPAN assessments provide useful information about WHO. Results reporting practiced by GFATM is mostly focused on output, as such mixing contribution and attribution thus making questionable statements.

Belgian development cooperation actively contributes to social protection for health. Unlike the strong focus on healthcare system strengthening, Belgium appears to be a less coherent donor in this domain. DGD ultimately accepts conflicting approaches, seemingly unaware of the problem and does not have a mechanism to work towards a coherent line of conduct by all Belgian development partners, in the same partner country.

What the report learns about DGD's strategic work

Belgium can build on an exceptionally coherent package of activities in health. The focus on strengthening healthcare systems is a guiding principle that *de facto* links all Belgian channels. Social protection activities however do not show such coherence. Belgium finances different models of health insurance schemes.

Governmental aid makes a strong effort to align to government policies and adheres to the mandate and role of WHO, expertise of Belgian research institutions, especially Antwerp Tropical Institute, and the strategic unit within Enabel-Brussels.

Although Belgium and EU seem to share the same vision on system approach for health, it was never subject to an open policy. Moreover, the EU is *de facto* a genuine leveraging companion of Belgian

development ambitions in the health sector in Central Africa. EU acknowledges the Belgian expertise on health systems strengthening and devotion to Universal Health.

Despite a positive attitude towards WHO, Belgian's aversion to vertical approaches and clear preference for horizontal ones*, in casu* healthcare system strengthening, it is surprising that GFATM receives more than the double of what UNWHO receives. The longstanding donor relation with GFATM is not matching the vision emanating from the Belgian health strategy. Moreover, efforts to influence GFATM through the EC constituency in the GFATM, did not bring any notable change in its vertical approaches.

What the report learns from DGD's knowledge management.

Knowledge management is generally problematic. DGD is badly equipped to follow-up its strategic focus and learn from partners' experiences. First difficulty is lack of strategic planning per partner country which never goes beyond the short timeframes of usual program cycles. Second handicap is lacking overview of achievements. Furthermore, context-related information (fragility) is not reflected on in strategy notes and approaches.

Belgian governmental cooperation in health encounters the consequences of fragile situations. On the ground, the study noted unexpected permeability between EU, Belgian governmental and non-governmental activities, especially in Burundi and the DRC. NGA's are actively engaged in research and training and probably the main reason for *de facto* coherent Belgian approaches in health and good understanding with Health authorities in partner countries. DGD administrative documents are not/can not taking into account this reality.

Multiple procedures (dialogues, reporting tools, assessments) meant as quality support mechanisms for better performance of Belgian NGA's, are poorly utilized by the ministry. Track records and overviews of successive interactions with NGAs, beyond programming cycles, are inexistent. For example, it is not documented whether DGD has given *Memisa* sufficient incentives for effective and rigorous use of monitoring and evaluation systems in order to document results.

Taking cognizance of evaluations, and introducing them into ready-to-use knowledge, is still an unexplored chapter that could also be of use in preparing positions for EU meetings.

The Multilateral Organization Performance Assessment Network (MOPAN) is an underutilized source of information. The network offers opportunity to assess effectiveness of important multilateral organizations. There is still a lot of untapped information requiring systematic use, such as field observations, studies, assessments and evaluations for effective positioning in the multilateral environment.

Recommendations

For the health strategy paper to let it play its role in programming decisions, reference to the following topics (non-exhaustive) in a ***country (knowledge management) file*** need to be made: (1) government decisions that are important milestones for local health sectors, (2) Belgian achievements and contributions to progress in the local health sector, (3) Belgian/European positions taken by Belgian development cooperation in the course of local policy dialogues, (4) (Belgian and/or local) resource

persons with good knowledge of the health sector, (5) NGA's/(local)resource persons known for their specific expertise in health. (6) Former foreign students of Tropical Institute of Antwerp that returned to their country and actively contribute to shaping the health sector in their country.

Translate and integrate transversal themes in the health sector policy note. Gender, social protection, fragility, environment are all subject to separate strategy papers and need translation into health objectives. The role of civil society in the health sector should be subject of reflection, allowing health NGAs clarify and valorize their specific expertise, position and contribution to health.

Influence and cooperate with the EU for health: a theme for a reflection note. Consult evaluations about health activities and convert them into useful information and knowledge in order to underpin dialogue on health within EU. We need to better map EU cooperation and its results. In order to make such a compilation useful, EU non-experts should understand how to "lobby" for quality development cooperation in health through EU *comitology*.

Document successes and failures and draw lessons serving as a basis for assessing Belgian sector strategies. Certain information can only come from elsewhere, though, ultimately DGD will have to tailor supplied knowledge to its needs. The Be-cause-Health network could play a role in DGD's knowledge management system, if only the ministry would/could make clear requests to the network so that it generates useful knowledge for Belgian policy decision making processes.