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**The Challenge of Donor Coordination in Global Health -  
What's at Stake?  
Kaiser Family Foundation, Washington DC  
April 22, 2014**

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**JEN KATES, PhD:** We know there are multiple donors providing aid to low and middle income countries. In some cases, close to 20 on a single issue in a single country and there's now a much more heavy emphasis on the role of host governments, host countries, and civil society in helping to promote, design, and own their own response. So it raises a lot of challenges. Indeed, the proliferation of donors has created challenges for negotiating, for coordinating, and for delivering effective programs that support civil society, that support services and, of course, uphold other established principles for development assistance.

To explore this question, we at Kaiser did some analyses that were really designed to be a backdrop to at least help us understand which donors are providing support on which issues in which countries. It's perhaps a first order question. If you don't know that, it's hard to even go further and say is it working, is there a need for more coordination, are there too many donors on an issue, not enough, or something else. So I'm going to provide some overview findings from four analyses we did on HIV, TB, malaria, and family planning and reproductive health. These are all available to you as individual reports and what I'll do is just provide some findings from across the reports.

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For today, we wanted to have a conversation with you and with our esteemed group of experts from different perspectives. We know that the issue will not be resolved today but perhaps we can all shed some light on new opportunities for moving forward. In our conversations that we were having with the panelists leading up to this and just this morning there are—this is a really important moment. There's a lot happening and a lot of opportunity we think to seize on some of the energy around this and perhaps find ways to make it better.

As I mentioned, I'll first present the findings and then I'll sit down and have the panelists join me. Their full bios are in your packets but let me just let you know who we have with us today and thank them very much in advance for being here. We have first Ariel Pablos-Méndez who is the Assistant Administrator for Global Health at USAID and thank him for being back here with us.

We also have Shu-Shu Tekle-Haimanot who is a Geneva-based Senior Specialist in Governance for the Global Fund to Fight AIDS, TB, and Malaria and we really thank her for being here from Geneva.

Matt Kavanagh, Senior Policy Analyst at Health GAP and Josh Michaud, my colleague here at Kaiser who's Associate Director for Global Health. As I mentioned, they'll join us.

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Let me just give you a sense of what we found when we look across these four areas and this is just really designed to illustrate some of the potential issues that we could discuss. So what we know what the global context is, right? There's many, many donors, there's an increasing number of large-scale global health initiatives, and there's evidence from different studies of aid fragmentation, redundancy, inefficiency, and, of course, burden on host countries. We'll hopefully get at some of that in the panel discussion.

So what does this mean? There have been calls for greater donor coordination. Those started a while ago and I tried to identify many of these and you can see there's all of these general moments in time when the donor community and others came together and said we need to harmonize, we need to coordinate. Here are some of the key milestones in that effort and here are some of the health-focused ones and we still know that there's fragmentation, there's lack of coordination and burden. Having these principles doesn't necessarily translate into a better system.

We know that if you a low or middle-income country or an NGO working in that country; often you might not know who is actually providing assistance on a particular issue in your country. We can talk about it but those of us who have gone and talked to ministers of health, ministers of finance about a

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particular issue, often that's what you hear. I actually don't know who's providing what. It doesn't come to us directly or we don't have that transparency.

How do they best identify donors whether it's a country or civil society? How does civil society know what the gaps are if there's not a transparency around who's supporting different areas? Are donor governments themselves aware of one another's presence? In some countries there's a lot of coordination; in others there's not. What does this mean in the current era of austerity and the increasing focus on country ownership?

What we did is we want to map the landscape to some extent in a few key areas. We looked at a three-year period of data from the OECD to look at donor presence and magnitude so this is a very specific data set. It doesn't capture all donors, it doesn't capture private sector donors for the most part. It captures governments, donor governments, and multilaterals that provide aid, ODA to low and middle-income countries.

We looked over a three-year period to capture some fluctuations. We looked at four areas. We looked at disbursements. We wanted to actually look at the amount of money being provided to the country and this just tells you who was included in that.

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Looking across the four there were some interesting things. First, if you want to know how many donors, in this three year period, how many donors were there in each of these sectors here you can what's interesting is HIV, and family planning, and reproductive health have the most number of donors. That means there were 37 donors that provided HIV assistance to low and middle-income countries that provided at some point in that three-year period, 36 in family planning and reproduction health, fewest on TB, and a little bit more on malaria.

In terms of recipients, for all the donors, how many recipient countries were there? You can see, again, reflecting more donor HIV and family planning had the most number of countries that received some assistance, then TB, and then malaria. This is interesting. The top five by each sector and these are all in your packet so if you want to look at the data later you can but you can really see that there is a tremendous concentration of donors in each of the sectors. One interesting thing, and you can see it a little bit here too, this is the bilateral and multilateral breakdown, is that the Global Fund really matters, obviously, and that's particularly the case for HIV, TB, and malaria, but for TB and malaria where the Global Fund is the major supporter of TB and malaria in the world. In HIV the reason it is the opposite is because of

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PEPFAR primarily and in family planning and reproductive health there is no equivalent of a Global Fund so most of the resources provided to family planning and reproductive health are bilateral so you can really get a sense of this.

If we look at the average number of recipients per donor, so this says for example, take a donor, on average how many countries are they reaching; 40 for HIV, 11 for malaria. Just to think about this, this means the US, for example, provides assistance to maybe close to 80 countries on HIV and some provide much less so on average it's 40. On average, a given donor provides assistance to 11 countries on malaria.

Here I think is a very interesting picture from the recipient perspective. On average, how many donors are working in your country on a particular issue? On average, eight donors on family planning/reproductive health, 10 on HIV, far fewer on TB and malaria.

Here's just a picture. We have these for each of the areas but the darker shades are where there's many more donors so you can see there's some countries where there's just a tremendous concentration of effort. That may be good, having that many donors could be important, in some cases though maybe it's too much and maybe there's an imbalance.

This is another way to think about it. This is, countries that have more than 15 donors for family planning

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and reproductive health, so Nicaragua and Tanzania, 20 donors each. Is that good, is that bad? It's hard to know but it does raise some questions. And then you can look at on the flipside we're not showing here, some countries have very few donors on a particular issue. Does that raise issues of vulnerability?

All of these present some questions that I hope we can get at in the panel. There's a large number of donors as we knew but it puts a premium on the need for transparency and coordination. At the same time, as you saw, there's very significant concentration among a small group and this suggests potential vulnerability. If most of a sector is funded by two or three donors, if one of those donors makes a change, changes priorities, has an economic shift, that could have real implications for that sector. It's not that there's an even distribution across donors so it's really dependent on a few donors.

What about new and non-traditional donors? We weren't really able in this data set to capture many of the emerging economies that themselves are becoming donors. We also didn't look at domestic financing which is such a key part of this. Private sector, so that's another part and that can address some of the potential vulnerabilities to funding shifts but it also raises other questions about coordination. If new actors

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are coming in is it an opportunity to do better or are there, again, potential challenges?

Domestic resources, and also I think a question that's important to ask is does coordination necessarily lead to increased effectiveness? I think we all believe that it's good but I don't think we should lose sight of the fact that it may be the thing that's going to give us the more effective response all the time. Coordination just for coordination's sake is not necessarily the goal here. The goal is better health programs and health outcomes.

What can be done and that is where I'm going to turn to our panel and ask them if they would please join me up at the podium. I'll have a little dialogue with them and then we'll turn to you for some questions. Thank you.

Let's turn to our panelists and, as I mentioned, I'm going to have each of them say a few words about this topic. We've had extensive conversations leading up and we asked them to be part of this because of their different perspectives on the issue so I'm going to first start with Ariel and let you say whatever you want about this topic. I know the focus on coordination and partnership has really been very much enhanced in the last few years. You've led a lot of work so I'd love to hear from you as to what the status is, what your thoughts are, really what can be done.

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**ARIEL PABLOS-MÉNDEZ, M.D./M.P.H:** Thanks. It was interesting your presentation, which is great to bring a unique lens to an issue that has always been discussed but to make it clear so thanks for doing that.

We were just discussing what is right. It's three, or ten, or five? We don't seem to have an answer to what is right so it makes it a more difficult conversation even having the data and the numbers. I also like to cite David Fidler who spoke of when people discuss the global health architecture and better coordination and he spoke of open-source anarchy. That in a way, the enthusiasm to support global health has led to many players coming in and that has changed the landscape mostly for the good. I think that the MDGs have been helpful because even though they do not control every action they set a direction for many to contribute too.

That said, for many ministries, for many ministries and many governments it is a headache to have to manage so many donors in some places and so the question is what is reasonable, what is appropriate to continue to harness the goodwill of people who want to support global health and do it in a way that is sufficient, and effective, transparent.

I think that for each area there have been processes. In a way, for HIV/AIDS when you put PEPFAR, and the Global Fund, and UNAIDS' Three Ones or some other three one here they

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oversee the majority of what happens really in that space. The Stop TB Partnership was set up in the year 2000 with that explicit purpose of better coordination and it has been helpful. The partnership knows what money is going for what where and allows some sense of coordination I think. I am familiar with the Stop TB Partnership from the early days quite well.

Malaria to some extent and family planning has been a recent increase in players, which is welcome. And with Family Planning 2020 we have an ongoing platform for that coordination but most of those are at the global level and the challenges are really in-country. It is for that, although there were many motivations that led to the creation of the IHP+, International Health Partnership. We are happy USAID has joined the IHP+ global compact and beginning to invite our country missions to also join.

Every time I visit country missions we always meet with the roundtable of donors and they happen to have ongoing relationships among themselves and, oftentimes, also with the ministry of health. In some places it's better than in other places. We are hoping the IHP+ helps formalize that relationship between the governments and the donors to know what's going on and what's going to happen, and how do we do it

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together. I've seen many great examples of that happening in countries.

**JEN KATES, PhD:** Shu-Shu, I'd love to get your perspective for a couple of reasons. One is the Global Fund is such a key player and funder of HIV, TB, and malaria and I would say in helping to reconfigure the response on the ground and the new funding model but also your role there. You work on governance issues and work with countries on partnerships in the AU in particular and so these issues I know you're constantly thinking about and trying to figure out how to help countries do a better job.

**SHU-SHU TEKLE-HAIMANOT, M.P.H.:** Thank you. First, I'd like to say thank you to Friends US and Kaiser for inviting the Global Fund. I think this is a very timely discussion because we in the Global Fund have been criticized for a number of years for not really coordinating with in-country donors, not coordinating with country processes and priorities.

I was saying that this is a very timely discussion, particularly for the Global Fund because in the past, the Global Fund has been criticized for not following coordinated processes at country level, for not working with in-country donors. So this is an important topic for us and as the Global Fund is now in an evolving and learning stage, particularly we are changing and constantly improving because we were set up as

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a 21st century institution. We have now launched the new funding model where we hope through the country dialogue processes that coordination will improve mainly through engagement by partners, engagement by governments, by civil society and this is really important.

Coordination for the Global Fund is important for a number of reasons because we don't have country presence so we rely on our partners and our donors to be able to really steer the ship if you will. It's important for a number of reasons. One, it's to build relationships. You build relationships in that coordinated mechanism. You build trust with people. You have dialogue as opposed to saying here it is, you know at the global level you've decided everything and implemented it but you're having a dialogue at country level to be able to understand their problems. You get to influence. There's a lot of influencing that happens in those discussions whether it's political, or programmatic, or technical influences. You are also understanding the context, the evolving situation of what happens in the health sector. It's really important to also insure that you are having an integrated group effort to all the processes that are happening in the health sector.

I think for us one of the lessons learned and from many of the work that we have been doing is that while global coordination mechanisms are good, they have to be able to

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interpreted at country level and adopted to country context and that these have to come with a binding document with clear delineated roles and responsibilities. For us, this is really important for maximizing all the resources but also for maximizing engagement by governments as well. Thank you.

**JEN KATES, PhD:** Matt, you and I have had many conversations over the years about the issue of transparency and about, particularly from the perspective of civil society and how civil society needs to understand the landscape to be able to weigh in and help monitor and implement programs. Most of the work I know you've done personally is on HIV but Health GAP looks more broadly at the health sector, maternal and child health and other areas so just love your perspective on this. I know that you recently were in South Africa seeing this firsthand where there's been some progress but also some challenges.

**MATTHEW KAVANAGH:** Thanks, Jen. I think from the civil society and the kind of watch-dogging and monitoring both the US government and at country level with partners there, I think we see three big areas that I think would be worth diving into. One very clearly is transparency. When we think about transparency it's less often the way that donors talk about transparency than it is about what's actually being implemented on the ground. If I right now ask what is the US government

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funding in X community in Kenya can I find the answer to that? The answer today is no. I can find which contracts were awarded which is a huge plus. The dashboard has made some very serious progress where transparency didn't exist before and so I think the administration's really to be applauded for having taken that step.

But the next step has to come which is from a community level, what services are being provided, what's being funded, who's doing it, and what kind of impact can communities actually expect. That matters a lot because, for example, if you're an activist in Kenya and you're trying to hold your government accountable, you're trying to hold the NGOs that are supposed to be using donor money to provide services, and you're trying to hold the donors themselves accountable, right now it's nearly impossible to do so because there's not clear targets, there's not clear pieces there. I think that's one thing that's worth talking about.

A second piece that I would say is really for us to think a little bit about the difference between coordination and impact and you would put this up there as an important topic and I think that's right. Because while the IHP has kind of made some moves toward coordination, and in some places has been very effective in getting—especially when countries have owned it—a one national plan strategy. It's also true that

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more than half of IHP countries either have made no progress or very little progress on MDG's four and five. If that's true, clearly, either there's something massive missing or coordination is not the problem for those countries or the IHP is failing. It is one of those three things and I think we have to interrogate which of those. It is what kind of donor coordination actually matters.

I guess the third thing I would put up there is what the process at countries really looks like. When we think about who needs to be coordinated I get very nervous when we've decided that we have a very good strategy to make sure that all the donors talk to all the governments and spend lots of time doing so to come up with a plan. One clear example is South Africa five years ago. Had that been the plan on HIV 10 years ago in South Africa the plan would have been no ARVs, the government was against so this is a problem that we have. This is a dance that donors have to balance. How do you respect country sovereignty while also insuring that we actually have impact at the country level. To me, I think that that's got to be much more about how do we think at country level about the planning processes that happen.

If the US government, every mission sat down and had an open meeting with civil society on each sector and said what do you think the gaps are. Here's what we're planning to fund.

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What do you think? Is this the right region, is this the right intervention; how are these implementers doing at actually implementing the vision that we're laying out in Washington. That could transform conversations and it would mean that civil society actors would be able to hold both the US governments, and other donors, and their own governments accountable. It should be obvious where governments are not acting, where PEPFAR is leading or where USAID is leading NFP. It should be obvious to civil society actors what a huge role donors are playing. Where that's not happening then civil society actors should be able to ask why not, why are you funding X and not Y when Y is our real concern. Those are the three things that I would out.

**JEN KATES, PhD:** Thank you. Josh, I'm going to turn to you to round out this. We worked together on the analyses and one of the things that we concluded at the end was that that were a lot of unanswered questions. This was really a snapshot that probably raised more questions than it answered so wondered if you wanted to share your thoughts on that, other things that could be looked at and just your reflections on general on some of these issues.

**JOSH MICHAUD, PhD:** Just repeating what you said, the analyses are really an attempt to just get the general outline about this problem and to put some numbers around this issue of

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donor coordination. We were looking for this information early on. We didn't see it and we thought we'd put this forward and hopefully, it sparks some conversation both here today and going forward.

In the process of doing this analysis and reading the literature on this and following the news on this it struck me, at the risk of repeating some of the things that have already been said, some of the common themes that I saw. One of the dangers of being the fourth panelist is that you're obviously going to repeat people. Certain elements need to be there in order for donor coordination to work and in isolation they might not be sufficient but together they are sufficient but each of them is probably necessary for a well functioning donor coordination effort to occur in-country.

Probably first and foremost, and it's been mentioned already, is the fact that the country itself needs to be both able and willing to herd the cats as it were and to put forward and be able to put forward because if they don't have the capacity to do so they won't be able to do this. To bring everybody together and to provide a forum and to have a strong vision for their health plan in that country and to have a well elucidated plan for that country. The donors themselves need to be flexible, open, transparent, accountable, and need to be sensitive and aware of both the desires and the wants of the

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country and what other donors are doing in that country as well. That, of course, comes along with transparency and accountability agenda, which has been mentioned already, and the participation of civil society and the private sector as well.

Then there needs to be a forum for this conversation to occur. The IHP+ is one example of that. There are others out there. The country coordinating mechanisms sometimes have been built up into a broader health sector forum to discuss these things and are an important element of this necessary menu of things.

When all these things happen, and it's hard to identify a particular situation where all of these things work perfectly, but there is certainly a spectrum where different elements appear in different countries and donor coordination works well in different situations. I think we can come into some specific examples of that later on but those seem to be the necessary elements to good donor coordination.

**JEN KATES, PhD:** Just a follow up for you and then I have a couple other questions before we go to the audience. We were talking about a recent, emerging case study that we should all be thinking about in terms of the issue of how to coordinate, where it matters, how we can make it work. I don't know if you want to elaborate.

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**JOSH MICHAUD, PhD:** I was just at a discussion where donors and country representatives came together to discuss the situation in Burma, or Myanmar. This is a country that was essentially closed off for decades and only recently opened its borders and invited donors to work in the country and has a government, which is now looking forward and trying to build for the health sector, work with donors, and make progress on health. It's a situation where you have basically almost a blank slate and it has become a tremendous problem of donor coordination because there are so many willing donors wanting to contribute to the development of Myanmar and the health sector there. You have a government, which is willing and very much desires to see progress made in the country yet the capacity is limited and the experience is limited. That makes it a very difficult coordination problem.

From the reports out of the country, there are efforts and people are trying to be flexible but it's still a very limiting and sort of a bottleneck at the capacity level. People from the ministries are doing the classic meeting, for meeting, for meeting and don't have time to move forward because they're meeting with one bilateral and multilateral donor after another. It seems to be an interesting, perhaps an unusual and unique case study of making donor coordination

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work, learning from other examples where donor coordination has been going on for much longer but it's a great, great study.

**JEN KATES, PhD:** Shu-Shu, do you want to come in on that because we were talking in advance about the example of a country that really has an IHP+. Maybe the jury's out in some way how well it's working, but an example of where a country really owned that process and that's where it potentially were working as well as some of the burden that you've seen on other countries with donors, again, well-meaning but what it might mean from a limited capacity perspective.

**SHU-SHU TEKLE-HAIMANOT, M.P.H:** Thank you. I think one country that comes to mind, particularly with the IHP+ is Ethiopia. I think Ethiopia, what they have done is they have taken the global coordination mechanism of IHP and became a signatory in 2007 and then worked out modalities. How would that apply to the country context given their systems, the kind of financing modalities that they would require and made partners sign a national IHP+ if you will, a national global. Currently, I understand in 2012 there are 11 development partners that have actually signed on to the national IHP+ mechanisms.

What they worked out was what are some of the funding modalities that would work for them. There is an MDG performance fund that allows donors to buy into the existing

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system or there's an alternative where they can support budget program support for those donors who are willing to do so. This allows the government to be able to strengthen their systems. They have a joint financing mechanism, they have a joint review mechanism, a joint planning system. What they've done is they developed a health sector development plan where all partners buy into that process. Then for those donors who are not interested in either or the schemes there are alternative mechanisms where they can actually finance and have a review.

This has reduced, (a) the number of missions. You can imagine in a country like Ethiopia where there are numerous partners, I think I was told there were 27 partners working in health and this is just one study that we saw but there could be numerous numbers for each sector.

What that means is reduced time and low administration costs, low transaction costs, one forum for reviewing things, one forum for dialoguing, discussing, transparency both on government side and also the donors, civil society, private sector, etc. This is a country where it took the global coordination mechanism, adapted it to its own situation in context that has worked well.

Of course, I think there is still room for improvement if you look at value for money in other specific sectors but I

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think if you will look at the kind of significant progress that Ethiopia has made in the last 10 years in improving aid effectiveness I think the results speak for themselves including achieving MDG 4. They did not get additional resources for achieving MDG 4. They used Global Fund resources and other resources to strength the broader health system and delivered the MDG 4 and Ethiopia is on track to deliver a number of the MDG 4 targets today.

I think this demonstrates where the country had good leadership, commitment, understood that primary healthcare was going to be delivered through a wide system of community-based health workers where they promoted health extension workers and it moving up, not down, approach but moving up and working through those systems. They've used monies from PEPFAR and also Global Fund to support health clinics, infrastructure. Today in Ethiopia, there are around 3,000 new clinics that were built as a result of all these monies.

I think in a country where there is strong leadership and capacity and willingness to do things it can happen. That's not to say that IHP+ works everywhere else and I think those data are seen. This is where in a country for example, and I'm not going to name a country, but for a country where this is no strong government leadership, there is no capacity, there is weak capacity coordinating multiple partners who have

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different interests, who have different needs to their resources is complex. It's not a straightforward task and when you have those coordination mechanisms and you don't have a very strong ministry of health that's not playing a stewardship role then you get chaos and that's where you see the resources and aid is not effective. Thank you.

**JEN KATES, PhD:** Matt, anything to add from the study you did in South Africa on these issues?

**MATTHEW KAVANAGH:** We looked at PEPFAR in South Africa which has been in quote, unquote "transition" for the last few years and I think it is illustrative of the challenges of donor coordination but also the challenges of data. One of the major things that we found was that when after 2010 the country started to transition and PEPFAR started pulling out of doing direct services and especially around ARV treatment; what we found was that there was no structure in place to know exactly where the patients were, how many patients there were, and how many staff there were. The result was that at the end of the transition we don't know what portion of patients that were previously in PEPFAR supported clinics are still in care. We just have no idea. One estimate was that 19-percent fell out which would be tens of thousands of folks. This was a study done by a Harvard researcher.

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I think one of the things that that highlights for me is this question of what information do we need where. There we strategically—the donor was making a strategic decision in theory in partnership with the government to transition and to move where the funding was. What we didn't have at headquarters' level and at the donor level was the level of detail to know how to do that well. Where previously it had made lots of sense to say the implementing partner knows where their patients are exactly, when major transitions happen in donor funding, and this is where your threats come in, you see a major transition happen. Yet the data isn't there and the knowledge isn't there to be able to insure both programmatic stability but also continued growth.

One of the things that we've really asked is was that the chief priority given that South Africa has six million people in need of ART eventually. Was it the moment to say let's pull back from ART? Were there way where the donor should have stayed engaged in that sector and that would have been one of the conversations that would have happened from civil society, that would have said, whoa, we're not sure that everything the government is saying is actually accurate. When they say this sector is going to be fine we can tell you that there's a hiring freeze so they're not going to hire those nurses that you think they're going to hire and these are

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challenges that donors face. I think it's the reality that we need to expect a little bit more in terms of the level of information and the level of engagement with communities that donors have, especially when making major decisions like that.

**JEN KATES, PhD:** Ariel, lastly, before we turn to questions, I know you were just at the Global Partnership for Effective Development Cooperation meeting in Mexico about a week or so ago. Can you tell us a little bit about what the tenor of the conversation was around this there?

**ARIEL PABLOS-MÉNDEZ, M.D./M.P.H:** That's the last on the list you shared of efforts to try to do better, and this is the Global Partnership for Effective Development and Cooperation last week in Mexico. It is a high level meeting, ministers of foreign affairs, finance, health, a few of health but many topics there. I was really taken by the shift that has occurred in the last 10, 15 years as I noted earlier that where the focus was on debt relief and more ODA in development. That was where the energy was and now clearly the energy has changed and there's a far greater sense of the need for domestic resource mobilization coming from the countries, the receiving themselves.

Minister Ngozi from Nigeria is a clear champion and it is fantastic to see how the authority is emerging as to what to be done. South-South cooperation, which you pointed out, is

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not yet accounted for and may add another layer of complexity to this space. When it comes to the domestic resource mobilization, an area at USAID where we pay a lot of attention, it's a difficult dance. In some areas we have crowded out local investment. In other areas maybe we need to do more. Some of that may be reflected in your bars.

When countries begin to grow how do you engage them back in? How do you crowd them back in to health, to AIDS. There's no easy way to do this and sometimes it is a dance and you need to pull back so that they come. How do you measure that gap there is a difficult thing but data certainly will be a good thing for all of us to have. I think that we're trying to do a bit more in the area of a preventable child and maternal deaths following the call to action. We are trying to become a lot clearer as to how we do that, what is the data.

I think a good example, more specific in the work that we're doing, is when it comes to procurement mechanisms and supply chain mechanism. We used to have a lot of parallel systems so it was a very visual manifestation of the lack of coordination, different donors, different suppliers, different channels. What we recently witnessed recently at PEPFAR and USAID and all of our partners is really a great core lessons, with the governments to establish even sometimes physically a

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single platform or coordinating platform for procurement and supply chain.

A lot of this is already beginning to happen but this issue of how do we engage in the dance of domestic resource mobilization, whether they're crowding us out as donors or simply in areas where we believe as countries move to middle - income, and many are moving to middle-income status. How do you—the hydraulics of that decision is something that is new for all of us. The country-held partnerships in PEPFAR will help us do that. IHP+ should help us do that as well.

**JEN KATES, PhD:** You want to add something?

**SHU-SHU TEKLE-HAIMANOT, M.P.H:** For the Global Fund this domestic financing is an important priority, particularly because we are a financing institution. Last year, in order to raise—our target was 15 billion dollars. One of the things that we actually did was to include implementing countries to be part and parcel of the replenishment process. In this process I'm happy to report that there were a number of African countries, low income countries that contributed resources directly to the Global Fund but also to their own health budgets.

We are working with a number of countries getting a number of ministers of finance who are co-championing between ministers of finance and ministers of health. We are also

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championing with key imminent personalities who are either from civil society, first ladies who are working around domestic financing issues, looking at people who are working at innovative ways.

I think one of the interesting for us and working with donor coordination first is to really convince countries also that they have to maximize their engagement in HIV/AIDS, TB, and malaria even where there is strong donor support. Secondly, it's also for donors to really use their skills to help make the case, to build the business case or to make the arguments to use those skills. It is to leverage those resources to have policy dialogues and policy changes around how do you increase given the fiscal space. We're asking for incremental changes because domestic financing is not going to be for tomorrow. This is a long haul but how can you get countries to move at least from 15-percent or 8-percent to 20-percent incrementally over the years? I think there's a lot that our donor partners can help in the advocacy component making the cases but also building the capacity of ministries of health to make a case to ministers of finance.

If ministries of health are actually making business cases to international organizations for financing or to donor there's no reason why they can't make that argument

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Having said that, I think sustainability is not synonymous with complete domestic takeover in the next 10, 15, 20 years, especially for low income countries. For low income countries because they're based on a requirement for long-term, some resources from external financing. My call is that while global health commitment, global health stakeholders are here is that we should view health or support to health more like a marathon rather than a sprint. I think in health sector it's harder to show the results in the next 20, 15 years. It's like if you go to infrastructure you put money, well in a year you can show a road but the results for health sectors takes time. Thank you.

**ARIEL PABLOS-MÉNDEZ, M.D./M.P.H:** I think this is a very important point. The data, and the clarity, and how we engage countries. Half the countries that were low income in the year 2000 are already middle income and more are growing. It's not black or white or suddenly they are middle income. It's a slow progression so how do we engage this transition we call economic transition of health is very important. Maybe one of the financial tools which is not captured fully when you look at ODA is interestingly, we came out of debt relief a decade ago is loans. I think that the World Bank does a lot more loans increasingly as opposed to just straight grants. You move to very highly concessionary loans and then same on

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commercial loans and full loans. These may allow us for the money not to disappear but to take ownership and sustainability in a different way so that there are no gaps in the transition.

I think that increasingly we should do more of that. I think the Global Fund banned four countries, banned three countries, maybe are making loans as opposed to straight grants may be a transitional strategy. The USA is not a bank and we, nonetheless, have mechanisms like DCA, Development Cooperation Agreements, that may allow us to secure loans from commercial banks to support enterprises that are public or private in nature.

There are many other ideas that need to come beyond the traditional grant, straight grant as a way to do these with or without intermediaries. I think this space and how we engage the economic transition of health, how do we move less domestic resources both the motivation and the resources in countries that will be increasingly able to do so. How do we respond as a global community? It's a different measure of coordination now with the partner countries themselves.

**MATTHEW KAVANAGH:** I think it's important to recognize too and keep our eye on the ball of impact here. The danger is that we fetishize the various mechanisms that are out there and we lose the impact piece. For example, to go back to South Africa for a second, the current national strategic plan is

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hundreds of millions of dollars short. The idea that we should be looking at South Africa as a middle-income country is really challenged if we also want to have impact on the epidemic and this has happened in several IHP countries as well. We have this challenge of you have made a fantastic plan and there is not the money for it. One part of that is absolutely domestic resources and one of the best ways I would argue to think about how to mobilize domestic resources is to be capacitating civil society and to be engaging in open, transparent process that give civil society as much information as they can. To demand that actually countries themselves and governments step up and do more. I know that what our partners in-countries are doing all the time.

At the same time, when the donor community pulls everybody together, creates a plan, the answer is we are 500 million dollars short and the donor community goes, oh well. This is not an effective development strategy and it's not an effective health strategy, especially when we're dealing with epidemics and we're dealing with critical MCH pieces. I think one clear step that has to be taken and we need to have more of it is the transparency of who is funding what and what impact that's going to have and what services are going to be funded. And then two, greater accountability mechanisms for when the answer is we don't have enough money what's the strategy.

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Sometimes it means we are going to have to make hard choices but where those hard choices are made quietly in back rooms that has a really negative impact on the ability of civil society to be able to demand challenges.

To move away from HIV for a minute, partners of ours in Uganda have been suing the Ugandan government demanding on maternal mortality grounds and saying your health budget is insufficient and they've gotten serious traction. One of the things they tried to do is figure out who is funding maternal health in Uganda and they could not figure it out. They could figure out how much money was there but they couldn't figure out where it had gone. This is a place where donors could really coordinate and smartly give the information to civil society and help show them the gaps. The danger is that will mean that civil society will demand more of both donors and governments but this seems like a positive outcome for health.

**ARIEL PABLOS-MÉNDEZ, M.D./M.P.H:** If I may, Matt, on that, the data will be important and one parameter that we should discuss last week was making sure that 0.7% percent of GDP was going to come and help and we have that figure. The other thing that had to happen now in this transition is, in countries that can, not all countries can, but in countries that can is really what is the proportion of the GDP that is being collected in taxes. There is progress in that front.

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Among the low-income countries in the last five years, the proportion of GDP going to taxes went from 12 to 16-percent. Among the low, middle-income countries it went from 14 to 18-percent. Clearly, for the advocacy community that monitors this data in countries, in countries that are moving from the low-income country you want them to move above 15 maybe to 20-percent of the GDP for taxation and make sure that those resources will then serve the social services and health, and education and so on. These are different methods that we also need to keep an eye on but it's a dance and we need more analysis, more data in these spaces and there are some that will be happy to share, something that will be a great topic of conversation.

**JOSH MICHAUD, PhD:** Just a very quick point to say it's interesting that the Modernizing Foreign Assistance Network has come out with a statement saying that this is the big agenda for them pushing forward on transparency and accountability. It ties into many of the things that we're talking about now. I think it's an important agenda moving forward. When we looked at doing the reports we realized that there was a lot of data that we didn't have access to, we'd like to have access to so going forward if we were to do a follow-up on this that would be the next step to do. What are the picture in domestic financing for this and get into the next step, sort of project

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level where are people working, not just how much money to which countries.

**JEN KATES, PhD:** Let's turn to the audience. Let me just preface by saying this was just a snapshot and part of the people we assembled people here and wanted to have this conversation is we had data limitations in areas we could look at. We couldn't use this data set for example to look at maternal and child health funding or to look at funding for NTEs. There are potentially very important and different pictures in other sectors around donor coordination and the number of donors, particularly as these areas are getting more renewed attention in recent years. There's potentially an opportunity to do better but also lessons to be learned.

I know there's people here who have experience in lots of sectors and I think we're trying to draw on that too so that the conversation can be rounded out in some of the common themes but also maybe unique challenges could be brought to bear. With that we'll turn to you all and we'll take three questions at a time. Please just say who you are and where you're from.

**SARAH MELILLO:** Hi, I'm Sarah Melillo with Creative Associates International. Thank you all for the panel. It's very interesting. I'm interested if you could highlight if you're aware of any research about what works. I know that was

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one of the big questions and maybe not the scope of this research so maybe you can provide examples from your own work about when coordination has provided good health outcomes or better programming both from a research side but also practical and anecdotally what does this look like. What can we take away?

**RACHEL WILSON:** Rachel Wilson from PATH. Thanks for a great panel. A couple of questions, first, just to say as Jen mentioned, there's a plethora of global initiatives also around maternal, newborn, and child health. We've seen FP 2020, as you've mentioned, but also the Every Newborn Action Plan is coming out, the Global Action Plan for Pneumonia and Diarrhea, the Global Vaccine Action Plan, a number of global initiatives that are similarly—I'm actually on the RMNCH steering committee which is one of those bodies that's trying to help in some of this coordination but there's several others that are. One of the things that I continue to hear from a country level is this frustration of a range of initiatives that are being from the donor level asking the countries to create these plans.

They don't have as many funds behind them as some of the initiative that you're talking about but I think that the same challenges of coordination and alignment are relevant with these. I'm curious, first of all, how can we learn as a community from what you all have learned to make sure that

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we're not replicating the same challenge over again as there's increased attention to these issues. How are we making sure that some of the initiatives that you're all working on are aligning with these new initiatives that are coming out? Each of you have referenced those. I know that the Global Fund has been starting to support some of the commodities work for maternal, newborn, and child health and obviously with FP 2020 there's been some increasing alignment with HIV.

I am curious if you can say a little bit more about how can we make sure that we're looking forward and making sure that those coordinating mechanisms are building on where we've been and where we need to go and not creating another set of silos.

**DR. CHRISTINE SOW:** Hi, I'm Christine Sow from the Global Health Council. Two questions, first is there's been a lot of referencing of the need for data and information. I was wondering if you could speak to the promise or potential of the International Aid Transparency Initiative, IATI, and is it actually becoming what we think it may in terms of being able to provide a lot of that information for planning purposes?

The second question is just around the role of civil society and I think one of the challenges in having civil society play that role in holding governments and partners accountable is that civil society tends to be fragmented around

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its interests. How can we work to be more effective in nurturing civil society to have one voice or a collective voice or come together to actually be more effective in playing that accountability role not just at a community level but also at a national level and at a global level. I'm thinking about the UHC meeting last week and we didn't have a big voice of civil society there. We had a few representatives but how can we encourage that? Certainly the work that Global Fund has done through CCM has helped catalyze civil society's role but I think that's one example but what are some other examples of how donors and partners can be instrumental in that. Thank you.

**JEN KATES, PhD:** So just to summarize, we had a question about what research or anecdotal evidence for what works with coordination. What are some good examples and models potentially? The second was just to summarize what Rachel said, without creating another coordination mechanism for the coordination mechanisms how can we better coordinate the mechanisms. Lastly, the International Aid Transparency Initiative is an opportunity and then also, how do we coordinate civil society. I will turn it over to our panelists and see who wants to pick up on what, who wants to start.

**ARIEL PABLOS-MÉNDEZ, M.D./M.P.H:** I can start by saying three important questions. I think Aid Transparency has its

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power and the USG has moved forward with open data, dashboards and USAID has done well in the whole of the USG in doing so. I think data is a good way to do this to your question because everybody likes to coordinate, nobody likes to be coordinated or there is that. If we have transparency of the data then everybody can look at the picture. I think if we can all commit to that, that would be very, very important.

You also alluded to the MCH challenges and I think MCHs had been directly neglected in the global health dollar space until recently. Whereas, in AIDS, or TB, or malaria USG, and the Global Fund may account for almost 80-percent of the total, not so when it comes to maternal and child health. There are many, many more players, smaller players so it's challenging but in a good way because recently that has been the area of global health that has been growing because of new commitments, new resources, new players. That poses challenges but you're part of one of the efforts to try to coordinate and IHP+ itself is trying to do better beyond some tools for assessments and so one, which are useful.

IHP+ and the global health leaders group is trying to look for example at the measurement. One of the indicators, make sure everybody uses the same, defines it the same way, asks for them at the same time as opposed to all sort of wild stuff during the year. That is moving and the streamlining

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that it gives is going to be a good thing coming this way. We should do the same with financing to the global compact of IHP+ to try to have these. Again, I will say clear data to spend data will be the better way than trying to have a singular architecture, which I don't think is going to be feasible.

**MATTHEW KAVANAGH:** A couple of thoughts. We have this range of initiatives and I echo your initiative fatigue. Sometimes it's important though as we know because politicians are politicians and so initiatives get people's attention and all of a sudden we get backing for things like will you insure universal healthcare everywhere. The answer is no so we have to chip away it and it's a challenge.

I would say that there's a couple of things that it feels like we really could do and I think one—both an answer to what works and an answer to how do we coordinate better. I would say we really have to think about, and at the risk of echoing myself again, impact on the ground in locations. If the question was in Kasumu are there enough midwives, are there enough people delivering antiretrovirals? Are there enough people giving out bed nets? Are there enough bed nets themselves, all of these questions. Then the next really important question being and if not, who's going to fix it. This is where we don't get to so at the risk of being mean I'll just say I love the dashboard. It's really helpful but the

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level of detail that I can get to is that I can see that Pathfinder who I'm sure is doing great work in Kenya at some point, we will now incrementally fund the award 14,713 to obligate the remaining balance to fully fund and reduce the performance period from five to three years.

I'm sure that that means something but that is not the same as what does that mean in Kasumu? Does that mean that there are going to be services delivered that somebody needs to be held accountable for. I do think that this is an area where we can make some progress. It's in part about data and it's in part about service delivery. If we look regionally, we look where we are and we try to get to that level of coordination that's really different than the kind of macro level national coordination that's often happening. It's also hard, right. It takes more staff, it takes more time, it takes more attention and there are only so many people to go around so I am not trying to be unrealistic.

I would also say that on the civil society side of things I think two things. One, I think we have to be clear about what donor funding is good for and so maybe this is less on civil society and more on the macro impact piece. But I think where we've seen donor funding be effective it's doing hard things, especially where governments are ill equipped to do them. This is one challenge that we have is figuring out

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what does that mean. In every contest it means something different and to your point about not displacing things shift. We need to not displace other funding and make sure that that is a priority while also staying clear on what kind of impact are we trying to have and why is it that donor funding should go to that particular kind of intervention at that particular moment. For me, that's a lot about what won't happen without it and what will have the highest impact. I think sometimes when you answer that question you get to some of the civil society pieces.

One thing we just did recently is we asked a bunch of our colleagues, totally random unofficial sample what portion of you—and these are colleagues in the global south who are working for advocacy organizations. What portion of you have an entire staff person devoted to national advocacy? The answer was 3-percent and so this is one macro challenge that we might think of as a governance question to give it over to USAID a little bit. It's not just a health question, it's a governance question. It's a democracy question. It's a question of are there activists, are there Matt Kavanagh's in countries that are able to spend all of his time pouring through data to try to figure out why services aren't being delivered and the answer is often not. Part of it I think is a capacity challenge, which is a little bit of a fake way to

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answer how do we all coordinate better because I don't know the answer to that.

I do think that there's, especially in the global south, serious capacity challenge and one of the things that we've seen is that as we move randomly many of the people who I know who have done the best advocacy work for donor funded direct service initiatives which is interesting. The dirty secret is that a lot of advocacy happens quietly by people who are doctors, and nurses, and patients, etc. There is this other role that a lot of our best global health funding plays which is to capacitate organizations who are full of amazing people who then are able to do some really interesting advocacy. If we added a little component to that that was and also, why don't you also do the watch-dogging piece that could go a long way toward the effectiveness of civil society.

**SHU-SHU TEKLE-HAIMANOT, M.P.H:** Just to contribute I think on the research I encourage you to look at the IHP+ website where it has numerous documentation, surveys, and research it has done around countries, particularly on countries that have worked well and countries that haven't worked well. I think the ones that I have seen so far are Ethiopia and Rwanda seem to have done very well even in terms of health outcomes using this platform.

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On a plethora of initiatives and RMNCH I think we all share that but I would encourage you to look at how HIV, TB, malaria, particularly the HIV coordinating mechanisms or even the CCM coordinating mechanism are constructed. I think there's a lot of lessons to be learned from the HIV, TB, malaria folks that is happening in-country. To draw some of the lessons what has worked and what hasn't worked but also to build on what is there at country level. We don't want to build another country coordinating mechanism for RMNCH. What I would want to see, and I think what countries would want to see would be to see how you integrate that. They're aren't HIV, TB, whatever, there's one patient that's got all these diseases or one of these diseases or something so we would want to see in a coordinated approach and how do you fit into that. I'm happy to report at least the Global Fund this year has started a small initiative supported by a number of donors. We're looking at women, girls to integrate that into the new concept, the new funding model and how to support high impact interventions for results so that is something to look forward.

I think in terms of civil society I think—thank you for raising that. We, the Global Fund would not be here without civil society. They're an important component and I also would encourage you to look at the platforms of how the Global Fund works and interacts. We have what is called the Global Fund

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Advocacy Network that's funded by the Bill and Melinda Gates and others. It's amazing the work that they're doing and capacitating regional civil society but also in-country. We have established out of that an African civil society platform that is now actually looking at capacitating an in-country advocacy, in-country evidence-based advocacy, particularly looking at the domestic financing work that we're doing.

There are a number of interesting things that you can draw and I think capacity at a national level, this is something that really we need to work on for civil society and advocacy. That's really important and the same goes for RMNCH. I think there's a number of advocates that are working but how do you get them to be coordinated, how do you get them to go on one agenda and I think we all need to work together to do that. There is good work that is already being done and see how we can build on that.

On the issue of data, I think that's really important and that's across the board. Particularly for resource inflows, resource outflows, who's doing what, et cetera, and I think IHP+ indicates—one of the surveys that I read was that although some of the countries are doing really well it was the donors were reluctant to show what they financing, what kinds of data. I think there's a balancing to be done between countries and donors as well. Thank you.

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**JEN KATES, PhD:** We're ready for another round.

**JASON WRIGHT:** Good morning, everyone. My name is Jason Wright. I'm the U.S. Director of the International HIV/AIDS Alliance. Thank you, Jen and Josh for putting this together. It's an issue that's very near and dear to my heart having been the donor coordination advisor at USAID for many years before I joined the Alliance. It was frustrating for a number of years that the US government couldn't figure out a way to engage with the International Health Partnership+ and I commend you, Ariel, for taking the initiative to have USAID sign on. That's part of my question how you go beyond having one agency as opposed to the whole US government engaged in the IHP+. Then sort of a two-part question about the political will aspect of how you engage both at the global level and at the country level. In terms of the global level, obviously, HIP+ was an initiative of the labor government in the UK and the coalition government doesn't have the same sort of initiative behind this.

So looking at the bilateral governments what sort of political will is there for them to continue to engage both IHP+ as well as other coordination mechanisms. Then from the bottom up, Shu-Shu, you mentioned the issue of stewardship, the role of the ministries of health, the ministries of finance to do this. We've mentioned Rwanda, Ethiopia, South Africa. For

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example, we've had Nepal and Bangladesh in Asia as IHP+ signatories but where do you as a panel see some of the other political leadership coming from the bottom up to take the country ownership to play this coordinating role, this stewardship role to make sure that there's harmonization and alignment among the donors? Thank you.

**MS. Nkem:** Hi, my name is Okeke Nkem and I'm a consultant with Medicalincs. It's a startup organization that's focused on how you use tele-health to leverage limited resources, especially human resources in West Africa with regards to health care. Thank you for having us in and for your time. You spoke about coordination and I think when you point out the need for having data I think that's where the donor coordination actually really helps because you have different data depending on who you use as a reference. So the World Bank has their own, even things as simple as population status, has a foundation as my preferred choice but they have something different from what the World Bank does that so things like that. When you talk about data generation I think coordination is also useful if you can shed more light on that.

You also spoke about complex political structure and how that can be very complicated in trying to implement things. From my experience I worked as a physician in West Africa. Sometimes when you're down there you see that things don't

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trickle down at all. Is there any plan in sight to do something more like the *Undercover Boss* on TV with the donor organizations? I think having a more grassroots level presence could help bring up things that you would never know.

**BETH MITCHELL:** I like to thank the panel for this discussion. It's been very interesting for me. I'm Beth Mitchell. I'm the Pacific Islands Desk Officer at the Department of State and I'm not an expert in the health field. My question or statement here is more of a personal comment. I think if you're going to talk about donor coordination, which I think is a good thing, especially in this field, I think that a little bit of effort and consideration should be given as Matt and Josh spoke about. Pacific Island countries I would say are more online with the Burma. You have a nice civil society and you don't have a lot of capacity or will power in the government to put into place or to work and put effort into a public health system.

I think that it's important to put part of your—when you're doing projects in a country put some of your funds and effort into building up the capacity of the civil society and the government in this area to give their ministries of health the powers, the skills and capacity to be able to advocate for putting a healthcare system into place. Thank you.

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**JEN KATES, PhD:** We had three questions. The first was around IHP+ and the USAID and US government's relationship to it and then the broader political buy-in into IHP+. The second was around data coordination in a sense. Great to call for more data but how do you trust the data that's out there I think is one of things you're saying and there's different sources. You could have all the data in the world but if you're sitting there not understanding it or not knowing where it's coming from it's of little use. Then your *Undercover Boss* idea is a really interesting one. I heard that some of the panelists are ready to volunteer to do that work. Lastly, then your supporting of the point that was made by many about civil society. You added another element that particularly where there's very nascent civil society or nascent beginnings of a domestic response to something that provides a really unique moment to bolster civil society at the same time that donors may be going in to build up the formal infrastructure of the government.

Anyone want to respond to any of those or offer comments about some of those questions?

**JOSH MICHAUD, PhD:** Can I just say something about the Pacific Islanders. In the report we looked at all the regions around the world and found—you might not be surprised—there wasn't a huge donor presence in the Pacific Island countries.

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Mainly regional, Australia, etc., were the donors that were there but the US also. My sense is in that in those cases where you have very small countries without the capacity or nascent capacity the approach they've taken, or my take in other areas. I don't know about health enough to say for sure, but a regional approach where you bring countries together to advocate and perhaps come up with strategies that work across a set of countries that might be too small on their own or unable to on their own come up with the right strategies that work for them, coordinate with donors, etc. Often the donors will consider them regional groups rather than specific countries. I don't know if that particularly answers your question but I think that's one approach that has been used in the past. The donor coordination aspect, because there's not that many donors looms less large but it's still important clearly.

**ARIEL PABLOS-MÉNDEZ, M.D./M.P.H:** Thank you for your point on the IHP+ and you obviously know the interagency dimensions of the work. As noted earlier, when it comes to issues like HIV/AIDS, the CCMS, the Three Ones, the magnitude of PEPFAR, and the Global Fund has made that not as challenging perhaps as we've heard before about MCH where it's hard to get all of the dimensions of a fast growing space. For that reason, it was particularly important for USAID to step up to the plate with IHP+. It's also part of our global health

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initiative philosophy and USAID forward for country ownership and country engagement that it makes a lot of sense to do that better. We are proud that I was glad I got to sign the Global Compact last year. It would be a year exactly. It takes some time but the state has now rolled out guidance also to our missions so that the missions can begin to engage as appropriate in the country complex of IHP+. Kamier Kajavie who's sitting here in front has been a focal point is going to Ethiopia where there's an opportunity perhaps for a mission to engage and in other places. USAID have been informally at some of those tables all along but it's great that we can actually make it more formal.

One issue that has been growing in this conversation, which is a great conversation, thank you all, is the capacity of the countries to engage in the coordination. I think that advocacy, civil society is part of the equation because you need that advocacy, you need that accountability. The missions of health that grew up with so many big initiatives around them is trying to mind them plus decentralization, the ministries of health have been weakened in a way in the last decade.

Supporting the capacity to the ministers as the stewards of the health systems is very, very important. We are in the midst of developing a global strategic of human resources for health from Recife last fall to Cape Town in

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October. One of the areas where we went to develop not only the frontline workers, we also need those who are the stewards, capacity for stewardship, policy analysts, people who can gather the data, who can make sense of the data locally, and so on, because in South Africa, we may not focus on this. Donors have less than 5-percent of the total expenditures. There's a problem in South Africa. Look at the 95-percent, how do we leverage that. If we don't have somebody to look at that data, to advocate for that data, it was important.

I think that a stewardship capacity will be important and the civil society, not only focus on accountability but also think times. For example, KFF has done a magnificent job of getting data, making sense of the data, sharing the data and when it comes to some of the countries it's often not a one dollar but really an aggregate of players and think-tanks have been evolving now in developing countries to help us do better. I think that stewardship capacity in the government, and the civil society going forward will be crucial for this area.

**SHU-SHU TEKLE-HAIMANOT, M.P.H:** If I may just add on that, I think that's going to be really critical, particularly as we move now to the post-2015 development agenda for health. Increasingly, I think in the last 10 or 15 years is that national institutions have been neglected, particularly around capacity building the stewardship and the ministries of health,

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whether we like it or not, are the custodians of health. They have an obligation to their citizens and they have to play that role of bringing all the pieces together, private sector, civil society, other players who are at country level. I think that is really important and I know that USAID through their governance leadership does that but I think more needs to be done to capacitate those people who are making decisions or who are going to be negotiating those donor grants or those 2015 post UNGA, et cetera.

On civil society capacity building, I think for the Global Fund this is really an important area. This is why we actually—a couple of years ago we launched the dual-track financing, primarily also because they were not able to access resources at country level and with that, I think we've done a lot of work in capacitating a lot of civil society. I think still more needs to be done, particularly capacitating national level civil society but there is a lot to be learned and to draw on that and I think even in some of the Pacific countries there is work on both supporting capacity for governments as well as civil society groups. I think the stewardship role overall and building national institutions for strategies and negotiating those strategies is going to be really important.

**MATTHEW KAVANAGH:** It should be noted that supporting the capacity of the ministries is just critical and I think

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that this is something that has been neglected. This is everything from secunding staff to supporting finances there. I think it is a critical gap to hear further focus on and I hope that that is something that is built up more fully. Part of what that means is a shift, I think, from thinking about country ownership that seems like a word that I have a hard time getting my hands on sometimes so like what does it mean because it means different things to different folks. To me, I think that that's a governance question. We sometimes confuse this with a who pays question. To your point, how does a country own something, is not necessarily—the portion of PEPFAR in South Africa is small compared to what the government does there and in other places. If we ask this as a governance question then it is different because it is a question of who decides what will be funded.

In some places I think the US government is doing a really interesting job. In South Africa the PEPFAR management team now exists, as far as I know, kind of unique in the world but certainly potentially a model where you have the PEPFAR country coordinator sitting with the folks from administrative health, sitting with the deputy president's office, and literally saying we are thinking about putting out this RFP, do you agree. What's interesting is that shifts the locus of decision making from Washington to Pretoria and I think that

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that's a really important shift and it's not just symbolic if it's real and that builds up capacity overall.

Now, what's missing there is the civil society piece of that but if you inserted that you'd have a really interesting model that I think the USG could, in fact, be exporting and doing in a way that's really helpful. This is different when you are the massive donor than if you're funding a small program and so, obviously, different coordination mechanisms have to make sense.

As we think about data coordination I would say what we're still missing is this level of gap analysis and I think this is one place where HIV has done well and others could follow, although still problematically. Which is to say if we're going to try to have this impact then what is the gap analysis exactly and it is much less helpful if it's a global gap analysis or a national gap analysis, which is the level that we are. We have to get down to what's the gap analysis in various countries—what are the gaps, who's going to fill them, and who will be accountable for them.

One of the things I think this means is we have to be careful of double counting because I do think that we have a real problem at large with many donors and governments all taking credit for the same outcomes. I work in political Washington and I understand the imperative to show impact but

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it does us a disservice when we say things like our programs have accomplished this when they are the entire national level numbers. That doesn't help anybody because it's unclear who's doing that. It's not because the government has done an amazing job and the US came in and funded one person or is that, in fact, because the US has actually funded the dramatic portion and is propping up huge sectors that wouldn't otherwise be. Making all of that is just so important both for the data mining of the process and for the accountability process. I would urge us to think about how to get further toward that where we can say clearly that in this district the US has identified that we're going to fix this problem and X donor can say oh, if the US is going to do that, then we will do something different. It has to be at the more localized level and it has to be about service delivery, not about funding as the outcome.

**JEN KATES, PhD:** One thing you made me think of in our reports if you look at them we did go one extra step which is just by saying a donor is working in country X on an issue doesn't give you that much information. Could it literally be that that donor's account is ODA provided technical assistance for one tiny program or one person or is it really funding a significant share of what you might expect? We do attempt to have a gradation, a heat map of sorts so you can see not just

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the little presence of donors but the magnitude of their assistance. I think that provides another lens. It also could raise other questions like is it helpful to have 20 donors in a country when 18 of them are providing a tiny, little amount and maybe it is, maybe those are very specific needs, but without the gap analysis I think it's a question.

We are just about out of time. I have some thoughts from listening to everyone but I wanted to see if anyone on the panel wanted to say anything else before we close.

**SHU-SHU TEKLE-HAIMANOT, M.P.H:** Just to say in closing, I think for me a couple of the game-changers that will happen in the coming years is that, one is to be transparent about resources are going to be decreasing in the future. This is something that people are going to have to come to the reality in terms of in the health sector because we've had it for so many years. The global landscape is changing, economies are developing and then too, to make hard choices. Governments and donors will all have to make hard choices so those hard choices are more money for health or more health for money. These are the kinds of things that I think we will have to be thinking of in the future, and particularly as we are now going forward into negotiating the new post-2015 agendas and the financing for it. Thank you.

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**MATTHEW KAVANAGH:** With total respect I disagree completely. Not on the latter but on the former which is just to say I think that that's not true that ODA is decreasing. I think it is increasing for health and so one can probably tell me the answer to this. What is interesting is that you do see a growth and I think part of why you see a growth, especially in health is because we're able to show impact and this is the kind of thing that if we can stay focused on will, I think, continue to return evidence and return impact. We have fluctuations but I'm actually buoyed by the fact that despite massive global recession we still saw some growth, we saw some leveling off. HIV has been having a hard time of late, been replaced by donor funding or by country funding, which is really interesting.

I think overall we're relatively well positioned to continue to grow but we have to make the political case for it. Part of the worry about donor coordination is that we end up in this world of how do we make hard choices with bad amounts of money. I think that there's another alternative which is how do we make the case for what next level impact we can have because that's how we get the money to actually drive forward to that.

**ARIEL PABLOS-MÉNDEZ, M.D./M.P.H:** If can take the middle path on that, it is not written one way or the other. I

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can tell you that we've been lucky in the global health program at USAID to see the support of Congress to continue to increase, particularly family planning, maternal and child health. I am impressed with Washington working because of that passion. Results matter. Global health is good at measuring. We had to be good to measure the new dimensions of this complexity that we just discussed and we need to do better in areas where we see opportunity. I think that with ending preventable maternal and child deaths USAID is working with many partners. It is going to be very difficult to disentangle what you were asking the specific—because money is fungible and that's why a comfortable governance is important. Money is fungible. If a dollar does something here, somebody stops doing there, somebody has to be able to look at the whole and at the end, do we have the impact?

We have been really diving in as we are calling USAID in the 24 countries that account for 75-percent of all the kids deaths for example. We are finding that as a whole, although we're always good things, everybody's doing good things, we are falling short on family planning. We are falling short on routine immunization; we are falling short on nutrition; we are falling short on newborn, for example. Those are areas that even comparing to countries in the same region in the same band of income we can do better. How will we do it? It will not be

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just USAID but the analysis itself is important, talking to everybody in the countries is important.

I have to say that, again, the issue of impact, the issue of data, really important, and continue to be optimistic. The demand for health doesn't decline like the culture that indeed shrinks a proportion of growing economies, health continues to grow with economies and the demand seems to be infinite if I may say so. How we pay for it is going to be a challenge but clearly the need will be there. We continue to evolve and the resources, I believe, will continue to materialize.

**JEN KATES, PhD:** Thanks. I think we're out of time. Just a couple thoughts just hearing everybody and what the panelists said and what you all said. If you take a little bit of a longer view of the last almost three decades now I think the 1990s, there was just the beginning of more attention to global health. There was this idea there was a global health agenda that was becoming one that was discussed and it wasn't until the prior decade where all these initiatives around health emerged. That was really the heyday of really steep rises in ODA and much more global attention and leading to more donors and all this. We're in a very different moment now and the moment is potentially leveling off of ODA in some areas, a rise in domestic support and other new actors. But really a

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time with this conversation about ways to do it better and to have impact is one that's, I think, happening at a level that we haven't seen so we should seize that opportunity.

We heard a lot about impact and if we leave with anything today I think that's a critical piece because it's not coordination for coordination, it's coordination for impact. To your point, if the data can show where we're falling short and then the coordination to address that, is what it's for. Otherwise, it probably doesn't matter.

Then a lot about civil society as a key actor in the trajectory around coordination and then, lastly, transparency. Not just transparency again for transparency's sake but transparency of good, useful information.

I will leave it with that. I'll ask everyone to join me in thanking our panelists and thanks to you for being here.

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