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**A POLICY ANALYSIS OF AID COORDINATION AND  
MANAGEMENT IN THE HEALTH SECTOR OF BANGLADESH:  
  
ASSESSING THE INSTRUMENTS, EXPOSING THE AGENDAS,  
AND CONSIDERING THE PROSPECTS FOR GOVERNMENT  
LEADERSHIP**

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**Thesis submitted to the Faculty of Science of the University of London for the  
degree of Doctor of Philosophy**

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**January 1999**



## **DEDICATION**

**For Sarah and Salvador.**

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## **ABSTRACT**

### **A policy analysis of aid coordination and management in the health sector of Bangladesh: assessing the instruments, exposing the agendas, and considering the prospects for Government leadership**

In the 1990s, the coordination and management of aid in the health sector became more firmly established on policy agendas as a result of concern that the increased volume of aid and increasing number and diversity of donors in the sector was leading to an unmanageable proliferation of demands on recipient Governments. Global interest in coordination, coupled with a dearth of critically-informed, conceptual or empirical, analyses of the subject, gave impetus to this in-depth examination of the processes at work.

Based on a review of the literature, this study began by defining the issues and developing a typology of instruments used to coordinate aid. A conceptual framework was developed for assessing coordination mechanisms. The framework was tested through an historical analysis of aid coordination revealing the enabling and constraining factors governing progress in this area of development management. Bangladesh was chosen as a case study, primarily due to a long-standing, concerted effort of the World Bank to coordinate a number of bilateral donors through a country-based Consortium.

Drawing upon interviews with stakeholders, documentary analysis, as well as a questionnaire survey, an entrenched, non-comprehensive system of aid coordination and management exercised by donors was exposed. Caution on the part of Government officials in assuming a prominent rôle in aid management was exacerbated by fragile systems and weak capacity. This was reinforced by aid agency practices. Evidence suggests that coordination may be less concerned with the purported aims of rationalising external assistance to Government's programmes, than with the desire among competing agencies for leadership in the sector. Aid agencies and Government recognise that aid coordination provides a powerful tool with which to exercise leverage over the policy process. This consideration has coloured their desire to lead coordination processes and conditioned the extent and manner they wish to be involved in coordination arrangements. Given the findings of this study, the prospects for improvements and government leadership in aid coordination and management appear equivocal at best.

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## ABBREVIATIONS

ACC	Administrative Committee on Coordination (of the UN)
ADB	Asian Development Bank
ADP	Annual Development Programme
AIDAB/AusAid	Australian International Development Assistance Bureau
AIDS	Acquired Immune Deficiency Syndrome
AL	Awami League
ARI	Acute Respiratory Infection
AfDB	African Development Bank
AsDB	Asian Development Bank
BADC	Belgian Administration for Development Cooperation
BNP	Bangladesh Nationalist Party
BWI	Bretton Woods Institution
BWZ	Bundesministerium für Wirtschaftliche Zusammenarbeit, Germany
CAG	Comptroller and Auditor General
CCA	Common Country Assessment
CDD	Control of Diarrhoeal Diseases
CIDA	Canadian International Development Agency
CPR	Contraceptive Prevalence Rate
CSN	Country Strategy Note
CSP	Civil Service of Pakistan
DAC	Development Assistance Committee (of the OECD)
DANIDA	Danish Development Agency
DCA	Development Credit Agreement
DFID	Department for International Development, UK
DGIS	Directorate General for International Cooperation, Netherlands
DHS	Directorate of Health Services
DSPEC	Departmental Special Project Evaluation Committee
ECB	Economic Cooperation Bureau, Japan
ECNEC	Executive Committee of the National Economic Council
ECOSOC	Economic and Social Council (UN)
EC	European Community
EPI	Expanded Program on Immunisation
EPS	Essential Package of Services
ERD	Economics Relations Division
EU	European Union
FIAS	Foreign Investment Advisory Service
FINNIDA	Finnish International Development Agency
FP	Family Planning
FPD	Family Planning Directorate then Family Planning Division
FPHP	Fourth Population and Health Project (World Bank & cofinanciers)
FYP	Five Year Plan
GDP	Gross Domestic Product
GNP	Gross National Product
GOB	Government of Bangladesh
GOBI	Growth Monitoring, ORT, Breast Feeding & EPI,
GTZ	German Agency for Technical Assistance
GWCC	Government - WHO Coordinating Committee
HAPP-5	Health and Population Project - 5 (World Bank & cofinanciers)

HOA	Heads of Agencies (of UN organisations)
HEU	Health Economics Unit
HIV	Human Immuno-deficiency Virus
HPSS	Health and Population Sector Strategy
HQs	Headquarters
IATF-BSSA	Inter-Agency Task Force on Basic Social Services for All
IBRD	International Bank for Reconstruction and Development
ICDA	International Cooperation and Development Agency, Belgium
ICPD	International Conference on Population and Development
IDA	International Development Association (of the World Bank Group)
IDB	Islamic Development Bank
IDRC	International Development Research Centre (Canada)
IEPS	Initial Executive Project Summary
IFAD	International Fund for Agricultural Development
IFC	International Finance Corporation (of the World Bank Group)
IFI	International Financial Institution (IMF, World Bank, ADB, etc.)
ILO	International Labour Organisation
IMED	Implementation, Monitoring and Evaluation Division
IMF	International Monetary Fund
IMR	Infant Mortality Rate
JCGP	Joint Consultative Group on Policy
JGF	Japanese Grant Facility
JGUAG	Joint Government UNICEF Advisory Group
JICA	Japan International Cooperation Agency
KfW	Kredit Anstalt für Wiederaufbau, Germany
LCG	Local Consultative Group
LDC	Least Developed Country
MCH	Maternal and Child Health Care
MDU	Management Development Unit
MIGA	Multilateral Investment Guarantee Agency (of the World Bank)
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
MOF	Ministry of Finance
NEC	National Economic Council
NGO	Non-governmental Organisation
NGOAB	NGO Affairs Bureau
NHP	National Health Policy
NPA	National Programme of Action
NOK	Norwegian Kroner
NORAD	Norwegian Agency for International Development
ODA	Overseas Development Administration, UK
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
ODM	Overseas Development Ministry – now DFID, UK
OGSB	Obstetrics and Gynecology Society of Bangladesh
ORT	Oral Rehydration Therapy
PCFPD	Population Control & Family Planning Division (then PCW; FPW)
PCP	Project Concept Paper
PCW	Population Control Wing (Ministry of Health and Family Planning)
PEC	Project Evaluation Committee
PHC	Primary Health Care



PHN	Population, Health and Nutrition
PHO	Population and Health Office (of the World Bank)
PIP	Programme Implementation Plan
PIV	Project Implementation Volume (of FPHP)
PP	Project Proforma
PPC	Project Preparation Office (of HAPP-5)
PPO	Population Project Office (of the World Bank)
PRSD	Programme Review and Strategy Development (UNFPA exercise)
RBM	Resident Bank Mission (World Bank local office)
RC	Resident Coordinator
RCS	Resident Coordinator System
RTI	Reproductive Tract Infection
SAR	Staff Appraisal Report (World Bank project description document)
SDC	Swiss Development Cooperation
SEARO	South East Asia Regional Office (WHO)
SEP	Sector Expenditure Programme
Sida/SIDA	Swedish International Development Cooperation Agency
SIP	Sector Investment Programme
SPFHP	Second Population & Family Health Project (World Bank)
STI	Sexually Transmitted Infection
SWAp	Sector-wide Approach
SWOT	Strengths, Weaknesses, Opportunities, Threats
TAPP	Technical Assistance Project Proforma
TM	Task Manager
TOR	Terms of Reference
Tk.	Taka, Bangladesh national currency
TPFHP	Third Population and Family Health Project (World Bank)
UCI-90	Universal Childhood Immunisation by 1990
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNCDF	United Nations Capital Development Fund
UNDP	United Nations Development Fund
UNESCO	United Nations Educational Scientific Cultural Organisation
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNHCR	United Nations Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRC	United Nations Resident Coordinator
UNROD	United Nations Relief Office, Dacca
USAID	United States Agency for International Development
US\$	United States Dollar
WFP	World Food Programme
WHO	World Health Organisation
WID	Women in Development

## CHAPTER ONE

### Too many lollies? The sweet and sticky of aid coordination

#### 1.1 Introduction

*Strictly off the record, the problem is simply one of too many lollies. The Government behaves like a child. We, the donors, act like aunts and uncles. Its hands are full; yet we compete to push more of our own lollies, and it keeps trying to grasp them.*

Representative, UN agency, 1996

The past two decades have witnessed an upsurge in the number of external agencies involved in the health sectors of low-income countries. Concomitantly, there has been an increase in the volume of resources transferred through multilateral, bilateral and non-governmental organisations to these health systems. Notwithstanding the beneficial impact of increased resources, recipients and donors are increasingly concerned about the effects of this trend and, particularly, how to coordinate the different inputs.<sup>1</sup>

A common concern about aid to countries' health sectors stems from the perception that health systems are weakened by poor coordination of external resources.<sup>2</sup> Recipients frequently despair of an unruly mélange of external ideas and initiatives that, too often, results in project proliferation and duplication, unrealistic and contradictory demands and, ultimately, a loss of control over the health development process. Donors often express concern over aid efficiency and effectiveness, two areas it is assumed will gain from increased coordination. Consequently, both recipients and donors frequently call for ways of better managing the aid relationship.

Although the concept of coordination holds considerable intuitive force, and presages an elixir to many ills of aid, some aid practitioners and academics have voiced scepticism.<sup>3</sup> Such misgivings may be spawned by disbelief over the actual ends to which coordination is advocated and pursued. One does not need to be cynical to question the extent to which coordination is truly driven by a desire to rationalise the aid relationship (i.e., enhance the efficiency of aid and reduce the heavy burden fragmented 'assistance' imposes on recipients). Coordination may equally be conceived as a means for the coordinator to exercise power over the coordinated. Underpinning this view is the notion that each actor

pursues his or her own narrow self-interests rather than some common good, such as the 'value-added' to the entire health sector which might result from improved coordination. The relative dependence of low-income countries on development assistance, and the major power imbalances between the aid agencies themselves, may lead the weaker parties to dispute the very desirability of coordination, particularly where it is equated with hegemony and control. Yet, given the relatively independent nature of agencies in the aid regime (as arms of donor governments or branches of the United Nations 'family'), and autonomy of recipient nation states, it is understandable that sceptics question the extent to which coordination is at all feasible. Of course, neither of these suppositions rules out the possibility for some middle ground where inter-dependencies among givers and between givers and takers favours coordination for a more mutually beneficial relationship.

Over the past decade, efforts to initiate and/or improve aid coordination have been made in direct proportion to the calls for improved coordination. Anecdotal reports assert, paradoxically, that enthusiasm and initiative do not correlate with success. This raises a number of questions which have yet to receive adequate consideration: what, for example, is successful aid coordination?; what can be learned from past experience?; what constrains and facilitates aid coordination?; and what are the prospects for improved practice? This research aims to provide answers to such questions.

This Chapter begins with why aid coordination is on the health sector agenda, what is meant by coordination, and what forms it has taken in the health sector. The Chapter then turns to the study itself: setting down the research questions and aims; mapping out its parameters; proposing a framework to assess aid coordination efforts as a hypothesis for testing; and elucidating and justifying the research design and strategy adopted. In order to understand the context in which aid management has taken place in the case study country, Chapter Two provides some basic information on Bangladesh, particularly to explain foreign control of the aid management process. Chapter Three explores the manner in which the Government of Bangladesh has managed foreign assistance, particularly in the health and population sector, from the country's independence in 1971 to 1997 – with emphasis placed on the manner in which donors have prevented the system from reaching its potential. The succeeding three chapters - 4, 5 and 6 - describe the evolution and functioning of three distinct donor-driven coordination arrangements, before presenting competing views and assessing their effectiveness. Chapter Four looks at how efforts to improve the operational assistance in the United Nations system have played themselves out in the health sector in Bangladesh. The long-standing 'Consortium

of donors' is the focus of Chapter Five. Chapter Six focuses attention on the most recent development in aid management, namely the sector-wide approach. The final Chapter returns to whether there are too many lollies; where the sweet and sticky interact. Drawing on a summary of the study's findings, Chapter Seven refines the conceptual framework *ex hypothesis*, enumerates the determinants of health sector aid coordination in Bangladesh and assesses the prospects for improved practice. The thesis concludes with a set of guidelines for aid coordination and identifies a central research question for further investigation.

## **1.2 What gave rise to interest in aid coordination in the health sector?**

Barry dates the inception of donor coordination with the first *ad hoc* meeting of creditors to India which met in 1958 to resolve the country's foreign exchange crisis.<sup>4</sup> Over the decades, as the volume of aid to developing countries escalated, so increasingly was the need for coordination recognised. Interest in coordination of external resources in the health sector can be traced to several factors both within and outside the sector.<sup>5</sup> Five sector specific trends can be identified: the expanding number and increasing heterogeneity among external agencies; the growing proportion of assistance in many health budgets; the proliferation of aid projects; the gradual transition in the forms, channels and systems of aid; and the nature and goals of health sector reform.

### *1.2.1 Increasing number and diversity of external agencies*

The 1980s saw a growth in the number and type of agencies involved in the health sectors of developing countries. This growth may have contributed to increased interest in the area of coordination. In Ghana, for example, in 1992, Smithson found 199 donors "stumbling over each other".<sup>6</sup> That situation was not atypical. At the same time in Zimbabwe, in addition to approximately twenty multilateral and bilateral agencies, Green and Matthias identified 254 non-governmental organisations (NGOs) with activities to improve health.<sup>7</sup> The present study found that in Bangladesh, 18 bilateral agencies and 13 multilateral agencies committed funds to the Ministry of Health and Family Welfare between 1992 and 1996, while more than 400 NGOs were active in the sector. The absolute growth in number of external actors in the sector coincided with the emergence of new players. Whereas the World Bank did not provide health sector loans before 1980, by the early 1990s it had become the most important external financier in countries of low and lower-middle income.<sup>8</sup> Other significant multilateral agencies to emerge during the 1990s included the European Union and regional development banks.<sup>9</sup>

A further development concerns the composition of the aid community. A marked shift was witnessed during the late 1980s and 1990s when an increasing proportion of aid was channelled through NGOs.<sup>10</sup> By 1990, an estimated 23% of external assistance was provided to the health sector through NGOs, up from 13% in 1982.<sup>11,12</sup> There are, however, great variations among agencies and countries. In Bangladesh, for example, USAID now provides 100% of its health sector assistance directly to NGOs<sup>13</sup> and in some sub-Saharan African countries, NGOs account for up to 50% of health service delivery.<sup>14</sup> A common view holds that these agencies “resist coordination.”<sup>15</sup> Although the multilateral institutions, such as WHO, are obliged to work through the apparatus of the government, such is not always the case for NGOs; although they may have to be licensed or registered to work *with* government, they do not have to operate *through* it.

The proliferation of actors provides strong justification for enhanced efforts at coordination. According to LaFond, “increased involvement of donors may bring more confusion to the development process.”<sup>16</sup> In some countries, the situation is exacerbated by the rapid succession of agencies. In Mozambique, for example, the end of the 1980s saw dramatic reductions in Soviet and Italian aid and the arrival of the World Bank, the European Community and Danish aid. With the new donors came new agendas and consequent confusion for ministry officials.<sup>17</sup> In such turbulent environments, coordination is urged as a means of continuity.

### *1.2.2 Increasing volume and importance of aid*

Related to the increased number of donors is the growing importance of aid in terms of public health expenditure in many countries. Whereas, in 1977, external resources accounted for only 0.5 per cent of health sector expenditure in developing countries, this figure had increased to roughly 3% by 1990. Growth in external finance was particularly marked after 1986.<sup>18,19</sup> Although marginal in global terms, aid plays a crucial rôle in many low-income countries. For example, according to 1990 data, in twenty three sub-Saharan countries, as well as in Guyana, Bhutan and Nepal, external assistance, as a proportion of total health expenditure, exceeded 25 percent; in eight countries it exceeded 50 percent.<sup>20</sup> These figures may, however, underestimate the true extent of aid in public health expenditure. In Nepal, for example, where the official figure is 30 per cent, an estimated 40 per cent of external aid is not reported to government, hence Nepal's actual reliance on aid is significantly higher.<sup>21</sup> Chad represents an extreme case of dependency. While public per capita expenditure on health barely changed between 1985 and 1990, external assistance tripled in that period, to about five times the amount apportioned by the Government.<sup>22</sup>

In those countries where aid has assumed prominence in the health budget, the need for coordination between expenditures of domestic resources and aid arises *ipso facto*. Yet poorly coordinated external assistance in the context of aid dependence carries an additional risk. In particular, when donors make forceful but divergent demands on policy and planning machinery, which are often already weak and overextended, there is a great likelihood of inconsistency and incoherence in government response. Aid, it has been argued, is influential in shaping recipient policies and programmes.<sup>23,24</sup> A five country study found that the main investment strategy pursued by health ministries was “maximising resource flows into the health system at any cost” and one cost is often coherence.<sup>25</sup> The study cites the case of Nepal, where “the Government regularly accepts donor projects which conflict with national policy goals.” Justice also found that “in exchanges between donor agencies and recipients countries, the donors' priorities predominate.”<sup>26</sup> Such findings were confirmed by an analysis of the formulation of two health policies in Uganda.<sup>27</sup> Many health sector reviews suggest that donors often promote different policies, distinct administrative systems and even disparate therapeutic regimes. Increasing aid dependency in the health sector underlines the urgency to establish coordination arrangements which promote greater consistency in donor behaviour.

### *1.2.3 Project proliferation and recipient institutional weakening*

The swelling ranks of donors has tended to result in a proliferation of projects. As many governments do not maintain a comprehensive and up-to-date system for collecting information on externally funded activities, the exact number of projects is rarely known. Morss coined the phrase 'institutional destruction' to describe the negative cumulative outcome of projects on ministerial institutional capacity.<sup>28</sup> These effects relate to the time and other resources devoted to administering aid (particularly the burden of maintaining multiple and duplicative management systems), the displacement of national priorities resulting from the salience placed on donor goals, competition for scarce local skills which inflates salaries and result in perverse incentives, and the blurring of lines of authority and accountability.

Clift maintains that “it is the multiplicity of projects, however worthy in their own right” which presents the greatest impediment to development.<sup>29</sup> Multitudinous, donor-driven projects may not only undermine administrative capacity, but also have an erosive effect on the government's capacity for coherent strategic planning, leading to fragmentation

and inconsistency. Because project funds do not pass through the government budget, project proliferation reduces the scope for preparing comprehensive sectoral budgets.

A World Bank Director summarised the situation as follows:

The most obvious dimension where existing investment assistance is not as effective as it could be, lies in the fragmented nature of the assistance: the multiplicity of donors, the multiplicity of objectives, the multiplicity of management systems, the multiplicity of procurement, disbursement, accounting and auditing procedures. In such a context, even if each individual piece of project assistance was well designed, it is difficult to see how any government, whatever its so-called absorptive capacity, could effectively manage such a mosaic of aid.<sup>30</sup>

The deleterious effects of project proliferation have been noted in numerous ministries of health. In Mozambique, health officials were found to be spending “most of their working hours entertaining visiting delegations, meeting donors, and preparing project documents.”<sup>31</sup> Foster describes international health agencies as competing for 'clients'.<sup>32</sup> WHO calculated that a project director in West Africa was out of post for 120 days in one year to attend different donor-sponsored events.<sup>33</sup> The proliferation of projects, and demands associated with them, is one of the major concerns prompting attention to coordination.

Paradoxically, interest in aid coordination may also relate to its potential to enhance the capacity of recipients to execute projects more successfully. LaFond echoes the sentiments of others when she writes that “donors' experience investing in health in the 1980s was often disappointing.”<sup>34</sup> Fund disbursement was too often sluggish and slippage in project implementation was widespread. This gave cause for concern as the agencies faced increasing pressures from their governing bodies and other constituencies to demonstrate results, preferably quick and measurable ones.<sup>35</sup> Donor staff, in turn, were often evaluated within their agencies on their ability to 'empty the pipeline' of funds.<sup>36</sup> Their capacity to do so hinged to a great extent on the ability of health ministries to approve and implement projects. Ironically, analysts such as Cassen<sup>37</sup> and Van Arkadie<sup>38</sup> pointed out that the ability of the recipient administration to absorb funds and undertake project related tasks was contingent, among other things, on reducing and rationalising donor demands. Improved inter-agency coordination may, therefore, have been seen by donors as a vehicle to enable recipients to improve upon the rates of project implementation and, thereby, meet exigencies which donors faced.

#### *1.2.4 Changes in the forms, channels and systems of aid*

Demands for enhanced donor coordination in the health sector have coincided with the shift in the forms, channels and systems of aid, particularly the experience with programme support and nascent moves toward sector-wide approaches.<sup>39</sup> During the late 1970s and 1980s it became increasingly apparent that project effectiveness depended, not only on project design, but also, and often significantly, on the wider policy environment. Consequently, aid disbursements became increasingly tied to institutional and policy changes agreed to and implemented by national authorities.<sup>40,41</sup> One instrument which was introduced to support this change in aid policy was programme aid, also known as budget support. These are generic terms which denote the provision of a variety of material goods which are sold by the recipient to the private sector, thus generating local currency which is available to the treasury or specific ministries. Two characteristics of this form of assistance were germane to aid coordination: (1) as the funds generated were disbursed through the budget, in theory, they obviated the need for parallel systems for aid management; and (2) as donors usually demanded some say in how the funds were allocated or the reforms enacted, they presaged greater external involvement in the policy and budgeting processes. In practice, a review of programme aid in the health sectors of Nigeria and Mali found it to be as labour intensive as project assistance for both donor and recipient, since funds were tightly ear-marked and accounting procedures cumbersome.<sup>42</sup> Nevertheless, experience with this form of health sector aid, although limited, drew attention to the effects of uncoordinated and contradictory donor support.

The impetus for sector-wide approaches (SWAp) took firm root in the mid-1990s, when the World Bank threw its intellectual weight behind the concept with the wide circulation of three policy papers<sup>43,44,45</sup> and made the sector approach the centre piece of its new health lending strategy.<sup>46</sup> Although consensus is emerging around the notion that a SWAp does not represent a single aid instrument but an approach to health development,<sup>47,48</sup> there is general agreement that the idealised SWAp is underpinned by six principles, four of which are: (1) the key stakeholders agree to a broad, medium-term sector policy or strategic framework; (2) the strategy is reflected in a prioritised, public expenditure programme which is sector-wide in scope and, therefore, inclusive of all planned spending by both government and donors; (3) all major donors endorse the strategy and expenditure programme and agree to phasing out assistance which is inconsistent with the approach; and (4) donors use and strengthen common implementation and administrative arrangements which are integral to, and do not duplicate systems already in place in the recipient's public administration.



The sector-wide approach has fuelled interest in aid and donor coordination for a number of related reasons. A successful SWAp would behove all major donors to agree on the content and direction of a broad policy framework, set priorities with respect to resource allocation, and ensure that all expenditure be coordinated through an agreed public expenditure programme. This, in turn, demands a degree of consistency among actors whose views might be informed by a range of values and ideologies. Yet disagreements must be overcome, for it has been recognised that offers of aid for activities which do not conform with aims of the sectoral strategy, or fall outside of the agreed investment programme, could dilute the aims of sector reform if accepted by the recipient. For example, the World Bank has complained that by prioritising hospital construction, both Japan and France subverted the Bank's reform package which gave priority to public health and essential clinical services. It argued that these 'gifts' resulted in greater allocations of subsequent recurrent budgets from primary to tertiary health services, thereby subverting the policy aims of its proposed reforms.<sup>49</sup> In their review of practice in sub-Saharan Africa, Gilson and Mills conclude that "the critical lesson of past experience is that health sector reform requires a policy package rather than a series of independent reforms;"<sup>50</sup> others concur by calling for a 'comprehensive approach'.<sup>51,52</sup> Donors acting alone or at ideological odds with the reforms will frustrate the process.<sup>53</sup>

Not surprisingly, it is often difficult for donors and recipients to arrive at an agreement over the sector strategy and even more so for recipients to comply with conditions stipulated in accompanying loan and/or grant agreements. Compliance may require the combined political clout of the entire aid community. As such, coordination has been promoted as a mechanism for blocks of donors to increase their leverage over recipient administrations, through, for example, agreements on common sanctions. Nolke speculates that, in sub-Saharan Africa at least, coordination is perceived as a power-base for development agencies.<sup>54</sup> Some actors have been explicit in this regard: according to an European Union council resolution, coordination would "maximise the ability of the Community and its Member States to exercise an influence on the area of development."<sup>55</sup>

Proponents of the sector-wide approach aspire to systems for appraisal, disbursement, procurement, reporting, accounting, and auditing of external resources which dispense with multiple, distinct, bilateral arrangements between individual donors and recipients in favour of common systems embedded in the recipient's public administration upon which

all donors can rely. Therefore, the debate moved on from the unresolved problem of 'harmonising' donor procedures and requirements to getting donors to make greater use of national systems for financial management, performance monitoring and procurement. Designing such systems, which meet the needs of all parties, will require an unprecedented level of coordination among donors and between donors and government, and raises concerns about accountability and attribution. Nevertheless, the feasibility has been discussed at the global level,<sup>56</sup> with recipient governments<sup>57</sup> and within particular countries, and some progress has been recorded (e.g., Ghana<sup>58</sup> and Zambia's 'basket account'<sup>59</sup>). Effective sector-wide investment is predicated upon concerted action and will require strong mechanisms for coordination.

#### *1.2.5 Coordination and the goals of health sector reform*

While new approaches to assistance have drawn attention to the desirability of enhanced donor coordination, so too has support for what has been loosely called 'health sector reform.'<sup>60</sup> Greater efficiency, effectiveness and equity are central, although at times conflicting, objectives of health sector reform.<sup>61,62</sup> Aid coordination is germane to sector reform for its potential to contribute to the attainment of each of these goals.

Although definitions of efficiency abound, for the purpose of this discussion, efficiency is defined as an input-output measure. Two types of efficiency are commonly distinguished. Allocative efficiency relates to the extent of optimality in the distribution of resources among competing uses; in other words, whether an activity is worth doing in reference to its social benefits and costs. Aid may thwart allocative efficiency for two reasons. First, donors may not select the project that gives the greatest health benefit for a given cost (assuming there is an objective way to value benefits). This happens most frequently with 'tied aid' when economic criteria are relegated to secondary consideration in deference to donor commercial interests. Bollini and Reich report that all but one of Italy's bilateral health sector assistance projects during the 1980s consisted of capital intensive infrastructure investments of primary benefit to Italian construction firms.<sup>63</sup> Political and diplomatic motives may equally over-ride economic criteria in decisions regarding aid allocations. Inappropriate capital investments, whatever their motivations, may carry deleterious long-term recurrent cost implications which run counter to allocative efficiency (hence the World Bank's discomfort over aid financed teaching hospitals). Second, failure to meet allocative efficiency may arise because donor judgement of benefits differs from recipient judgement (i.e., a matter of values). This occurs when donors fund predetermined activities without due consideration of local preferences. Failure to meet allocative efficiency criteria for either reason may not only

subvert the optimal use of the aid itself but may also divert local matching resources (human, administrative, financial) from investments made according to economic criteria. Coordination may therefore serve the interests of efficiency to the extent to which it facilitates greater consistency (and transparency) in matching external investment with priorities determined through evidence-based approaches (e.g., burden of disease and cost effectiveness studies).

Technical (or operational) efficiency relates to the extent to which choice and utilisation of input resources produce a specific health output or service at lowest cost. LaFond notes that "health facilities in Pakistan, Nepal and Ghana were frequently over-staffed reflecting the priorities of donors' vertical programmes" as opposed to efficiency considerations. In some cases, the number of staff exceeded the average number of patients seen in a day.<sup>64</sup> Examples of technical inefficiency are legion: services overlap; ministry officials are often obliged to meet a succession of missions when one gathering would suffice; non-complementary technologies are employed; programmes often have multiple information, accounting and reporting systems and are subject to repetitive evaluations.<sup>65</sup> These are familiar characteristics of health sector aid which, if checked through improvements in donor coordination, would provide significant gains in technical efficiency.

Effectiveness is commonly understood as a measure of the extent to which a project, programme or sector attains its set objectives. In this regard, external resources ought to be evaluated on the basis of their contribution to a coherent sector-wide strategy and policy framework. Health assistance has often been criticised for inducing fragmentation, as opposed to coherence, as a function of the competing, shifting, and sometimes conflicting policies, programmes and activities which are advocated and funded.<sup>66,67,68</sup> For example, in Uganda, five national health plans were found to co-exist, each funded by a different donor.<sup>69</sup> Coordination can provide the means to enhance the use of external resources to reinforce the effectiveness of the sector as a whole.

Although the definition of equity is much debated,<sup>70,71</sup> the concept is broadly concerned with the distribution of burdens and benefits of the health care system. From the perspective of the user, equity is about who pays for and who benefits from services. With respect to benefits, coordination may, for example, reduce geographical inequities. In the absence of aid coordination, there have been reports of donor supported islands of excellence in seas of under-provision. According to Green and Matthias "there is certainly enough evidence of the wasteful duplication of facilities provided by different

NGOs in specific locations, coupled with an absence in other areas.”<sup>72</sup> As for the distribution of burdens, the *ad hoc* or uncoordinated application of payment systems may lead to some patients paying while others do not. A World Bank review found, for example, in one West African country “three different cost-recovery policies, each sponsored by a different donor agency” in different parts of the country.<sup>73</sup>

The equity implications of aid may also be considered from the perspective of service providers and administrators. For example, in Lesotho, the ministry of health reported on the effect of aid on staff morale as follows: “Donor input into one area can cause resentment in another; better working conditions and transport facilities in donor funded projects appear in stark contrast to conditions other staff are working under.”<sup>74</sup> Similar effects related to inconsistencies among donor practices have been reported in Kenya and in Ghana.<sup>75</sup> Differences in per diem payments is particularly divisive. The Joint Consultative Group on Policy (JCGP) of the United Nations is forming a common approach among member agencies for payment to government staff,<sup>76</sup> and *ad hoc* efforts have been recorded in numerous countries to harmonise compensation to civil servants for their participation in donor-funded projects.

#### *1.2.6 Factors exogenous to the health sector*

In addition to sector-specific issues, at least three factors external to the sector have played a rôle in placing aid coordination on the agenda. First, beginning in the early 1980s, aid has come under ever greater scrutiny.<sup>77</sup> A number of studies of aid management found aid coordination wanting and recommended improvements, particularly at the country and sectoral levels.<sup>78,79,80</sup> The second trend relates to the increasing instability and insecurity in large parts of the developing world and the concomitant increase in the diversion of aid from development to relief and rehabilitation activities.<sup>81</sup> The need for improved coordination under these circumstances is heightened by the fact that there are usually questions surrounding the adequacy or perceived legitimacy of the recipient state.<sup>82</sup> Consequently, funds tend to be disbursed through a variety of non-governmental channels,<sup>83</sup> in some instances in the context of an institutional void,<sup>84</sup> in others without the consent of government and frequently without regard to any coherent or comprehensive plan.<sup>85</sup> Substantial uncertainty within agencies over mandates under complex emergency situations further frustrates attempts at coordination. Green, in assessing the rôle of the UN in emergency responses, asserts that the ability of the various UN agencies to speak in a “harmonious chorus” will, to a crucial extent, condition its success in contributing constructively in these complex situations.<sup>86</sup> Given the drift toward instability and the major rôle of outside institutions in periods of

instability, the relevance of improved systems of coordination cannot be overstated. The third factor, relates to the previous point, namely the mounting confusion over UN agency mandates.<sup>87</sup> This concern is echoed in the health sector where there is not only significant overlap in functions and mandates<sup>88</sup> but, in many instances, open competition over leadership and coordination.<sup>89</sup> While both WHO and UNDP have formal mandates to coordinate UN operational and technical cooperation at the country level, this responsibility has been increasingly usurped by the World Bank.<sup>90</sup>

The above inconclusive discussion points to a wide range of factors which have converged to place the coordination of external inputs firmly on the health policy agenda. It suggests that donors have been the principal driving force behind coordination. Yet, in light of recent enthusiasm expressed in sector-wide approaches, it appears that governments may also be seeking mechanisms through which aid management can support the implementation of agreed national policies, through national systems. Although particularly evident in the well documented cases of Ghana<sup>91</sup> and Zambia,<sup>92</sup> interest in SWAs has been recorded in at least ten additional low-income countries.<sup>93</sup> Perhaps the very notion of aid and donor coordination may be undergoing a transformation, with the focus less on aid and donors and more on recipients and their policy making, management and administrative capacity. To focus the discussion, the next section will explore the concept of coordination.

### 1.3 The concept of coordination

*Heading the list of confusing concepts is the term 'coordination,' which many see as one of the key goals of UN reform.*<sup>94</sup>

K. Lee, 1998

#### 1.3.1 What is meant by aid coordination?

In spite of agreement among donors on the need for improved aid coordination, even those taking a leading part in advocating or practising it have failed to define what they mean by the term. For example, the Development Assistance Committee of the OECD has undertaken a series of reviews on the subject, yet its published guidelines and principles do not set out a concise meaning.<sup>95,96,97</sup> The World Bank has made repeated calls for greater donor coordination in the health sector, but has proposed no clarification of the term. Both UNDP and WHO claim some authority for coordination of UN activities in the health sector, yet neither has proposed a formal or working definition of the concept.

The existing literature, both conceptual and empirical, is also of limited utility in defining coordination. Where definitions have been proposed, they tend to range from minimalist,<sup>98</sup> to descriptive,<sup>99</sup> to normative.<sup>100,101</sup> Some have noted its process nature<sup>102</sup> while others have pointed to its numerous dimensions, covering different objectives and activities. Barry, for example, suggests that it can involve any one of three clusters of activities: consultation (the exchange of information or perspectives); concertation (the development of consensus, for example, around policy, programme objectives and priorities); and operational coordination (for example, sponsoring joint activities or relying on common management arrangements).<sup>103</sup> Weiss makes a useful distinction between 'coordination by command,' 'coordination by consensus' and 'coordination by default.'<sup>104</sup> Yet, none of these approaches is satisfactory if one is concerned with who is coordinating whom, what and to which ends. A more encompassing definition of health sector aid coordination at the country level was developed as a starting point for this study:

any set of formal or non-formal activities, relating to health sector development, at any level, led by the recipient or a donor agency, which aims to ensure that external inputs to the health sector strengthen and enable the health system to function more effectively, and in accordance with local priorities, over time (adapted from Buse and Walt<sup>105</sup>).

This definition recognises that aid coordination may take a number of forms. Implicit is the notion that coordination is not a static quality, but an input-output oriented process and a means to an end. Here the emphasis is on improving the effectiveness of the health system. Although there may hopefully be links between good aid coordination, sectoral effectiveness and health outcomes, there are a host of intervening variables as well. On the one hand, there is scepticism about the contribution of aid to development<sup>106</sup> and, on the other, convincing evidence that much health gain is produced outside of the health sector.<sup>107</sup> Our concern is that through coordination, aid contributes to making the health sector more effective and efficient rather than further undermining it. While both donors and recipients are involved, and may act independently of one another to seek improvements in the working relationship, this definition puts the recipient in the driver's seat in so far as the direction of development is concerned. The definition purposefully leaves ambiguity between donor coordination and aid coordination and does not touch on the related issue of integrating external resources within the framework of domestic resource management, two points to which I will return throughout the discussion.

### *1.3.2 Health sector aid coordination mechanisms*

A range of activities can be construed as aid coordination, provided they aim to ensure that aid strengthens and makes health systems more effective. It is useful to distinguish between those activities which are led or initiated by government from those predominantly donor instigated, while recognising that, in practice, many will be jointly executed. Recipient led strategies fall into three categories, although overlap occurs: (1) those which develop and/or strengthen capacity, institutions or systems to coordinate external resources; (2) the development of plans around which donors can coordinate; and (3) the establishment of fora which permit greater information exchange.

#### *1.3.2.1 Capacity strengthening and institution building for improved aid coordination*

It has been argued that the key to donor coordination lies with the recipient government “willing the end and instituting the means to achieve it.”<sup>108</sup> The ability of the recipient to undertake the latter is severely constrained, particularly in highly aid-dependent countries, by the weakness of existing institutions. WHO states that developing capacity for aid management has been identified as a priority by most countries in greatest need.<sup>109</sup> Apparently, expertise in financial management and budgetary analysis, health information systems, systems development, institutional and policy analysis, and planning are required. There is also the difficult task of developing the talent to handle the politics of coordination; confronting large external agencies demands considerable political acumen.

Of equal importance to skills acquisition is the development of institutional structures which facilitate productive skill deployment. Some ministries of health have established formal structures for managing donor resources (e.g., aid coordination units). There are, however, few examples in the literature of effective management of external resources by such structures. Ghana provides one possible exception, where a ministry restructuring in 1993 enhanced the power of the external aid coordination unit,<sup>110</sup> thereby enabling it to “pro-actively control donor activities.”<sup>111</sup> There is evidence that some donors appreciate the value of aid management departments. For example, one division within WHO has a mandate to strengthen such units.<sup>112</sup> In Sierra Leone and Guinea-Bissau, the African Development Bank offered to allocate those resources it had earmarked for autonomous project implementation units to indigenous aid management units if they could be effectively established by the ministry.<sup>113</sup> There are, however, problems associated with these units. First, there may be conflict over control of the departments, perhaps as a function of the resources involved. In Zambia, for example, the Planning and Management Unit and the Health Reform Implementation Team each has a mandate,

although ambiguous, in managing donors.<sup>114</sup> In Nepal, within the ministry of health, there co-exist two planning divisions, each with a perceived rôle in donor coordination. Second, the establishment of dedicated units for aid management begs the question of the desirability of separating the management of external from domestic resources; it could be argued that a better alternative would involve general strengthening all departments which have a mandate for resource management (e.g., budgeting, procurement, etc.). More needs to be learned about the effectiveness and costs of aid coordination units.

Associated with the development of recipient skills and institutions for aid management is the issue of systems. One of the problems of poor donor coordination is the profusion of aid management systems, each developed to meet the needs of an individual donor. Strengthening national systems for aid delivery and monitoring, such as procurement, accounting, auditing and performance monitoring which meet the requirements of the majority of donors, would represent a large step toward improved aid coordination.

#### *1.3.2.2 Planning as a coordination tool*

The planning process provides a powerful vehicle for aid coordination. Through the process, common government-donor policy direction can be articulated, priorities established, the principal strategies and programmes outlined, institutional responsibilities (both local and foreign) assigned, and the costs of programmes explicitly set down against contributions provided by the ministry and the donors involved. A national health plan has, therefore, been described as an essential tool through which to negotiate with donors<sup>115</sup> and may enable the recipient to be proactive in negotiations.<sup>116</sup>

The basis of good planning is an accurate analysis of the situation. Donor-ministry collaboration in the preparation of a situation analysis can strengthen coordination. In the foreword of a situation analysis in Lesotho, the minister of health affirms, perhaps merely as a rhetorical gesture, that “the information compiled is expected to allow our traditional partners in health - like international and bilateral agencies - to identify areas of common interest for future joint ventures.”<sup>117</sup> The preparation of the document itself was a joint undertaking of the ministry and the EC, World Bank and WHO. It has been stressed elsewhere, that a plan's success rests primarily on its ownership. Two countries (Zambia and Ghana) provide indications of the potential of coordination as a by-product of planning.<sup>120,121</sup> It should be noted that both countries have avoided voluminous and detailed plans, opting instead for quite loosely defined strategy documents and annual spending plans around which to unite donors.



#### *1.3.2.3 Recipient-led consultations*

The third cluster of recipient-led aid coordination strategies comprise consultations or other exchanges between the government and donors pertaining to policy directions, priorities and/or activities. These may be organised nationally, sectorally, thematically or sub-sectorally and include a range of the players from either side. To be effective they need to reduce the number of repetitive and redundant bilateral interactions between donors and the recipient administration and provide information which leads to more successful coordination. These range from the annual, formal, rather structured Round Table Process,<sup>122</sup> often co-chaired by the ministry and UNDP, to monthly meetings convened by the secretary of health where donor agency representatives share coffee, information, views and intentions which may lead to improved coordination. Whereas the formal processes often rely on informal discussions, the latter may be insufficient for coordination. The advantage of the formal consultations is their proclivity to force the preparation of concrete plans and the articulation of commitment to these.

One can also distinguish four clusters of donor-led coordination strategies: (1) lead donor arrangements; (2) changes to the forms, channels and systems of assistance; (3) organisational changes in the donor institutions; and (4) enhanced information management. In reality, these do not form discrete categories as components of one strategy may also be involved in others, yet they are helpful in thinking about what constitutes donor-driven coordination.

#### *1.3.2.4 Lead-donor coordination arrangements*

Three distinct forms of coordination through lead-donor arrangements can be discerned. In geographical zoning, or 'area-based programming,' assistance is directed to a particular province or district for health system development under the aegis of a lead agency. Zoning may allow the recipient to meet primarily or exclusively with the lead agency instead of the usual range of donors for the area in question. In addition, it should decrease the number of external actors, reduce donor competition for popular projects and scarce resources, encourage greater policy coherence and decrease activity duplication in any one zone.

From the existing literature, it is not possible to ascertain if the purported benefits of area-based programming obtain in practice. However, studies suggest some negative impacts. In Ghana, a review found that central officials were reluctant to accept zoned support because it led to differential systems development while local officials commented upon

the dissatisfaction staff feel when posted to a 'neglected' district.<sup>123</sup> Zoning may also impact negatively on geographical equity. By choosing to work in some areas rather than others, donors may neglect poorer or less accessible populations. In Mozambique, for example, Colombo found that 18 districts had up to 6 NGOs providing services and assistance, 85 districts had one or two NGOs, and 25 districts were left uncovered.<sup>124</sup> At times, zoning may undermine local ownership of health systems development through a process of balkanisation. Cliff writes, "in just one example of many possible, an NGO project leader banned a MOH nutritionist from entering 'his' district."<sup>125</sup> The most important down side of zoning may rest in the loss of policy coherence from a national perspective. With these types of arrangements, donors may lose sight of, or actually undermine, the implementation of national policies and plans.

Sub-sector specialisation is a variant of the lead-agency coordination strategy. As in geographical zoning, an agency is designated a lead rôle, in this instance not for a region, but rather for a sub-component of the health sector. Sectoral sub-components may comprise areas such as financing, reproductive health, management support, essential drugs, etc., depending on the structure of programmes within the ministry. Sub-sector specialisation is appealing in that it provides the opportunity to realise the comparative advantages of individual donors. This form of coordination is intended to reduce the number of actors in a sub-sector area, decrease the number of contradictory policies signalled to the ministry in a certain field, and reduce the number of interactions the ministry has with external actors in regard to a particular issue or programme intervention. The benefits of issue-specific coordination may lie in its potential to engender a culture of coordination in the health sector. In that the focus is narrower than the entire health service structure, a greater degree of coordination may be possible than where more ambitious goals are set. Where positive results are achieved, issue-specific coordination may act as a model encouraging wider coordination

An example of sub-sector specialisation is provided by initiatives in Zambia in the early 1990s. While the overall management of donors was said to remain the prerogative of the ministry of health, donors were assigned lead rôles in specific areas. For example, in the field of manpower planning and policy, ODA took the lead with WHO and JICA in subordinate positions; in quality assurance, DANIDA provided leadership with WHO as a co-partner. In a number of domains, however, it remained unclear which agency was in fact responsible for coordination. For example, under the category labelled HIV AIDS/STDs/TB, no fewer than eight major agencies had a 'lead' rôle at the national level.<sup>126</sup>

In practice, thematic leadership may evolve in an *ad hoc* manner in response to concerns common to a number of donors instead of according to an overarching plan to designate lead agencies in a comprehensive manner for all facets of the health system. Whether or not such initiatives will enhance or undermine sector-wide coordination remains open to question. Issue-specific emphasis may have deleterious effects on the wider system similar to those caused by vertical intervention programmes: sapping resources and competing with sector-wide mechanisms. Moreover, it is not clear whether thematic coordination instruments have been effective. For example, a WHO assessment of country-level HIV/AIDS coordination found few success stories<sup>127</sup> and one study in Zambia suggested that less than a third of all external resources for HIV/AIDS were coordinated through the National AIDS Programme, which was intended to coordinate action in this field.<sup>128</sup>

Sectoral consortia provide the third variant of the lead donor model. The consortia differ from other lead agency arrangements in two crucial respects. First, in the other models, most of the key agencies would be assigned or assume leadership in one area or another. In the case of consortia, one donor leads the entire process and pack of donors. Second, in the consortium model, the scope of coordination entrusted to the leader is much greater than in the other models, often encompassing the sector as whole.

Consortia often exhibit a number of features which facilitate coordination. Typically they involve the most important actors and provide a mechanism through which to pool knowledge, negotiate a division of labour based on comparative advantages, and reduce duplication. Consortia respond to a need for formal leadership and encourage donors to work within a set framework of priorities. To the extent that donors pool resources and utilise common implementation arrangements, efficiency savings can be realised. From the perspective of the recipient, the demands and conflicting signals from the donor community are reduced as they are channelled, mediated and filtered through the voice of the lead agency.

Yet the consortia carry disadvantages as well. These relate primarily to the power and influence which the leader of the consortium, once ensconced, may exert over other donors, the recipient administration and the policy process in general. The pros and cons associated with the World Bank-led Bangladesh Consortium are addressed in Chapter Five.

#### 1.3.2.5 Reforming the forms, channels and systems of aid to facilitate coordination

As noted above, changes in the forms, channels and approaches to assistance have motivated interest in coordination, but also constitute strategies through which to attain improved coordination. Channelling funds through multi-donor consortia provides one such mechanism. A less ambitious strategy is project cofinancing, which involves pooling donor resources into one discrete project. Smaller donors often find it attractive to buy into a project designed and executed by a development bank or multilateral agency. Cofinancing may improve coordination if it diminishes project proliferation and donor-induced policy or service fragmentation. Cofinancing has additionally been touted as an aid management, resource saving device. Recipients, in particular, are likely to benefit from not having to meet several donors consecutively nor report on activities in multiple formats.

Two types of cofinancing are distinguished. In *joint cofinancing*, donors designate a lead agency for project execution and management. Nolke argues that this type of coordination is most likely to occur where an agency with a high level of analytical resources and meagre financial assets interacts with a financially flush but analytically-poor institution.<sup>129</sup> Cofinancing between the World Bank and the African Development Bank (AfDB) during the 1980s has been explained in these terms.<sup>130</sup> In *parallel cofinancing*, donors maintain responsibility for a discrete area of a project, and control their own funds. This type of coordination does not have the advantage of reducing the burden on the recipient (separate accounting and supervisory missions may still be demanded), but it does offer opportunities for greater coherence between participating donors in terms of policy content.

Cofinancing has mixed potential as a coordination tool. The extent to which it has become the norm is not clear, and certainly the proliferation of single-donor projects persists. Perhaps donors cannot or will not face the potential loss of control and visibility inevitably involved with cofinancing. The utility of cofinancing when it is undertaken as a one-off venture may be limited. Finally, where cofinanced projects have been undertaken, there is little evidence of the extent to which they actually reduced recipient workload. There is certainly limited understanding of recipient's perspectives on cofinancing.

The use of programme assistance and sector-wide approaches (SWAs) to achieve greater coordination of external inputs has been discussed above (section 1.2.4). Both

hold significant potential for aid coordination, particularly the SWAp because it provides a process through which donors and recipients work together to resolve the inevitable tensions related to policy, planning and resource deployment in the aid relationship. Yet, it should be recognised that both are ambitious strategies requiring substantive changes on the part of donor agencies, and are most likely to succeed where there is strong institutional capacity in the recipient country, precisely those aid-dependent states which need donor coordination most urgently.

#### *1.3.2.6 Reforms to the way donor agencies do business*

Given the constraints to coordination identified in the preceding discussion, it is apparent that a number of institutional changes affected by donors would facilitate the management of aid by recipient ministries of health. These include the harmonisation of procedures as well as changes in organisational values, structures, and programming processes.

Donors' administrative procedures can divert scarce recipient skills from regular functions of government.<sup>131</sup> If each external agency sets unique requirements (relating to project identification, appraisal, formulation, execution, monitoring and evaluation, accounting and auditing, equipment procurement, hiring and benefits for local staff and consultants, project and programme cycles, etc.), the result is heavily inflated transaction costs for both parties. The benefits of subordinating such differences in procedures for administrative simplicity would be immense for recipients. In the health sector there have been reports of tinkering at the margins with harmonisation. In some countries, for example, donors have agreed on common per diem rates and payment of salaries in local currencies. An ambitious experiment is being tested in Zambia to produce a single set of planning, budgeting, disbursement, accounting and auditing procedures for donor funds channelled to the districts.<sup>132</sup> In Bangladesh, this is already the case for that portion of donors' funds channelled through the World Bank's Trust Funds.<sup>133</sup> Cofinancing, programme aid and consortia achieve harmonisation to varying degrees, yet the greatest potential lies with the sector-wide approach.

Van Arkadie suggests that a number of donor procedures "reflect little more than administrative convenience" and "inertia" which should prove amenable to change.<sup>134</sup> Yet, harmonisation of procedures at the sectoral or national level produces a dilemma for donor agencies. While it may improve aid efficiency for the recipient, how will numerous national initiatives be reconciled at the headquarters level? Donor agencies naturally prefer to operate with the same procedures in all countries they assist. These ways of

doing business have evolved organically over time in response to requirements established by the institutions to which they are accountable. According to Cassen *et al.* “harmonisation of procedures is one of the oldest problems on the aid coordination agenda, and one of the most intractable.”<sup>135</sup>

Nevertheless, there is merit to Van Arkadie’s assertion that there is scope for change, particularly in institutions which place positive connotations on the concept of coordination. Engendering organisational values supportive of coordination has proven influential in the behaviour of front line agency staff. Donors can demonstrate commitment to coordination through, for example, the inclusion of coordination in their mission statement, the creation of incentives rewarding coordination, training field staff in skills conducive to coordination (i.e., negotiation, communication, etc.), and including aid coordination as a criterion of project approval. Nolke’s analysis of eight major donors suggests that, in setting coordination as a corporate goal and institutionalising staff instructions, incentives and procedures in support of this goal, the World Bank has developed a culture which encourages coordination, albeit not always apparent in the field.<sup>136</sup> Nolke acknowledges that attaching organisational value on coordination may be necessary, but insufficient and suggests that structural changes may also be necessary.

Clift argues that the main organisational change relevant to coordination is decentralisation.<sup>137</sup> Broadly speaking, decentralisation may entail devolving some decision-making, shifting personnel to the country-level, and increasing staff analytical capacity at that level. Decentralisation involves a variety of costs. CIDA, for example, aborted its experiment with decentralisation, partially because it found it three times as expensive to maintain an officer in the field as in Ottawa.<sup>138</sup> Other structural changes which would increase the viability of coordination include, among others, extending the duration of postings and reducing the number of bilateral relationships with countries.

Coordination of inputs will be further served as donors switch from top-down, globally inspired programming approaches to those which are more country and sector-specific (e.g., World Bank Country Assistance Strategy). Other reforms which would facilitate coordination include: longer time-horizons; developing alternative criteria of employee effectiveness to fund disbursement and implementation rates; and recognition of aid coordination as a discrete activity requiring adequate resources reflected in a separate budget line and programme of work. Notwithstanding the apparent success of the World Bank in affecting structural and value changes which have made the organisation and its staff more amenable to aid coordination, case studies of CIDA and WHO suggest that

these agencies found it difficult to implement the types of reforms outlined above which would enable them to work in greater harmony with other donors at the national level.<sup>139,140</sup>

#### *1.3.2.7 Donor information management*

Communication is both a strategy and a necessary but insufficient condition for aid coordination. The gathering and exchange of data is at once a preliminary and an integral step to all preceding strategies of aid coordination. It can range from formal, chaired, minuted meetings of all key donors in the sector along a spectrum to informal exchanges between two representatives over drinks. It can take the form of joint needs assessments, situation analyses or policy-studies which can serve as the basis for developing a common donor or ministry-donor platform on issues in the sector. A data base of ongoing and planned donor interventions and support can provide donors and the ministry with a fast and easy way of finding out what others are doing, where the gaps lie and whether or not donor inputs match ministerial priorities.

In the health sector there have been some moves toward joint information management but there remains considerable scope for improvement. The limitations of joint data gathering are essentially twofold. First, there are the problems related to making the mechanism work. One experiment in Sudan failed when the majority of donors did not report on their activities. While a number of reasons for this failure were proposed by the project executors, it was principally a function of the low priority placed in practice on coordination.<sup>141</sup> Second, a more fundamental question relates to whether or not such expensive, time-consuming exercises yield useful information and lead to improvements in coordination. This is an area which deserves future study.

### **1.4 The aims and scope of this enquiry**

While enthusiasm for, and experience with, health sector aid coordination apparently abounds, very little has been documented, either conceptually or empirically, about the process. At the time when this research was conceived, there existed no case studies on the subject in the published literature and a search for grey material identified only one desk review, an MSc report,<sup>142</sup> and one cursory review undertaken by a consulting firm.<sup>143</sup> The review provided a limited description of the *intention* of the Government of Zambia to use its Strategic Health Plan as a “framework for all donor contributions to the sector.” When the present study was in its initial stages, a proposal for a four country study on health sector aid management in southern Africa was being prepared. Its results

became available earlier this year,<sup>x144</sup> as did those from a study of five countries in French West Africa.<sup>145</sup> The former concluded that “while difficult, coordination is attainable, even in the most fragmented settings.” Such rather optimistic conclusions were drawn by researchers who themselves were intimately involved in coordination processes in the countries under consideration. Based on their experience they proposed a number of “essential steps in improving aid management.” These included the need for the ministry of health to develop a vision, to devote substantial resources, and to focus early efforts on a problem on which there is some agreement between donors and the recipient ministry. The work from West Africa revealed a pattern of weak government capacity to control external funds, mechanisms which did exist being donor-driven, but “signs of a growing recognition of the benefits of donor coordination.”<sup>146</sup> In addition to these studies devoted wholly to the issue of health sector aid coordination, other descriptions and analyses of health sector aid coordination may be found in reports on related issues, such as that described in a recent study on the rôle of aid in rehabilitation in Cambodia.<sup>147</sup> However, due to the lack of health-sector specific analyses of aid coordination, this research began with a review of analyses of aid coordination more generally, to determine how they approached the problem and what they had learned.

#### *1.4.1 Theoretical contributions*

Theoretical contributions to the study of aid coordination have been largely provided by organisational analysts. Mingst, for example, used a resource dependency approach (i.e., organisations interact to exchange resources which are scarce) to examine coordination between the World Bank and the African Development Bank across a number of African countries.<sup>151</sup> She argues that the organisations were predisposed towards cooperation by the fact that they shared largely similar objectives and institutional practices, but that the actual impetus to coordinate through project cofinancing resulted from their interdependence on each other’s resources. Cofinancing could provide the AfDB with technical knowledge and well-appraised projects to fund, whereas the World Bank would gain the AfDB’s coveted legitimacy among African states as well as attracting financial resources to its projects. As the realm of coordination between the two agencies was confined to project cofinancing, the study could reveal little about the mechanics of coordination, about multi-party coordination, nor about the place of the recipient therein.

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<sup>x</sup> The southern Africa study, once commissioned, made use of the conceptual framework developed for the present study which is presented in the next section.



Nolke, another organisational theorist, conducted cross-sectional, network analyses of inter-agency coordination at the global level.<sup>152</sup> He argued for the need to move beyond resource dependency approaches because they do not give sufficient attention to the context of inter-organisational relationships.<sup>153</sup> Instead, he used the notion of network structure (i.e., “the pattern of interactions between organisations”) to explain whether or not donors coordinate, with whom and why. Nolke suggested that these patterns are governed by variables such as the origin of the agency’s resources as well as its governing structures. Thus, for example, Nolke contrasted multilateral with bilateral organisations and hypothesised that the multilaterals will seek more interactions as a function of their systems of governance based on a large number of member states. His empirical work involved tracing the degree of interaction among desk officers at headquarters (as indicated by phone calls, correspondence, etc.), mapping the position of the agency on the network structure, and relating this position to specific characteristics of the agency. He assumed that a high level of interaction, coupled with the perception among operational staff that these linkages are effective, constitutes effective coordination. While Nolke’s work is useful in high-lighting the organisational factors which theoretically facilitate and constrain coordination, the static, cross-sectional approach not only fails to capture relationships as they evolve over time, but does not accommodate a consideration of the recipient in the analysis. Nolke supplemented his work with one country level case study of donor perceptions of the effectiveness of their efforts to coordinate among themselves in Mali.<sup>154</sup> Here, donors considered themselves to have been doing a good job, facilitated by the relatively small number of donors and the fact that the needs were so great that donors did not have to compete for good projects and local personnel. Network analysis has also been used to explore and attempt to explain leadership and its central function in coordination.<sup>155</sup>

#### *1.4.2 Empirical contributions*

Empirical work was found to include two early and substantive over-views of coordination; one as a part of a broader, multi-country study addressing the question of whether and how aid actually works to achieve its stated objectives (published in 1986),<sup>156</sup> and one commissioned by the OECD and published in 1988.<sup>157</sup> The first of these studies found that “in several countries the donors not only fail to coordinate, but actually compete.” These studies concluded that the constraints to aid coordination include: (1) the commercial and political interests of donors (i.e., donors want to keep options open so as to pursue domestic interests); (2) the fact that donors are aware that their ideological and technical differences will be made explicit if substantive coordination is attempted; and (3) that coordination is resource consumptive. Recipients

were found to be apprehensive about donor coordination due the perception that: (1) unified donors would be in a better position to leverage economic and institutional reforms; (2) it would reduce the ability of the recipient government to play donors off against one another; and (3) it would make conflicts between ministries of finance and line ministries more explicit. Based on the background studies provided for the first of these publications, Lipton argued that, although coordination is a 'good thing,' the barriers to improvement in practice are fundamental.<sup>158</sup> This is the case because both donors and recipients are trapped in a 'prisoners' dilemma.' For their part, although donors largely recognise the benefits of coordination and the overall costs of poor coordination, they are constrained from taking the actions which would result in improved coordination (such as untying procurement, using common management arrangements, etc.) by the assumption that the effect of such actions would be cancelled out by 'less scrupulous donors' not doing likewise. A similar logic guides the pattern of perverse competition among recipient line ministries. Lipton concludes that 'trust or enforcement' are the necessary but elusive preconditions for effective coordination.

Another paper which approached the topic of coordination through the prism of aid effectiveness was written by Van Arkadie based on experience in Bangladesh and Tanzania.<sup>159</sup> Like Lipton, Van Arkadie argued that the standardisation of donor procedures was a worthy objective, but that there exist strong incentives on the part of both donors and recipients to by-pass or pre-empt what are in effect formal structures of control. In terms of the homogenisation of policy among donors, Van Arkadie warned of the dangers to the recipients in terms of the loss of legitimate differences of opinion and strategies.

Whittington and Calhoun published a short paper outlining the factors responsible for non-compliance of donors with a project monitoring system which they had assisted the Government of Sudan to establish as a first step to improved donor coordination.<sup>160</sup> These authors pointed first to the rôle of agency staff who, on the one hand, lack incentives to engage in cooperation and, on the other, have little room to engage in cooperation at the country-level because of the centralised nature of decision-making. Whittington and Calhoun also suggested that perceptions of the likely futility of attempts to coordinate reinforced the bureaucratic resistance to initiatives in this area. Ross, a senior analyst with the Canadian International Development Agency (CIDA), contributed to understanding the constraints to coordination from the perspective of his agency.<sup>162</sup> He argued that four factors impaired CIDA staff from effectively coordinating with other agencies: (1) while technical experts will often agree to cooperate in a specific area, that the political level

often overrides them (i.e., non-developmental objectives prevail); (2) bureaucratic priorities for fund disbursement and accountability militate against use of common systems; (3) high-level managers think that coordination will take care of itself (i.e. they do not perceive a problem); and (4) many managers give priority to successful delivery of assistance, irrespective of the opportunity costs of poorly coordinated aid.

UNDP sponsored two evaluations of aid coordination in the early 1990s. The first examined how UNDP might better support capacity building for aid coordination in the least developed countries.<sup>163</sup> It concluded that “aid coordination cannot be set apart from the LDC’s capacity for managing the mobilisation and use of development resources.” The evaluation viewed the development of self-sustaining capacity within recipient administrations as a “challenging and unavoidable task;” one which should form UNDP’s “guiding mandate” but in which UNDP’s contribution had been lamentably “modest.” In effect, the report argued that UNDP, as a neutral agency, should focus its limited resources on playing a key rôle in supporting LDCs efforts to develop sustainable capacity for resource management. The second UNDP review sought to establish a niche for UNDP in aid coordination and management by recipient governments.<sup>164</sup> The report argued that UNDP had the mandate, presence and tools to provide aid coordination services to the donors and to ensure their transfer to national institutions in developing countries. The study concluded that UNDP was constrained, however, from fulfilling its mandate primarily by limited in-house capacity and resources at the country level. In the mid-1990s, a consulting firm was commissioned by the Sida to carry-out four country case studies to assess operational coordination among UN organisations at the country level.<sup>165</sup> This review found that while inter-UN coordination was seemingly improving, because the UN was becoming increasingly marginalised in the field of development assistance, whether or not its assistance was well coordinated was of increasingly limited relevance.

A short article was published in 1986 on the need for and obstacles to better aid coordination in Togo.<sup>166</sup> Its title suggested that the analysis was from the recipient’s perspective yet, curiously, its authors were staff of the IMF and the World Bank. They argued that the public sector investment programme was the keystone of coordination in Togo. In 1988, Clift published an account of aid coordination in Kenya.<sup>168</sup> His analysis provides a useful addition to the literature, for he makes the connection between coordination and control. In particular, he exposes the manner in which the World Bank sought to ‘discipline’ other donors (and the Government) to adhere to agreed frameworks

which were largely inspired and imposed by the Bank's coordination instruments (e.g., public expenditure programmes or Consultative Group plans).

Other publications relating to aid coordination do exist, such as the proceedings of a workshop convened to discuss aid management issues as well as possible coordination arrangements in newly independent Namibia.<sup>169</sup> Yet, these do not contribute a great deal to understanding the dynamics of coordination. Collectively, the literature described above, although high-lighting constraints and opportunities to improved aid coordination, is non-cumulative and contributes only limited understanding of aid coordination dynamics in the health sector.

#### *1.4.3 Bangladeshi literature*

There has been a significant treatment of the aid regime of Bangladesh in the literature. A number of studies of aid dependence and the rôle of aid in the political and economic development of the country have been published. These include, for example, early work by Just Faaland and his colleagues at the Christopher Michelson Institute in Norway on the relationship between donors and the government, particularly with the IMF and the World Bank (see Chapter 2 for an analysis of these relationships).<sup>170</sup> Two members of Bangladesh's first Planning Commission, Professors Rehman Sobhan and Nurul Islam, wrote a great deal on the political economy of Bangladesh's dependence on foreign aid,<sup>171,172,173,174</sup> as have other foreign analysts.<sup>175,176</sup> Sobhan provided a particularly radical critique of the aid system which argued, among other things, that aid had placed undue influence in the hands of the donors and thereby abridged national sovereignty and thwarted egalitarian development in the country.

A variety of surveys of aid flows to Bangladesh and their influence in economic development have been reported upon.<sup>177</sup> In addition, a number of reviews of the aims and achievements of individual donors such as Sida,<sup>178, 179</sup> CIDA<sup>180</sup> and ODA<sup>181,182</sup> have been undertaken. Some of these have been commissioned by donors and others are written by academics and critics - yet they do not deal with donor coordination.<sup>183</sup> One study on coordination arrangements in the education sector was undertaken by UNESCO, but it's approach consisted simply of identifying donor-supported projects. The health sector had not even received such a cursory treatment.

#### *1.4.4 Framework of this study*

In light of the limited academic treatment of the topic, this study aims to make a contribution to knowledge by identifying and exploring what is known about the efforts

which have been made to coordinate external resources in one particular country setting. On one level, the study attempts to describe the various arrangements and their characteristics. Given access to the pertinent documents, this represents a relatively straight forward task of tracing and recording the history of the processes employed, the actors involved and the context within which they occurred. The study will, therefore, make a contribution through synthesis and interpretation. To the extent the research moves beyond documentary sources and combs the ideas and perspectives of those involved, it may also ‘down-load’ some history which has not been recorded.

At another level, the study aims to make a conceptual contribution to both the study and practice of aid coordination. It proposes to do so by testing and refining a method of assessing aid coordination arrangements. In so doing, it forces a rigorous examination of the aims and characteristics of coordination and raises the question as to whether or not an analysis of coordination is not, in fact, inherently subjective in nature.

The greatest strength of the research may lie in its potential to transcend the narrow self-interests of the parties to coordination and provide a third party account of the pros and cons of the processes at stake, and particularly of the politics of aid coordination. It is acknowledged that enquiry into “questions concerning the nature of facts and values, of perceptions and observations, of reason and cognition, of science and objective knowledge” have sparked a lively debate over the nature of policy analysis and lies at the root of competing policy-analytic approaches (positivist/empiricist, Popperian critical-rationalist, pre-suppositionist, normativist, *inter alia*).<sup>184</sup> Without wishing to become embroiled in the debate, it is felt that the non-aligned, doctoral student can provide a unique and objective perspective – not in the value-neutral sense – but in the tradition of the honest-broker; the disinterested outside observer of interest parties. If the research is not wholly successful in achieving objective neutrality, it may, at the very least, provide the forum to counter-pose prevailing and opposing views of stakeholders. It could, thereby, make a particularly valuable addition to aid management literature in that very little is known about the views of recipients concerning the processes generally, and of aid coordination specifically.

Having elucidated the forms, achievements, motivations and stakeholder perspectives concerning aid coordination in Bangladesh, the study concludes by advancing a set of principles which could govern and guide the nature of future external investment in

health sector development, in Bangladesh and in other low- and lower-middle income countries.

To summarise, the objectives of the study are: (1) to design and test a conceptual framework for assessing the effectiveness of aid coordination and management mechanisms; (2) to analyse the effectiveness of aid coordination found in the health sector in Bangladesh; (3) to determine the factors which facilitate and constrain effective coordination and management of aid; (4) to elucidate stakeholders' interests and expectations of aid coordination; (5) to assess the prospects for improvements in aid coordination practice; and (6) to arrive at a set of principles which ought to govern aid coordination.

### **1.5 What should coordination achieve and, therefore, how can we evaluate it?**

While the evaluation of coordination arrangements may be inherently subjective (e.g., certain parties may equate effective coordination with hegemony over the development agenda and the compliance of other actors to it, whereas others may view coordination as a means to improve sectoral functioning), a variety of criteria suggest themselves as a starting point for this study. First, there are the goals of health sector reform, discussed above in relation to their coincidence with the broad goals of aid coordination. Second, one can consider arrangements in light of the principles governing aid coordination which donors have established, rhetorically or otherwise. A set of principles guiding aid coordination was agreed by the Development Assistance Committee (DAC) of the OECD along with the World Bank, IMF and UNDP.<sup>185</sup> When extrapolated to the health sector, the following five principles emerge: (1) the ministry of health should take the lead in managing and coordinating external resources; (2) donors should provide technical assistance to enable the ministry to assume the leadership function; (3) external resources should be coordinated, managed and deployed as part of a national health plan; (4) the government should encourage multilateral and bilateral agency involvement in the formation of the national plan and attempt to achieve genuine consensus on the final product; and (5) donors should attempt to subvert their administrative requirements, commercial and other interests in pursuit of the objectives of the plan. It should be noted that the DAC principles are embedded in the principles upon which the sector-wide approach is predicated.

These principles, coupled with my working definition of coordination and the goals of health sector reform, suggest a conceptual framework for evaluating the effectiveness of

various aid coordination arrangements which has been elaborated in greater detail elsewhere.<sup>186</sup> While built on foundations established and accepted by the aid community, the conceptual framework underlying this study remains unique to itself. Such a personalised approach was necessitated by the conceptual underdevelopment of the theme of aid coordination. The framework (see Table 1) proposes that aid coordination strategies should be assessed according to the following twelve criteria.

- \* The institutional leadership and ownership of the coordination arrangement. Does the mechanism belong to one donor, a group of interested donors, is there joint donor-recipient ownership? Has the mechanism been institutionalised in the recipient's administration?
- \* The scope and quality of participation in the arrangement. Is it an exclusive club of two or three dominant actors, is the recipient administration fully involved and does civil society have a voice? What procedures are in place to ensure that the weaker participants are listened to?
- \* The periodicity of the instrument. Is it, for example, a one-off meeting on a particular subject? Is coordination sporadic, periodic or continuous?
- \* Integration. To what extent is the mechanism and its products embedded in the recipient policy, planning and resource management processes?
- \* The realm of coordination. Is the mechanism concerned with consultation, concertation or operational coordination?
- \* The breadth of coordination. Does the coordination mechanism attempt to take a sector-wide approach or is it geographically- or issue-specific?
- \* The authority of, and adherence to, the decisions taken. Is there strong adherence to the rules and decisions by all parties, by only some actors, or do decisions have no binding authority?
- \* Costs. What are the opportunity costs associated with the mechanism? Does the arrangement consume a great deal of limited recipient time and other resources and achieve few of its goals?
- \* The impact of coordination on sectoral efficiency. Does the mechanism reduce service duplication and harmonise aid delivery and management procedures, etc.?
- \* The influence of coordination on sectoral effectiveness. To what extent, for example, does the coordination mechanism diminish donor-induced fragmentation? To what extent is aid marshalled through coordination mechanisms in support of a sector-wide policy framework?

- \* The effect of the mechanism on equity. Does the mechanism correct some of the geographic and other inequities exacerbated by current aid practices, or does it have minimal or no effect?
- \* Sustainability. Does the mechanism promote or detract from the goal of sustainability? Does it ensure that resources are used to enhance the functioning of the system over time?

**Table 1: Characteristics & criteria for assessing the effectiveness of aid coordination arrangements**

Process criteria	Process indicators & questions
Ownership	<ul style="list-style-type: none"> <li>◇ Does the mechanism belong to one donor or a group of donors?</li> <li>◇ Is there joint donor-recipient ownership?</li> <li>◇ Is the mechanism institutionalised in the recipient administration and, if not, what steps are being taken toward this end?</li> </ul>
Participation	<ul style="list-style-type: none"> <li>◇ What proportion of the key stakeholders are involved?</li> <li>◇ Are the recipient administration and civil society involved?</li> <li>◇ Do all members participate regularly?</li> <li>◇ How are the views of less influential members considered?</li> </ul>
Periodicity & continuity	<ul style="list-style-type: none"> <li>◇ Is the process a one-off event, sporadic, periodic or continuous?</li> </ul>
Integration	<ul style="list-style-type: none"> <li>◇ Is the mechanism integrated with the policy and budgeting processes?</li> </ul>
Realm	<ul style="list-style-type: none"> <li>◇ Are the purposes of the instrument consultation, concertation, or operational coordination?</li> </ul>
Breadth	<ul style="list-style-type: none"> <li>◇ Does the mechanism focus on one aspect of the health sector or is it comprehensive and sector-wide?</li> </ul>
Authority & adherence	<ul style="list-style-type: none"> <li>◇ Do stakeholders adhere fully, partially or not all to decisions taken in the coordination forum?</li> </ul>
Costs	<ul style="list-style-type: none"> <li>◇ What are the human, institutional, and other costs involved in maintaining the mechanism?</li> </ul>
Outcome Criteria	Outcome indicators & questions
Efficiency	<ul style="list-style-type: none"> <li>◇ Does the mechanism serve to: (1) reduce duplication; (2) enhance harmonisation of procedures; (3) increase use of evidence-based decision tools?</li> </ul>
Effectiveness	<ul style="list-style-type: none"> <li>◇ To what extent does the mechanism: (1) diminish sector fragmentation; (2) decrease conflicting policy signals; (3) allow donors to support a coherent sector-wide plan?</li> </ul>
Equity	<ul style="list-style-type: none"> <li>◇ Does the mechanism: (1) correct inequities in targeting of assistance; (2) correct inequities in payment for services; (3) increase parity of benefits and perks for aid-supported staff?</li> </ul>
Sustainability	<ul style="list-style-type: none"> <li>◇ Are the costs of the mechanism sustainable?</li> <li>◇ Are institutional arrangements and national skills developed?</li> <li>◇ Are incentives for participation and sanctions for non-participation established?</li> </ul>

This framework provides broad-brush criteria against which aid management arrangements may be evaluated. It is not suggested that there is a single, best model for aid coordination, for this would depend on the context, among other things, but rather proposes a number of questions which may help to measure the effectiveness of particular arrangements found in the field. While such a ‘technocratic approach’ has



value as a comparative tool, it is limited in that it leaves implicit the power balance between the players and does not reveal their aspirations. Consequently, the research tests the utility of the framework using a political- economy approach and makes reference to additional dimensions to coordination which the framework fails to capture.

## **1.6 Research strategy and methods of enquiry**

### *1.6.1 Comparative historical policy analysis*

This research employed a case study approach. Case studies are thought to be well suited for the exploration of complex questions in which the problem is ill-defined and there exist competing and contradictory interpretations.<sup>187</sup> A case study permits an impressionistic analysis of a situation and allows for the identification of variables which might not have been expected to be related to the problem. It is particularly valuable to policy analysis because it provides an opportunity to examine process issues. The logic of the case study method, and its qualitative selection of cases (non-probabilistic sampling), lies in its power to explain particular relationships of which it is representative. In other words, it can demonstrate the operation of some identified theoretical principle. Generalisability, in the case study context, refers to the ability of the study to expand and refine existing theory.

In light of the complexity and poorly understood nature of aid coordination, an empirico-inductive approach was followed. Adopting, *a priori*, one particular explanatory theory for the research was rejected on the grounds that it might unduly limit the investigation. Smith warned “adherence to particular theoretical biases can lead to investigative ethnocentrism.”<sup>188</sup> Anderson concurs, arguing that “the main purpose of political enquiry and analysis [should be] the explanation of political behaviour, rather than the validation of a given theoretical approach.” Analysis began, therefore, with a broad historical policy framework and data collection, which was later followed with further development of the conceptual and explanatory frameworks in an iterative process.

A comparative approach, in the sense of contrasting experience in different countries, was considered and rejected after a reconnaissance trip to a selection of possible comparison countries identified overwhelming constraints (mainly relating to the time and financial resources required for adequate analysis). In its place, an in-depth study in one country, Bangladesh, was chosen. The criteria for country selection included the: (1) relatively high level of aid dependency in the health sector; (2) large number and heterogeneity of donors; (3) relative political stability; (4) availability of an historical record (i.e., documentation related to aid coordination); (5) presence of a long-standing

and concerted effort among a number of key donors to maintain an aid coordination instrument in the health sector - one which has been frequently cited by its proponents as a success story<sup>189</sup> and a possible model for social sector support in other countries<sup>190</sup> and would, therefore, likely provide lessons; and (6) interest among some Government and donor agency officials in facilitating a study of aid coordination so as to improve its practice.

The logic of comparison, however, which allows for the exploration of diversity, held considerable appeal. Consequently, the original study design intended to compare aid coordination in a small number of policies or programmes (tracer policies) within Bangladesh's health sector so as to avail itself of some of the features of a comparative study. During initial stages of the field work, this approach was abandoned as it became apparent that studying individual policies and programmes would not yield insights into the overarching challenges faced by the Ministry of Health and Family Welfare (MOHFW) in managing the donors *in toto* and of integration of all external resources in the sector. Instead, it was decided to examine and compare the various approaches and instruments which have been utilised to coordinate aid in the sector over time.

The study is informed by policy analysis, a field of enquiry concerned with both prescription and description.<sup>191</sup> While there exists considerable debate on the meaning and methods of policy analysis, the present study adapts, for its simplicity, a framework proposed by Walt and Gilson.<sup>192</sup> In drawing eclectically upon a number of theoretical disciplines, the authors propose that policy analysis focus on four dimensions: content; context; process; and actors. Policy content can be thought of as the substance of policy (i.e., the details of the mechanisms of coordination). The context surrounding policy making and implementation is the second dimension of policy analysis. For the purpose of this study, two distinct contexts as well as their interface required consideration: namely, the Bangladeshi political, economic and social context; and the context governing the operation of the aid agencies (e.g., the introduction of internal policies which encourage staff to cooperate with partner agencies, etc.). In keeping with Leichter's<sup>193</sup> work on context, the study considered the influence of situational factors (e.g., the transfer of a particular official who had acted as a lynch-pin for coordination), structural factors (such as extent of decentralisation in the development agencies, the effect of the bifurcation of the ministry of health), cultural factors (such as acceptability of rent-seeking, views on cooperation, or even whether languages posed barriers to coordination) and exogenous factors (such as changes in the impact of the end of the cold war on aid volume, or the changing mandates of UN agencies subsequent to global

agreements) on aid management and coordination. The process by which policy is formulated and implemented forms the third dimension. Process is typically concerned with agenda setting and decision-making in relation to particular policies. This study focused on processes involved in aid management and coordination. In particular, the manner in which disparate donor ideologies, values, ideas and priorities were reconciled and coordinated with those of other donors and the GOB. Two sets of actors were of particular interest to the study; personnel from donor institutions (working at the headquarters or country-based offices of multilateral and bilateral agencies) and bureaucrats working in the Bangladesh civil service (mainly at the national level in the MOHFW and the oversight ministries). The analysis, therefore, followed those who view policy as a product of the environment from which it evolves, the mechanisms of decision-making, the actors making and affected by it and, particularly, the inter-relationships between these variables.<sup>194,195,196</sup>

An historical perspective was adopted. The policy process demands such an approach because, as Gorden *et al.* point out, policies do not crystallise at a particular point in the decision process but evolve, over time, through complex interactions among various interest groups.<sup>197</sup> The historical context is crucial since we are not only interested in policy decisions, but also want to understand their genesis and long-term ramifications. A cross-sectional approach would not provide that understanding. If the research is not merely to inform but to improve practice in aid management, then the sequential model of "historical prediction" should be utilised. Tosh asserts that efforts to manage social and political change can be informed by this model.<sup>198</sup> He sees it as a systematic analysis of trends which attempts to separate those features which are ephemeral from those which are enduring so as to help understand how feasible certain reforms may be. As Maines states, "studies...that do not take into account fundamental differences in temporality will always produce misrepresentative conclusions."<sup>199</sup> The study covers the period from the independence of Bangladesh in 1971 to developments at the end of 1997 when data collection was completed.

### 1.6.2 Methods

It has been asserted that "no comprehensive methodology for policy research exists."<sup>200</sup> According to Jenkins "the nature of the policy problem is such that a variety of approaches are required to deal with the complexity of the process."<sup>201</sup> The potential loss of data and misinterpretation arising from the adoption of a singular approach can be great when dealing with a multidimensional problem such as coordination. Others have observed that "policy researchers frequently find themselves at the fringes of existing

social science methodology - adapting, combining and improvising as they go.”<sup>202</sup>

Moreover, because the empirico-inductive approach did not lend itself to rigorous advanced planning of methods, nor did the challenging environment from which data was to be extracted, the methods were exploratory, innovative and iterative. Quantitative and qualitative methods were used to complement one another, to corroborate results and to provide insights that either approach on its own would not have yielded. The following methods were employed: (1) network and stakeholder analyses; (2) document review; (3) semi-structured interviews; (4) observation; and (5) administration of semi-structured questionnaires.

#### *1.6.2.1 Mapping stakeholders and networks*

The research began with a stakeholder analysis. Such analysis has been traditionally employed by project designers so as to identify primary and secondary stakeholders and to assess their resources, interests and influence with respect to the viability of the intervention under consideration.<sup>203,204</sup> In this research, the intervention was the process of coordination. Here, the stakeholder analysis was overlaid with a network analysis. Networks have been defined as “a patterned set of relationships among actors or groups in a social space.”<sup>205</sup> It is assumed that networks of organisations (and individuals therein) are formed so as to trade in scarce resources, such as financial, analytical or local knowledge.<sup>206</sup> In this study I was mainly interested in why networks, such as the Consortium, are formed, who and why agencies seek participation in networks, as well as the influence of networks on policy process issues, for example, how networks function to promote coordination and how networks are used to influence decision-making. The research aimed to map the principal networks established to coordinate external resources in the health sector, identify the participation and location of actors in various networks, gauge the level and intensity of interactions. In addition, it sought to assess the influence of particular networks on policy process and examine the relationship between the nature of networks and the coordination outcomes they produce. In effect, the use of these tools was not dissimilar to the process of political mapping,<sup>208</sup> except that the units of analysis were not “the political dimensions associated with changing health policy”<sup>209</sup> but those associated with coordination.

As the study was primarily designed to address the question of how the MOHFW manages and coordinates external resources, it was limited to an analysis of the networks involving Government, bilateral and multilateral agency stakeholders. NGOs were explicitly excluded. Although NGOs greatly complicate the picture of external resource

management and coordination in Bangladesh, their resources are small relative to bi- and multilateral and not channelled through government budgets.

#### *1.6.2.2 Document review*

An extensive review, synthesis and interpretation of primary and secondary sources, published and unpublished, relating to health sector planning and aid management in Bangladesh was undertaken. Documents were obtained from a variety of sources, the most prominent being the archives of the World Bank in Washington, where particular use was made of the correspondence files relating to five consecutive Bangladesh population and health credits. An effort was made to determine the original purpose of the documents so as to facilitate their interpretation. The major types of documentation reviewed included the following:

- Government policy, planning and project documentation, particularly MOHFW generated documents (e.g., health chapters of Five Year and Annual Plans, policy statements, etc.) and project documents (e.g., Project Proformas, project status reports, etc.);
- Minutes of most meetings of the donor Consortium held between 1992 and 1997 as well as *ad hoc* meetings of donors concerning the health sector between 1973 and 1997; and various inter-agency meetings held in Dhaka including meetings of the United Nations 'Heads of Agencies,' the Joint Consultative Group on Policy;
- Correspondence, primarily between the Government of Bangladesh (GOB) and the World Bank, but also between the GOB and other donors and among donors;
- Memoranda, primarily World Bank intra-agency memos regarding its projects in the health sector in Bangladesh;
- Mission aide-memoires, mainly pre-appraisal, appraisal, supervision and mid-term review missions for World Bank-led health projects, as well as most World Bank Back-to-Office reports on these missions;
- Donor project documents, such as, World Bank Staff Appraisal Reports, UNICEF Master Plans of Operations, UNFPA Programme Review and Strategy Development Reports, etc., as well as consultancy reports.

#### *1.6.2.3 Semi-structured interviews*

Due to the fact that processes of policy-making presented in formal structures and public documents often differ from how decisions are made in practice, coupled with the truism that much decision-making remains unrecorded, this study employed semi-structured

interviews with key ministerial and donor personnel to substantiate and complement data collected through other means. The sample was primarily of serving personnel involved in aid management selected on the basis of organisational position, but proceeded with 'chain' sampling (i.e., the initial sample provided further contacts). Some informants were identified through historical records. Government officials (past and present) were interviewed from the MOHFW, the Economic Relations Division (ERD) of the Ministry of Finance, and the Planning Commission, Ministry of Planning. Officials from headquarters and field offices of numerous bilateral and multilateral agencies as well as a number of their consultants were interviewed. A list of those consulted forms Annex 1.

#### *1.6.2.4 Semi-structured questionnaire survey*

Well into the process of field research, after preliminary meetings had been held with key stakeholders and consultations had been held on the nature and intent of the research, a semi-structured questionnaire was administered under the auspices of a Government-led Task Force on Sector-wide Management. A questionnaire-type survey instrument was drafted and shared for comment with the Task Force and donors not represented on the Task Force. Based on feedback from the stakeholders, three separate questionnaires were drafted for officials of: (1) Government; (2) donor agencies located in Dhaka; and (3) donor headquarters. Attempts were made to pilot-test the questionnaires on the three target groups, but only the Government responded positively.

The finalised questionnaire prepared for Government officials was sent to the Secretaries of the following departments: (1) ERD, Ministry of Finance; (2) Finance Division, Ministry of Finance; (3) Planning Commission, Ministry of Planning; and (4) MOHFW. Each Secretary was asked to nominate two officials who could meet with the researcher independently and respond to the questions in the survey instrument. The same questionnaire was also sent directly to another six Government officials who were identified as being particularly knowledgeable on aid coordination. Meetings were arranged with these officials so as to complete the questionnaire. It was repeatedly stressed that the Task Force was not seeking definitive positions nor commitments from the officials, but was interested in support for and/or concerns relating to health sector aid coordination. Separate questionnaires were sent to officials in 19 donor headquarters agencies and to officials of local offices of the donors (21 agencies) for self-completion (the Task Force targeted the most influential donors in the sector; 21 out of 31). Questionnaires for local donor officials were sent to two officials who had recently transferred out of Dhaka to WHO's SEARO and Sida's Stockholm office. Annex 2 contains the questionnaire sent to local donor agencies.



Completed questionnaires were received from eight Government officials, mainly senior-middle management staff of the MOHFW. Responses were received from 14 donor officials/agencies, mostly single respondents, and usually the most senior, field-based, health professional in the agency with input from headquarters.

#### *1.6.2.5 Participant observation*

It has been suggested that participant observation is less a method than a strategy for data collection.<sup>210</sup> It was envisioned as a useful approach because it might reduce problems of reactivity and provide the opportunity to gain an intuitive understanding of the 'aid culture,' thereby allowing for the collection of more reliable data and for improved insights into the data collected. In particular, it offered a chance to gain an appreciation of the informal mechanisms of coordination. Three strategies were used to take advantage of participant observation. First, to inject myself into the social circuit where much informal coordination takes place. Second, opportunities were sought to participate in various donor management and coordination fora (for example, aid negotiations, Consortium meetings, etc.). Here, I was more of an observer than a participant, with an overt presence and the aims of my research widely known. Third, to undertake studies commissioned by the stakeholders relating to the coordination machinery which would provide first hand knowledge of the processes and issues at stake.<sup>211</sup>

#### *1.6.3 Validation techniques*

The quantitative information obtained was not always reliable and the qualitative aspect of the study drew heavily on the interpretation of events by both key-informants and the researcher; it is, thus, subject to significant bias. Examining points of complementarity and diversity of opinion, and interpreting their meaning, presented an integral yet challenging component of the study. The reliability of the findings were validated in two principle ways. Triangulation was used to counterbalance the merits and demerits of a particular method, to corroborate evidence and develop a more clear picture of the issue at hand. Triangulation refers to seeking data from a wide range of independent sources and the use of a variety of research methods.<sup>212</sup> The second method, peer checking, provided a further means to validate the findings. Preliminary results were shared with key stakeholders, in the form of two draft reports,<sup>213,214</sup> to check for factual accuracy and to probe for alternative interpretations. In addition, views and preliminary conclusions were shared in seminars for feedback, further refinement and verification of validity.<sup>215</sup>

#### *1.6.4 Caveats, limitations and biases*

An in-depth, single country case study can make an important contribution to knowledge, particularly given the significance of context in uniquely distinct policy environments. However, a multiple country study may have allowed for comparisons and for the testing of hypotheses beyond what is capable here. Moreover, even within the single case, what may have been desirable in terms of application of methodology and collection of data was not feasible. A note setting out the process, barriers and milestones involved in the field research forms Annex 3. One constraint related to the fact that not all agencies and officials were equally willing to share information on their programme or their perspectives and knowledge. As a result, data sets remain incomplete and patchy. It also introduces a potential selection bias in that, perhaps, conclusions were largely drawn from information provided by those agencies which were amenable or most active in coordination. Another issue was that officials were, on occasion, unwilling to participate in various proposed methods in which their participation was essential for success. Encouraging officials, for example, to maintain telephone diaries to provide proxy indicators of network position and intensity failed. These failings of application of intended methodology may have partly related to the tendency prevalent among many officials to show great interest in the concept of improved coordination, but be averse to any scrutiny of their current practice, particularly where this was undertaken by an outsider. It may also have been a reflection of the low priority placed on health sector aid coordination by many officials or, alternatively, an indication that they were too busy. Attempts to become an insider (through participant observation) meant, inevitably, to be perceived as affiliated with one or another agency and, thereby, losing one's status as 'neutral observer,' thus introducing further bias (due to the need for sponsorship). There was also the problem of dealing with revisionism and dishonesty. Documentation often revealed discrepancies between what was put forward to different audiences, thereby suggesting that all documentation be treated with caution. Likewise, there was a proclivity for respondents to voice views which they wanted to have others hear, irrespective of whether or not these represented their actual views or intentions. With reference to the limitations of the survey, described above in section 1.6.2.4, the findings are derived from a very small sample of officials. It is, therefore, difficult to draw hard and fast conclusions. In addition, it should be noted that the sample also suffers from a particular selection bias. As was to be expected, donors more 'committed' to coordination responded to the questionnaire and were, by and large, also members of the present Consortium. On the Government side, most of the respondents are officials of the MOHFW as opposed to other relevant Government departments.



Finally, it may be necessary to state that it is beyond the scope of this research to consider whether or not the Government and donors, to the extent that they do coordinate and manage external resources, are pursuing rational and effective policies in the health sector. Here, I am, concerned with the ‘how and why’ of coordination not with the appropriateness of policy content.

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## CHAPTER TWO

### **The context of aid coordination in Bangladesh: the anatomy of aid dependency**

#### **2.1 Introduction**

The objectives of this Chapter are two-fold: (1) to situate the analysis of attempts to coordinate aid in place and time; and, more specifically, (2) to draw attention to those contextual factors that are likely to have had some influence on coordination arrangements. The Chapter focuses on those factors that help to explain why aid coordination was placed on the health policy agenda and why its practice remained externally-driven for so long. As such, it explores donors' perceptions of Government integrity and capacity, ownership of the policy agenda, and the interests sought by stakeholders through their participation in coordination processes.

#### **2.2 Politics in Bangladesh**

*Ever since its inception in 1971, Bangladesh's urban-based, political, bureaucratic and military élites have dominated the political process and have been accountable to no one but themselves.*<sup>1</sup>

S. Kochanek, 1996

##### *2.2.1 Pre-independent Bangladesh*

The political history of Bangladesh is characterised by governance which is neither representative of, nor accountable to, the people. In 1947, after nearly two centuries of British colonial rule, the present day territory of Bangladesh became East Pakistan. It has been asserted that, during the period of Pakistani rule, Bangladeshis were by, constitutional design and political practice, effectively excluded from national power.<sup>2</sup> Those who exercised political and administrative power in East Pakistan were regarded as accountable to President of Pakistan and unresponsive to the interests and needs of the people of East Pakistan. In the 1970 elections, the Awami League (a Bangladesh nationalist political party) won a landslide victory in the provincial election and a majority in the Pakistani national assembly. When the Awami League was blocked from forming the Government, a civil war erupted which was to last nine months and claim approximately one million lives – mainly Bengali.

### 2.2.2 The 'honey-moon' days of post-independence (1971-1975)

On 16 December 1971 Bangladesh gained its independence. The Awami League, which had acquired a pre-eminent rôle as the vanguard of the nationalist movement in the 1950s and 60s, assumed power. At its helm was Sheikh Mujibur Rahman, who rode on a wave of populist sentiment unleashed by the success of the war. The socialist-oriented Government<sup>α</sup> set to work rebuilding a country immobilised by war, de-linked from the central institutions which had dominated its development for decades, bereft of its entrepreneurial class, faced with the necessity of repatriating ten million refugees from India and Pakistan, beset with 20 million internally displaced persons, and a heavily armed, factious population with heightened expectations following emancipation.<sup>3</sup>

The new regime was to face a number of set-backs to its *dirigiste* programme. The global economic crisis and world-wide inflation of 1973 drove down Bangladesh's terms of trade and resulted in high domestic inflation, which precipitated a series of economic problems. A succession of bad harvests, two droughts in 1972/73 and severe flooding in 1974, contributed to wide-spread famine and appreciable loss of human life (250,000). The protracted show-down between the Government and the World Bank over the assumption of Pakistan's external debt led to a deceleration of aid commitments and disbursements.<sup>4,5</sup> This was exacerbated by the American administration's decision to withhold food aid shipments in 1974.<sup>6</sup> The action was ostensibly taken on account of the GOB's decision to enter into a trading relationship with Cuba; yet this rationale provided a subterfuge for US hostility toward the new Government in general (Pakistan was a close ally of the US), and particularly to Bangladesh's stated programme of nationalisation, socialism and international non-alignment. The Government's problems were compounded by severe internal dissension and infighting within the Awami League, which led Sheikh Mujibur to purge the leadership of the party and later his cabinet. Allegations of corruption and incompetence were increasingly levelled at both the Awami League and the bureaucracy.<sup>7</sup>

Collectively, these events prompted a climate of political and social destabilisation, which Sheikh Mujibur attempted to counter through an increasing centralisation of power and by taking an ideological volte-face. On the economic front, his commitment to socialism was wholly reversed as he was eventually forced, by the near collapse of the economy, to

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<sup>α</sup> The Awami League stated its commitment to a socialist economy. In practice, this was limited to nationalisation of most of the large manufacturing industries (particularly jute) and banking. Most of these assets had been abandoned by Pakistanis and fell into Government hands *de facto*. The very unequal distribution of land was left unreformed.

turn to the Americans, the IMF and the World Bank for financial help in the autumn of 1974.<sup>8</sup> In October 1974, after two years of resisting a World Bank-styled aid consortium and IMF advice, the Government acquiesced to both in exchange for renewed aid pledges. A precedent was, thereby, set by which donors sought to influence domestic policy through the aid regime. In January 1975, the constitution was radically amended to establish a presidential form of government under one-party rule. Having done so, Sheikh Mujibur removed any vestige of democratic governance. As the first of many political leaders to use proclamations to supersede the authority of the constitution, Sheikh Mujibur also set the stage for a continued pattern of compromised state accountability.

### 2.2.3 The 'bureaucratic-military democracies' (1975-1990)

In August 1975, Sheikh Mujibur was assassinated and a tumultuous period of authoritarian rule was ushered in.<sup>9</sup> A series of *coups d'état* began in November at the end of which General Ziaur Rahman (Zia) emerged as *defacto* leader of Bangladesh. Zia assumed the *de jure* title of President in April 1977. Thereafter, he established the Bangladesh National Party (BNP) through which he contested elections in June 1978 (presidential) and in January 1979 (parliamentary). It has been alleged that these were held to satisfy the requirements of western donors, particularly the US.<sup>10</sup> It was reported in the *Far Eastern Economic Review* that "A senior Bangladesh army officer recently told a visiting foreign journalist in Dacca: 'The West, especially the US Congress, likes it if we can be called a democracy. It will make it easy for us to get aid. That is the main importance for the election.'"<sup>11</sup> The victories of the BNP in these elections, which were judged neither free nor fair, enabled Zia to boast of civilianising his administration.<sup>12</sup> When this failed to produce the desired legitimacy, Zia turned to the ideology of Bangladeshi nationalism and national unity.<sup>13</sup> Under his rule, corruption was reported to have been institutionalised, the material gulf between those with access to power and those without widened, politically inspired killings spiralled and law and order deteriorated.<sup>14</sup> After being the target of a reported 20 mutinies and coups, Zia was assassinated in May 1981.

Zia was succeeded by Justice Sattar, his Vice President, but only until March 1982 when General Ershad launched a bloodless *coup d'état*. Ershad appointed himself Chief Martial Law Administrator and later, in December 1983, President. Ershad then followed Zia's example of using electoral means to legitimise his rule. He established the Jatiya Party and, through victory in elections in May 1986 that were boycotted by much of the opposition and described by a British observer team as 'a tragedy for democracy,'<sup>15</sup> emerged as another military President in civilian garb. The opposition parties formed a

short-lived coalition and, through the use of mass action, succeeded in forcing Ershad to hold fresh elections. These took place in March 1988 and, as they were boycotted by the opposition, resulted in the installation of an unrepresentative parliament.<sup>16</sup> Under Ershad, the successive parliaments remained weak and democratic institutions did not flourish. Having failed to gain legitimacy through democratic means, Ershad turned to clientelism to generate support. He dispensed patronage through the distribution of foreign aid and greatly increased spending on the armed forces. According to local scholars, Ershad's neo-patrimonial rule "turned the state apparatus into a mere private government, where he established a kind of personal rule based on material interests and rewards for loyalty and support...rule was maintained through bribery, socio-political patronage and various kinds of rewards to his clientele."<sup>17</sup>

#### *2.2.4 The paralysis of partisan democracy (1991-1997)*

Opposition to the Ershad regime, which had been active since the early 1980s, intensified in November 1990 and led to a popular uprising that resulted in the restoration of formal, if limited, democracy. The leaders<sup>18</sup> of the BNP and the Awami League, who generally despised and opposed one another and had failed to coordinate their opposition to Ershad during the 1980s, finally agreed to co-operate in order to depose Ershad and set up a neutral, interim administration which would oversee parliamentary elections. Consequently, both the military<sup>18</sup> and foreign donors<sup>19</sup> withdrew their support from Ershad, and he was forced to resign in December 1990.<sup>20</sup> An interim Government was sworn in and presided over what was considered to be a relatively free and fair election in February 1991.<sup>21</sup> Although both parties won approximately 32% of the vote, the BNP won the greatest number of seats and formed the Government. The constitutional provision for the election by parliament of an additional 30 seats reserved for women, enabled the BNP to obtain a majority by horse-trading with the smaller parties. The *entente cordiale* between the Khaleda Zia and Sheikh Hasina did not, however, last long.<sup>22</sup>

Complaints by the Awami League of Government vote-rigging in a by-election in March 1994 set off a process in which democracy was caught between a Government whose credibility was questioned (by both the opposition and outside observers) and an opposition which resorted to extra-parliamentary and non-constitutional means to press a series of ultimatums. When the Government refused to capitulate to demands for, among

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<sup>18</sup> Begum Khaleda Zia, the head of the BNP, is the widow of former President General Zia, who was assassinated in 1981. The Awami League is headed by Sheikh Hasina Wajid, current Prime

other things, the installation of a neutral care-taker Government to oversee elections, on 28 December 1994 all opposition members of parliament resigned. After eleven months of parliamentary grid-lock, on 24 November 1995, Khaleda Zia dissolved parliament and set elections for 18 January 1996. The opposition maintained its position that a neutral administration supervise the elections and made use of political agitation to cause the repeated postponement of elections. One analyst, reflecting on 1995, commented that “the unprecedented deterioration of law and order created a high level of public insecurity and risked the survival of democracy”<sup>23</sup> (i.e., risked a return to military rule).

When elections were eventually held in February 1996, the BNP claimed a ‘landslide’ victory – yet the major opposition parties boycotted the polls, voter turnout was less than 10%, charges of ‘widespread rigging’ were levelled, and “independent monitors denounced the process as flawed.”<sup>24</sup> The impasse continued and opposition to the ‘new Government’ intensified. In March 1996, the civil service entered into the fray by issuing an ultimatum to the Government demanding the installation of an interim government with the threat of an indefinite strike. The 25 month stalemate came to an end on 30 March when a care-taker Government was sworn in and elections set for 12 June.

Despite an attempted army revolt just preceding the poll, the June 1996 election was considered a triumph for democracy in the country; international observers declared it to be ‘free and fair’ and voter turnout was over 70%.<sup>25</sup> Sheikh Hasina’s Awami League narrowly won the election and formed the Government. Nevertheless, the politics of confrontation continued in the parliament, press and streets. According to one observer, the defeated Begum Khaleda Zia spent 1997 “attempting to design a viable strategy to topple the government.”<sup>26</sup> Opposition members routinely walked out of, and boycotted the parliament, charges of conspiracies and corruption continued, and politically motivated hartals persisted through the period to the end of 1997.

### *2.2.5 Political life in Bangladesh: a synthesis*

*It has been demonstrated that politics in Bangladesh revolve around personalities, not ideas or institutions.*<sup>27</sup>

L. Ziriling, 1992

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Minister, and daughter of Sheikh Mujibur Rahman, who led Bangladesh from independence until his assassination in 1975.

Although democracy was restored in 1991, and there are now over 125 political parties, limits remain to the extent to which the state can be said to be representative of, and accountable to, the population.<sup>28</sup> Political events in Bangladesh have served to debase the principles and institutions of representative government. Prolonged military rule (accounting for 15 of the country's 26 years) and recourse to force for the resolution of political conflict, have negatively influenced democratic institution building. Martial law was imposed for 3 years and 8 months by Zia and for 4 years and 4 months by Ershad. The fact that two of the three leading political parties (BNP and Jatiya) have a military legacy raises questions about their democratic legitimacy. Furthermore, tendencies towards divisive and corrupt partisan politics militates against democratic norms.

The manner in which non-military regimes assume power is one source of concern. One commentator has written that "incumbent government parties in particular and parliamentarians in general have tended to misuse public resources in order to remain in power. As a result, most parliamentary and presidential elections have been orchestrated by the party in power with serious violations of campaign finance rules and questionable use of government functionaries and facilities, often including coercion, fraud and resulting in political violence."<sup>30</sup> As a result, prior to the June 1996 election, no sitting government had lost an election. One analyst has asserted that all "successive regimes have been preoccupied with setting up arrangements for their own survival."<sup>31</sup> The voter registration process and the electoral rolls have been described 'highly suspect,' and the violation of election laws 'common' by those in power.<sup>32</sup>

Fractured, divisive and confrontational partisan politics are the norm in democratic Bangladesh. The opposition parties are continually looking for issues with which to confront the Government at a great cost to social stability. In 1989, there were 247 hartals (closing of offices, shops and blockading of streets due to political agitation) called by a spectrum of social and political groups.<sup>33</sup> During the constitutional impasse of 1994-95, there were reported to be 175 days during which political disturbances took place, including 92 days of country-wide hartal and 22 days of continuous non-cooperation.<sup>34</sup> In 1996, 54 working days were lost due to hartals.<sup>35</sup> According to Rashiduzzaman, the hartal represents "uncompromising politics" and the "hollowness of conventional party politics in Bangladesh" and undermines the constitutional process.<sup>36</sup> In so far as "it is an open secret in Bangladesh that paid mercenaries, demonstrators and armed activists, hired by both the opposition and pro-government groups, make up the street mobs [hartals],"<sup>37</sup> few observers view them as a healthy democratic response of a blossoming civil society.

Sohban contends that “the survival of absolutism in democratic politics leads to the resurfacing of the presidential culture where a strong chief executive finds it more convenient to operate with the support of a coterie of civil servants or personally loyal political associates.”<sup>38</sup> Such tendencies might be explained by social relations in Bangladesh which are “dominated by a network of patron-client relations... This patron-client system is based on a hierarchically structured, complex maze of mutual obligations and personal ties... These... contribute to the highly personalised, factionalised character of patrimonial politics in Bangladesh. They are reinforced by a strong sense of individualism, low levels of trust and a lack of commitment to abstract objectives and ideology.”<sup>39</sup> Others concur, suggesting that the political culture of Bangladesh is shaped by three structural factors: atomism; patron-clientism; and neo-patrimonialism.<sup>40</sup> A less sophisticated analysis has focused on the ‘ego-mania’ of the politicians.<sup>41</sup>

#### *2.2.6 Donors’ perceptions*

Whatever the causes of the political culture of Bangladesh, donor governments have likely questioned the legitimacy of the Bangladeshi leadership for most of the country’s history. The perceived illegitimacy of successive administrations has presumably coloured the views of donors with respect to: (1) the adequacy of accountability within Government; (2) the relationship between the state and its citizenry; and (3) the conviction and vision applied by the Government to the economic and social development of the country. In particular, it may account for the low levels of trust and confidence placed by donors in the GOB and predisposed them to exercise great caution in the aid relationship. Paradoxically, the dim view held by most donors of successive political and bureaucratic administrations within Bangladesh has not tempered their proclivity to provide massive amounts of aid to Bangladesh (see sections 2.4 & 2.5). Donors have opted, instead, to tighten their grip over the management of their assistance.

However, recent events in Bangladesh led the aid community to express cautious optimism with respect to political developments. First, the decision by the military to refrain from becoming involved in the constitutional problems during 1994-95 was seen as a positive step. It has been argued that donors themselves had a hand in ensuring this outcome. According to Murshed and Chowdhury, “world opinion, expressed strongly through the aid mechanism, played an important rôle in encouraging the soldiers to maintain a posture of pragmatism and restraint.”<sup>42</sup> Second, provision for the routine installation of an interim care-taker government preceding elections has been written into the constitution, which may subvert the tendency of incumbent governments to tip the



playing field in their favour. Third, the elections of June 1996 were deemed to be free and fair by the large contingent of international observers.<sup>43</sup> These achievements were widely lauded by the aid group in 1996 and cautiously suggested that the road to a more representative and accountable government was being traversed.

There was optimism on the economic front as well. The average annual growth of the GNP for 1995-96 was 5.5%<sup>44</sup> and 5.7% for the year ending 30 June 1997.<sup>45b</sup> The discovery of large reserves of natural gas in the Bay of Bengal attracted dozens of oil companies and prompted *The Economist* to write an optimistic piece about Bangladesh's economic prospects.<sup>46</sup> Yet the politics of intransigence, re-introduced in late 1996, suggested that the honeymoon, particularly with donors, may already be over. When the Bangladesh Development Forum met in Dhaka in 1997 and was confronted with a BNP-sponsored *hartal*, donors warned that "Bangladesh's development appeared likely to be substantially undermined by the politics of intolerance, violence and intimidation."<sup>47</sup>

### **2.3 The rationale for aid to Bangladesh**

Given the extent to which Bangladesh has been riven by internal dissension and beset by political corruption, it would appear difficult to explain why donor agencies took up the challenge of assisting the country and why they have continued to allocate large quantities of aid. Donor involvement can be explained by geo-political and strategic interests which prevailed during the Cold War, humanitarian motives, economic and trade interests in the donor countries as well as the desire to influence domestic and foreign policies of Bangladeshi regimes.

#### *2.3.1 Geo-political and strategic objectives*

The major powers with a geo-political interest in Bangladesh were India, China, the USSR, and the US. However, due to a variety of considerations, only India and the US provided Bangladesh with any significant amount of aid, both in return for the possibility of influence. India played a major rôle during the war of independence as it had an interest in emasculating Pakistan, its rival and Islamic neighbour. In the immediate post-war era, India was the paramount donor to Bangladesh; and during the first six months of independence, India alone accounted for 67% of aid disbursed to the country.<sup>48</sup> India's interests, it has been suggested, included: (1) the promotion of internal stability so as to ensure that an anarchical situation would not once again develop and spill across its long land border with Bangladesh; (2) the consolidation of a secular state in the region; and (3)

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<sup>b</sup> This is in contrast to an estimated annual per capita growth of 1.8% during the period 1990-92.

the creation of a land barrier with China.<sup>49</sup> Although Bangladesh has been described as having been strategically important to China,<sup>50</sup> China made its first aid commitment to Bangladesh only after belatedly recognising the country following the change of regime in August 1975. China remained a peripheral donor, presumably because it did not expect to gain much influence in the country.

Within the context of the global cold war, Bangladesh would not have been a front-line player. Nonetheless, both the USSR and US acknowledged Bangladesh's strategic importance in the region. Both superpowers were equally interested in expanding their sphere of influence to the exclusion of one another and China. Given US hostility to Bangladesh during its liberation war and the support Bangladesh had garnered during the war from the Soviet Bloc, Sheikh Mujibur's first state visit outside of the sub-continent was to the Soviet Union.<sup>51</sup> From the American perspective, although there was initial opposition to the formation of the country, once Bangladesh had secured independence there was an interest in ensuring that stability was restored and a presence established, so that rival powers could not do the same. As a result, the Americans rapidly established themselves as the single largest bilateral donor country to Bangladesh (although, as mentioned above, commitments and disbursement dried up in 1974 as the Americans applied pressure to the Mujibur regime).

### *2.3.2 The humanitarian case for aid: poor socio-economic status and extreme vulnerability*

*Bangladesh is not a country of strategic importance to any but her immediate neighbours...If aid is to come for development of Bangladesh it is more likely to be for economic reasons or on general humanitarian grounds.*<sup>53</sup>

J. Faaland & J.R. Parkinson, 1976

*Today no country compares with Bangladesh in the concentration of poverty among so many, in so small an area and with so bleak an outlook.*<sup>54</sup>

M.M. Ahmad & J.G. Townsend, 1998

Not long after independence, Henry Kissinger is attributed with having referred to Bangladesh as an 'international basket case.'<sup>55</sup> Nevertheless, an humanitarian case for aid has persisted over the ensuing decades. There has been a degree of economic stability over the past decade, attributed by the World Bank to a programme of economic adjustment and structural reform, launched in 1990. Although this aimed to establish a

liberalised, market-based, and private sector-driven economy, with a GNP of US\$ 260 per capita (in 1996),<sup>56</sup> Bangladesh remains among the poorest of low-income countries.<sup>57</sup>

UNDP's composite Human Development Index has consistently ranked Bangladesh towards the bottom of the non-OECD countries (i.e., usually around 145 of the 177 countries listed).<sup>58</sup> Despite a widely hailed successful population programme,<sup>59</sup> with an estimated population of 123 million in 1996, it is the world's most densely populated country.<sup>60</sup> Bangladesh remains a predominantly rural country (approximately 80%). Consequently, the structure of the GDP is dominated by the agricultural sector, but there has been recent growth in manufacturing, particularly in ready-made garments. The nation is ethnically relatively homogeneous and 88% of its population is Muslim. It has a remarkably under-educated population – with women particularly disadvantaged by a rate of illiteracy estimated to be 78%.

There have been some notable improvements in health related indicators since independence. The infant mortality rate, although still very high, fell from 148 per thousand live births in 1971 to 77 in 1993; and under-five mortality fell from 239 to 122. Life expectancy at birth is thought to have increased from approximately 44 in 1971 to 58 years at present. During same period, the total fertility rate fell from an estimated 7 to 3.5, which is primarily explained by an increase in the contraceptive prevalence rate from approximately 2% at independence to a current estimated level of 45%. Immunisation coverage (EPI), which was approximately 1%, in 1981, increased to over 70% by 1993. Microbiologically safe water, notwithstanding current concern relating to arsenic contamination, is reported to be accessible to 98% of the population.

Despite these achievements, a number of health problems persist and new challenges are emerging. The main causes of death, particularly in children, are reported to be diarrhoeal diseases, acute respiratory infections, malnutrition, and accidents and injuries. The adult population still suffers from high rates of tuberculosis, chronic hepatitis B and reproductive morbidity, yet cardiovascular diseases, hypertension, diabetes, accidents and violence, are now also frequent causes of morbidity and mortality. With social and economic change and rapid urbanisation, sexually transmitted infections, and environmental and occupational concerns, have recently appeared on the health policy agenda.

In Bangladesh, poverty, inequality, low educational attainment, malnutrition and ill-health provide a compelling case for aid. The rationale is reinforced by the natural adversity to which the country is subjected, which includes recurrent flooding, periodic cyclones and tidal surges. A retired World Bank official suggested that “all donors wanted to be seen to be doing something to ease the poverty in the country.”<sup>61</sup> While most donors to Bangladesh have couched their rationale for aid in humanitarian language, Thomson’s analysis suggests that those countries which have provided aid primarily upon humanitarian grounds were the Scandinavians, the Netherlands, West Germany, Canada and Australia, although in the latter two, trade considerations were also of considerable importance.<sup>62</sup>

### *2.3.3 Economic objectives of aid: trade & export promotion*

In light of the poor economic standing of Bangladesh, it would be untenable to suggest that domestic economic objectives were paramount among the motivations for the provision of aid by donor countries. Nonetheless, in so far as aid was tied and benefited the domestic economies of the donors, export promotion can not be ruled out as a complementary incentive. An evaluation of Canadian aid to Bangladesh provides some evidence:

In 1979, when Bangladesh awarded the procurement contract for 30 diesel locomotives financed by the Saudi Fund for Development to a Japanese rather than a Canadian firm, there was much displeasure in Canada. Thus in 1980, when Bangladesh requested financing for 50 additional locomotives, Canada indicated that it would be willing to fund 25 locomotives, but only if Bangladesh would find another source of funds for the other 25 and purchase all 50 from a Canadian firm.<sup>63</sup>

Tied aid is pervasive in the development establishment. According to World Bank data, in 1995 100% of aid from Australia, Belgium and the US was tied, while more than 75% of aid from the UK, Germany and Canada was tied. Among the large donors to the health sector in Bangladesh, Sweden stood out for tying only 40% of its aid.<sup>64</sup> It has been argued that “France and Japan and to a lesser extent the United Kingdom, Canada and the Federal Republic of Germany, have allowed trading interests to dominate, or at least influence, their programmes” of assistance to Bangladesh.<sup>65</sup>

### *2.3.4 Aid as a lever over recipient policies*

In addition to the reasons listed above, the motivation to provide aid can also, in part, be attributed to the desire of some donors to influence decisions regarding economic, social and foreign policies in Bangladesh. For example, American aid to Bangladesh has been described “as a reward for Bangladesh’s continuing moderate stance and gradual return to

a more capitalist economy.”<sup>66</sup> Sobhan has demonstrated that, during 1974, the US withheld commitments of aid to Bangladesh until Bangladesh suspended all trade with Cuba and that after the a pro-American regime was installed in 1975, aid disbursements rapidly escalated.<sup>67</sup> The World Bank has been more explicit than any other donor in linking its lending to the adoption of specific domestic policies.

## 2.4 Aid dependence

*The leverage of the regime whose survival, both as a regime and as a class, is dependent on external donors, is nominal and must remain subservient to those who keep it alive.*<sup>68</sup>

R. Sobhan, 1982

Former Planning Commission Member

The socio-economic indicators enumerated above make Bangladesh a particularly aid worthy country and, consequently, it has been a priority recipient of many donors. It has been argued that Bangladesh’s favoured status began in its early post-independence days when it “was treated with unparalleled generosity by donors.”<sup>69</sup> In the first seven months of the country’s independence, 14 countries had committed aid.<sup>70</sup> During the next year, the number of agencies either committing or disbursing assistance had grown to 21 bilateral agencies (13 DAC; 6 Eastern Bloc; 2 non-aligned) and 7 United Nations organisations. By March 1973, when UNROD (the initial UN relief operation) wound up, more than US\$ 1,300 million of external assistance had been mobilised.<sup>71</sup> Although aid commitments and disbursements slowed during 1974/75, aid has formed a significant, although declining, proportion of public outlays during the country’s history.

Annual aid commitments during the 1990s have fluctuated between US\$ 1.5 and 2.4 billion, disbursements between US\$ 1.2 and 2.1 billion, and the pipeline has always contained more than US\$ 5 billion.<sup>73</sup> Lagging disbursement and utilisation are blamed by donors on cumbersome government programming and administrative arrangements. The Government concedes partial responsibility for slow utilisation but also points to the complex and disparate rules governing donor agency procedures. During the 1990s, aid disbursements have declined in absolute terms, on a per capita basis and as a percentage of the GNP (Table 2). During this period, the country’s public debt has increased considerably, in absolute terms and as a percentage of the GNP (Table 3).

**Table 2: Official Development Assistance to Bangladesh (current dollars)**

Year	ODA	ODA per capita	ODA as a
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	US \$ millions	US \$	percentage of GNP
1990	2,100	19	9.4
1991	1,889	17	8.1
1994	1,758	15	6.8
1996	1,254	10	3.9

Sources: World Bank. *World Bank Development Indicators*, 1997, 1998.<sup>74</sup>

**Table 3: Bangladesh's Public Foreign Debt (1995 dollars)**

Year	Debt US \$ millions	Debt as a % of exports	Debt service % of GNP
1980	4,230	360	2.1
1990	11,464,	-	-
1995	16,370	298	2.5

Source: World Bank. *World Development Report*, 1996.<sup>75</sup>

In the health sector, there is insufficient data to provide a meaningful time-series analysis of aid dependency. In the 1983/84 Revised Annual Development Plan (i.e., capital budget) project aid constituted 33.4% of the total allocation for health and 78.5% of the allocation for population. An analysis of five Annual Development Programmes (ADPs) from the early 1990s (Table 4) suggests that: (1) population activities remained more dependent on external resources than health activities; (2) health has become more dependent on external assistance (compared with the 1983/84 level); and (3) aid accounts for a significant proportion of the ADP in the sector, although there is considerable annual variation.<sup>76</sup> However, these figures do not present an accurate picture of the true extent of aid dependence. First, a number of donors do not report their funds in the Annual Development Programme (e.g., WHO) which renders the ADP incomplete. Second, the ADP figures do not include the monetised value of food and commodity aid allocated to the MOHFW which was estimated to have accounted for almost 20% of aid to the sector in 1994/95.<sup>77</sup> Consequently, the true level of aid dependence is higher than Table 4 suggests. In light of the rôle donors play in the capital section of the budget, Islam and Wahid wrote, in 1996, that “economic growth in Bangladesh, to a large extent” is conditioned by what “donors decide to finance.”<sup>78</sup>

The influence of donors in the national affairs of Bangladesh has been extensively analysed.<sup>79,80,81, 82,83,84,85,86</sup> Their use of aid as a political lever has been implicated in profound changes in the political-economy of Bangladesh. As noted above, it has been argued by those close to Sheikh Mujibur Rahman, the country's first President, that the shift of his regime from a socialist and non-aligned position towards a neo-liberal economy, more closely integrated with the western capitalist world, was in response to the promise of a resumption of aid by the western donor community in 1974.<sup>87,88,89</sup> The

carrot of aid is said to have been dangled before military rulers to encourage elections, for example, those held under General Ziaur Rahman (Zia) in 1979.<sup>90</sup> Withdrawal of donor support has been argued to have been a contributory factor leading to the resignation of President Ershad in 1990.<sup>91</sup>

**Table 4: GOB & donor funding of health & population in the ADP (1990-1995)**

Financial Year	Funding of Health Projects in ADP		Funding of Population Projects in ADP	
	GOB	Donors	GOB	Donors
1990/91	45.9%	54.1%	29.7%	70.3%
1991/92	63.4%	36.6%	31.5%	68.5%
1992/93	52.0%	48.0%	38.3%	61.7%
1993/94	48.0%	52.0%	31.3%	68.7%
1994/95	61.4%	38.6%	33.5%	66.5%
Average 1990-95	54.1%	45.9%	32.9%	67.1%

Source: adapted from GOB publication<sup>92</sup>

Donors have also been intimately involved in economic and social policy making in the country. Even the World Bank admits that “most people perceive government policy announcements as a response to donor conditionality rather than a genuine commitment to change.”<sup>93</sup> Donor involvement in the country’s decision-making processes has early beginnings. Reflecting on the preparation of the country’s First Five-Year Plan (1973-78), Nurul Islam, then Deputy Chair of the Planning Commission, said it was the rule rather than the exception for donors to involve themselves in administrative, organisational and management matters, to the extent of vetting staff appointments.<sup>94</sup> Conditionality, he asserted, was not limited to the design of specific projects and programmes but encompassed issues of development policy and priorities within the sectors themselves – even when the donor investments constituted a small fraction of investment in the sector.

In a more general sense, it has been argued that aid has played a part in the continuity of social relations in Bangladesh. As noted above, the political economy of Bangladesh is marked by complex patron-client relationships. To an extent, the system of patronage has been sustained by the influx of foreign assistance. Observers, such as Haque, have argued that the government’s utilisation of aid has prioritised “the construction of infrastructure which could contribute concrete proof of the regimes efforts to help the rural poor. Such programmes also allow successive regimes to distribute patronage and win the support of local power holders.”<sup>95</sup> According to the foreword to a report written by a former member

of the Bangladesh Planning Commission for the Like-Minded Group,<sup>y</sup> the “picture which emerges is that of a vicious circle in which the government seeks legitimacy through a patronage system, aided by external assistance, but which merely strengthens the self-preserving ruling coalition who is content to contain the discontented majority.”<sup>96</sup> It has been further argued that aid has perpetuated the dependence. For example, Westergaard asserts that “in order to sustain the structures of power and prevent changes in the social structure, the various regimes in Bangladesh have relied heavily on foreign aid which has strengthened the structural dependence of the country.”<sup>97</sup>

Whether or not aid is somehow responsible for the arrested development in the social, political and economic sphere of Bangladesh is outside of the scope of this enquiry. Here, it is sufficient to note that the budget of the country has been marked with significant, if decreasing, dependence on external resources. This contextual factor has three axiomatic implications: (1) there has been a compelling case for aid coordination; (2) donors have had the potential to exercise significant leverage over Bangladeshi policy making; and (3) aid has provided a cushion for the Government by reducing pressure on it to undertake difficult reforms. Moreover, there are those who argue that donor influence is not only related to the volume of resources which the donors dispense but that “their power to do so [exercise leverage] has been further enhanced by the utter mismanagement of the economy by the political, administrative and business élite of the country.”<sup>98</sup> It is to the question of the administrative machinery to which we turn next.

## **2.5 Weak government capacity: a justification for external management of aid**

*...The old Bengal, Bihar and Orissa Province was an impossible charge and the Eastern Districts [Bangladesh] were the least favoured portion thereof...altogether this difficult country, the most thickly populated rural part of India, was administratively starved.*

District Administration Committee Report, 1913-14

### **2.5.1 Perceptions of government performance and capacity**

Since independence, the number of ministries have doubled to 36, the number of civil servants has risen to over a one million (which represents an increase in real terms

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<sup>y</sup> The Like-Minded Group is an informal body, established in 1984 by the heads of aid of Canada, Denmark, the Netherlands, Norway and Sweden, which sought to take a coordinated stand against the style and orientation of World Bank activities in Bangladesh, particularly the perceived neglect of poverty issues.



relative to population growth), and between 1980 and 1994 the number of directorates and departments in government increased from 109 to 220.<sup>99</sup> This has led some organisations, such as the World Bank, to question whether or not there is too much government in Bangladesh.<sup>100</sup> Nevertheless, numerous reports on public sector management and economic development in Bangladesh have found it 'administratively starved' in a qualitative sense. Consequently, it is the nature of governance within the administration which is of greatest concern to most observers.

Government performance is typically criticised by academics, donors, senior civil servants, business leaders, and the public-at-large, as weak, slow, and unresponsive. Its capacity to undertake basic functions is questioned, as is its aim of serving the people. Criticism has also been levelled at the government's use of aid. For example, a doctoral dissertation concluded that "despite many errors and failures, foreign aid did make an undeniable contribution, though not an optimal one, to the economic development of the country."<sup>101</sup> He lays responsibility for poor aid efficacy on the recipient: "It is a fact that countries [sic] achievement could have been much greater and more effective if the Government's efforts in planning and resource mobilisation had been more appropriate, planned and systematic. These shortcomings automatically call for the formulation and implementation of the right type of commercial, monetary and fiscal policy." Another PhD dissertation concludes that without "sound administration... increasing inequity and dependence are bound to result."<sup>102</sup>

Negative perceptions of government capacity provide the pretext for: (1) aid programmes which routinely circumvent government administration; (2) the establishment of parallel administrative and organisational structures within government to manage external resources; and (3) aid coordination arrangements which are externally-driven. The following sections examine issues of accountability, decision-making, civil service management and corruption which have served to create the dismal impression of Bangladeshi government in the eyes many observers and have served to undermine their confidence in its abilities.

### *2.5.2 Accountability and transparency*

Inadequate accountability pervades government life in Bangladesh. Although democracy has, in recent years, provided a potentially important framework for enhancing accountability, in practice however, parliamentary accountability does not yet work very well. Problems include the non-observance of parliamentary norms and procedures (e.g.,

no parliamentary question time, inadequate debate on policy and legislation, lack of consultation in policy development, weak committee structures, etc.), poor facilities (e.g., the lack of offices, equipment, research facilities, staff) and political corruption.<sup>103</sup>

Central to effective accountability is a robust and timely system of financial accountability. In Bangladesh, financial monitoring of government activities rests with the Comptroller and Auditor General (CAG), whose office verifies all expenditure, including those externally financed, *ex-post*. The CAG is criticised as being unsatisfactory for a number of reasons: (1) inadequate skills (i.e., no chartered accountants on staff); (2) outmoded practices and foci (e.g., focus on compliance with expenditure rules and procedures as opposed to value-for-money, or performance audits); (3) dual responsibility for accounting and auditing which compromises the integrity of the office; and (4) delays in issuing reports and following-up on audit observations.<sup>104</sup>

Donors, who require timely annual audited project accounts, were extremely critical of this aspect of government capacity – as delays beyond the covenanted agreements were common. For example, with respect to the World Bank's First Population Project, the annual accounts were reported as "always being late" and project financial statements had still not been audited two years after the project closed.<sup>105</sup> The follow-up project fared no better: "GOB compliance with audit requirements are seriously lagging" and in 1987, audits for 1983/84 had still to be completed.<sup>106</sup> Of greater long-term significance to donor confidence in GOB accountability was the fact that serious material audit objections were the norm rather than the exception. During the course of World Bank/co-financier Third Population and Family Health Project (TPFHP), a total of 907 observations were eventually raised by the auditors, of which 97 were of a serious material nature. These observations could take years to resolve. For example, although the TPFHP closed in 1992, in 1997 only 75 of the serious irregularities had been resolved.<sup>107</sup> Once resolved, the responsible officers have usually been transferred and it becomes difficult to take disciplinary action which further undermines accountability. Aide-memoires of the consecutive health and population projects of the Bank contained lists of outstanding and serious audit observations which carried over from one project to the next.

As mentioned above, one of the criticisms with the CAG's work is that it fails to undertake performance audits. Yet, this would be a difficult task given that ministries and departments (other than the Ministry of Finance) do not specify goals, key objectives, performance targets and prior year achievements which would allow for performance-based auditing. According to one study, when attempts are made, "the goals and

objectives as set out in government documents are not clearly spelled out. ...Some items are so broadly or vaguely listed that it is not possible for anyone to discern what it is supposed to mean.”<sup>108</sup> Performance-based auditing is further constrained by weaknesses and peculiarities in the planning and budgetary processes which do not facilitate the link between objectives and expenditures (this is dealt with in Chapter Three). The inability to judge performance erodes government accountability.<sup>109</sup>

Accountability is further impeded by the lack of transparency and openness in government. Officials are bound, by oath, to rules and laws which make it a criminal offence to disclose various types of information. One set of regulations even forbids civil servants, unless authorised “to disclose directly or indirectly to government servants belonging to sister organisations ...the contents of any official document, or communicate any information which has come into his possession in the course of his official duties.”<sup>110</sup> Civil servants are further inhibited from information-sharing as a result of a number of additional considerations: (1) they lack confidence in their decision-making capacities and, thus, operate according to a maximum safety rule; (2) they are unsure of their responsibilities and jurisdiction; and (3) information is viewed as an asset which may have a significant market value. As a result, the label ‘confidential’, ‘secret’ or ‘restricted’ is applied to the most mundane of documents. Limited access to public documents by civil servants, donors and the general public, renders government action and inaction opaque. One study of public administration carried out by independent international and Bangladeshi analysts reported that “a conclusion that may be drawn from the data collected for this Study ... is that government organisations are not held accountable financially or for programme performance.”<sup>111</sup> Perceptions of inadequate government accountability are reflected in donor reluctance to accord the administration a substantive rôle in the management and coordination of aid resources.

### 2.5.3 Decision-making in government

*A highly centralised structure without adequate delegation of authority and responsibility down the hierarchy, superfluous paperesserie, archaic record management, procrastinated decision-making, intricate communication patterns, non-familiarity with rules and procedures and other stumbling blocks are the principal causes that impair [government of Bangladesh] efficiency.*<sup>112</sup>

H. Zafarullah, University of Dhaka, 1994

Since the British colonial period, the national secretariat (i.e., conglomerate of civil service institutions) has been the pivot around which the entire public management process works (See Annex 4 concerning administrative arrangements). In the absence of effective government,<sup>k</sup> the secretariat has further entrenched itself.<sup>116</sup> Studies of the secretariat's capacity to make decisions have criticised the processes as too slow, too unpredictable, too centralised, too secretive and too prone to rent-seeking.<sup>117,118</sup> Such studies have provided some empirical basis to the criticism, noting, for example, the excessively long time that is required to hire a consultant, procure a service, complete tendering processes and take other decisions. Slippage is generally attributed to the proclivity of government officers to avoid decision-taking. "When a case is placed before an officer for his/her decision, the most usual response is to provide a guarded opinion and forward the file to the next higher officer. Each higher officer follows the same pattern until the matter reaches top. Few officers take risks that are involved in making a decision even if the position he/she is occupying authorises him/her to do so."<sup>119</sup> One reason why dispersed decision-making has not occurred in the administrative process is the absence of clear definitions of positions which renders officials uncertain of the extent of their authority. The constraints to decision-making have long been recognised and solutions proposed,<sup>120</sup> yet these have yet to be acted upon. Poor decision-making has implications for the aid relationship, including: (1) anxieties for donor staff; (2) increased transaction costs; (3) delayed government approvals for projects; and (4) slippage in project execution and fund disbursement. While government officials are maligned for their sloth and inefficiency, part of the problem rests with the system of human resource management in the civil service.

#### *2.5.4 Human resource management in the civil service*

Prior to independence, the civil service was generally regarded as a prestigious institution. A career in the elite Civil Service of Pakistan (CPS) was an aspiration held by many competent job seekers and, consequently, the CPS attracted the cream of society. Over the decades, the quality of the civil service has deteriorated and it no longer holds such high esteem.<sup>121</sup> Public administration is plagued by a number of problems which mitigate against good performance by its officials. Pay in the civil service is low and has diminished substantially in real terms since independence. For example, in 1994 the basic salaries of secretaries and joint secretaries were Tk. 10,000 and 7,800 per month (i.e., US\$ 250 and 195 respectively). The salary of a secretary has declined by 87% in real

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<sup>k</sup> Power has been centralised in the executive, parliaments have been weak and governments unstable. Between 1971 and 1991, the cabinet was reshuffled 97 times (Khan, Islam, Haque, 1996).

terms during the period.<sup>122</sup> It is reasonable to expect that low and eroding salaries can, at least in part, account for low efficiency, low morale, absenteeism, rent-seeking and the deteriorating quality of new entrants into the system.<sup>123</sup> However, other aspects of human resource management are also likely at play.

Career plans do not exist and serious constraints are associated with performance evaluation and promotion. “For most if not all government positions, position descriptions do not exist. In the absence of position descriptions, evaluations of individual performance can not be made on an objective criteria.”<sup>124</sup> Although merit-based personnel rules do exist, they are routinely circumvented and “more often than not, certain individuals either with political connections or because of their closeness to the chief executive have been favoured, while those with proven competence were ignored when it came to deciding promotions.”<sup>125</sup> This situation has been exacerbated by the rise in inter-cadre tensions and rivalries which have developed in post-independent Bangladesh and result in “intensive and excessive warfare.”<sup>126</sup>

Another problem with human resource management in the public administration concerns the area of specialist training. A random survey of personnel data sheets concluded that training is not effectively employed.<sup>127</sup> One of the cases of mis-utilisation of training cited an officer who had received three graduate degrees in health service administration from three different countries, but his postings with 11 different departments had never included any that were health-related.

Frequent transfers of senior officials between ministries and departments further impairs the performance and accountability of the bureaucracy. One study found that only 10% of deputy secretaries, joint secretaries and additional secretaries complete two years in the same post, and that eighty percent of these officials stayed in the same post for a year or less.<sup>128</sup> In the MOHFW, the ‘permanent’ secretary was changed four times between 1992 and 1996. If one considers the time required to traverse the learning curve, develop working relationships adequate to manage and supervise staff, acquire ownership and commitment to a programme and see through the implementation of decisions, it could be argued that such frequent transfer does not encourage efficient performance. This is a particularly pertinent consideration in the case of donor management, where personal relationships and continuity play a particularly strong rôle in building trust and the confidence that one’s counterpart will handle resources with integrity.

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Patronage and clientelism, the failure to apply criteria fairly in the appointment and promotion of civil servants, and the absence of *esprit de corps* has likely adversely affected the morale and efficiency of public servants thereby eroding the performance of the public sector. Donors frequently blame weak personnel management for problems in project implementation and respond to this risk by establishing dedicated project implementation units with expatriate, as well as seconded government officials, who are not liable to work through normal channels of bureaucratic control.

#### 2.5.5 Rent-seeking and aid

*Appropriation and corruption in Bangladesh have flourished because well-meaning donors have continued to pour money in with little regard for how it is used.*<sup>129</sup>

P. Thomson, 1991

Former CIDA official, Dhaka

Rent-seeking, the act of illicitly “seeking transfers of wealth through the aegis of the state,”<sup>130</sup> is a specialised form of corruption. According to Transparency International, an international NGO, “corruption is widespread in Bangladesh” and “corrupt practices have become institutionalised” in public office.<sup>131</sup> Findings of a national study of 620 households, conducted by the national branch of the organisation, provide an indication of the scale of rent-seeking. For example, 68% of complainants reported having made a payment to the police to file a complaint; 96% of respondents expressed the view that it was ‘almost impossible to get help from the police without money or influence;’ more than three-fifths of those households involved in a court case reported bribing court officials – more than a quarter did so through their lawyer; almost 90% of respondents expressed the view that ‘it was almost impossible to get quick and fair judgement from the judiciary without money or influence.’ Respondents also reported paying a variety of informal fees to get public services or exempt themselves from paying the state sanctioned prices. For example, in the health sector, 20% of households who had frequented an out-patient department during the preceding year reported making extra-payments for services, while approximately one-third of those seeking in-patient treatment did so through some extra-normal process. Seventy percent of households agreed that ‘there existed unethical practices in the procedure for admission into the hospital’ and 81% held similar views with respect to the supply of drugs and treatment. Systems losses were also widespread: a third of households reported obtaining reduced

water and electricity bills through private arrangements with their meter readers and almost 50% reduced their municipal taxes through the payment of informal fees.

Other sources corroborate the findings of Transparency International. For example, a report of the Foreign Investment Advisory Service of the World Bank stated that “Government intervention and rent-seeking have corroded the judicial, administrative and commercial machinery of the country. Access can, and frequently does, have its price. Officials simply do not take action or refuse to take action without sufficient encouragement.”<sup>132</sup> Although rigorous estimates of the cost of corruption to the Government are not available, one indicative study suggests that the Treasury loses about three times the amount of revenue to corrupt practices than it collects.<sup>133</sup> There are accounts of corruption under every administration in Bangladesh.<sup>134,135,136,137</sup>

Given the major rôle which aid plays in the economy, corruption has likely entrenched itself in this sphere of activity as well. Although concrete evidence is difficult to obtain, anecdotal accounts are available. These include admissions from Government officials themselves. For example, one former member of the Planning Commission is reported to have declared that “aid is not so much about helping others, as it is about helping yourself” (cited in Thomson<sup>138</sup>). Some go as far as venturing that “There is evidence that the growth in corruption paralleled the increase in development assistance;”<sup>139</sup> yet such evidence is not cited. Referring to Zia, Franda remarks that “despite his admission that corruption has increased significantly during his five years in power, and his realisation that this increase is due precisely to the massive amount of international aid flowing into the country, Zia is convinced that ‘aid from all countries should be increased.’”<sup>140</sup>

Within the health sector, there have been and continue to be concerns about corruption. Although there have not been systematic reviews of the issue, a number of recent studies suggest it may be wide-spread and operates at a number of levels. For example, one study, published jointly by the MOHFW and CIDA, estimated that over a twenty month period, 30% of oral contraceptives ‘leaked’ out of the system at a cost of US\$ 3.5 million.<sup>141</sup> UNFPA suggested that, in 1993, the cost of purchasing “excess condoms” was almost US\$ 4 million as a result of what has been called “systems losses,” although another study estimated that it was closer to US\$ 3 million.<sup>142</sup> A study undertaken by officials in the MOHFW found that informal fees are prevalent at all levels of the system and can amount to up to eleven times the amount which is officially charged.<sup>143</sup>

The actual and perceived levels of rent-seeking have surely played a rôle in the extent and manner in which donors have entrusted aid to their recipient counterparts.<sup>1</sup> Moreover, some donor officials perceive that Government officers may be averse to effective coordination because the transparency it behoves would reduce the room for political manoeuvring and rent-seeking.<sup>144</sup>

## **2.6 Health care services**

The health service market in Bangladesh is highly pluralistic and a plethora of treatment options exist. Non-governmental (for profit and not-for-profit) provision predominates. The first site of access for most services, other than maternal and child health (MCH) and family planning, is non-governmental, with choice of provider dependent on the symptom, sex, socio-economic standing and geographical location (urban/rural) of the individual. Although ‘allopathic’ practitioners are consulted in approximately 80% of cases when treatment is sought, the existence, length and quality of allopathic practitioners’ training is as variable as the quality of treatment they provide. A significant proportion, in some instances the majority, of treatment is sought from non-allopathic practitioners.<sup>145</sup> Indigenous systems of medicine constitute a considerable proportion of the market.

For fiscal year 1994/95, total expenditure in the sector was estimated at US\$ 855 million or approximately US\$ 7.1 per capita (not including food and commodity aid contributions).<sup>146</sup> Of this, 47% was accounted for by household out-of-pocket expenditure, while the Government contributed 27%, and donors the remaining 26%.

### *2.6.1 Private sector health care*

Private health care facilities have proliferated in Bangladesh since 1982 when restrictions on private laboratories, clinics and hospitals were relaxed. Between June 1995 and July 1996, one new facility was officially registered every 30 hours (not including non-allopathic medical facilities, physicians’ chambers or pharmacies).<sup>147</sup> The latter, particularly small chemist’s shops and indigenous practitioners, are profuse – even in rural areas. The sector remains poorly regulated and lacks systematic monitoring; as a result violations are widespread. Financial incentives often militate against good medical practice.

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<sup>1</sup> It has been argued that donor concern over levels of corruption have not always been in direct proportion to the actual level of corruption prevailing. For example, Sobhan suggests that USAID was very critical when allegations of corruption surfaced in the Mujibur regime, but was less vocal in its criticism when a more friendly, albeit more corrupt, government was installed under Zia.



### *2.6.2 NGO sector in health*

With donor support, NGOs have become extremely active in the population sector and, increasingly, the health sector. NGOs were estimated to have accounted for up to US\$ 50 million of sectoral expenditure for fiscal year 1994/1995 (i.e., approximately 6% of total expenditure on health and population).<sup>148</sup> Under its previous programme (1987-1997), USAID provided approximately 75% of its support for population and health activities to the NGO community directly, increasing to 100% under its current programme.<sup>149</sup> Although estimates vary, one survey found approximately 250 NGOs active in the sector, providing MCH-FP services (75%), EPI (40%) and clinical services (35%).<sup>150</sup> Others suggest that the true figure is around 400.

In 1990, the NGO Affairs Bureau (NGOAB) was set up in the Prime Minister's Office to provide NGOs with a one-stop registration, project approval and fund disbursement facility. By 1995, almost 1000 NGOs had registered. While NGOAB has reduced some of the red-tape under which NGOs operate, it still applies a plethora of rules. As a result, NGOs perceive the Bureau to place undue emphasis on control and regulation at the expense of facilitation, strategic oversight and harnessing and coordinating NGO activities towards sector priorities and goals.<sup>151</sup>

Although individual projects need approval from NGOAB, the Ministry of Health and Family Welfare will not necessarily always be consulted over decisions pertaining to health activities; consequently, this mechanism does not ensure NGOs contributions to MOHFW-established sector goals. Many NGOs have tended to work independently of the MOHFW. Therefore, in some areas, parallel systems exist while in others, services are provided in a patchy manner. There have been recent attempts by the Government to sub-contract delivery of MCH-FP services to some NGOs in remote areas and there have been a number of high profile NGO-MOHFW partnerships, predominantly in EPI, disease control programmes (notably TB and leprosy), and nutrition. A large initiative to improve PHC in urban centres is planned by the AsDB, under which the delivery of some service centres will be tendered out to NGOs (and private groups).<sup>152</sup>

To improve, among other things, GOB-NGO coordination in the MCH-FP programme, the MOHFW, with strong encouragement and support from USAID, established the National Steering Committee on Future Challenges confronting MCH-FP in 1994. The Committee, chaired by the Minister, produced a Plan of Action and constituted nine

working groups with NGO representation to work together to improve the programme.<sup>153</sup> Efforts have also been made by NGOs to coordinate among themselves through, for example, the Voluntary Health Services Society. In spite of these efforts, there remains much competition among NGOs for funds, as well as a geographical overlap of services and catchment areas and duplicate activities.

### *2.6.3 Government's health programme*

The Government has a vast physical and human infrastructure to provide health services. These are predominantly, and ostensibly, cost-free to the consumer, particularly at the Thana level and below; however, informal fees are prevalent at primary, secondary and tertiary facilities.<sup>154</sup> Family planning services form part of a comprehensive, multi-sector, multi-ministry population programme. Primary health care services have focused narrowly on MCH, provided mainly through the Family Planning Directorate, and a limited number of vertical programmes including EPI, CDD, ARI and the control of micronutrient deficiencies through the Directorate of Health Services. Broadly speaking, while the GOB has directed its resources towards the hospital sector, donors have directed aid towards PHC, particularly family planning and MCH. The MOHFW is responsible for service provision in the rural areas but is joined in the urban settings by the City Corporations under the Local Government Directorate. There has been a bias towards the development of infrastructure for the rural population.

Immediately after the war of independence, there remained few public sector facilities. By 1997, there were six post graduate teaching institutions with five attached hospitals (2825 beds) and eight medical colleges with their hospitals (6002 beds). Other public sector hospitals exist for the treatment of specific conditions (e.g., TB and leprosy). In addition, the country's 64 Districts have general hospital facilities with 50-250 beds in each (4750 beds in total). Almost 400 of the country's 467 Thanas have a 31 bed Health Complex with eight doctors and one sanctioned dental surgeon's post (each with a catchment population of approximately 1/4 million). These Complexes also provide outpatient services. Of the 4,800 Unions in the country, approximately 3,500 have Family Welfare Centres which are staffed by a (male) Medical Assistant and a (female) Family Welfare Visitor. In addition, there are also some 1,275 rural dispensaries at the Union level which are operated under the Directorate of Health Services and have posts for Medical Officers. Ninety seven Unions have Mother and Child Welfare Centres which are similar to the dispensaries but do not have a doctor. At the community level, door-to-door services are provided by approximately 20,000 Health Assistants (previously male posts but, in recent years, retirees have been replaced with females) and about 23,000

(female) Family Welfare Assistants who collectively also organise some 30,000 satellite clinics each month for MCH-FP. In addition, there are some 108,000 outreach sites to deliver EPI-Plus. There are approximately 130,000 personnel of different categories under the two service delivery Directorates of the MOHFW. Despite massive investment in infrastructure and personnel, the limitations and dysfunctions of the sector are numerous (see Box 1).

**Box 1: Limitations of the GOB health programme**

- bias towards rural service provision;
- bias towards family planning and maternal and child populations (until the 1990s);
- poor quality of care due, among other things, to: (1) shortages of essential drugs; (2) poorly trained and supervised staff; (3) poor staff morale and low staff attendance; (4) provider orientation to service provision;
- bifurcation of MOHFW into two directorates which renders seamless provision of health services difficult;
- wide-spread inefficiency due to: (1) centralised decision-making; (2) low utilisation of facilities; (3) 'systems' losses (i.e., theft); (4) overlapping staff deployment in two separate Directorates; (5) low worker productivity; and (6) expensive doorstep family planning service delivery mechanism;
- poor equity in public provision and finance (e.g., middle class capture subsidy for urban health services, the provision of free services is offset by informal charges in most public facilities);
- the effectiveness of the system is impaired by: (1) inadequate capacity for planning and management; (2) fragile support for, and ownership of, the reform agenda; and (3) poor prospects for financial and managerial sustainability;
- preoccupation with the development of a plethora of independent project activities and implementation units has led to fragmentation and distortion in the allocation of resources; and
- the availability of large amounts of health sector aid, and the imperative to disburse it rapidly, has contributed to inefficiency and waste, institutionalisation of prematurely made decisions, lack of consideration of alternatives, lapses and compromises in service quality, and erosion of incentives to make more efficient use of resources.

Between 1985/86 and 1994/95, the Government, with considerable foreign assistance, increased its funding of health and population activities by 6% and 8.5% respectively, in constant dollar terms (not per capita). In 1994/95, the GOB budget (capital and recurrent) for the health and population sectors was US\$ 374 million, comprising \$ 222 million for health and \$ 152 million for population. An examination of the Annual Development Programmes (broadly speaking capital investment budget) and Revenue Budgets (mainly recurrent) between 1990/91 and 1994/95,<sup>λ</sup> suggested that the share of health and

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<sup>λ</sup> The ADP and revenue budgets do not include the 'defence and public order' spending of government. An analysis of expenditure between 1989/90 and 1993/94 according to the Classification of the Functions of Government System (of the IMF), which included defence

population spending as a proportion of the GOB budget rose from 5.9% to 6.9%, as a portion of GDP from 2.1% to 2.4%, and in real terms from US\$ 2.40 to 3.10 per capita. Much of this expansion has benefited primary health care activities.<sup>155</sup>

Donors have heavily underwritten the country's public health investment, although figures, particularly earlier ones, are neither accurate nor complete (see Tables 4 and 5). At least 13 multilateral and 18 bilateral organisations committed funds to the MOHFW between 1992-1996 for operational activities in the sector (these are listed in Table 6). Major donors include the World Bank and the Consortium of nine bilateral donor agencies (discussed in Chapter 5). These collectively disbursed approximately US\$ 75 million a year through the IDA Fourth Population and Health Project<sup>x</sup> (most cofinanciers also provided additional funds outside of this large project). Other major donors include:<sup>8</sup> USAID (US\$ 30 million/year – primarily for family planning); UNICEF (US\$ 14 million/year, including supplementary funds, for children's and women's health through EPI-Plus, ORS, CDD, ARI and nutrition programmes); AsDB (US\$ 10 million/year – primarily for curative care); UNFPA (US\$ 7 million/year for reproductive health); and WHO (US\$ 5 million/year for technical assistance). The EC and JICA are relatively new players in the health programme and are poised to become major donors. In 1994/95, the country's bilateral and multilateral development partners financed approximately one half of the budget in the health and population sector. In addition, there are a large number of international NGOs which provide support to health and population activities; however, the volume of these resources is difficult to estimate. Donor support is currently provided through a profusion of projects and project units, but a shift from project to sector-wide financing has been considered in the 1990s (see Chapter 6).

There is considerable agreement among donors that they have paid insufficient attention to capacity building and institutional development, and that much effort in this area has been relatively ineffective due to systemic problems in public administration. These include training-posting mismatches, frequent staff turn-over, poor incentives and non-transparent promotions, etc. In particular, while a significant number of staff have

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outlays, found the category 'health affairs and services' roughly static, declining from 6.9% to 6.8% of the budget during the period.

<sup>x</sup> The project includes activities such as family planning, MCH, control of communicable and poverty-related diseases, organisation and management development, quality of care, and human resource development, *inter alia*.

<sup>8</sup> These are indicative figures derived by dividing the amount of each agency's approximate programme commitment by the number of years of the programme period.

received specialist training, incentives, accountability structures, and access to resources are lacking for proper deployment of acquired skills.

**Table 5: Annual commitments of major donors to the MOHFW (1992-96)**

Donor	US \$ commitment per annum
World Bank and cofinanciers of FPHP	75 million
USAID	30 million
UNICEF	14 million
AsDB	10 million
UNFPA	7 million
WHO	5 million

**Table 6: Donors having committed or disbursed funds to the MOHFW between 1992-96 (in alphabetical order)**

Bilateral agencies / Donor countries	Multilateral Agencies
1. Australia's AusAid	1. AsDB
2. Belgium's BADC	2. EC
3. Canada's CIDA	3. IDA
4. China	4. IDB
5. Denmark's DANIDA	5. ILO
6. Netherlands's DGIS	6. OPEC
7. France	7. UNAIDS
8. Germany's GTZ	8. UNCDF
9. Italy	9. UNDP
10. Japan's JICA	10. UNESCO
11. Germany's KfW	11. UNFPA
12. Norway's NORAD	12. UNICEF
13. United Kingdom's ODA/DFID	13. WHO
14. Saudi Fund	
15. Switzerland's SDC	
16. Sweden's Sida/SIDA	
17. South Korea	
18. USA's USAID	

## **2.7 The donor health sector agenda: from a war on population to sector reform**

Chapter One discussed the many factors which converged to raise the salience of aid coordination in health policy debates (see Section 1.2). One of the striking features in Bangladesh, which is likely to have influenced the extent to which coordination was seen by donors to be a high priority objective, was the changing agenda which they pursued in the health and population sectors. Early, fervent pursuit of the control of population growth gave way to attempts to leverage health sector reforms in the context of a neo-liberal economic approach to development and the state.

Until the late 1980s, very little emphasis was placed by donors on the health sector *per se*. In an analysis of donors' preferences within the country's First Five-Year Plan (1973-78), Nurul Islam has illustrated that health was a low priority, indicated by the lack of

reference to the issue by donors.<sup>156</sup> By contrast, donors were so worried about the consequences of population growth that, in early 1974, UNFPA wrote “there are so many external organisations involved in the family planning programme in Bangladesh that it is almost impossible to give a complete picture of external assistance available to the Government in this sector over the next three to four years.”<sup>157</sup> At about the same time, the Bank commented upon the significant level of funds available for population control in Bangladesh which were “far in excess of specific projects.”<sup>158</sup> A German mission to Bangladesh also noted the abundance of aid for population activities.<sup>159</sup> Even the Government, which was facing a balance of payments crisis in 1974, asked that certain donors interested in investing in the population programme, refrain from doing so.<sup>160</sup> By the late 1970s, it was becoming increasingly clear that funds for population control outstripped the ability of the Government to effectively utilise them. USAID was forthright in its suggestions that it, and other donors, scale back their investments in the sector.<sup>161</sup> The Bank also communicated to Government its intention to reduce funding for its Second Population and Family Health Project, in light of the difficulties the Government was experiencing in utilising funds available through its First Population Project.<sup>162</sup> Despite the general concern among most external agencies to check population growth, the pace of the programme was set by three of the largest donors in the sector: the World Bank, USAID and UNFPA.

Population control has been of central interest to the World Bank since independence. For example, during the first of the annual meetings between Bangladesh and the Bank, held in Washington in September 1973, the only project to which Robert McNamara, Bank President, explicitly referred was the population project. This was under appraisal and needed to be ‘pushed ahead.’<sup>163</sup> A 1974 Bank memorandum notes that, in its dealings with the Government and other donors, “our [Bank] insistence on the overriding priority of population problems to the country’s future” was made clear.<sup>164</sup> The three volume report *Bangladesh: Development in a Rural Economy*, published in September 1974, provided a neo-liberal alternative to the Government’s First Five-Year Plan (1973-78). The *first* of the three central elements of the Bank’s strategy for Bangladesh was an emphasis on population planning.<sup>165</sup> According to the Bank, “family planning is one of the most vital elements associated with economic development in Bangladesh and must be seen to succeed.”<sup>166</sup> Pressure continued to be exerted upon the Government even after the Bank had convinced it to elevate population control to priority number one.<sup>167</sup> For example, in a letter written on June 30, 1983, David Hopper, Bank Vice-President, instructed AMA Muhith, Minister of Finance and Planning, “to outline necessary measures to strengthen the program so that agreed national population objectives could be

met on time.”<sup>168</sup> According to a 1991 Bank document, concerning its involvement in the population programme in Bangladesh, “much of the culture of urgency remains. Project size has at least doubled every five years, constantly threatening to overwhelm implementation capacity, with little thought being given to internal efficiency or long run financial sustainability.”<sup>169</sup>

USAID was even more resolute in its preference of population control over health activities and in achieving rapid results in this field. The high priority placed by Americans on family planning was reflected in their attitude towards proposals to integrate family planning with the MCH programme. In 1979, Tim Ravenholt, the Director of USAID’s Population Office in Washington, thought that a merger would be a ‘disaster.’ “If this were done additional years would be lost before it again became clear that effective family planning services had been swallowed and lost in the general morass of a grossly inadequate general health care system.”<sup>170</sup> When the same issue was considered in 1983, USAID warned that integration “requires unnecessarily costly and long-term efforts to establish a PHC system instead of focusing on quick delivery of birth control services to meet the unmet demand...A population control program does not depend on a functioning primary health care system.”<sup>171</sup>

The sense of crisis, urgency and single-mindedness of purpose regarding the control of population growth also pervaded the work of the UNFPA. UNFPA took the attitude that donors could not “afford to limit their financial contributions” to efforts to control population growth in Bangladesh, even if the country was saturated with funds for population activities.<sup>172</sup> Some donors did, however, indicate their concern to UNFPA in 1978 “about UNFPA making a commitment for \$50 million over five years with no indication of how the money would be spent.”<sup>173</sup> In terms of strategy, UNFPA, like USAID, advocated extreme measures. In a letter to UNFPA headquarters, the UNFPA Representative in Dhaka wrote:

Most donor representatives here greatly admire the Chinese for their achievements; a success story brought about by massive compulsion...It is time for donors to get away from too narrow an interpretation of voluntarism and certain governments in Asia using massive incentive schemes, including disincentives and other measures of pressure, still deserve international support.<sup>174</sup>

Although the Bank, USAID and UNFPA may have been the leading advocates of population control, they were joined in their crusade by most other Western donors. These agencies demonstrated their preoccupation with population issues during the annual Bangladesh Aid Group discussions in Paris. An analysis of reports from these

meetings (1978-84) found that population consistently elicited considerable attention; population control was the third most frequent issue raised, accounting for over 17% of all interventions during the period.<sup>176</sup>

Coordination may have been further constrained as a result of differences of opinion among donors as to how to best approach the population issue. These differences mirrored two unresolved debates at the global level: one over whether contraceptive supply or 'beyond family planning' programmes (e.g., legislation, women's employment, education, *etc.*) would be most effective in reducing fertility;<sup>178,179</sup> another over the efficacy of vertical campaigns in comparison with integrating family planning services within comprehensive primary health care programmes.<sup>180,181</sup> In Bangladesh, there were additional disagreements over specific operational and technical matters (e.g., organisation and management of the programme, supervision of field workers, *etc.*). These differences were acknowledged by the various agencies themselves<sup>182,183,184,185</sup> and, according to the World Bank, provided one of two major obstacles to inter-agency funding of one single large project or programme in the sector.<sup>186</sup>

Over time, and for a variety of reasons, most donors, with the notable exception of USAID, began providing funds for health as well as family planning initiatives. Consequently, whilst much donor support during the 1970s and for much of the 1980s, focused largely on construction, field staff deployment and procurement to blanket the country in contraceptives, health activities during the 1980s began to attract a larger proportion of aid funds. At the time, emphasis was placed predominantly on selective MCH services. Thus, for example, while the major objective of the World Bank/cofinancier's Third Population and Family Health Project (1986-92) was "to assist the GOB to achieve the fertility, infant and maternal mortality reduction goals of its Third Five-Year Plan,"<sup>188</sup> in terms of actual expenditure, family planning accounted for approximately US\$ 200 million while the MCH component accounted for only US\$ 10 million.<sup>189</sup> The 1991 Staff Appraisal Report of the World Bank for the Fourth Population and Health Project, draws attention to the fact that "Bangladesh has been so preoccupied with the pressing problem of its population explosion that the general health situation has not received enough attention. Only in family planning does the Government appear to have established an effective system of providing services,"<sup>190</sup> while singularly failing to acknowledge the rôle of external investors in this imbalance. In 1990, Bank staff had themselves commented upon "the dichotomy between on the one hand a significant number of donors who prefer the Fourth Project to be primarily a 'health' project, and on



the other both GOB, the Bank and 2 or 3 major donors who prefer to put population first and health second.”<sup>191</sup>

Despite differences as to the relative emphasis donors placed on health, as opposed to family planning, as well as their motivations for funding health-related activities, by the early 1990s donors accounted for 54% of the expenditure on health projects in the country’s Annual Development Programme (i.e., approximately US\$ 52 million in 1990/91).<sup>192</sup> While this amount was still dwarfed by donor participation in the population budget (i.e., 70% of population project expenditure amounting to US\$ 113 million), health was receiving considerable donor attention.

Heightened donor investment in health in Bangladesh loosely coincided with global shifts in the policy agendas governing development assistance in general, and health in particular. The former was increasingly oriented towards creating a favourable climate for economic development through the promotion of improved governance, market liberalisation, and structural adjustment, *inter alia*.<sup>193</sup> The latter encompassed a raft of policy initiatives under the rubric of health sector reform.<sup>194</sup> In the health sector in Bangladesh, donors pressed for a range of systemic reforms<sup>195</sup> and, as a result, efforts were made to develop a comprehensive Human Resource Development Master Plan for the health sector, as well as a plan for institutional reorganisation of the MOHFW, etc.<sup>196</sup> In addition, a Public Expenditure Review for health and population<sup>197</sup> and, later, an analysis of the Flow of Funds in the sector (both firsts in Bangladesh) were undertaken to provide reliable information “for successful sector reforms.”<sup>198</sup> While agreement among donors on the necessity and timing of introducing these complex issues in Bangladesh would have required a significant level of policy coordination, the outputs of these exercises would have made the failure to coordinate aid in the sector significantly more explicit. Moreover, in the mid-1990s, the donors, led by the World Bank, introduced a sector-wide approach (see Chapter 6); the effectiveness of this was premised upon hitherto unprecedented levels of donor and aid coordination. Thus, in comparison with the 1970s and 1980s, the context in which aid was deployed and the objectives which it sought to achieve were remarkably different and, at least in theory, much more amenable to coordination.

## **2. 8 Aid coordination: some foreshadowing**

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While subsequent chapters will deal with specific instruments of aid coordination in the health sector, the following remarks touch on some broader issues as well as provide the context in which to situate these instruments. First, there is an apparent paradox with respect to the efficacy of health sector aid coordination in Bangladesh. Aid agency and Government officials, with some responsibility for aid coordination in the health sector, report devoting significant time to aid coordination activities. The survey described in section 1.6.2.4 found that respondents reported spending between 20 to 50% of their time on such work. Nevertheless, they are unanimously dissatisfied with the results. There was agreement that: (1) although government structures and processes exist which aim to coordinate aid, in practice, their ability to do so is wholly inadequate; (2) the tools which have evolved by donor effort are piecemeal and, therefore, inadequate to provide an overarching framework within which aid can be harnessed to meet national goals; and (3) there is too much duplicative micro-level coordination (e.g., in the early 1990s there was an MCH coordination cell in the MOHFW, an MCH Working Group set up by the National Steering Committee on Future Challenges, an MCH Coordination Group set up by UNICEF/OGSB and an MCH Forum organised by UNFPA).<sup>199</sup>

Second, it is important to understand that aid coordination mechanisms have tended to play more than the technical rôle ascribed to them in terms of rationalising the aid relationship. Indeed, coordination has exhibited a markedly political dimension in Bangladesh. Both the Government and the donor agencies have regarded coordination as a means to exert leadership and control over the development agenda and over the decisions and actions of other stakeholders. Coordination has accordingly been used as a subterfuge towards such ends. The struggle to be the coordinator of aid efforts is demonstrated by two case studies presented below.

#### *2.8.1 Establishing an aid group for Bangladesh*

*The formation of a regular donor consortium was not welcomed by Bangladesh; it was the donors who felt the need for coordination of their activities and who from the first pressed for the establishment of a consortium.*<sup>200</sup>

J. Faaland, World Bank Chief, Dhaka, 1981

It would appear that both the first Government of Bangladesh as well as the World Bank understood the influence which a consortium of donors could exert over the development process. As a result, its establishment became a serious point of contention. During the course of 1972, the Bank, the Government and potential members of an aid consortium met on a bilateral basis to discuss the pros and cons of a consultative group process to aid

coordination. It was hoped that, through such an approach, a suitable mechanism could be designed which would meet the needs of aid coordination as well as be acceptable to all participants. In the course of these discussions a number of differences of opinion surfaced.

The Bank took the position that a consortium should be reactivated along the same lines as the Pakistan consortium, in terms of: (1) its membership; and (2) annual meetings held in Paris which would be chaired and serviced by the World Bank.<sup>201</sup> In contrast, the Government wanted to manage and chair the proposed meetings, to hold them in Dhaka, and to invite non-DAC countries to participate as well. All three of these changes would have represented precedents to Bank procedures. The Bank argued that the management of the consortium had to be left to the Bank because, it reasoned, it had both donor and recipients as members and was, therefore, in a uniquely impartial position. In addition, the Bank drew attention to the practical difficulties of holding discussions in Dhaka.<sup>202</sup> The Government countered that the Bank could not be impartial in that it was dominated in terms of ownership, control and management by the donor countries, particularly the US and, as a function of its aid programme, was a vested player like any other donor. Rehman Sohban, a member of the Planning Commission at the time, noted that from the Government's point of view, it was obvious that a consortium controlled by the Bank would "merely infuse less conscious donors with the Bank's particular ideology... If donors came together under the auspices of the Bank a collective pressure point would be provided for the Bank to impose its ideology and policies...on Bangladesh."<sup>203</sup> Given the nationalist and socialist orientation of the regime, this represented an unacceptable situation.

The Government sought the support of friendly donors for its decision to hold the meeting on its terms. It allayed donor concerns with reassurances that the meeting's agenda would not vary in great detail from the standard format prescribed by the Bank and that the option to hold subsequent meetings outside the country remained open. Eventually, it was agreed that a two-day meeting would be held in Dhaka in March 1973. It would be chaired by the Deputy Chairman of the Planning Commission and invitations extended to nineteen international agencies and countries, including a number of Socialist ones. The first day of the proceedings would be formal in that there would be no discussion of the set statement which each delegate was invited to make. Instead, the Government would respond to those issues it considered important. The second day would be reserved for discussions and pledging.

Accounts provided by two participants,<sup>†</sup> suggested that the meeting went according to the prepared agenda with the exception of the question of the debt. The issue illustrates the manner in which coordination through the consortium proved to be a powerful tool. According to Rehman Sobhan,<sup>204</sup> the Bank intended to use the meeting to mobilise DAC donors to exercise collective pressure on the Government to accept its liability for a proportion of Pakistan's external debt. As the Government became aware of this strategy, it explicitly excluded the issue from the agenda. It advised donors that debt was not for discussion in the forum, but would be negotiated bilaterally with creditor countries once the sovereignty of Bangladesh was recognised by Pakistan. Nevertheless, nearly every donor is reported to have commented upon the debt issue during the first day of the meeting.<sup>205</sup> The Government learned from friendly donors that, at the concluding session of the meeting, some donors intended to make their pledges conditional upon Bangladesh's accepting a settlement of the debt question. The chair pre-empted this outcome by announcing that the meeting would not seek aid pledges and that donors should, therefore, not make pronouncements on pledges. "Notwithstanding this clear renunciation of the pledging component of the meeting, a number of donors, in a unique breach of diplomatic etiquette and with crass political insensitivity, went ahead and announced conditional aid pledges..."<sup>206</sup>

This incident of coordinated donor pressure, orchestrated by the Bank, confirmed the Government's fears over the use to which a consortium could be put. Nevertheless, it also pointed to the advantages that leadership over the consortium could bring. First, the Chairman declared, on behalf of the Government, that Bangladesh would forego further development assistance rather than accept conditional pledges. Accordingly, the Chair declined to take cognisance of the conditional pledges and had them expunged from the record of the proceedings. Second, the Government took advantage of its responsibility for preparing the aide-memoire, and used it to expose how aid agency officials had publicly attempted to manipulate the Government to accept a political settlement in exchange for aid. According to Sobhan, the President of the World Bank almost immediately sought to distance himself from events in Dhaka, writing to the Government of Bangladesh and members of the consortium to indicate the Bank's intention to back down on the issue and urge other donors to do the same.<sup>207</sup>

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<sup>†</sup> Rehman Sobhan, Planning Commission (1972-74); Just Faaland, World Bank (1974-75).

Due to a range of factors, the Government proved unable to maintain control over this mechanism for the next meeting of the group in 1974. Flooding, socio-political destabilisation, as well as the need for balance of payment support following the global economic crisis left the Government in a precarious situation. Under the circumstances, the ability and importance which the Government attached to mobilise internal support to counter external pressure had waned. After two years of resistance, the GOB succumbed to the Bank's pressure to reactivate a 'traditional' style consortium.<sup>208</sup>

In July 1974, the Government requested that the Bank form a donor consortium and call an emergency meeting of donors in August in Washington as well as a regular meeting later in Paris, to discuss medium-term requirements.<sup>209</sup> The Bank obliged and a traditionally styled 24-nation Bangladesh Aid Club was fashioned. It was reported in the *Far Eastern Economic Review* that "critics of the new aid consortium argue that Bangladesh has had to barter away the last vestiges of its original commitment to the ideals of 'socialist planning' in return for short term relief... The outlines of the 'reform' programme are said to have been made clear to the Prime Minister, Sheikh Mujibur Rahman, and his economic entourage during their recent Washington visit."<sup>210</sup> According to the Bangladesh representative of the Bank in Dhaka, by the June 1975 meeting of the consortium, "Bangladesh had accepted the rôle apparently expected of her by the international aid community of an attentive and accommodating supplicant of assistance."<sup>211</sup> Clearly the ability of donors to persuade Bangladesh to accept the orthodox economic reforms was, in part, a circumstance of need; yet in part it was also due to the reinforcing nature of coordinated donor leverage exercised through the consortium mechanism. In addition, the creation of the Bangladesh aid consortium served to institutionalise the leadership of the World Bank in this dynamic.<sup>212</sup>

### *2.8.2 Aid coordination and health sector leadership*

I have demonstrated above that donor concern for population control was at the expense of aid coordination. It was also speculated that, as the policy agenda shifted to encompass systemic issues within the MOHFW, the benefits of improved coordination came into stronger relief. Nevertheless, it bears making reference to an intense rivalry between the World Bank and UNFPA over the position of lead coordinator of aid in the sector, which was, arguably, viewed as a covert means to exercise hegemony over other actors.

Senior staff of the two organisations met in January 1973 to discuss their support to population control efforts in Bangladesh. According to Bank minutes of the meeting, "it was thought desirable that the Bank and UNFPA combine their efforts in developing the

project and exercising leverage for effecting the needed institutional changes and efficient implementation of the project.”<sup>213</sup> Consequently, the Bank joined other multilateral organisations in a joint mission to Bangladesh led by UNFPA. The overriding aim of the mission was to develop “a broad framework for family planning activities over the next 3-5 years in which external donors... might find an appropriate rôle of assistance...”<sup>214</sup> In early March, after completion of the mission, the Bank proposed to UNFPA “joint sponsorship by the Bank and UNFPA of a major multi-donor financing effort once we could determine the size of the package.”<sup>215</sup> Later that week, when UNFPA officials met with Bank staff to discuss, among other things, “the modus vivendi of various donor agencies to provide assistance to the Bangladesh program,” cooperation had given way to competition.<sup>216</sup> Although there was agreement on the need to coordinate their assistance and to “decide on the rules of the game much in advance of their [both agencies] involvement in the program (i.e., (1) division of responsibilities; (2) mechanism for coordination and communication; (3) management of program),” tension was expressed over how this was to be achieved.

Apparently, the Government’s Planning Commission had proposed to the multi-agency mission that a sub-group of the Bangladesh Aid Consortium be formed. UNFPA was ready to formalise the suggestion, but the Bank stated that it was not yet in a position to participate in such an initiative because it had yet to define its rôle in the sector.<sup>217</sup> In the above-mentioned meeting, convened to discuss donor coordination, the Bank informed UNFPA “that if the rules of the game implied no communication on the project except through one channel (i.e., UNFPA) this would be a non-starter.”<sup>218</sup> Moreover, the Bank wanted to discuss donor coordination arrangements only after it had appraised a specific project.<sup>219</sup> However, what was really at stake was expressed in a separate Bank memorandum. This memo alleged that “Dr Sadik [of UNFPA] was trying to indirectly suggest that UNFPA be treated as the ‘sole channel of communication’ between the government and the donors for a joint project financed by different agencies.”<sup>220</sup>

According to the memo, the proposition was unacceptable as “the Bank would like to have direct influence on the development of the program as well as on the operation of the project through its project package and agreements.”<sup>221</sup> The Bank was also irked that UNFPA would provide funds “for the preparation of a longer-term plan for financing by UNFPA and other donor agencies... This type of proposal might conflict with the Bank’s overall approach and financing plan already discussed with the Government. As UNFPA has little control over other donors or agencies of the UN System, their planning will tend to be lopsided and be the result of responses to agency pressures.”<sup>222</sup> The memo concludes with the suggestion that Bank experts prepare a national population plan for

Bangladesh so as to pre-empt the UNFPA initiative.<sup>223</sup> Accordingly, the Bank wrote to the Government one week later proposing a Bank mission to Dhaka which would “offer a financing plan that may serve as a basis for assistance by interested bilateral and multilateral agencies.”<sup>224</sup>

In March 1973, there were differences of opinion over aid coordination arrangements for the sector. While the Government proposed that donors be coordinated in Dhaka through a consultative group arrangement, which was supported by UNFPA, the Bank was opposed since it was not yet in a sufficiently strong position to be assured leadership and did not trust this task to UNFPA. Both agencies, however, foresaw the potential of a national plan to provide a vehicle for coordination and leverage and were, therefore, competing to have their own consultants assist the Government with its preparation of such a plan. By July 1973, when the Bank’s sector-cum-appraisal mission had taken place, UNFPA and the World Bank had more or less decided to go their own separate ways. UNFPA had made recommendations to the Government concerning which projects it would assist and the Bank was considering a three-year project. According to the Bank’s project issue paper<sup>φ</sup>: “since the project period is short and the country needs immediate financing of large magnitude, it is proposed to postpone a formal aid coordination between different agencies for a longer (second phase) project...Therefore, during the next three years the GOB may receive aid from donors for items not financed by IDA but no formal effort for aid coordination would be made.”<sup>225</sup> The report went on to suggest that there may still, however, be scope to involve donors in a Bank project over the longer term: “a sector report that will follow the appraisal report may form the basis of funding by different donors for a longer term project.”

For a variety of reasons, including inflation-related cost escalation, the Bank’s original project grew in size, duration and expense, leading the Bank to propose to the Government that cofinancing be sought from other bilateral funding agencies.<sup>226</sup> This decision was to set the stage for donor coordination through the Consortium mechanism (discussed in Chapter 5). The Bank explained to prospective cofinanciers, such as the IDRC in Canada, that “we would be playing the rôle of honest broker and coordinator and would not in any way be ‘telling individual donors what they would be expected to do.’”<sup>227</sup> Yet this tack put the Bank on a collision course with the Government and UNFPA. First of all, the Government wanted only those external agencies with funds earmarked for population activities, such as USAID and UNFPA, to provide aid to its

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<sup>φ</sup> These are short internal documents which justify lending operations to senior management.

population programme. Therefore, the Government informed the IDA that its involvement in the program should be minimal, that the Bank should seek to cofinance the project with UNFPA and USAID, and that aid from SIDA, NORAD and CIDA and other donors be used for purposes other than population control.<sup>228</sup> Second, UNFPA continued to reiterate to Government its desire to coordinate activities in the sector.<sup>229</sup>

The impasse was resolved over the short-term by the Bank and UNFPA agreeing to coordination exercised by the population planning section of the Planning Commission as proposed by the Government.<sup>230</sup> For its part, the Government conceded to UNFPA and the Bank the prerogative to support initiatives in the sector through distinct projects. It provided all other agencies, irrespective of whether or not they had dedicated funds for population, the freedom to support population activities. In practice, this arrangement resulted in minimal coordination of donors provided nominally by Government. The Bank's project officer suggested in an interview that the GOB was reluctant to assume a high profile rôle in donor coordination in the sector at the time because it felt itself to be too weak to coordinate donors effectively and because GOB officials were very concerned about taking decisions which might displease their superiors or any of the donors.<sup>231</sup> Given the prevailing vacuum, the World Bank achieved a modicum of coordination through its project which was cofinanced by five donor agencies (although it was unequivocal in its insistence that its financial contribution be of sufficient magnitude to permit it a leadership rôle in the project).<sup>232</sup> Both UNFPA and USAID continued to operate relatively independently of each other and other actors in the sector. Referring to disagreements among donors during the protracted preparations and negotiations over the first World Bank and UNFPA projects, Jack Parkinson (then IMF representative) writes, "the inter-agency bickering among external donors and organisations resembled a situation of the blind leading the blind in comparative ignorance."<sup>233</sup>

Although an uneasy truce had been agreed, problems remained. On the 25<sup>th</sup> of January 1974, UNFPA convened what it intended to be the first of a series of annual meetings in New York for donors interested in the population programme of Bangladesh. At the meeting, UNFPA announced the appointment of a resident UNFPA coordinator to be posted to Dhaka by March 1974. This officer would meet frequently with Government and donor representatives to "clarify the funding picture for population activities in Bangladesh."<sup>234</sup> That the UNFPA coordinator "play a central rôle in coordination of assistance" was supported by donors such as SIDA.<sup>235</sup> Presumably by some pre-arrangement, at the meeting, the Ford Foundation proposed the formation of a local technical committee which was endorsed by USAID and UNFPA. The Bank, while



agreeing in principle to field level exchanges of information, cautioned that the committee's formation be subject to Government support and prior approval due to "GOB sensitivities to donor coordination and the known desire of it to be the central coordinator."<sup>236</sup>

The Government was indeed opposed to regular meetings of donors. According to a back-to-office report from a Bank mission to Dhaka in April 1974, Nurul Islam, Deputy Chairman of the Planning Commission, informed the Bank that it saw "no special reasons for regular meetings of representatives of donors in Dhaka as suggested by the Ford Foundation." He argued that the office of population planning in the Planning Commission provided sufficient coordination of donor involvement in the programme.<sup>237</sup> Despite Government sentiments, the report continues: "It seems that Ford Foundation has strong views on such a meeting and suggested that it might organise and chair these meetings if the Government fails to do so." UNFPA decided to pre-empt the Ford Foundation and took the lead with respect to organising local meetings. The report of the acting UNFPA country director on the first six months of work (i.e., from May to November 1974) notes "an informal donor's meeting, now to be held every month on a rotating basis among donors to the Government's programme, was organised, in cooperation with the Ford Foundation and USAID in Dhaka."<sup>238</sup>

Although UNFPA was, by virtue of having a member of staff on the ground, in a position to initiate informal donor's meetings, its monopoly over these meetings did not last very long. While the Bank had intended to postpone organising meetings for the sector until it was able to station an official in Dhaka to handle population issues, appointing a suitable candidate became a protracted process. Consequently, the Bank convened, purportedly at the request of several donors (only USAID is explicitly named), on 25 November 1975, the first meeting of a 'population sub-group' under the Bank's Local Consultations Group.<sup>239</sup> In contrast to the UNFPA meetings, which included only a very narrow range of donors (i.e., UNFPA, USAID, Ford, and the Bank), the population sub-group of the Bank's Local Consultations Group included both a much larger group of interested donors<sup>k</sup> as well as Government officials. What further differentiated these meetings from those organised by the UNFPA, according to the Bank's perception, was that the latter were "informal shop talk" in style, with a "random exchange of information" and with "relatively little organised discussion."<sup>240</sup>

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<sup>k</sup> The population sub-group included UNDP, IDA, UNFPA, UNICEF, WHO, USAID, Australia, Canada, Germany, Sweden, Norway, Iran, Japan, Saudi Arabia and the Ford Foundation.

Shortly after the first meeting of the population sub-group, the Washington office of the World Bank informed its Dhaka office that it had received an “informal complaint from UNFPA re Bank usurping their rôle through calling this meeting. Another donor also asked questions.”<sup>241</sup> Given the very different nature of the two fora, the Bank was readily able to justify the purposes that its meetings served. When the Dhaka-based UNFPA coordinator affirmed the value of the meetings and provided her support for their continuation,<sup>242</sup> Nafis Sadik, of the UNFPA headquarters, conceded “that since a decision has been made by the IBRD to hold inter-agency meetings regarding the implementation of its own programme, UNFPA welcomes and appreciates the invitation extended to our Coordinator to participate.”<sup>243</sup> What it is important to note, however, is that Sadik only conceded to the Bank the holding of meetings regarding ‘its own programme,’ not the entire population programme.

This case suggests that coordination may be less concerned with the purported aims of rationalising external assistance to the Government’s programme, than with the desire among competing agencies for hegemony over sectoral developments. It could be argued that this two year rivalry used aid coordination as a pretext for gaining leadership and control. Indeed, the Bank’s own Performance Audit Report of its First Population Project issued in June 1986 commented “While the need for coordination was clearly recognised, agencies such as USAID, UNFPA, WHO and later UNICEF, funded their own projects, as differences of opinion arose between the Bank and these agencies about...who was to provide leadership.”<sup>244</sup> In their struggle, the organisations used a number of mechanisms, nominally designated to facilitate aid coordination, to serve their cause, including: (1) preparation of national operational and financing plans; (2) establishing a presence at the country level; (3) taking a lead agency rôle vis-à-vis other donors; and (4) organising formal and informal meeting arrangements.

## 2.9 Chapter summary

- Since independence, aid has formed an integral component of the country’s public expenditure programme. This has provided donors with an influential voice in consideration of the Government’s internal affairs and has necessitated the evolution of aid and donor coordination instruments.
- The political and administrative arrangements prevailing over the course of the country’s history are likely to have given donor agencies the impression that the Government did not know its own affairs best, that it served interests and objectives other than those of the aid agencies, and/or could not be trusted to use the external resources

placed at its disposal to their most judicious advantage. These considerations are likely to have influenced donor thinking in relationship to the desirability and feasibility of relinquishing leadership in the management and coordination of aid to the Government.

➤ Weak Government capacity has provided a long-standing and ongoing justification for strong external leadership over aid coordination. Attempts to improve Government capacity to manage aid have neither been sufficient nor effective in adequately augmenting the capacity of the Government to displace the negative perceptions held by donors.

➤ Civil servants represent a primary beneficiary group of donor assistance. They tend to adhere to protectionist attitudes toward the existing power configuration, which usually benefits special interest groups, themselves included. Any reforms to aid coordination which might reduce their discretionary authority, privilege and/or rent-seeking opportunities would likely be resisted.

➤ There has been a shift in the donor agenda in the health sector from a preoccupation with population control at-any-cost (including duplication or blanketing of services) to sectoral reform, with an emphasis placed on efficiency, effectiveness, systemic concerns and systems losses. This shift has likely changed donor attitudes and expectations with respect to aid coordination.

➤ The fact that the agenda in the health sector has been influenced and, often, largely set by donor interests and priorities is likely to have undermined the perception that Government could lead donor coordination.

➤ Both aid agencies and the Government of Bangladesh have understood from the very beginning of their relationship that aid coordination is a powerful tool with which to exercise leverage over the development process. This consideration has likely coloured their desire to lead coordination processes and conditioned the extent and manner of their preferred involvement in various coordination arrangements.

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## CHAPTER THREE

### **The Government and aid coordination: unable, unwilling or undermined?**

#### **3.1 Introduction**

This Chapter describes the principal Government-led instruments through which attempts were made to coordinate external assistance between 1972 and 1997. An overview of the responsibilities held by the overarching institutions is presented along with how these have changed over time. In addition, the modalities of policy-making, planning and project approval are discussed in relation to the contribution they make to aid coordination. The limitations faced by the Government are explored from both donor and Government perspectives. Emphasis is placed on identifying the behaviour and exigencies of external agencies which have impaired the ability of Government-led initiatives to fulfil their potential.

Although policy and planning is at the centre of this Chapter, it does not follow that effective policy and planning necessarily leads to improved aid coordination. In particular, the ‘rationalist’ notion that a linear and sequential policy making and planning process will lead to the development of ‘optimal’ plans<sup>2</sup> into which all parties will contribute resources in an orderly manner is not being acclaimed. Indeed the thesis is informed by the school of thought which argues that policy-making is in practice ‘incremental’ and about ‘muddling through.’<sup>3</sup> Moreover, this research acknowledges the perils and frustrations of policy implementation<sup>4</sup> and the failure of much health sector planning in practice.<sup>5</sup> Despite these limitations, the Chapter is concerned with policies and plans for two reasons: (1) they constitute the principle arsenal at the disposal of Government to coordinate aid; and (2) according to the principles upon which the conceptual framework of this thesis is constructed, they *ought* to provide *the* basis for aid coordination.<sup>6</sup>

#### **3.2 Government institutions for aid coordination: the Planning Commission and the ERD**

When the Planning Commission was constituted in January 1972, it was conceived of as a ‘super-ministry.’ The Prime Minister selected its leadership from among “those who were his closest advisers during the liberation struggle.”<sup>7</sup> Consequently, the top echelon of the Commission, the Deputy Chairman and its three academic members, was drawn from outside the civil service. The Minister of Planning served as the Chairman of the

Planning Commission and the other members enjoyed the status State Ministers. The Chiefs of the ten divisions of the Commission were granted the designation of Secretary (i.e., the highest ranking civil servant). At the outset, the posts of Minister of Finance and Minister of Planning were filled by the same individual, which vested great authority in the chairmanship. In early 1973, the Prime Minister took over the Planning portfolio, thereby assuming the Chair and elevating the status of the Commission higher yet.

The delineation of the functions and organisational structure of the Commission was left to the leadership of the Commission. According to the Deputy Chairman, these were approved by Cabinet “without any serious discussion or debate,” presumably because the Ministers and the bureaucracy felt that the composition of the Commission was imposed by the overwhelming authority of the Prime Minister himself.<sup>8</sup> Among its functions, the Commission was “to prepare national plans, annual, five-year and perspective [i.e., long-term], ... in accordance with the socio-economic objectives of the Government” and “to determine external aid requirements and negotiate the total quantum and composition of aid required.”<sup>9</sup> The Planning Commission was thus vested with exclusive responsibility for aid coordination.

Executive responsibility for aid negotiation and management was vested in the External Resources Division (ERD), one of the ten divisions of the Commission. It was reasoned that an administrative arrangement, wherein the ERD was situated within the Planning Commission, would provide good links between the related processes of planning, budgeting and external resource mobilisation and allocation. The ERD assumed a high profile during the era of President Mujibur Rahman by virtue of the fact that the Chief of the ERD exercised a dual rôle as Secretary, Ministry of Planning (and thus also Secretary, Planning Commission) and as Secretary of the ERD. Substantive knowledge of the sectors resided within the other divisions and sections of the Commission which facilitated the linkages between domestic planning and aid allocation by the ERD.

During the course of the Mujibur administration, aid coordination for the population sub-sector was delegated to the Chief of the family planning section of the Planning Commission. It performed this function, at least in the eyes of the Commission’s members, satisfactorily.<sup>10</sup> During the period a number of attempts were made by the section Chief to promote donor coordination. The record states, for example, that the Chief made repeated requests to both the Bank and UNFPA that they consider inclusion of one another’s staff in their respective project appraisal and supervision missions, that other donors join in these as well, and donor consensus be forged through the production

of joint aide-memoires. "He [the Chief] feels that this will lead to better coordination between the two agencies in project identification, funding and implementation. He has stressed the need for such meetings held during McNamara's visit."<sup>11</sup> Yet, the authority which the section could wield over the donors to ensure coordination was undermined by the views and interests of the aid agencies themselves.

### *3.2.1 Donor challenges to the Planning Commission's authority over aid coordination*

First, while the donors acknowledged, at least rhetorically, the pre-eminent rôle of the Planning Commission in aid coordination, the perception persisted among donors that the Commission had a limited ability and willingness to coordinate.<sup>β</sup> The second factor which undermined the Commission's ability to coordinate donors lies in their constant meddling in the organisation of the Government's machinery. For example, while the Bank "agreed that any IDA financing needs to take place within the framework of the Government's policy of being sole coordinator of external assistance in the field of population,"<sup>13</sup> it had its own ideas about how this should take place. The Bank proposed, as a negotiating pre-condition for its First Population Project, that a new division within the Planning Commission be established for donor coordination.<sup>14</sup> The Government, however, decided against setting up a new division in the Commission and opted instead to establish a 'population planning division' within the Ministry of Health and Population Planning and to delegate to it some coordination functions previously held by the Commission. The Bank informed other donors that it saw "no alternative but to accept this decision for the present; we will, however, propose the establishment of a small project unit in the Planning Commission which would carry, intentionally, rather fuzzy terms of reference."<sup>15</sup> Consequently, following a meeting of the prospective cofinanciers, the Bank informed the GOB that: (1) all donors agreed with the IDA proposal to establish a unit in Commission; and (2) its head be appointed only after consultation with donors.<sup>16</sup> These became key issues during project negotiations which were eventually resolved with the donors backing down on both.<sup>17</sup> The example illustrates the extent to which donors attempted to dictate to Government the administrative arrangements which should govern aid coordination. Given the internecine warfare which prevailed within the public administration at the time,<sup>χ</sup> such interference must have placed tremendous pressure on

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<sup>β</sup> For example, according to a Bank memorandum regarding a conversation between Bank staff and a high level SIDA official in 1973, SIDA expressed concern that "the Planning Commission has played a passive rôle in either developing the program or obtaining assistance from the donors."

<sup>χ</sup> Rivalry and factionalism in the three major institutions in post-independent Bangladesh (i.e., bureaucracy, political parties and army) have been widely acknowledged (e.g., R Jahan, 1980).

the individuals and institutions which were not favoured by the donors which in turn may have limited their abilities to carry out their intended briefs.

Perhaps the greatest challenge to the Commission's ability to coordinate donors was the direct one posed by donor interest in taking over the coordination arrangement from Government. Section 2.8.2 of the preceding Chapter provided a brief account of how UNFPA and the Bank jostled to attain a leading rôle. Although both donors conceded leadership to the Government, both envisioned a substantive rôle for themselves.<sup>18,19</sup> The Bank emerged as the convenor of a population sub-group of the aid consortium as well as the lead donor for a large multi-donor project and thus the *de facto* coordinator. In light of the resources and leverage which donors commanded relative to the beleaguered Government, it is not surprising that the Government's rôle fell victim in the process.

### *3.2.2 Internal challenges to the Planning Commission: the ERD takes over aid coordination*

The Planning Commission's rôle in aid coordination was challenged from within Government as well. Towards the end of the Mujibur regime, the vanguard position of the Planning Commission as a super-ministry was under threat.<sup>20,21</sup> In 1976, after the assassination of Mujibur Rahman, the privileges of rank were removed from the Planning Commission and the ERD was taken out of its executive jurisdiction. The reorganisation saw the Ministry of Planning separated into two divisions: Planning; and External Resources (ERD). This separation made the ERD a more autonomous division, effectively severing its close ties with the members and divisions of the Planning Commission. Through this process the ERD's commitment to policies and programmes arising out of the planning process diminished while enabling the ERD to enforce its own priorities through the aid negotiation process.<sup>22</sup> The bifurcation of responsibilities was reinforced in 1978 when the ERD was moved from the Ministry of Planning to become a division under the Ministry of Finance. This surrender of control of the ERD removed, in the eyes of Bangladeshi academic, Rehman Sohban, "a major sanction from the arsenal of the Planning Commission...with which to influence the effective utilisation of aid and to see that development priorities decided at the time of the Annual Development Plan were adhered to."<sup>23</sup>

In the 1990s, formal responsibility for aid coordination continues to be vested in the ERD, Ministry of Finance. Its main responsibility involves mobilising and negotiating aid flows with donors to ensure that aid is provided on terms that are in the best interest of the economy. In addition, the Division prepares the GOB's memorandum for the Annual



Consultative Group meeting in Paris and is the contact point for the Local Consultative Group of donors in Dhaka. The ERD is involved in the negotiation of individual projects at the request of the concerned line ministry.

The extent to which the ERD is involved in sector-level aid coordination is, however, minimal. First, the ERD is less concerned with sectoral programmes than with traditional project finance. Second, because the ERD's organisational structure corresponds to the source of aid, as opposed to line ministry functions, knowledge of sector needs and priorities is at a premium. Limited understanding of the sector constrains the ERD's ability to assist the MOHFW in coordinating aid in support of a sectoral strategy. Moreover, ERD's aim of maximising aid has predisposed it to supporting all external investment regardless of whether or not it might be duplicative of other assistance. In the study's survey, the ERD was thought to perform an adequate function with respect to aid coordination by only 2 of the 9 donor respondents and none of the Government officials.

The ERD is also concerned about the lack of aid coordination, but considers itself relatively powerless to effect it. For example, in a meeting between senior ERD and Bank staff, the Secretary commented that the design of the Bank's Third Population and Family Health Project was "faulty...because the project was put together on the basis of ideas developed by different donors." Moreover, according to the Secretary, USAID's contribution to the sector should also have been incorporated into the larger umbrella project.<sup>24</sup> In discussions in 1988 preceding the formulation of the Bank's Fourth Population and Health Project, the ERD again expressed its desire that the Bank incorporate USAID's contribution under the project, but the Bank wrote: "for the moment we declined this request."<sup>25</sup> Eventually American assistance took place outside of the coordination of the Consortium initiative.

### 3.3 Policy frameworks and aid coordination

*Government decision-makers are responsible to no-one and do not have to justify, defend, or explain their actions. Decisions are taken in secrecy by a small group of people and then announced in the form of an ordinance.*<sup>26</sup>

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Policy can be thought of as "determining the routes to be travelled and the destinations, while planning establishes the means whereby the terrain is to be traversed."<sup>28</sup> As such,

policy frameworks may ideally provide a number of potential avenues through which aid can be coordinated – for policies may be developed through consultative processes whereby consensus among stakeholders on priorities and goals emerge, they may be linked to decisions regarding aid allocation, and they may set out the instruments and institutional arrangements which governments and donors alike will employ to achieve the broad policy objectives.

These ideals have not obtained in the health sector in Bangladesh. A well-articulated health policy has never existed. Instead, the sector has been governed by priorities which have been set by default – driven, in an *ad hoc* manner, by domestic interests and donors acting individually or collectively. These priorities have rarely been widely ascribed to. A number of attempts have been made to arrive at a comprehensive national health policy, but none has yet succeeded.

The processes of policy making in Bangladesh have been criticised on a number of counts. First, too little appears to be known about how it works. One Bangladeshi academic noted that “...it is difficult to find a well researched case study of the processes underlying policy formulation in the country. Who makes policies and how is a mystery even to the most well-informed citizens. The mystery breeds suspicion, allegation, and misinformation.”<sup>29</sup> Others question the quality of decision-making. Quality suffers, in part, because those designated to formulate policy are seemingly too busy or averse to doing so. “Empirically, it has been observed that the ministries in the Secretariat are often busy with administrative and regulatory issues – the issuance of a licence or the posting and transfer of a clerk or peon. As a result, relatively less time is spent on policy formulation and planning.”<sup>30</sup> It has also been argued that decision-makers are not adequately equipped for the task. The World Bank, for example, cautioned that: “policies are likely to fail since they are not underpinned by sufficient analytical evaluation. Those engaged in formulating policy often lack the technical skill, and fail to carry out the painstaking research needed to explore the potential impact of alternative policy directions.”<sup>31</sup> In light of the constraints imposed upon and by the civil service which were described in Chapter Two (sections 2.5.3 and 2.5.4) the deficiencies in policy formulation could be expected.

Implementation of policies is similarly problematic. Hogwood and Gunn propose ten preconditions which must obtain if a policy is to achieve its objectives.<sup>32</sup> In the health sector in Bangladesh, few of these are present (e.g., objectives are widely agreed to; those in authority can demand and obtain compliance, etc.). In part, slow or inadequate policy

implementation can be traced to the concentrated nature of the decision-making circle which results in shallow support or resistance to policy uptake. It has also been suggested that because the policies which do emerge are generally set so broadly, their interpretation and implementation can be easily manipulated to suit the needs of powerful individuals and groups.<sup>33</sup> Another problem relates to the “widely held belief in the lack of integrity of Government, [which makes it] difficult to muster support for its policies or to generate the conviction that they were not conceived in the personal interests of individuals.”<sup>34</sup> Others have noted that “the donors, especially the World Bank, appear to be in the driver’s seat” in so far as policy formulation is concerned.<sup>35</sup> The Bank acknowledges its dominant rôle in the policy process and specifically that “most people perceive government policy announcements as a response to donor conditionalities rather than a genuine commitment to change.”<sup>36</sup> Foreign sponsorship and ownership of policy is likely to weaken the loyalty held by the administration towards it. Variants on all of these issues are evident when the *de facto* policies of the health sector are examined.

### 3.3.1 *Whose population policy?*

The country’s first population policy (1976) provides a fitting illustration of donor involvement in initiating a policy, playing a significant rôle in defining its content, and, consequently, forming its primary constituency. During the course of formulating the initial World Bank/cofinancier population project, the donors became increasingly concerned about the Government’s low level of interest in fertility control. As the time of project negotiations drew near, the Bank felt that Government commitment was “the over-riding concern on the part of most other donors.”<sup>37</sup> As a result, at the final meeting of the cofinanciers prior to project negotiations, “the donors wanted IDA to tighten up on several of our [Bank] proposed negotiating conditions, in order that the Government’s agreement could be taken as a sign of commitment.”<sup>38</sup> This in spite of the fact that the Bank noted that it and other donors were concerned that they were ‘committing’ the GOB to a population programme which “they may be both unwilling and unable to sustain.”<sup>39</sup> Upon completion of negotiations, the donors were pleased that their objectives had been seemingly met; the new administration had demonstrated its commitment through signing the credit agreement (i.e., taking a loan to curb population growth) and had declared population as the country’s number one problem.<sup>40</sup> The Americans, although not party to the IDA project, attempted to take some of the credit, by claiming that “USAID agitation, among other things, has prompted a welcome series of actions and statements on population by the Bangladesh Government... These beginnings need to be pressed forward vigorously and continuously both as imperative for Bangladesh and as a necessary demonstration to the donors.”<sup>41</sup>

One of the actions for which donors pressed was the promulgation of a national population policy. The donors, therefore, were pleased when President Sayem reconstituted the National Population Council after the change of Government. At the third meeting of the Council, on 25 June 1976, with the President in the chair, the Additional Secretary, Ministry of Health, Population Control, Labour and Social Welfare, presented “an outline of a proposed population policy for Bangladesh...the proposals were based on a draft policy paper *prepared for him* jointly by me (Dr Pisharoti, Resident Population Expert, Dhaka, World Bank), Dr Penny (UNFPA), Sathianathan (WHO advisor to Ministry of Health) and M Jordan (USAID).”<sup>42</sup> Notwithstanding the fact that the donors had written the draft policy outline on behalf of the Government, the Bank made it clear that it additionally expected that its expert would continue to work “closely” with the Ministry to finalise the “details” of the policy.<sup>43</sup>

Despite enactment of the national population policy in 1976, donors, unsurprisingly, were anxious over the degree to which the Government was committed to its implementation. This concern was expressed in terms of questioning the adequacy of the financial allocation made by the Government to population activities (raised explicitly by the World Bank, UNFPA, USAID, Australia, and Germany and perhaps others as well),<sup>44,45</sup> threats by the Bank to withhold “resources to the population program, unless the current trends observed in the decline of dedication, lack of discipline and inadequate performances are reversed,”<sup>46</sup> repeated complaints about inadequate implementation of the programme,<sup>47</sup> and, in particular, over poor implementation and disbursement on the first Bank cofinanced project.<sup>48</sup> Concern persisted into the late 1980s over the perceived lack of strong political commitment to the population programme,<sup>49</sup> so much so that the Bank observed that “we [the Bank] need to walk carefully to avoid giving the impression the program is more important to us than to the Government.”<sup>50</sup>

It is unlikely that the country’s population policy had any great influence on aid coordination at the time or subsequently. Donors’ decisions regarding strategy, investment priorities and favoured organisational design had preceded the articulation of the policy and, as indicated in Chapter 2, had been made relatively independently of each other and the Government. Moreover, foreign sponsorship of the policy had the effect of dampening domestic interest in utilising it as a common framework for joint action. The development of a health policy was beset by similar problems, limiting again any utility which may have been served as far as aid coordination was concerned.

### *3.3.2 A national health policy or a donor health strategy?*

The first official statement of health policy appeared in the First Five-Year Plan (1973-78).<sup>51</sup> It emphasised a shift from curative urban-based care to a comprehensive rural-oriented system. Ten broad, ambitious, and, with hindsight, unrealistic objectives were set. By December 1978, as implementation of the First Population Project of the Bank and its cofinanciers floundered, the Bank commented on the “urgent need for a health policy statement taking the changes since 1973 and the current socio-economic and political environment into account.”<sup>52</sup> At the time, other donors, such as Sweden, concurred with the need for the Government to formulate a health policy.<sup>53</sup>

In 1982, the expert committee established to develop a National Drugs Policy indicated that its implementation should only take place within the context of an comprehensive national health policy.<sup>54</sup> However, it was not until five years later, in March 1987, that a four-member presidential committee was appointed to formulate such a policy. The committee did not include any serving MOHFW officials but did include Dr Zafrullah Chowdhury, the principle architect of the country’s radical drugs policy, and Professor M Yunus, the economist-founder of the world-renowned Grameen Bank.<sup>55</sup> In August 1988, after 16 months of deliberations, the committee presented its report to the President. The proposed policy was not debated in Cabinet until almost one year later, in July 1989, and only after another six month delay was an outline of the policy presented to Parliament, in January 1990. The health policy was finally introduced as a bill in Parliament in July 1990 – to be enacted on October 17<sup>th</sup> if the bill was passed.

As the proposed policy threatened the interests of the medical establishment, the Bangladesh Medical Association called an immediate national 72-hour strike by all physicians against what it termed ‘an anti-people policy.’ The Association had refused to meet with the committee during the earlier consultation period and had chosen instead to put forward a 23 point charter of demands as its contribution to a national health policy.<sup>56</sup> According to the World Bank, these amounted to little more than a list of job-related demands aimed to improve the lot of the physicians themselves, not the health of the country. Nevertheless, given the wide-spread and, increasingly, violent opposition to the eight-year old regime of President Ershad, the medical profession was not only able to sabotage the national health policy, but was thought to have been an important element in the political equation which resulted in the toppling of the Ershad Government in December 1990.<sup>57</sup> Consequently, on the first day of the interim Government, the national health policy bill was cancelled by the acting President.<sup>58</sup>

By the early 1990s, donor calls for a national health policy became more frequent and insistent. Donor interest in the existence of such a policy took on a new dimension presumably as a result of three factors. First, as noted in Chapter 2 (section 2.7), aid agencies had by this time become more involved in health activities as they made the link between contraceptive uptake and the quality and availability of MCH services. Second, donor involvement in the sector began to encompass systemic issues (e.g., financing reforms), which required broader analyses and interventions across the breadth of the sector. Third, it had begun to dawn upon donors, particularly the Bank and not exclusively in Bangladesh, that aid was highly fungible – which meant that their investments in the sector were not necessarily additional to what Government might invest, but more likely substituted for Government spending (in practice, donor investment in primary health care enabled the Government to finance activities which were of lower priority to the donors). The recognition of these factors led to donor demands for comprehensive, sector-wide policy and spending plans. Donor concern was expressed to the Government in statements such as the following from a Bank/cofinancier supervision mission of their Third Population and Family Health Project (TPFHP) in 1991: “The Mission considers the absence of a declared National Health Policy in Bangladesh a serious setback to the development of the population and health sector. It urges the Government to evolve a comprehensive health policy...”<sup>59</sup>

In October 1993, the Government of Khaleda Zia began formulating a National Health Policy (NHP). The donors, as represented by an IDA/cofinanciers mission expressed their support because of “the fact that the sectoral strategies and investment priorities have been evolving over the last two decades dictated by circumstances.”<sup>60</sup> A group established by the donors to review the IDA/cofinancier Fourth Population and Health Project (FPHP) went so far as to acknowledge that “the absence of a health policy to guide strategies and prioritisation of activities fosters a situation in which the donor’s priorities and inputs to the sector, in practice, become the health policy.”<sup>61</sup>

As had been the case with the population policy, donors wanted to ensure that their interests were reflected in the NHP. Therefore a supervision mission of the FPHP proposed to the Government that “a preliminary mission from the Bank...initiate a dialogue on a detailed review of the sector, which would provide the technical basis for carrying the policy forward.”<sup>62</sup> By December 1993, the Government reported that its thirty member, “high powered committee had met twice.”<sup>63,64</sup> The Bank provided the committee with a policy framework which it had drafted for the Government’s

consideration and informed the MOHFW that “in order to translate the policy into a program of action, the application of the guiding principles outlined in the framework would require a robust base of valid and relevant information about the sector.”<sup>65</sup> Hence, the Bank proposed that it carry out a sector review which would provide recommendations on prioritisation of investments, *inter alia*. It was the Bank’s opinion, that “in the absence of the review, the policy, even if it incorporates the guiding principles contained in the [Bank’s] suggested framework, may not have a substantial basis for becoming a reality.”<sup>66</sup> By this the Bank presumably referred to the fact that the policy would not enjoy donor confidence and, therefore, support unless donor views were adequately incorporated in the policy. The MOHFW had, however, unspecified reservations concerning the conduct of the review.<sup>67</sup> By February 1995, the Bank-led Consortium expressed its concern over the delay in formulation of the NHP - and was informed that the Government had changed its strategy and was now opting for a “health programming exercise conducted through holding of workshops with technical people.”<sup>68</sup> Time was, however, running out for Khaleda Zia’s Government which, facing a protracted show-down with the opposition groups, forestalled, among other things, progress on the health programming exercise.

Donors continued to feel the need for an overarching document setting out the Government’s goals and priorities for all investment in the sector, yet they had become more aware of the difficulties inherent in putting a policy in place. For example, a CIDA official wrote that the Canadian High Commission was “concerned with lack of clear GOB health and population policy but felt that much of this resulted from conflicts between medical association and former Ershad regime.”<sup>69</sup> The doctors had been on strike again in early 1994.<sup>70</sup> According to an interview with a Bank official, the donors increasingly viewed the formulation of a health policy as too volatile, complex and time consuming for their participation.<sup>71</sup> Hence, the Bank opted to explore the idea of a sector strategy instead. Its annual supervision mission in November 1995 “informed the Government that a well thought out sector strategy needs to be developed and that the Bank will undertake to do the work in partnership with the Government.”<sup>72</sup> The existence of a Health and Population Sector Strategy (HPSS) became a pre-condition for further Bank lending to the Government in the sector.

In November 1996, the new Government of Sheikh Hasina established yet another committee to prepare a National Health Policy. The donors had some reservations regarding the manner in which the policy was to be formulated. WHO, for example, expressed its opinion that the time frame was unrealistic (i.e., 6 months) and that

membership of policy group was unduly balanced towards hospital physicians.<sup>73</sup> The FPHP Consortium was apprehensive because 4 out of the 5 members of the committee were clinicians and that the Secretary, MOHFW, was not a member.<sup>74</sup> However, the donors' approach to the issue differed from their previous reactions; instead of making great ado over these problems, the donors chose instead to impress upon Government that the NHP should be modelled on the strategy document for the sector which the Bank was taking the lead in developing.<sup>75</sup> Minutes of one Consortium meeting urged that "the Consortium should take a pro-active approach in ensuring that the National Health Policy is consistent with the Health and Population Sector Strategy."<sup>76</sup>

While the Government's exclusive committee articulated a National Health Policy, the parallel exercise of strategy development became the principal focus of donor and MOHFW attention. The major concern of many donors was that the Bank's strategy should not substitute for a Government vision and policy for the sector. Within a FPHP Consortium meeting "an anxiety was expressed that unless the GOB was at the centre of the process [of HPSS preparation], and not merely consulted at the draft stage, the Consortium may again end up with a project/program which contains donors driven strategies, that without adequate Government ownership made for poor implementation ... The Consortium should not run faster than the GOB as such an approach could be detrimental to the process of sustained development."<sup>77</sup> The European Union members of the FPHP Consortium, alarmed that the Bank was usurping Government leadership over policy formulation, took the unusual step of expressing their opinion to senior Bank management that exclusive focus on the HPSS would entail "that the lack of [health] policy... will not be seriously addressed."<sup>78</sup> CIDA also wrote to the Bank: "We are preoccupied first and foremost with the ownership of the HPSS which must be with the GOB."<sup>79</sup>

Thus as it dawned upon the donors that there may come to exist, for the first time, an overarching document governing the allocation of *their* collective investments in the sector, they became less sanguine about how it should be developed. Even USAID, which operated outside of the Consortium, (see Chapter 5) informed the Bank that "we would like to reiterate our concern that the development of the HPSS remain as open and collaborative as possible with maximum GOB involvement and leadership of the process. This is critical since the HPSS will guide the development of the Bangladesh population and health sector for the next five years by all development partners."<sup>80</sup> Under pressure from most donors, the Bank evolved a more participatory process to develop the sector strategy which included senior MOHFW participation. According to a participant of the



multi-donor HPSS reconnaissance mission, “it was apparent to most that the Government is prepared to go along with this sector strategy in order to develop the next project as quickly as possible.”<sup>81</sup> By August 1997, the Government had officially endorsed the Strategy as its own.

The Secretary, MOHFW, gave the Bank and its cofinanciers the assurance that elements of the HPSS would be incorporated in the national health policy.<sup>82</sup> When this research was completed at the end of 1997, the donors were still asking to review the yet unreleased draft NHP.<sup>83</sup> Donor investment decisions had, by then, however, already been made on the basis of the HPSS document. The policy was, therefore, increasingly superfluous to them and of little utility to the cause of aid coordination. It remains to be seen the extent to which the donor inspired health strategy is of any greater value in so far as coordination is concerned (see Chapter 6).

### 3.4 Planning processes and aid coordination

*Donors are critical of many aspects of Bangladesh administrative performance, but are insufficiently sensitive to the administrative consequences and costs resulting from the complexities of the aid system itself.*<sup>84</sup>

B. Van Arkadie & K. de Wilde, 1984

The planning process can, and should, provide a powerful instrument through which external resources can be harnessed in support of a country's policy objectives. In Bangladesh, the absence of a formal health sector policy further elevates the potential rôle of the planning machinery. Under the direction of the Executive Committee of the National Economic Council (the highest political authority for development activities, chaired by the Prime Minister), the Planning Commission prepares the country's development plans. Based on these plans, the Commission is responsible for allocation of resources between sectors and for an assessment of external aid requirements in consultation with ERD and the line ministries. In addition, the Commission reviews all externally aided project proposals formulated by the line ministries, recommends allocation of funds to projects within each sector, and prepares a list of 'aid worthy projects' for presentation to the donor community.

The General Economic Division of the Commission is responsible for organising and managing plan preparation activities. This Division writes the plans' macro chapters, whereas the sectoral chapters are the responsibilities of the sector divisions of the

Commission. These divisions establish task forces of relevant experts, drawing upon the concerned ministry and directorates as well as outside bodies, to provide various inputs into the planning process. The sector chapters tend to follow a set format<sup>a</sup> and are each followed by a lengthy portfolio of projects envisaged to enable plan targets to be met.

In 1973, the Commission developed a 20 year Perspective Plan covering the period 1975-95 and the first of a series of Five-Year, and Annual, Plans (Table 7). “The broad outlines of strategies and policies enunciated in the Five-Year Plan became matters of hard choice and policy decision in the course of the Annual Plans. They specified, appraised and evaluated projects and programmes for inclusion in the annual development programme.”<sup>85</sup> The Annual Development Programme, formulated by the Commission in conjunction with the Ministry of Finance, specified, within the financial envelop set in the Five-Year Plan (FYP), expenditures on items and projects approved for inclusion as development expenditures. In theory, spending on externally aided projects could only take place once an activity was included in the Annual Development Programme.

**Table 7: Bangladesh’s Five-Year Plans**

Plan	Period	Comments
First Five-Year Plan	1973-78	* overly ambitious given poor implementation capacity, political turmoil, floods and world-wide inflation
Interim Two-Year Plan	1979-80	* planning undermined by spill-over of 1374 projects from First Five-Year Plan * ambitious targets not met
Second Five-Year Plan	1980-85	* Bank found health and population chapters of plan ‘unviable’ and ‘impractical.’ Therefore, Bank proposed priority investments for donor funding
Third Five-Year Plan	1985-90	* Bank ‘takes the lead’ to ‘translate plan into a national program’
Fourth Five-Year Plan	1990-95	
Fifth Five-Year Plan	1997-2002	* health and population sections overshadowed by HPSS document (developed independently and mainly by donors)

There was no shortage of plans to guide the deployment of aid in accordance with Government priorities. In addition to the Five-Year and Annual Plans, in 1990, a Three-Year Rolling Investment Plan was introduced. When the Fourth Five-Year Plan lapsed in 1995, a new FYP was not formulated, instead the Government embarked upon another planning exercise: the ‘Participatory Perspective Plan for Bangladesh 1995-2000.’ Shortly after Sheikh Hasina’s Government came to power, the decision was taken to reintroduce the FYP process beginning in July 1997.

<sup>a</sup> The general format was: introduction; review of past performance; financial progress; goals; strategies; programme components; other issues and measures; financial implications.

At times, the Planning Commission did attempt to utilise its plans to facilitate donor coordination. For example, World Bank correspondence records that “At Government’s request, a meeting of local consultations group was held today to hear presentation by Dr Sattar of Government’s population plan for the period 1978-85...This is the first attempt of the Government to sensitise the donor community of the character and extent of the plan proposal with view to encouraging their support.”<sup>86</sup>

Generally, however, there has been dissatisfaction with the planning process and, in particular, a consensus appears to have emerged between donors and the MOHFW that the Commission has yet to produce a sufficiently clear strategic policy framework and explicit expenditure plan to guide external investment towards nationally-defined needs and priorities. Government officials expressed the unanimous view that the Planning Commission was either irrelevant or inadequate in aid coordination in the health sector, a conviction which was shared by all but one donor.<sup>87</sup>

Donor, particularly World Bank, criticisms of Bangladeshi plans began early in the history of the population and health programme. Shortly after the Commission began work on the First FYP for population in 1972,<sup>88</sup> the Bank sent a mission to Dhaka. This mission found the Commission’s plan ‘unsatisfactory,’<sup>89</sup> and a later mission informed the Commission that “the Bank mission may have to assist [the Government] in preparing a detailed plan of action.”<sup>90</sup> The implication was that the Government’s plans were inadequate. Only months later, after the Bank’s First Population Project had been largely designed, the Bank reported that it would develop a ‘sector report’ which could form the basis for coordinated funding of the population programme by different donors.<sup>91</sup> The Population and Nutrition Project Division of the Bank prepared such a report.<sup>92</sup> In effect, the Bank not only found Government plans deficient, but adopted the stance that it could and should usurp this function from the GOB in order that aid could be programmed in a coherent fashion.

Close donor involvement in plan preparation continued during the subsequent planning cycles – partially as a reaction to donor perceptions of weak Government planning capacity, and partially because of the recognition of the power of plans over investment directions.<sup>93</sup> The dissatisfaction of the Bank with the Government’s Second FYP, led it to inform other donors that “we are in the process of preparing a detailed assessment of the requirements and constraints of the Bangladesh population program as a basis for judging which priority investments should and could be undertaken during the next seven years, irrespective of sources of financing.”<sup>94</sup> Similarly, in respect to the Government’s Third

FYP, the Bank noted that it had “taken the lead in helping the GOB develop and translate it into a national program.”<sup>95</sup> Later at a meeting convened by the Bank in Paris to discuss the Third FY Population and Health Program, the Norwegian delegation confessed confusion as to whom to address its concerns; the Bank or the Government.<sup>96</sup>

These donor responses to the FYPs set a precedent whereby donors found fault with Government plans and consequently worked together with the MOHFW, either bilaterally or as a small group, to develop plans which were suited to their own needs and purposes. It was, therefore, not unusual that in 1995, “The Chairperson [of the FPHP Consortium] made a reference to deficiencies in the perspective plan of the Government and said that a sectoral analysis was being undertaken for the next [Consortium] project.”<sup>98</sup> Nor was it remarkable that the donors would invest a relatively large amount of assistance (US\$ 1 million) to establish an expatriate-led project preparation cell (PPC) within the MOHFW to expedite planning of the IDA/cofinancier Fifth Health and Population Project (HAPP-5). One of major tasks of the PPC was to prepare a ‘Project Implementation Plan’ (a detailed plan covering all public sector activities under the purview of MOHFW for a five year period) so as to translate the donor-inspired Health and Population Sector Strategy into a set of concrete activities – some of which the donors would fund. The PPC undertook this work in isolation from the Planning Commission. The limited reference which donors made, in practice, to the Commission’s FYPs in shaping their own activities is reflected in the Bank admission that “both the first and second [Bank population] projects experienced problems because they came on stream a year before the Five-Year Plan allocations were made.”<sup>99</sup>

Yet the donors encountered problems when they attempted to circumvent the Planning Commission and forge their plans directly with the Ministry of Health and Family Welfare. These were principally due to the perceived lack of ability and willingness on the part of the MOHFW to undertake the time-consuming and difficult planning processes. The lacklustre response of the MOHFW may have arisen because formal responsibility for planning remained in the Planning Commission while that for donor coordination rested with the ERD. Inadequate MOHFW ownership of what it described as a donor-driven programme may have also been at play. Moreover, it was also widely held that the lack of human resources in the MOHFW was a limiting factor to effective planning. Although all 20 officer level staff of the planning cell of the MOHFW had a masters degree, and many of these from foreign institutions (see Annex 5), and despite the fact that a Health Economics Unit was established in the MOHFW under the FPHP, there remains a notable dearth of health planners and economists.

In recognition of the impediments to MOHFW leadership in planning, the donors adopted a two track approach but disagreed amongst themselves on which should take precedence: capacity development or encouraging symbolic MOHFW participation in planning exercises. Numerous aid agency missions, such as that for the mid-term review of the FPHP, recommended “strengthening MOHFW planning capacity.”<sup>100</sup> Another mission noted that “a number of specific recurrent problems need to be addressed in the medium-term: the overloading of the planning cell of the MOHFW with a lack of conscious grooming of competent people to provide continuity and institutional capacity in the long run;<sup>β</sup> the planning departments in the Directorates of health and family planning are weak and their planning rôles are not clearly understood or discharged...”<sup>103</sup> Yet, despite acknowledging the limitations to the MOHFW’s planning capacity, when HAPP-5 was under identification, the Consortium “felt it necessary to make a strong representation at this stage to GOB, to ask for the chief of the planning cell, with two senior representatives from the planning cells of the two directorates, to fully lead the planning process.”<sup>104</sup> During a later meeting of the same group, some donors felt that “GOB’s participation in the planning process needs to be more visual and the donor members should not be prescribing the nature and content of HAPP-5.”<sup>105</sup> The Bank took the view that “if the donors and technical advisors are providing support to articulate and make the project more sound, this should not be looked at as lack of ownership.”<sup>106</sup> Other donors, however, insisted on the primacy of capacity development within the MOHFW: “The World Bank might rightly argue that it took the initiative to develop a draft HPSS in the absence of initiative from the MOHFW and its lack of capacity, as demonstrated by the MOHFW’s inability to keep active the HPSS technical groups in-between World Bank Missions. If we accept this lack of initiative and capacity, then surely the priority issue for GOB is to augment capacity in MOHFW so that it is able to lead the process of development of the reform-filled HPSS and to plan the major HAPP-5.”<sup>107</sup>

While the aid agencies differed over whether the MOHFW should have a more ‘prominent’ or ‘substantial’ rôle in the planning process and how best to bring about either; a more consequential issue was largely ignored. It is apparent that donor interest lay involving the MOHFW in planning donor-driven initiatives (e.g., HPSS and HAPP-5) as opposed to enabling it to make a greater contribution to the government’s long-established and on-going planning instruments (e.g., Fifth FYP). Hence, donors persisted

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<sup>β</sup> In stark contrast to the short tenure of most officials in any one post, the joint-chief of the planning unit in the MOHFW served continuously in his post for 18 years (under the protection of Bank influence it is rumoured) until being transferred in 1996.

in applying pressure on the stretched planning capacity of the MOHFW to devote resources to the donor planning processes with the attendant opportunity costs to the GOB's system.

Close donor involvement in the planning process could have provided a useful basis through which consensus was forged on strategies and resource allocation, which, in turn, could have been beneficial in terms of coordination. The benefits of donor engagement in the planning process were not, however, fully realised as two factors intervened. First, because donors recognised the potential of plans to shape the orientation of spending programmes – and the potential of their advisors to shape the nature of these – a competitive, rather than cooperative, dimension prevailed over the process. Donor rivalry was particularly evident in the area of technical assistance which was ostensibly offered so as to reinforce the Government's capacity to plan. The point is illustrated by events leading up to formulation of the Second FYP. In March 1976, the newly appointed Additional Secretary, PCFPD, of the Planning Commission (Dr Sattar), sought assistance from the Population Council for a long-term resident advisor for his planning unit.<sup>110</sup> He later advised the Bank that he wanted a full-time, expatriate advisor for this unit but, having reconsidered his request to the Population Council, now favoured assistance from an international organisation. The Bank chief in Dhaka informed headquarters that "it is this unit which has to be guided so as to help the government maintain a continuity of the policies evolved by them jointly with the Bank."<sup>111</sup> He suggested "that the Bank promptly assure Sattar that the technical assistance needed to develop his planning unit would be made available by the Bank...A representative from the Population Council is already in Bangladesh...It is therefore essential that we move promptly if we wish to offer Sattar the necessary assistance."<sup>112</sup> The Bank impressed upon Sattar "the importance of the GOB's being particularly circumspect in the choice of technical assistance having possible implications for existing programs and future policies and strategies of the GOB."<sup>113</sup> In due course, the Bank provided technical assistance and later established, within the Commission, a special unit as well. UNFPA then announced its "intention to provide support to the Government of Bangladesh in building up capabilities of the Planning Commission. This will occur through the establishment of a unit in the Planning Commission."<sup>114</sup> To which the Bank responded, "as you know, under the First IDA-supported project an External Evaluation Unit at the Planning Commission was established. Could this external evaluation unit also undertake the function of the new unit you are proposing?"<sup>115</sup>

Second, it is possible that the nature of donor involvement in the planning process had the unanticipated effect of dampening GOB commitment to the effort and its products. There are indications that a reactive element obtained. The Deputy Chairman of the Planning Commission recorded, for example, that “another important, though unpublicised, reason for the preparation of the Five-Year Plan was its use as a basis for negotiating foreign economic assistance. There was a widely-held impression that the donors expected a recipient country to have a Plan setting out a consistent framework of investment priorities and policies, which would enable them to assess the needs for assistance and the form it should take.”<sup>116</sup> Such expectations on the part of donors were evident within the health sector.<sup>117</sup> Bank documents reflect the prescriptive tone of many donors with respect to planning: “Responding to the request from the GOB for early action for the development of a second project, the Bank advised the FPW [a division in the Ministry of Health] to formulate the second plan proposals for the population sector (1978-83).”<sup>118</sup> Donor’s procedural exigencies (e.g., producing a plan document according to agency processing schedules) and agendas, particularly those of the Bank, may, among other things, have diluted Government commitment to its own plans. One Consortium member remarked that “the donors’ worry about the lack of GOB participation and ownership in the face of World Bank pressure to implement the project (disbursement of this loan and putting next one in place).”<sup>119</sup> Nonetheless, despite wide-spread acknowledgement of the folly of their approach, the donors persisted in dominating the planning process.

If forceful donor involvement in the planning process weakened the credibility of the plans within Government circles, so too did the nature of plan formulation. On one hand, officials of the Planning Commission were “technocrats who saw their rôle primarily as economic advisors. There was no effective dialogue between them and the political leadership...”<sup>120</sup> As a consequence, there would have been a limited understanding on the part of planners as to the political feasibility of their intentions and potentially limited political backing for the plans which emerged. On the other hand, plans were formulated in a most restrictive manner. Islam writes that “although the Plan [First Five-Year] was a socio-political document, there was no public debate or discussion about its objectives, priorities and strategies. It was never presented to Parliament for debate or discussion. Nor was it exhaustively debated by the Cabinet.” The latter was “very limited, haphazard and disjointed.”<sup>121</sup> This set the stage for a circumscribed planning process largely confined to the Commission which had the effect of marginalising the planners from the realities confronting, among others, the executing agencies and donors. Overtime the locus of power shifted from the Five-Year and Annual Plans to the project design and approval process.

Currently the day-to-day activities of planners at all levels are directed towards formulating projects, gaining their approval and renewing existing ones. As a result, planners are largely reactive to the interests and demands of the donor community and operate within highly fragmented context. For example, the proposed health and family welfare programme for the Fourth FYP consisted of 211 distinct projects; 76 under the Directorate of Family Planning (DFP) and 137 under the Directorate of Health Services (DHS).

### **3.5 The project process: a disjointed approach to aid deployment**

*The Government's PP process, as currently structured, serves bureaucratic control, rather than development planning objectives and its purposes and contents should be re-examined.*<sup>122</sup>

P. Osinski, KfW Consultant, 1990

Had the planning processes produced widely shared plans, which presented vision and priorities, linked these to spending programmes, and thereby identified resource needs and gaps, the project process could have worked as a sanctioning tool which ensured that only those activities which supported plan objectives were designed and allocated resources. In the absence of such plans, investments in the sector have been made in an *ad hoc* manner in accordance with interested party priorities and proclivities. These investments are not necessarily linked to any agreed set of priorities (as priorities have not been precisely nor explicitly articulated) nor are they appraised in relation to other actual or anticipated spending plans.

Although the project formulation and approval process is not embedded in a strategic planning framework, it is governed by complex and time-consuming procedures. The process differs depending on the size of the proposed investment and whether or not the activity consists solely of technical assistance or whether capital investment is involved. Hypothetically, project ideas may be conceived by any entity in Government but, in practice, donors and domestic constituencies (such as the medical establishment or contractors) play the dominant rôle. Project ideas are formalised into a prescribed format, the Project Concept Paper (PCP), submitted to the planning units in the Directorates and, depending on the volume of resources involved, forwarded to the planning cell in the MOHFW, the appropriate sectoral division of the Planning Commission, and/or



ultimately to the Executive Committee of the National Economic Council (ECNEC). In theory, each of these bodies considers whether or not the concept is financially viable within the framework of the FYP and ADP and in accordance with the governments' policy thrusts (although the latter are open to interpretation). Each of these bodies may suggest that the sponsoring agency modify the proposal or alternatively recommend its approval to the relevant executive official (i.e., Director-General of the Directorate, the Minister of Health and Family Welfare, the Minister of Planning, and/or the Prime Minister). As the PCP is prepared, the MOHFW holds informal discussions with interested donor(s). In practice, donor-funded consultants often provide considerable inputs into the preparation of the PCP on behalf of the Government. The Bank itself noted that "The Bank leadership in project formulation should be maintained; however, efforts should be made to transfer this responsibility to GOB in an increasing measure."<sup>124</sup>

Once a PCP is approved, the sponsoring entity develops either a Technical Assistance Project Proforma (TAPP), in the case of consultancy services or training, or a Project Proforma (PP), if the project comprises predominantly capital support. Both of these documents are subject to similar but distinct approval processes depending on their value. Once the PP or TAPP is examined by the appropriate planning unit at the Directorate level, it is passed on to the planning cell of the MOHFW for processing. If the project is favourably considered by the Joint-Chief of the planning cell, and is worth less than Tk. 20 million (US\$ 500,000) it is passed to the Departmental Project Evaluation Committee which can recommend approval to the Minister, MOHFW. If the value of the project is between Tk. 20 and 50 million (up to US\$ 1.25 million) it is processed by the health or family welfare division of the Planning Commission and submitted to the Project Evaluation Committee (PEC) of the Commission which in turn passes its recommendation to the Minister for a judgement. Decisions regarding approval of PPs with a value of more than Tk. 50 million are, on the recommendation of the PEC, placed before the Executive Committee National Economic Council (ECNEC) for approval. At any of these stages, the PP may be returned to the sponsoring agency for modification.

Upon approval by the appropriate authority, a Government Order for project implementation is issued; dedicated project implementation offices are established and a Project Director appointed (often after approval by the sponsoring donor). The Project Directors often follow the PP/TAPPs unyieldingly, thereby introducing additional rigidity into this drawn out approach to activity planning.

The entire approval process takes between one and two years, which donors considered time consuming, expensive and counter-productive in terms of facilitating aid disbursement.<sup>125,126</sup> Donor frustration was such that it was taken up by the UN Heads of Agencies in their first meeting with Prime Minister Sheikh Hasina.<sup>127</sup> Over the course of project design and approval, the ERD leads the formal aid negotiation with donors – although these are largely *pro forma* since the donors have usually discussed details with the implementing agency throughout. Indeed, donors are so involved in initiating PPs that the Bank found it necessary to remind its staff that “the involvement of the Planning Commission, in addition to the implementing ministries, right from the early stage of project identification and appraisal, is necessary for getting PPs approved early.”<sup>128</sup> Yet, despite donor involvement, they remained irked by the time it took to gain project approvals, as illustrated by the following exchange surrounding the Third Population and Family Health Project:

At the Paris Aid Group meeting, Mr Hopper [Bank Vice President] told Secretary Karim [Health] and Planning Commission member Huq in no uncertain terms that he wanted this project declared effective by that date [the terminal date of effectiveness by which time all conditions of effectiveness have to be met]. This seems unlikely because.. of ..approval of project proformas...Planning commissioner Huq nearly sent Hopper into orbit when he said that one project proforma needed to be rewritten now that Sweden is no longer cofinancing the project. Hopper reminded Huq that Sweden had withdrawn as a cofinancier some seven months earlier, and asked why no action had been taken to revise PP in the interim.<sup>a</sup> <sup>129</sup>

Of course donors held an effective sanction over project approval which made a mockery of the entire processing machinery. The power donors exercised was already evident to planners as the First Five-Year Plan was being implemented. According to the Deputy Chairman of the Planning Commission, “there were two constraints on the choice of projects for inclusion in the annual development programme. One was the need to accommodate ongoing projects. The other was the availability of foreign financing... The donors could determine the pattern of development expenditure by the exercise of their choice amongst the list of projects presented to them for financing. Even when the donors selected from within the list of projects presented by Government, they could affect significantly the composition of the development programme in a given year by delaying commitment for some projects and accelerating commitment of funds for others. Thus

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<sup>a</sup> Eventually the Government had to ask that credit effectiveness be delayed for a further 6 months, arguing that, in part, the delay was due to “...conditionalities put forth by the cofinanciers [which] require in-depth examination by the government..” In that loan effectiveness was contingent on approval of 22 PPs as well as signing cross-agreements with all the cofinanciers, numerous conditionalities would have been involved.

they could change the priority of individual projects over time within the list of projects agreed upon by the Government.”<sup>130</sup>

Donors undermined the Government’s attempt to utilise the project approval approach as a lever over coordinated investment in the sector in another manner. As noted above, inclusion of a project into the Annual Development Programme (ADP) was theoretically intended to serve both to rationalise projects into a coherent set of activities and to act as the green light for spending. However, the ADP never comprised a complete list of projects, as certain donors, for example WHO,<sup>131</sup> operated outside of this mechanism. As a result, the utility of the ADP as a planning tool was seriously compromised.

There were additional barriers which constrained the Government from engaging in strategic planning. One barrier involved the amount of time officer level staff were required to devote to project managerial and administration which left little time to consider macro issues. This was due, in part, to the culture of decision-making described in Chapter Two (section 2.5.3). The costs of tying up senior decision-makers in mundane matters of administration was exacerbated by the onerous task of managing numerous aid relationships and responsibilities. One health sector donor warned that “the constant stream of foreign visitors, if continued, might divert staff time and resources from core activities.”<sup>132</sup> Ironically, by core activities, the donor referred to its own project activities and not the Government’s broader programme of work.

The over-riding emphasis within the bureaucracy on the processing and approval of PCPs, PPs, and TAPPs and the preoccupation with administration may have been reinforced by the excessive focus among donors on the specific projects which they supported. By way of illustration, the UNDP Resident Representative in Dhaka voiced his concerns to the GOB over the slow rate of implementation of UNFPA projects: “it is one of the lowest of any national programme.”<sup>133</sup> To remedy the problem, UNFPA proposed that the Government utilise UNFPA funds to hire national or expatriate advisors to assist the responsible Project Directors to hasten project implementation.<sup>134</sup> The implications of this solution raised concerns for the Bank: “most of the Project Directors for UNFPA projects will be those handling our project funds too. And when the Project Director has the national/expatriate advisor and staff putting pressure on him on daily basis for executing UNFPA projects, it is likely that implementation of our project components might get neglected.”<sup>135</sup> As a result of such donor competition, pressure was brought to bear on the MOHFW to concentrate resources on project implementation as opposed to ensuring that project activities took place within a coordinated environment.

The constant barrage of conflicting advice from donor agencies may have also made it difficult for ministry officials to coordinate aid. In one of the many instances when such conflict arose, the Bank acknowledged that “resolving [i.e., reconciling] these two sets of recommendations may be a problem for the PCFPD. This illustrates the need to define as precisely as possible the terms of reference of future advisors to avoid possible overlaps and conflicts.”<sup>136</sup> Yet, it proved difficult to avoid the differences among donors which existed across a broad range of issues. The effect that this had on an over-stretched and under-resourced bureaucracy was predictable – more projects were spawned so that all approaches could be accommodated.

Two project-related issues further impaired Government’s ability to coordinate aid: (1) the magnitude of aid projects; and (2) donor tendencies to set up ring-fenced project implementation structures. The value of donor projects are massive in comparison to the US\$ 2 per capita, annually available from the public purse for health (in 1995).<sup>137</sup> For example, the IDA/cofinancier projects doubled in value with each successive project; the FPHP disbursed over US\$ 770 million during its six years of implementation.<sup>138</sup> The Bank conceded that “at least some of the pressure for a large scale project in Bangladesh relates to ‘lending pressure’ within the Bank.”<sup>139</sup> As a Swedish evaluation of its aid to Bangladesh noted with respect to the FPHP, “With programmes of this size, it is rather self-evident that the Government’s coordinating rôle falls victim to interests of efficiency. The nature of the programmes as gigantic by-pass operations, set to avoid the negative influence of the bureaucracy tends to be perpetuated.”<sup>140</sup> The ‘by-pass operations’ entail the establishment of project implementation units, which create special interests of their own. In the words of a WHO official, “the FPHP put a large amount of resources into the hands of 66 Project Directors without thought of how these individuals would impact on the sector as a whole. They are in powerful positions and have ambiguous loyalties - no clear lines of authority nor career plans. This makes it difficult for higher GOB authorities to exert control.”<sup>141</sup>

To a large extent aid, particularly that programmed outside of the Consortium, obviated the management procedures embedded in the Bangladeshi administration. Instead donors opted to establish exclusive bilateral arrangements; allegedly to meet their accountability requirements but equally to expedite project implementation. This created two problems. First, the projectised approach favoured interactions between Project Directors (who were outside the control of the MOHFW chain of command) and their sponsoring donors at the expense of wider interactions between line staff and all concerned donors. Second, the

problem of duplication arose. Ironically, although donors were concerned about duplication of aid management systems, they suggested that their own ought to remain and those of the Government be phased out. For example, “The mission [IDA/Cofinanciers supervision mission of FPHP] is concerned with the multiplicity of project monitoring instruments, and stresses the need to streamline these, e.g., the PIV,<sup>‡</sup> the IMED reports, etc. The PIV should be used as a monitoring tool by the Project Directors, higher management in the Directorates and Ministry.”<sup>142</sup>

One of the most intractable coordination problems involved harmonising the funding cycles of the projects with the Government’s allocation system. For example, the German delegation involved in preparation of the FPHP observed that “at pre-appraisal, Fourth Project preparations were by about one year behind the time schedule that would have been required for good coordination with GOB’s own PP preparation process and macro-planning for the Fourth Plan. This coordination would have been essential to secure adequate Government counterpart financing for, e.g., adequate staffing of the MOHFP for its expanding functions etc.”<sup>143</sup> However, as another Mission reported:

...the approval and funding problems which the population and health sector is currently suffering from, are not instances of occasional or *ad hoc* failure to plan properly or manage the budgetary process correctly, but rather reflect a structural weakness in the Government procedures when dealing with large scale programmatic support from donors. This structural weakness is a direct consequence of the difference in the time requirements of the appraisal and approval process of the Consortium members on the one hand and the time requirements of the planning and budgeting process of the Government on the other... The problem, as the Mission sees it, is not only the Consortium’s cycle is not harmonised with the Government’s Five Year Plan cycle, but also that currently the Government and Consortium procedures are incompatible in their timing of preparation and approval requirements, thus making it impossible to have the two fully coincide.<sup>144</sup>

Although the mission proposed an in-depth analysis of the problem so as to arrive at “suggestions aimed at harmonising the planning and budgeting process,” progress in this area does not appear to be promising given the pressures which dictate donor funding cycles. For example, with respect to the FPHP the Bank “decided to accelerate the processing of the project, in order to bring it to the Board within the current fiscal year, when more IDA resources are likely to be available because of slippage of other projects in the FY91 lending program for Bangladesh.”<sup>145</sup>

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<sup>‡</sup> The Project Implementation Volume (PIV) was introduced by the Bank because it considered the GOB’s Project Proforma and IMED reports inadequate for project management and monitoring.

The foregoing discussion suggests that the project preparation and approval process did not ameliorate the problems of aid coordination which arose as a result of the absence of policy and planning frameworks capable of governing investment in the sector.

Notwithstanding these limitations, it should be noted that project cofinancing did provide a significant measure of coordination over certain donor-supported activities in the sector. One prominent example of cofinancing, that supported by the Bank-led Consortium, is considered in Chapter 5.

### **3.6 Aid coordination through the budgetary process**

The government's budgetary process provides yet another means through which aid can be coordinated – for the budget, among other functions, acts to allocate resources.<sup>6</sup> In Bangladesh, the development (mainly capital) and revenue (mainly recurrent) budgets are prepared and presented separately. The former is largely funded by foreign assistance supported by counter-part funds and the latter from domestic sources. The Finance Division of the Ministry of Finance has overall responsibility for the budget preparation process. However, as described above, the Planning Commission, through the preparation of the Annual Development Programme, is in effect responsible for the preparation of the development budget – as the translation of the ADP into the development budget is a mechanistic process which does not involve decisions regarding resource allocation .

A number of factors prevent the budget from achieving its potential as a coordination tool. These relate to the procedures themselves and to donor compliance. Resource estimation provides an example of both. The ADP has to be finalised by the Planning Commission in early May so that it can be forwarded to the ECNEC for approval in May prior to its submission to Parliament as the budget for the new fiscal year (which starts in Bangladesh on July 1). Yet estimates of aid availability for any one year can not be made until the Paris Aid Group Meeting in April at which donors make pledges for the forthcoming fiscal year. The uncertainty is exacerbated by the fact that donors make pledges, as opposed to commitments (which differ significantly from disbursements). In practice, according to an evaluation of the process, pledges made in April at the Paris Aid Group meeting were “unlikely to be disbursed during the forthcoming year, due to delays in project approval and mobilisation.”<sup>146</sup> The budgeting process is further weakened by the practice of donors providing equipment and technical assistance directly to their projects (e.g., WHO which does not operate through the ADP process because, it has

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<sup>6</sup> Neither the Secretary nor Minister are involved in budget formulation as this is done by the Directorates which forward the budgets to the Ministry of Finance and the Planning Commission

argued, WHO is a multilateral technical agency not a donor<sup>147</sup>). The evaluation cited above noted that “the ERD attempts to obtain details of the equipment and technical assistance provided direct to the projects from the donors, but many do not provide these figures promptly enough for their timely inclusion in the actual expenditure columns of the budget and some to not comply at all.”<sup>148</sup> As a result the budget remains a weak tool in relation to aid coordination.

### **3.7 Government-led donor coordination consultations for health sector**

Respondents in the survey undertaken for this study unanimously endorsed the notion of some form of Government-led, Government-donor coordination arrangement in the health sector. No such arrangement currently exists although, for a brief period in the late 1980s, the Secretary is said to have convened meetings of donors<sup>149</sup> (although no substantiating documentary evidence was found). During the formulation of HAPP-5, a concerted effort was made to merge a number of apex committees into one Government-led apex body to undertake aid coordination. At the time when this research came to a close, these efforts had not yet borne fruit (see Chapter 6). Most donors conclude that the Government is not only unable to coordinate aid in the health sector, but also lacks the willingness to do so.<sup>150</sup> According to a WHO official, “the Government is not very interested in aid coordination.” Hence, WHO “would not invest a dollar in aid coordination until the Government is clearly interested in taking up the challenge and is willing to try some alternative to the Consortium.”<sup>151</sup>

The Government also utilises informal methods of coordination. For example, by hosting luncheons for potential donors or having *ad hoc* meetings with donor officials. While informal dialogue between Government and donor officials is a necessary but insufficient condition for effective aid coordination, it is impossible to pass comment on the effectiveness and actual contribution of such approaches to the desired ends.

### **3.8 Chapter summary**

➤ The Government has concluded that “in the absence of a well planned and systematic aid negotiation and coordination arrangement for the health and population sector, piecemeal aid allocation and donor pressure for assistance in particular areas have resulted in duplication of efforts in some areas and inadequate attention to other areas...”<sup>152</sup> The GOB has thus recognised the problem, while only superficially diagnosing its causes and doing relatively little to take remedial action on these.

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directly. This limits the extent to which budgets truly reflect sector priorities and enjoy the

- The absence of an over-arching sector policy and, until very recently, an agreed strategic plan setting out the Government's priorities, provided interested parties with a virtual *tabula rasa* for investment. This tended to be allocated on a project-by-project basis, in an *ad hoc* manner, largely uncoordinated from other planned activities in the sector.
- Broad policies which have been endorsed by the Government, such as the population policy and the health and population sector strategy, have been largely driven by parties within the donor community. Shallow Government ownership of these policies has limited the extent to which the Government and certain donors are willing to deploy their resources with reference to these frameworks.
- The over-arching institutional arrangements for Government-led aid coordination are inadequate for sector level coordination: (1) the ERD because it is organised according to source of funds, largely severed from the planning process, and aims to maximise aid mobilisation; and (2) the Planning Commission because it has been gradually emasculated, many of its responsibilities devolved to the line ministries, and because donors have tended to operate relatively independently of its plans. These institutions may have been further constrained from fulfilling their aid coordination functions by the competition among donors to establish fiefdoms within them as well as donor moves to usurp coordination functions from them.
- The Government-led planning machinery has not proven effective at coordinating and managing aid because: (1) it places excessive emphasis on project formulation and approval to the detriment of strategic planning for the sector as a whole; (2) there exists an inability, or unwillingness, on the part of high-level decision-makers to delegate lower-level decisions which results in a preoccupation with routine tasks at the expense of strategic planning; and (3) at the sector level, planning skills are in short supply, inadequately developed, and overwhelmed by the exigencies of project processing and administrative demands.
- A Government-led, sector-level, apex body for coordination of external resources has yet to be established.
- Some culpability for the relative absence of GOB leadership, and the weakness of its institutions, in aid management rests with donors themselves. Particularly with their proclivity to operate behind closed doors, by inundating Government officials with foreign visitors and other donor demands, and by inducing confusion through advocacy of contradictory policy prescriptions.

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authority of the Principal Accounting Officer – the Secretary.



➤ Government commitment to policies, plans and projects, and their use to coordinate aid, may be eroded by Government perceptions that these have been formulated primarily to satisfy donor demands and requirements.

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## CHAPTER FOUR

### **Coordination of United Nations health sector support: necessary, insufficient & irrelevant?**

*In the first few years of its existence Bangladesh undoubtedly benefited from donor coordination through the United Nations.<sup>1</sup>*

J. Faaland, World Bank Resident Chief, Dhaka 1981

#### **4.1 Introduction**

In the early 1990s, 18 United Nations (UN) organisations were active in Bangladesh, disbursing approximately the same amount of external assistance as all the bilateral organisations, the Asian Development Bank (AsDB) and the European Community combined.<sup>2</sup> Thirteen of these agencies provided operational assistance to the Ministry of Health and Family Welfare and as a group provided approximately 45% of external assistance.<sup>3</sup> The UN agencies thus formed an important feature of the aid regime and coordination among them would, therefore, have been necessary in its own right. Yet the UN agencies tended also to occupy a special niche as a function of their normative authority (i.e., knowledge-based competence) and perceived neutrality<sup>a</sup> which bestowed upon them a potentially unique position in aid coordination arrangements.

This Chapter assesses the implementation of a series of global initiatives of the United Nations System designed to coordinate the operational activities of its member organisations at the country-level. The rationale and intent of each of the mechanisms is described, as is the manner and nature of their adoption in Bangladesh. Emphasis is placed on the extent to which these instruments have impacted upon aid coordination in the health sector and an argument is constructed as to why the mechanisms have been largely ineffectual. As the organisations form part of a system, theoretically conducive to coordination, an analysis of their ‘failure’ to coordinate is instructive for the lessons it offers this study.

#### **4.2 Resident Coordinator System: is it a system?**

Since its establishment in the 1940s, the United Nations has evolved into a web of 41 institutions. It currently consists of 18 Funds and Programmes (such as UNDP, UNICEF

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<sup>a</sup> WHO’s neutrality derives from its one-country, one-vote system of governance. In general, multilateral organisations are perceived to be more neutral than the bilaterals.



and UNFPA), 18 specialised agencies (e.g., WHO and the development banks) and five regional economic commissions. Notwithstanding the number of these organisations, the propensity for them to coordinate their action should have been facilitated by two factors: (1) they do not face the same pressures as their bilateral counterparts to situate their programmes within the rubric of national political or economic objectives; and (2) they were established as part of a system through which coordination could have been imposed by command. Such a system, however, has not evolved. The Funds and Programmes are sub-organs of the Economic and Social Council (ECOSOC). The Executive Boards of these organisations report through ECOSOC to the General Assembly of the UN and are in this manner responsible to the UN Secretary-General. The specialised agencies, in contrast, are independent, inter-governmental organisations with their own governing councils. Their Executive Heads, therefore, act in a relatively independent fashion from the General Assembly and the Secretary-General. Within these constraints, and under external pressure to do so, efforts have been made to establish instruments which might facilitate improved coordination among these organisations.

The responsibility to coordinate the UN family was formally vested in UNDP by the General Assembly in 1970.<sup>4</sup> During the mid-1970s, a number of changes were made to the position of the UNDP Resident Representative to solidify its coordination capacity. This led to the creation of the resident coordinator system (RCS) in 1978 which sought to raise the status of the individual coordinator to "first among equals" among representatives of UN organisations. The Resident Coordinator (RC) would be appointed by the UN Secretary-General, rather than the UNDP Administrator, and would have "over-all responsibility for, and coordination of, operational activities for development carried out at the country level."<sup>5</sup> Despite nominal Secretary-General sponsorship, the RCS remains closely affiliated to UNDP. A survey in 1995 found that over 95% of Coordinators were from UNDP, while the remaining 5% were seconded to UNDP from their respective organisations for the duration of their assignment.<sup>6</sup>

The resident coordinator system incorporates a variety of instruments to facilitate the integration of UN assistance into the development programmes of recipient countries. Documentary instructions from UNDP headquarters on how the RCS should function are numerous and comprehensive. The system has, however, remained fragile, in part because the responsibility vested in UNDP has never been matched with adequate formal authority and, in part because the system has lacked financial support and credence of its member organisations. Until 1995, it is debatable whether the RCS could be properly described as a 'system' *per se*.

Recent steps have been taken to further bolster and formalise the RCS. In July 1994, the Secretary-General appointed the Administrator of UNDP as the Special Coordinator for Economic and Social Development and transferred managerial functions of the RCS to UNDP.<sup>7</sup> The UNDP Executive Board took the decision to allocate 1.7% of its core budget (beginning in 1996) to the RCS and established the Office of UN System Support and Services to facilitate country level coordination.<sup>8</sup> UN General Assembly resolution 50/120,<sup>9</sup> passed in 1996, requested that the Secretary-General: (1) develop common guidelines for performance appraisal which included an assessment of the contribution made by UN staff to coordination; and (2) urge Executive Heads of the UN organisations to direct their country representatives to promote the RCS. The resolution also invited the organisations to provide appropriate support to the system and reaffirmed the need to enhance the authority of the resident coordinator to propose amendments to the programmes of the various UN organisations prior to submission of these to their respective governing bodies.

In Bangladesh, the RCS has been led by consecutive UNDP Resident Representatives. Participants include the UN organisations as well as the World Bank, AsDB and, to a lesser extent, the IMF. The preparation of annual RCS work plans and budgets began in 1995.<sup>10,11</sup> The budget for the RCS (exclusive of salaries) was US\$ 60,000 for 1997.<sup>12</sup> With the exception of UNDP,<sup>α</sup> none of the organisations provides direct financial support to the RCS. Some joint activities, however, have been undertaken on a cost-sharing basis (e.g., commissioning advocacy documents). Given the increasing workload of system coordination, most UN organisations recognise the need to provide increased human resource support to the RCS. Consequently, WFP seconded one of its staff to UNDP for RCS-related tasks for three months during 1996.<sup>13</sup> The idea of recruiting additional staff was floated, but post cost-sharing was resisted by a number of agencies.<sup>14</sup> The following sections analyse the progress achieved in system coordination in Bangladesh, and its relevance and impact on coordination of external resources to the health sector.

#### **4.3 Meetings under the aegis of the Resident Coordinator System**

A variety of groups and committees have been proposed and/or established within the UN system to enhance system-wide coordination at the country-level, although not all of these instruments have been instituted in Bangladesh. In Bangladesh, these include meetings and a programme of work by the Heads of Agencies, the Joint Consultative

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<sup>α</sup> These include a full-time National Programme Officer and Secretary.

Group on Policy, the UN coordination committee, thematic groups, and programme review groups.

#### *4.3.1 Heads of Agencies Meetings*

The Heads of Agencies (HOA) meeting is the principal coordination tool of the UN in Bangladesh. The chiefs of the entire UN country team, including the development banks, are invited to monthly HOA meetings which they usually attend (the Government is not represented). Currently, the meetings are called and chaired by the Resident Coordinator, who sets the draft agenda and writes the minutes, although the chair rotated during the early 1990s. Discussions in this group are wide-ranging: from whether or not to undertake a particular system-wide activity (such as the preparation of a 'Country Strategy Note');<sup>15</sup> to developing a common UN position on a specific issue; to issues such as the security of staff.<sup>16</sup> The forum has served to formulate joint UN positions to present to Government at, for example, the annual Consultative Group meeting in Paris.<sup>17</sup> Joint stands have also been taken on operational issues, such as bottle necks to project implementation. HOA meetings have been used to organise briefings by each of the organisations on their respective mandates, activities, and modes of doing business so as to improve mutual understanding and, thereby, the prospects for coordinated action.<sup>18</sup> Although joint reviews of programmes and projects prior to their submission to respective governing bodies has not taken place, UNICEF presented its proposed programme (1996-2000) to the rest of the UN family at one of the HOA meetings. The group has used the mechanism to discuss co-sponsorship of events, such as an NGO-GOB preparatory meeting for the Beijing Conference on Women, and of joint advocacy documents.<sup>19</sup> In 1996 and 1997, this venue provided the UN organisations an opportunity to comment on the Resident Coordinator's work plan, budget and annual report.<sup>20</sup>

In a departure from early ways of doing business, at the time of this research, the group was discussing how to achieve coordination in a more systematic manner, through for example, a coordinated UN strategy. Two initiatives were under consideration.<sup>21</sup> The first involved exploring options for intensified collaboration among the agencies at the sub-national level, in one particular district or Thana, thereby reinforcing the Government's decentralisation reform process. The other area involved developing a united strategy on constraints faced in programme execution and implementation. There is a perception among members that, to date, these meetings have tended to emphasise administrative issues and have, consequently, provided inadequate opportunities for substantive programme coordination.<sup>22</sup> Moreover, there is little evidence from the minutes that the HOA meetings provide an overarching framework for sectoral coordination of UN

support nor any direct support for coordination in the health sector.<sup>23,24,25,26,27,28,29,30,31,32,33,34,35,36,37,38,39,40,41,42,43</sup>

#### *4.3.2 The Joint Consultative Group on Policy (JCGP)*

As organisations which report to the UN Secretary-General, UNDP, UNFPA, UNICEF and WFP form the Joint Consultative Group on Policy (JCGP) at both the global and country levels (i.e., four of the eighteen UN agencies which provide operational support to Bangladesh).<sup>λ</sup> Collaboration among members at the country-level has been mandated by the UN General Assembly in 1989<sup>44</sup> and by the governing bodies of the member agencies. It was decided in 1996 that the implementation of General Assembly resolution 50/120, concerning the strengthening of operational coordination, would become a principle focus of the JCGP.<sup>45</sup>

The JCGP constitutes a potentially important group for aid coordination within the UN, not only because its members collectively account for approximately 40% of the UN's resource contribution to Bangladesh, including the IFIs,<sup>46</sup> but because they report directly to the Secretary-General. JCGP representatives meet monthly to discuss substantive, operational and administrative issues with the chair rotating on an annual basis (the meetings are not minuted). In 1994, the JCGP articulated a joint mission statement for their organisations in Bangladesh, which included a series of common goals and objectives.<sup>47</sup> Although nebulous, the statement was intended to serve as a first step in identifying joint indicators and setting time-bound targets. A more comprehensive declaration was jointly sponsored and published (together with other UN organisations) under the title "A Fork in the Path: Human development choices for Bangladesh."<sup>48</sup> This document, according to the JCGP members, served as the basic framework which guided the articulation of the individual agency country programmes.<sup>49</sup>

An 'issues' paper commissioned for a meeting of Executive Heads of the JCGP held in Dhaka in February 1994 provides pertinent findings concerning the potential for coordination among the JCGP agencies.<sup>50</sup> The report notes that JCGP organisations in Bangladesh "have been working together on individual projects in a few sectors, but collaboration options have not been systematically explored." The paper pinpointed a number of factors which inhibit these organisations from achieving greater collaboration at the country-level. These included the lack of clarity on the rationale for collaboration

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<sup>λ</sup> In 1994, the executive heads of UNCDF and UNHCR requested inclusion in the JCGP. This was opposed by UNFPA and WFP. The perception was that enlargement would make the Group unwieldy and would debase the common denominator. (JCGP Briefing Notes, 5 February 1994).

among “most UN staff members,” coupled with a perception that “few positive outcomes have resulted from collaboration efforts so far” and that “JCGP collaborative efforts have resulted more in promoting a ‘culture of meetings’ rather than a ‘culture of action’.” The report concluded that experience suggested that: (1) success depended on the personalities of heads of country offices; (2) organisations resisted coordination because they perceived “another organisation to be too bureaucratic, too aggressive in its individual publicity, too poor to make any financial contribution, or too narrow in its approach to development;” (3) officials were concerned that collaboration increases bureaucratic procedures and reduces action; (4) coordination is impaired by the lack of familiarity with procedures of each other’s agencies; and (5) coordination takes time and increases work-load.

The above-mentioned JCGP meeting recommended a number of steps to overcome the obstacles to coordination identified in the issues paper.<sup>51</sup> The proposals included: deputation of staff to other member organisations; fielding a joint mission to examine means for streamlining operations in light of differing programming cultures; and organising joint staff retreats to promote coordination and system-wide goals. While follow-up on these issues has been discussed in the JCGP meetings, there has only been limited progress in practice. Deputation of staff proved difficult, particularly for the less well represented agencies, since the view is held by most agencies that their staff are already over-stretched and secondment would seriously impede programme implementation. To some extent, the team-building recommendation has been taken forward under the aegis of the larger UN community through, for example, a briefing series on mandates and a UN staff retreat. Harmonising procedures, however, appears to represent a more intractable problem (see below).

Some progress has been achieved on two issues pertinent to coordination, one substantive and one procedural. In an effort to coordinate JCGP follow-up to the Fourth World Conference on Women, in 1996 the Group commissioned, on a cost-sharing basis, a consultant to review the work of each of the members so as to identify areas for collaborative programming. Although a draft report was produced,<sup>52</sup> by the conclusion of this research, it had not led to tangible coordinated follow-up. Second, in accordance with directives from their headquarters, the Group examined payment to Government staff among all UN organisations.<sup>53</sup> It found significant differences in practice among the agencies on the types and levels of cash and non-cash benefits paid. Consequently, an effort was underway to harmonise payments and develop an exit-strategy over the medium-term for the JCGP, a process which was de-linked from the actions of the other

UN agencies who would need to seek guidance from their respective headquarters on the issue.<sup>54</sup> Whether or not an exit strategy will be agreed among JCGP organisations and collectively acted upon, remains to be seen.

As a step toward harmonising their diverse programming processes, the Executive Heads of the JCGP proposed that the RCS undertake a Common Country Assessment (CCA) in each country where the UN is active operationally.<sup>55</sup> The idea was that there should be a common approach to identifying, collecting and analysing a country's basic data prior to formulating agency-specific programmes. The need for such an exercise was acknowledged by the Group in Bangladesh,<sup>56</sup> particularly in light of the fact that: (1) there is limited involvement of the agencies in one another's programme formulation; (2) no common UN framework for programme monitoring and evaluation exists; and (3) the JCGP recognises that it could play a lead rôle in consolidating and giving focus to the indicators that have emerged from the global conferences held in the 1990s on social issues (section 4.6). However, given competing priorities and the political environment in Bangladesh at the time the Executive Heads pressed for the Assessment, initiation of the CCA was postponed, at least until the country strategy note was finalised (see below).<sup>57</sup>

In summary, although the JCGP is a small group, relatively homogeneous, subject to central (albeit distant) authority (i.e., the UN Secretary-General), and its members have received directives to coordinate their operational activities, progress towards such an end remains constrained. Coordination remains dependent on the decision of individual agency representatives who will not necessarily weigh positively the generalised benefits of coordination against its all-too-apparent costs. Deliberations within this forum have not touched on the issue of coordination at the sectoral level, which suggests that the JCGP has limited relevance to health sector aid coordination. Given overlap between the JCGP and Heads of Agencies meetings, some questioned the very existence of the JCGP. If the group is limited in size simply because it facilitates consensus building (as indicated in the footnote above), the prognosis for more agency inclusive, donor-driven coordination would appear to be poor. The Government contends that the existence of the JCGP, and its activities, "is not felt in its quarters."<sup>58</sup>

#### *4.3.3 Other meetings*

General Assembly resolution 47/199<sup>59</sup> called for the establishment of inter-agency, field-level committees to review all proposed substantive activities of each UN organisation (e.g. draft country programmes and major projects) prior to their submission to the respective governing bodies for approval. This type of committee has not been

established in Bangladesh, although UNICEF has utilised the HOA meetings to this end and other organisations may use less formal mechanisms to sensitise other UN agencies to their intended programmes. Resolution 47/199 also proposed that ‘thematic groups’ be established by interested UN organisations to develop joint strategies for tackling specific issues of national importance. One such theme group, on HIV/AIDS (discussed below), has been established. There is a feeling, however, among the UN organisations that there is presently no need for additional theme groups in light of the many technical sub-groups, established under the local consultative group (LCG) initiative, which include a broader range of development agencies.<sup>60φ</sup>

#### **4.4 Country Strategy Note: not even a paper pretence**

In 1989, the General Assembly requested that in order to give greater ‘coherence’ to UN programmes at country-level, a “document containing the integrated operational response of the UN system” be developed.<sup>61</sup> Three years later, the Country Strategy Note (CSN) was introduced by General Assembly resolution 47/199 as another instrument for inter-agency coordination.<sup>62</sup> The Note is intended to outline the inputs of different UN organisations in response to priorities and strategies identified in the development plans of recipient countries. The CSN was to cover a time period consistent with the recipient’s plans so as to ensure effective integration of UN assistance into the country’s development process. CSNs are voluntary in nature and are formulated by national governments, through a process of consultation between the government and the UN system. All relevant ministries and UN organisations are to be involved. CSNs are submitted to the governing bodies of UN organisations to encourage their respective country programmes to be more responsive to recipient priorities and promote improved UN coordination.<sup>63</sup>

In Bangladesh, UNDP transmitted guidelines for CSN preparation to its counterpart in the ERD in September 1993. An early decision taken by the Government’s Human Development Steering Committee to embark on the CSN in parallel with the preparation of the Fifth Five-Year Plan,<sup>64</sup> was later reversed for reasons which are not clear. As a result, a number of the UN organisations, particularly the JCGP members, went ahead to develop their frameworks of cooperation on an individual basis with their counterpart departments in Government. In September 1995, the Government once again requested

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<sup>φ</sup> It is pertinent that since the 1980s, there has not existed a sub-group on health within the LCG initiative. This was primarily the case, it was argued by the Bank, because of the existence of the donor Consortium. As discussed in the next Chapter, the Consortium could, however, not substitute for a LCG sub-group because, as a cofinancing instrument, it excludes most donors to the sector.

support from the UN to prepare a CSN.<sup>65</sup> This decision may have been related to the Government's embarkation on the Participatory Perspective Plan at that time. However, as a number of UN organisations had just initiated newly approved programmes (i.e., UNDP, UNICEF, WFP and WHO), the UN suggested an alternative approach to CSN preparation.<sup>66</sup> This involved collating an inventory of ongoing and planned UN-supported activities and comparing these with the priorities of Government so as to identify gaps and areas for inter-agency collaboration.<sup>67</sup> The Government agreed to prepare a modified CSN and established an Inter-Ministerial Working Group led by the ERD to oversee its preparation. A retired senior government official was recruited to prepare the document according to a terms of reference agreed by the UN and the Government's Working Group.<sup>68</sup>

Believing that the modified CSN, once completed, would not be very useful as a joint strategy document, the Resident Coordinator decided instead to use it to obtain the new administration's (i.e., Prime Minister Sheikh Hasina) endorsement of ongoing UN programmes of assistance. There were also plans to convene Heads of Agencies meetings around the 'common themes' identified in the CSN for coordinated follow-up through the UN system. This second best option was overtaken by events, particularly the Government's decision in 1996 to reintroduce the five-year planning process (Chapter 3, section 3.8). Therefore, at the conclusion of this research, the CSN was again being recast so that it could dovetail with the GOB Plan (1997-2002) and, in particular, so that it could serve to incorporate the UN agenda into the FYP.<sup>69</sup>

As the CSN had not been completed at the close of this research, it was not possible to assess its effectiveness in improving aid coordination. Nevertheless, a number of concerns had been raised by stakeholders. Given the halting process of the preparation of the CSN in Bangladesh, the commitment of the GOB and UN organisations to the exercise remained in doubt. Some officials questioned the wisdom of introducing yet another planning and aid coordination instrument, particularly since the CSN suffers from three substantive weaknesses. First, although the CSN is to be formulated by the government in partnership with the UN, in Bangladesh the exercise was UN driven. Moreover, the Note is intended to be responsive to recipient priorities. In Bangladesh, the UN Chiefs sought to use the CSN "to get our [UN] agenda into the Five Year Plan."<sup>70</sup> Second, coverage of the CSN is limited as it excludes the IFIs, bilateral donors and NGOs – all significant actors in the health sector. Third, while the consultation and drafting process may have been useful in sharing information and consensus building at the macro-level, it is unlikely that the Note would provide the specificity for meaningful



guidance at the *sectoral* level. Consequently, the CSN will most likely remain of limited value to the MOHFW in coordinating external assistance.

#### **4.5 UNAIDS: a little coordination and a lot of expense**

The UN Joint Programme on AIDS (UNAIDS) represents an innovative approach of the UN to provide ‘coordinated and rationalised’ system-wide support to countries in their response to HIV/AIDS.<sup>71</sup> Through the Programme, the local heads of the cosponsoring organisations (UNFPA, UNICEF, UNDP, UNESCO, WHO and the World Bank), together with those of other UN organisations as well as a national counterpart agency, are intended to coordinate their support to HIV/AIDS activities in the context of a government-led HIV/AIDS plan. Inter-agency planning and action were anticipated outcomes.<sup>72</sup>

Although UNAIDS operates as a coordination mechanism under the UN ‘thematic group’ initiative,<sup>73</sup> it was heralded by its cosponsors as “an almost totally new approach in the cooperative efforts of our respective agencies... a new type of cooperative venture.”<sup>74</sup> UNAIDS is intended to reinforce, not supplant, existing national efforts for HIV/AIDS coordination.<sup>75</sup> While the initiative functions within the RCS, implying that responsibility and accountability rests with the Coordinator, the Group is convened and chaired by any member of the group appointed by the Resident Coordinator.<sup>76</sup> The selection of the Chairperson is based on a consensus decision of the Group taking into consideration, not merely commitment to HIV/AIDS work, but more importantly, the candidate’s leadership skills and commitment to UN coordination. In approximately 60 countries, the Group is supported by a Country Programme Advisor funded by UNAIDS, but notably, selected by the Group itself.<sup>77</sup>

In Bangladesh, a UN Theme Group on HIV/AIDS was established in October 1995 and had met four times, or roughly quarterly, by the close of 1996. As it proved difficult to convene the heads of cosponsoring agencies for the sole purpose of the Theme Group, it was decided that meetings would be held monthly, at the tail end of the regular Heads of Agencies and JCGP meetings. The Group has been chaired by successive RCs but, in 1997, the Group decided to rotate the chair annually.<sup>78</sup> In addition to participation by the cosponsoring organisations, the ILO and UNCDF were also invited to join the Theme Group.<sup>79</sup> The Government had not, at the close of this research, been included in the Group; primarily, it is argued, because the UN wants to get its own house in order first.<sup>80</sup> In addition, as there is no national AIDS programme and the National AIDS Committee has no executive powers, it was contended by the Theme Group Chairperson that an

acceptable national counterpart body did not exist.<sup>81</sup> Voices within Government argue that the Director of the National AIDS Project would provide a logical government representative but the Chairperson did not agree.<sup>82</sup>

Resources for administrative and logistic support to the Group are provided from UNAIDS centrally, while at the country-level UNDP provides administrative and financial services. UNAIDS appointed a Country Programme Advisor to Bangladesh in May 1996. Small amounts of funds are entrusted to the Theme Group for joint UNAIDS activities (US\$ 90,000 in 1996<sup>83</sup> and US\$ 100,000 was requested for 1997<sup>84</sup>). In addition, JICA, provided UNAIDS with US\$ 90,000 for strategic planning and other activities.<sup>85</sup> Additional activities jointly planned by the Group, as set out in its annual plans, are funded by the member organisations separately or on a cost-sharing basis outside of the framework of the UNAIDS operational budget.<sup>86</sup>

In relation to aid coordination, one accomplishment of the Group was the preparation of a UN HIV/AIDS/STD/RTI Master Plan for 1997 based on an inventory of ongoing and planned activities of each member in these areas. These activities were found to be worth approximately US\$ 1.6 million for 1997.<sup>87</sup> The exercise alerted the Group to areas where they could collaborate, where they risked duplication and where gaps remained.<sup>88</sup> In light of the programme planning processes of at least two of the cosponsoring agencies at the time (i.e., World Bank and UNFPA), it was expected that the Master Plan would provide the opportunity for greater coherence and complementarity among some UN-supported activities. Another coordination-related activity involved the Group joining forces with the wider donor community in supporting the Government's formulation of a national HIV/AIDS/STD policy. Subsequently, the Group assisted the Government to develop a national strategy and plan of action which could potentially enable future donor support to HIV/AIDS/STIs to be coordinated within the framework of an agreed plan.<sup>8</sup> Initiatives were also undertaken to increase dialogue between the bilateral agencies and the Theme Group.

Although UNAIDS enjoyed a measure of success (e.g., level of participation, preparation of the UN Master Plan, etc.), the Programme faces a number of challenges. These relate both to the manner in which the mechanism functions and its relevance to sectoral coordination. In relation to the former, the individual mandates and programmes of work

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<sup>8</sup> The development of an AIDS plan had been planned since 1993, with UNDP support, but did not materialise because of major problems in project design.

of the member organisations compete with their allocation of resources (time, advocacy capital, etc.) to UNAIDS which is perceived at the country-level as a ‘tack-on’ mandate by some of the heads of agencies.<sup>89</sup> The Country Programme Advisor suggested that a number of steps could be taken to bolster coordination through the Programme.<sup>90</sup> The inclusion of UNAIDS related work in the work plans and performance appraisal systems of the heads of organisations was viewed a critical incentive to achieve a higher level of commitment to the Programme. Second, while the decision to rotate the chair among members may engender wider ownership of the mechanism, it may prove counterproductive by moving away from the judicious principle of appointing the person with the greatest commitment and skills for inter-agency cooperation.<sup>x</sup> Third, given that regular, monthly, informal, and well-attended donor-Government meetings for coordination around AIDS had been established in 1995, coordination through the restrictive Theme Group may have been a retrograde step in the case of Bangladesh.<sup>91</sup> Consequently, success may require the inclusion of Government in the Group. Donor ownership of Bangladeshi development programmes is pervasive and reinforced by exclusive donor clubs. Indeed there was some evidence that Theme Group members viewed UNAIDS as a mechanism through which to exercise collective ‘pressure’ on the Government to adopt donor views in relation to HIV/AIDS.<sup>92</sup> The fourth problem relates to value-for-money. The costs of administering a programme with an expatriate-led country office amounts to no less than US\$ 400,000 per year. While the mandate of UNAIDS is admittedly broader than agency coordination, it remains that in Bangladesh UNAIDS can at best, if it is indeed effective, provide coherence to the relatively small contribution of the UN agencies in the AIDS sector (i.e., US\$ 1.6 million).

UNAIDS, as viewed from the perspective of the MOHFW’s challenge of coordinating donor resources for HIV/AIDS activities, is a mixed success. On the positive side, the inventory-type exercise may serve to reduce duplication and gaps in UN assistance. However, since UNAIDS is not designed to serve as a funding or project execution channel, the Programme will not necessarily reduce the burden on the MOHFW of managing numerous relationships and projects with the individual Theme Group organisations. To reduce this load, UNAIDS would need to promote project cofinancing among its members supporting activities within the same ministry. There are no plans for such an approach.

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<sup>x</sup> Heads of agencies may argue that they meet these criteria *ipso facto*, but this is not axiomatic.

While UNAIDS marks a step in the direction of improved donor coordination, two further steps would be required to achieve the Programme's full potential. First, the mechanism would need to incorporate the resources of bilateral agencies since they provide the lion's share of aid for HIV/AIDS. However, UNAIDS has no mandate to coordinate bilateral assistance and it is unlikely that the bilateral agencies would acquiesce to UNAIDS assuming such a rôle. Second, ear-marked resources for HIV/AIDS coordination would need to be transferred to the Government so as to enable it to assume coordination responsibilities. This raises two issues. First, although it is encouraging that dedicated resources are available to improve coordination within the UN, some question whether or not a Theme Group might have sufficed without the creation of another costly Programme (i.e., UNAIDS).<sup>93</sup> Second, it is not clear that these funds would not have been better spent in developing indigenous capacity for aid coordination.<sup>8</sup> The latter would, however, be dependent upon Government commitment and leadership on HIV/AIDS which, according to the UNAIDS Theme Group Chair,<sup>94</sup> was lacking, and in many countries is not forthcoming until the epidemic is in an advanced stage.<sup>95</sup> Finally, experience with UNAIDS raises the question of whether or not pursuing inter-sectoral coordination mechanisms is to the detriment of sector-focused coordination efforts?<sup>p</sup>

#### **4.6 Common framework for follow-up to UN conferences in the social sectors**

1990 to 1996 witnessed nine international UN conferences addressing social sector concerns.<sup>a</sup> These enabled the international community to agree on shared values, time-bound goals, and strategies to achieve them, and, thereby, provided a vehicle for 'coordination by consensus.' The UN Secretary-General called for integrated UN follow-up to these conferences, with emphasis placed on the country-level, under the aegis of the resident coordinator system. A common UN framework was proposed which was to provide assistance to countries to realise the commitments they undertook at these Conferences, while reducing the burden on them with regard to implementation. Moreover, the framework was intended to galvanise the UN organisations around the agreed goals and to develop mechanisms for coordinated delivery of assistance at the

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<sup>8</sup> In the case of HIV/AIDS, developing such capacity within the MOHFW may not be an appropriate location because of the multi-sectoral nature of the required response.

<sup>p</sup> If one assumes that heads of agencies have a limited amount of time and resources to devote to coordination activities, and that by extension coordination fora compete with one another to attract attention, then inter-sectoral coordination activities must detract, *ipso facto*, from sector-specific ones.

<sup>a</sup> The conference themes, venues and dates were: education (Jomtien, 1990), children (New York, 1990), environment (Rio de Janeiro, 1992), human rights (Vienna, 1993), population (Cairo, 1994), social development (Copenhagen, 1995), women (Beijing, 1995), human settlements (Istanbul, 1996) and food security (Rome, 1996).

country level. The latter included, for example, developing common data systems for planning and monitoring purposes. Consequently, in November 1995, the UNDP Administrator urged all Resident Coordinators to orchestrate an integrated follow-up to the conferences held to date. He suggested that thematic groups be established involving UN organisations and national authorities. Guidelines were issued to the RCs in an effort to facilitate their support to implementation of conference recommendations. It was envisioned that these would be drawn upon for planning purposes, for example, in the preparation of the Country Strategy Note, and would provide a framework for the thematic groups which emerged.

In Bangladesh, the grand visions forged at the international conferences appeared as distant as the prospects for coordinated follow-up. The latter has been characterised by individual efforts of UN organisations to promote the preparation and implementation of national plans of action according to their respective mandates. Two partial exceptions pertain to the Fourth World Conference on Women and the International Conference on Population and Development (ICPD). In neither instance has a thematic group been formed as envisaged by the Secretary-General. In the case of the Beijing conference, the JCGP commissioned a consultant to write a joint advocacy statement and to identify areas for joint programming. Although a draft report was prepared,<sup>96</sup> no substantive action was taken by the time the research had been completed. With respect to ICPD follow-up, UNFPA assisted the GOB in preparing a plan of action<sup>97</sup> and facilitated the involvement of the Bank, WHO and UNICEF in the process.<sup>98</sup> UNFPA also advocated to ensure that the Conference goals were reflected in the MOHFW's health and population sector strategy (1997). Notwithstanding the benefits of coordinated planning, the ICPD plan of action is so broadly written that it will be of limited value in activity planning and coordinated follow-up.

It is, therefore, not clear whether conference goals have furthered UN operational coordination in a substantive manner.<sup>99</sup> Thematic Groups were not established and there was very limited inter-agency follow-up. In 1997, the Resident Coordinator announced his intention to develop a matrix setting the nine Conference Resolutions against the planned activities of relevant Ministries and UN organisations, which may provide a starting point for this task.<sup>99</sup>

#### **4.7 Harmonisation of procedures and programming cycles**

The onerous and disparate administrative and programming procedures of the UN organisations have been criticised for diverting scarce recipient resources from priority tasks and for imposing substantial losses to aid efficiency. Heavily inflated transaction costs occur for both donor and government, but particularly the recipient, when each organisation sets individual requirements relating to programme identification, appraisal, implementation, monitoring and evaluation, accounting and auditing, procurement, hiring and benefits for local staff and consultants, training, and project cycles, etc. A number of UN General Assembly resolutions have called for rationalisation and harmonisation of procedures. In response to the resolutions, some initiatives have been undertaken at the global level, for example, UNDP, UNICEF and UNFPA agreed in 1997 to harmonise their budget presentations (i.e., to use the same definitions and break down of costs).<sup>100</sup>

In Bangladesh, in 1994, the JCGP identified the need to simplify procedures and harmonise programming cultures and cycles. A proposal was made to field a multi-agency headquarters mission to determine the scope for progress in this area<sup>101</sup> which did not materialise. In 1997, an inter-agency Operations Consultative Group was established, but it will deal mainly with administrative matters of concern to the aid agencies (e.g., post adjustments reflecting cost of living, schooling, *etc.*).<sup>102</sup> The organisations intend to undertake a Common Country Assessment, sometime after the CSN is completed, which may identify areas for harmonisation of data collection. In summary, little progress has been achieved. Local representatives are of the opinion that meaningful change will need to be driven from their respective headquarters in the context of system-wide reforms.<sup>103</sup>

UN organisations have not yet achieved much success in synchronising their programmes with the GOB's plans nor amongst themselves. The GOB's Fourth FYP concluded in June 1996 and the subsequent one commenced in July 1997. During 1993-1995, UNICEF undertook an interim programme so as to bring its cycle in line with that of Government,

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<sup>99</sup> This is not to suggest the Conferences did not seek and achieve other objectives nor that they did

UNDP and UNFPA. This was put off course by the Government, which temporarily suspended its five year planning process, and UNFPA, which extended its programme due to inadequate implementation. WHO operates under a biennium system and is thus at odds with the other organisations. As demonstrated in Table 8, the programming cycles of the major UN organisations operational in the health sector are not well synchronised. Moreover, the programme preparation processes of the organisations differ to such an extent that mere harmonisation of cycles may be insufficient to bring about substantive improvements in relation to streamlining the programme formulation requirements imposed on the GOB. No common framework for joint planning, monitoring or evaluation of programmes has emerged.

**Table 8: Programme cycles of Government and key UN agencies in health sector during the 1990s**

Agency	Programme period	Programme duration
GOB Fifth FYP	July 1997 to June 2002	5 years
UNFPA	January 1991 to December 1998	7 years
UNDP	July 1995 to June 1998	3 years
WHO	January 1996 to December 1997	2 years
UNICEF	January 1996 to December 2000	5 years
World Bank FPHP	July 1992 to June 1998	6 years
AsDB	Project by Project Basis	N/A

#### **4.8 Performance of UN system coordination: a synthesis**

A number of the mechanisms designed for UN system coordination are functional in Bangladesh. Frequent, regular, and structured Heads of Agencies meetings provide the dominant mechanism, although, as noted above, a number of other initiatives are also being pursued. The Resident Coordinator has observed, however, that the GOB does not utilise the RCS in its efforts to communicate with the UN nor so as to improve the coordination of multilateral assistance.<sup>104</sup> Government officials tend instead to interact with each of the organisations separately, perhaps as a result of the organisational structure of the ERD, perhaps because it is perceived as advantageous for them to do so or perhaps because the UN agencies encourage bilateral as opposed to coordinated relationships with the Government.

While the Government's non-participation in the system may represent a major short-coming for the RCS as a whole, limitations to the effectiveness of the individual mechanisms have also been identified. These relate to the willingness and ability of member organisations to support joint initiatives in the context of system coordination

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not provide value to recipient countries in other respects.

(see Box 2). The JCGP issue paper, for example, found that UN staff were sceptical as to the benefits that would accrue to their individual programmes from increased participation in the coordination instruments, while they were simultaneously aware of the costs involved.<sup>105</sup> Many UN staff suggest that a lack of time constrains them from increased collaboration. This in turn, relates to on-going workload, competing (and perceived higher order) priorities, inadequate (or non-existent) incentives and insufficient resources allocated to coordination activities.<sup>γ</sup> According to the present Resident Coordinator, increased salience would be placed on system coordination if member agencies were obliged to contribute financially to the RCS.<sup>106</sup> The RC's report for 1995 raised the fundamental point, as did agency officials, that the RC lacks the authority to ensure effective collaboration and as a consequence, the process remains voluntary on the part of UN organisations and, importantly, their representatives.<sup>λ107</sup> The report also drew attention to the lack of staff budget and conflicting agency-specific mandates.

## **Box 2: Constraints to UN system coordination**

### *Individual UN agency*

1. Lack of clarity among staff on rationale for coordination.
2. Differing perspectives and priorities among agencies.
3. Negative perceptions of other agencies.
4. Lack of familiarity with programming cultures of other agencies.
5. Concern that coordination will increase bureaucratisation and reduce action.
6. Officials lack time and resources (i.e., other higher order priorities prevail).
7. Country-level officials lack direction and guidance from headquarters.
8. Competition among agencies for leadership, visibility and resources.

### *RCS level*

9. RCS dependent on personalities and personal chemistries of participating officials.
10. RC lacks authority over system in which participation remains voluntary.
11. RCS lacks resources and impartiality.

### *Government level*

12. GOB has not provided a framework within which to coordinate UN assistance.
13. GOB encourages bilateral interaction with UN organisations instead of working through RCS.

In summary, the RCS is impaired by a lack of authority, incentives, resources and agency support. The previous RC asserted that almost all agency heads expressed the need to strengthen the system.<sup>108</sup> Yet, improvement is dependent upon clearer direction from headquarters coupled with incentives and penalties. It is pertinent to note that although

<sup>γ</sup> Interviews of agency chiefs found that the RC was alone in having coordination listed as a distinct activity in his job description.

<sup>λ</sup> There is anecdotal evidence that the motivation to coordinate is to some extent dependent on personal proclivities and the personal chemistry between officials. For example, many officials complained that one agency chief was particularly difficult to work with and they were pleased when he did not attend various meetings.



the most germane General Assembly resolution on coordination was adopted in 1989 (i.e., 47/199), by mid-1993 only one of the UN organisations in Bangladesh “had so far received a full and clear briefing from its headquarters” on the resolution.<sup>109</sup> Some have argued that support from member agencies will not be forthcoming while UNDP appears to remain at the helm of the RCS. They suggest that authority must lie with a neutral or more representative agency, or that some other mechanism be found to ensure the impartiality of the RCS. The RC in Bangladesh proposed that impartiality could be achieved with UNDP management, provided that funding was secured from the UN centrally (i.e., not from member organisations or UNDP).<sup>110</sup> Nevertheless, even if the present system can be improved, its sufficiency in relation to coordination of the entire donor community will remain circumscribed until it encompasses non-UN organisations in the process. This is particularly the case in the health sector where numerous bilateral agencies (including the AsDB) collectively disburse approximately 55% of aid to the MOHFW.<sup>111</sup> Nonetheless, it is unlikely that the RCS will assume any prominence in coordination beyond the confines of the UN family, even if it aspired to do so.

#### **4.9 The irrelevance of UN system coordination to health sector aid coordination**

At the sectoral level, the potential of the RCS to improve coordination does not appear promising. Accordingly, the RCS does not perform very well against the conceptual framework for assessing coordination, as summarised in Table 9 below. This is principally because the tools are too blunt to deal with the specificity of sector planning. Where more focused coordination initiatives have evolved, such as UNAIDS or joint UN support for decentralisation reform, the emphasis has tended towards cross-cutting and inter-sectoral issues, as opposed to coordination within one particular sector or in support of one line ministry. The RCS may, therefore, be necessary in terms of UN system coordination, but insufficient from the standpoint of sectoral coordination.

WHO, UNICEF and UNFPA, joined by other multilateral organisations which provide support to the health sector, might have been expected to utilise the RCS to coordinate their assistance to the MOHFW. WHO in particular, as the UN’s specialised health agency and as the organisation mandated to provide leadership to UN organisations involved in health-related activities at the country level, may have spearheaded the use of RCS instruments to promote aid coordination in the sector. By the time, however, that the RCS was being introduced, it is generally agreed that WHO was not well positioned to fulfil this mandate. WHO’s potential for leadership was undermined by at least five factors. First, it is only one of a host of actors in the sector, many of which are more influential in terms of resources and expertise (see Tables 5 and 6 in Chapter 2). Second,

the organisation's modest financial programme (i.e., regular budget funds) is fragmented into a large portfolio of small technical assistance projects which results in the programme being spread very thinly.<sup>σ112</sup> Third, there is the perception within Government and other donors that WHO's main function is the provision of technical assistance and not leadership. Such perceptions have been reinforced by its inability to consistently deploy well-regarded professionals with expertise in planning and systemic reform. Fifth, an evaluation of the organisation suggested that close ties between the WHO country office and the MOHFW acted as a "hindrance for greater inter-UN agency collaboration."<sup>113</sup> Yet, paradoxically, WHO has relatively poor access to the Minister and infrequent access to the Secretary (compared, for example, to the World Bank). WHO officials conclude that in light of the coordination services provided by the Bank it would not be feasible for WHO to spearhead a successful initiative to coordinate UN agencies in the sector.<sup>114</sup>

There is little evidence to suggest that the multilateral agencies entertained the notion of using the RCS tools to improve coordination. This did not occur, in part, due to the general weaknesses of system, but also to the covert (and sometimes open) competition among the UN organisations for: (1) leadership; (2) bilateral resources; (3) visibility; and (4) access to MOHFW officials to ensure that their corporate agendas were met. The tendency among the organisations for rivalry over sectoral leadership has been illustrated earlier in this thesis (section 2.8.2). The constraint to coordination imposed by the exigency of multilateral competition for bilateral funding is less demonstrable. What is clear is that the 14% surcharge on elements of bilaterally funded projects executed by WHO in Bangladesh acted as a lifeline for the agency at the country level (e.g., funding the majority of staff). An example of the pressures faced by agencies to remain visible and how this might militate against coordination is provided by UNFPA. Its representative in Dhaka informed headquarters that, in light of the crowded donor environment in Bangladesh, UNFPA "was facing a real challenge to remain visible."<sup>115</sup> In relation to UNFPA's experience in the Consortium, the representative noted that "the rivalry between the donors, especially the Bank and UNFPA is sometimes rather strong. The efforts made by UNFPA to be visible...are not always greeted [favourably] by the Bank."<sup>116</sup> Visibility was of similar concern to UNICEF. In discussions between UNICEF and the World Bank on the possibility of UNICEF participation in the Third Health and Family Planning Project, the Bank assured UNICEF's Executive Director, James Grant,

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<sup>σ</sup> For the 1996/97 biennium, WHO programme budget for Bangladesh amounted to roughly US\$ 9 million. With these funds, 35 projects were to be supported which was the equivalent of \$ 128,000 per project per year on average each.

and the Dhaka-based representative, that “UNICEF’s identity would be fully preserved.”<sup>117</sup> The Bank proposed that UNICEF join the Consortium as parallel cofinancier of the Bank project in a similar fashion as the bilateral agencies. However, in recognising UNICEF’s need for a high profile, the Bank suggested that UNICEF take the lead on MCH activities and finance key MCH components which would enable it “to speak on behalf of all agencies assisting the project, thereby giving UNICEF much more financial and political leverage.”<sup>118</sup> UNICEF was, however, despite assurances to the contrary, concerned about the risk of being submerged within the Consortium as an indistinct member. Hence, UNICEF proposed to the Bank that the project be split into two discreet projects: a family planning project led by the Bank and an MCH project led by UNICEF.<sup>119</sup> This proposition was rejected by the Bank and as a result UNICEF opted against participation in this coordination exercise.<sup>121</sup> Finally, competition over access to Government officials is likely also to have inhibited inter-agency coordination. Section 2.8.2 exposed how two multilaterals vied for government access so as to expedite the implementation of their own programmes.<sup>124</sup> The same section also provided evidence of a rivalry over the installation of policy advisors in the MOHFW. In conclusion, competition among the agencies has taken on many guises and has likely played a rôle in the ambivalence demonstrated by the organisations to pursue closer relations. As noted by the UNFPA Country Director: “if it is important to strengthen UNFPA collaboration with the Bank and the bilateral donors, it is also *most important* that UNFPA carry on its PRSD [programme formulation exercise] as planned in order to identify its proper niche, *independently* and without delay.”<sup>125</sup> He concluded that “overall, the collaboration with the World Bank has not been beneficial to UNFPA.”<sup>126</sup>

The lack of willingness to pursue coordination vigorously at the sector level may also, however, have been related to the propensity for ‘mandate spread.’ Mandate spread is proposed to describe a progressive and cumulative extension of an agency’s interpretation of its formal mandate into a more broadly defined effective mandate. It will be recalled that thirteen multilateral agencies provided support to the MOHFW during the period 1992-96. These organisations were motivated to become involved in the sector for a number of reasons including, for example, the availability of bilateral funds for project execution as well as shifts in thinking about development determinants, etc. Nonetheless, the organisations could readily justify their involvement by the impact of health-related activities on their organisation’s primary *raison d’être* (be that children, population, nutrition, women, or labour). The relative importance, however, that these agencies consequently attached to developments, including aid coordination, within the health sector may, of necessity, have been diminished by the fundamental concern they

held for the primacy of their mandated target group and related GOB partner organisations. Hence, fulfilling the obligations imposed by their respective formal mandates, may have taken place at the expense of attention to coordination at the sector level, irrespective of who led the process.

The impact of mandate spread on the willingness to pursue sectoral coordination can be illustrated by the cases of UNICEF and UNFPA. UNICEF is driven by the global consensus on children's rights articulated in the Convention on the Rights of the Child (1989) and given greater expression through the goals agreed at the World Summit for Children in 1990. These are reflected in the Summit's Plan of Action and include not only a range of health-related goals but also those relating to basic education, water and sanitation, and rights, *inter alia*. In Bangladesh, the goals are incorporated in a National Programme of Action for Children (NPA) which is, appropriately, multi-sectoral in scope and multi-ministerial in implementation.<sup>127</sup> To translate these goals into reality, UNICEF places much advocacy capital in support of a large number of Bangladeshi civil and state associations and committees. UNICEF's programme is given expression through a high-level review and coordination body, called the Joint Government-UNICEF Advisory Group (JGUAG). This group is chaired, appropriately, by the Planning Commission and has its secretariat in the Economic Relations Division, not the MOHFW. Consequently, senior UNICEF officials take greater interest in expending their political resources on broad, child-focused coordination through the JGUAG and other committees than on instruments designed solely to facilitate health sector coordination. Although the MOHFW is not the principal partner of UNICEF, the Fund does make significant investments in the health sector, in part, through the MOHFW. UNICEF's attention within the ministry is primarily, however, directed at a limited number of vertically organised, child-survival interventions (for example, CDD and ARI programmes). Strong relationships have developed between UNICEF and the MOHFW at the level of national programme/project directors and significant resources have been invested to ensure that these programmes yield results, in spite of the relatively dysfunctional health service infrastructure. Thus from both ends of the spectrum, concern with sector-wide coordination of external health investments has been passed over in favour of emphasis placed on higher-level, inter-sectoral bodies and lower-level project implementation.

Mandate spread appears to have also circumscribed UNFPA's interest in health sector aid coordination. As the Fund's central mandate is to promote population goals, its advocacy has focused on the National Population Council and, post-Cairo, on the National Committee for the Implementation of Recommendations of the ICPD (both bodies are

high level, multi-sectoral, and multi-ministerial). While the MOHFW is a key counterpart of UNFPA, health (sexual and reproductive) is only one of three main areas of work for the Fund. Consequently, a regard for the health sector *per se* and partnership with the MOHFW is only one of a number of competing interests of the Fund. The UNFPA Representative made this trade-off explicit in defence of criticisms against his lack of participation in coordination mechanisms, by drawing attention to the fact that UNFPA has its own programme to implement which must take priority.<sup>128</sup>

For UNICEF and UNFPA, and probably to an even greater extent the other UN organisations (with the exception of the World Bank), the imperative to realise their distinct mandates works against their support to mechanisms designed for health sector coordination. Corroborative evidence is provided by the extent to which the multilaterals participate in the World Bank-led Consortium, in which WHO, UNICEF and UNFPA each have some form of association (this is explored in the following Chapter). An examination of the participant lists of the meetings of the Consortium held between 1992 and 1997 reveals that 41 meetings were held. WHO participated in 92% of these meetings, but UNICEF and UNFPA only attended 70 and 34 percent respectively.<sup>129</sup> Indeed, the very existence of the Consortium may have detracted attention from the need to pursue initiatives within the United Nations system to coordinate aid in the health sector. It is arguably the case that WHO, UNFPA and UNICEF devoted considerably more resources to coordination through the Consortium than through the RCS. As is demonstrated in the next Chapter, however, the Consortium is plagued by a number of serious short-comings which limit its suitability as a substitute for improved UN coordination, among them the tendency of the UN agencies to remain relatively independent of it.

**Table 9: Assessing UN coordination against the conceptual framework for aid coordination**

Process criteria	Remarks
Ownership	<ul style="list-style-type: none"> <li>Established under the authority of the UN Secretary-General, the RCS is owned by the entire UN. In practice, due to management arrangements, the RCS is perceived to be owned more by UNDP than by the other agencies.</li> <li>Were individual mechanisms led by UN organisations other than UNDP, ownership might be more widely shared (e.g., follow-up to the Cairo conference which was led by UNFPA and involved an additional three agencies).</li> <li>There is limited joint-ownership of the mechanisms. UNAIDS provides an exception: the Theme Group is chaired by the Resident Coordinator while the Programme has locally-based staff reporting to its HQ in Geneva.</li> <li>There is little Government involvement in the RCS. No steps are being taken to institutionalise the system's activities within the Government – with the exception of the Country Strategy Note.</li> </ul>
Participation	<ul style="list-style-type: none"> <li>Participation in the mechanisms vary. The JCGP is a very restricted group of UN agencies as is UNAIDS. The Heads of Agencies meetings attract a larger group of agencies as does work on the Country Strategy Note.</li> <li>The JCGP and HOA meetings appear to be well attended, UNAIDS less so.</li> <li>Involvement in the mechanisms is limited to select UN agencies and therefore excludes bilateral donors, the Government as well as civil society.</li> </ul>
Periodicity & continuity	<ul style="list-style-type: none"> <li>The meetings of the system are regular, frequent (mainly monthly or quarterly) and continuous.</li> <li>The Country Strategy Note and the Common Country Assessment are intended to be on-going processes, yet completing either as a one-off exercise has not yet occurred.</li> </ul>
Integration	<ul style="list-style-type: none"> <li>To the limited extent that the JCGP and HOA groups make contributions to the Annual Consultative Group meetings as well as make joint statements on policy issues, they are reactive, as opposed to being integrated, to the policy process.</li> <li>The RCS has not effectively harmonised member programmes and thus these are not well integrated into the GOB planning cycles.</li> </ul>
Realm	<ul style="list-style-type: none"> <li>Emphasis is placed on consultation and, to a lesser extent, concertation while operational coordination is very limited.</li> </ul>
Breadth	<ul style="list-style-type: none"> <li>The focus of the RCS is mainly on the macro-level with emphasis on inter-sectoral linkages.</li> <li>Most instruments lack specificity for sector-oriented coordination.</li> </ul>
Authority & adherence	<ul style="list-style-type: none"> <li>The authority and legitimacy of RCS instruments are eroded in the case of the specialised agencies by virtue of these agencies reporting to their own autonomous governing bodies and to a lesser, but still appreciable, extent in the case of the Programmes and Funds which operate relatively independently of the Secretary-General.</li> <li>Very few agencies bind themselves to commitments made under RCS auspices.</li> <li>The programmes of the individual organisations are developed relatively independently of the RCS.</li> </ul>
Costs	<ul style="list-style-type: none"> <li>Compared to the US\$ one million annual cost of the Population and Health Office, which coordinates aid associated with the FPHP, the RCS budget of US\$ 60,000 is modest. However, this does not include the staff costs.</li> <li>UNAIDS presents poor value-for-money.</li> </ul>
Outcome Criteria	Remarks
Efficiency	<ul style="list-style-type: none"> <li>In that UN system coordination does not emphasise operational coordination nor the use of common implementation/management arrangements, few efficiency gains are achieved through the RCS.</li> <li>Little progress has been made in harmonising programming and administrative procedures.</li> <li>UNAIDS may potentially reduce duplication of activities but it is not clear that the other instruments serve this objective at the level of the health sector.</li> </ul>

Effectiveness	<ul style="list-style-type: none"> <li>◊ There have been limited attempts to harmonise some policy signals among the agencies - but these have been very few.</li> <li>◊ The UN coordination instruments have not been particularly useful in encouraging UN agencies to pursue common objectives nor do its agencies use the mechanisms to engage the MOHFW in dialogue over sector priorities. Consequently, it would not appear that the RCS improves sector effectiveness.</li> </ul>
Equity	<ul style="list-style-type: none"> <li>◊ Recent initiatives may harmonise remuneration for GOB staff under UN-sponsored programmes which would improve equity in a limited manner.</li> <li>◊ No impact on the equity in terms of payment for services or targeting of assistance.</li> </ul>
Sustainability	<ul style="list-style-type: none"> <li>◊ The mechanisms are driven and owned by the UN without any indication that GOB participation is intended; thus national capacity development for coordination is not under consideration and sustainability unlikely.</li> <li>◊ The existing system is financially dependent on UNDP which places the RCS in a vulnerable position.</li> <li>◊ There appear to be few incentives/sanctions for compliance, participation and non-participation in the RCS.</li> </ul>

#### 4.10 Chapter summary

- Due to the significant share of external assistance in the health sector provided by the large number of UN agencies, the need for coordination among them is incontestable.
- A range of global initiatives of the UN to promote enhanced coordination at the country-level have been introduced in Bangladesh under the aegis of the Resident Coordinator System. While these tools provide, to varying degrees, a measure of increased consultation, concertation and very limited operational coordination, the tools remain constrained by numerous factors enumerated in Box 2.
- Notwithstanding the general weaknesses of the RCS, its instruments were not designed, nor do they appear to have been adapted, to facilitate coordination of activities at the sector level. Consequently, the tools are largely irrelevant to aid coordination in the health sector.
- The UN agencies involved in the health sector have not pursued coordination through the RCS. This can be traced to the factors which weaken the system generally and, more specifically to competition among these agencies for leadership, resources and visibility.
- There is evidence that RCS mechanisms were employed to ‘pressure government’ to adopt specific policies and ‘get the UN agenda’ into government plans.
- Hence, while coordination of UN assistance would arguably have been beneficial, if not necessary, the systems which were designed to achieve it are not only relatively ineffective in their application, they are also largely irrelevant at the sector level. A number of characteristics of the UN system should have predisposed it to facilitating coordination (i.e., central authority within a loosely coupled system, directives to coordinate, similar operating procedures, absence of political and economic motives in programming decisions, etc.). Therefore, that the tools of UN coordination ‘failed’ does

not bode well for coordination of bilateral assistance as it is not governed even by these basic facilitating elements.

➤ The entrenched donor Consortium, which pre-dated attempts to bolster UN coordination, has diverted attention from UN agency coordination and thereby further undermined the potential of the RCS.



## 4.11 Chapter Four References

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## CHAPTER FIVE

### **The World Bank's health sector Consortium: coordinator or controller of aid?**

*The notion of 'Consortium' in this case refers to working together as true and equal partners in development in Bangladesh.*<sup>1</sup>

C. Pannenberg, FPHP Task Manager, 1991

#### **5.1 Introduction**

The Consortium, established by the World Bank to coordinate donors around a series of population and health projects, has been described by its architects as 'unique,'<sup>2</sup> 'remarkably effective,' 'a high point in donor coordination,'<sup>3</sup> and worthy of replication in other countries.<sup>4</sup> The Consortium unquestionably represents a lengthy and concerted effort on the part of a number of donors to accommodate differences in policy and operational practices so as to more tightly integrate a proportion of their aid to the sector.

This Chapter describes the evolution of the Consortium, its features and how it operates. The factors which account for its success are identified so as to assess the prospects for similar achievements, particularly those which are led by Government, elsewhere. Also set out are the types of interests which donors, including the Bank, pursued through their association with the Consortium as well as the factors which led other agencies to programme aid independently of the initiative. The exploration of the rationale for membership is pertinent as it offers insights into stakeholder expectations and concerns with respect to aid coordination. Similarly, problems internal to the functioning of the Consortium are analysed for their implications for coordination more generally. In addition, the contributions made by the Consortium are analysed on the basis of stakeholders' views in the context of the impact which it may have had on the ability and willingness of the Ministry of Health and Family Welfare to assume a more active rôle in aid coordination and management.

#### **5.2 Evolution of the Consortium approach**

*A pattern of leadership and assertiveness was established in the First Project that continues to this date.*<sup>5</sup>

World Bank, 1991

Although it was not until the late 1980s that the World Bank began to talk in terms of a ‘consortium approach’ to aid coordination in Bangladesh, elements of the approach arose out of the Bank’s First Population Project in the mid-1970s. The project was appraised by the Bank independently, which hoped through it to coordinate all, or most, external support to the sector.<sup>6</sup> Consequently, the Bank approached other donors for cofinancing; six agreed<sup>a</sup> while three major donors declined<sup>b</sup> because of differences of opinion over technical issues and who would provide leadership in the sector.<sup>7</sup> Nonetheless, the use of a cofinanced project, with attributes such as shared objectives, a common financing plan, the limited use of joint cofinancing, and some common disbursement, procurement, supervision, and reporting arrangements,<sup>8</sup> represents an essential element of the consortium approach.

An additional aspect of the consortium approach involved convening regular meetings of the project’s interested parties. The ODM (now DFID) made it clear prior to supporting the First Population Project that it wanted to “see a local project review committee set up, representing all interested donors and chaired by the Bank, which would meet regularly.”<sup>9</sup> On 3 April 1975, the Bank convened the first such meeting. Participants included a visiting Bank mission, the six cofinanciers, and from the Government, an official from the Planning Commission and one from the Population and Planning Division of the Ministry of Health. According to the Bank, “we intend to hold meetings from time to time of local representatives of donors to the IDA population project and to invite officials of the Government”<sup>10</sup> as part of an ongoing effort to improve coordination of development assistance to Bangladesh.

The third feature of the approach involved establishing an institutional presence in Dhaka so as to provide support to the coordination effort. The benefit of stationing a staff member in Dhaka to coordinate donors associated with the project (as well as those outside) was expressed in a back-to-office report from a Bank mission to Dhaka in April 1974 and couched in terms of the “need for close project supervision.”<sup>11</sup> The Bank considered three possible options for its field presence: (1) the project coordinator could be a member of the Resident Bank Mission (RBM) whose cost could be met out of the IDA administrative budget; (2) the coordinator could be a member of the IDA staff seconded to the Government and financed out of the IDA credit; or (3) a member of the

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<sup>a</sup> These were AIDAB, CIDA, KfW, NORAD, ODM (later ODA then DFID) and SIDA.

<sup>b</sup> These were USAID, UNFPA and WHO.

RBM and financed by the cofinanciers on a *pro-rata* basis. While the third option was favoured, one staff member anticipated problems in reaching consensus among donors on the appointment of an appropriate individual and in securing contributions from them, thereby presaging a number of problems which would arise through the shared financing of World Bank aid management services.<sup>12</sup> Although the Government raised its concern over the precedent and principle of using funds granted from bilateral donors to hire and place personnel on RBM staff, as opposed to within the Government service,<sup>13</sup> its views were ignored as donors agreed amongst themselves on a financing arrangement. According to the formula, the officer's salary and expenses were to be shared by Australia (7%), CIDA (7%), KfW (25%) and NORAD (27%) while the Bank would contribute 34% and the cost of office space, secretarial help, telephone and postage.<sup>14</sup> SIDA did not contribute towards these costs as it was cofinancing the project jointly with the GOB not with the IDA.

In terms of accountability, the Bank's view was that the incumbent should "represent the interests of IDA and the other external donors, and should be responsible to them, *not directly to the Government*. He should therefore be considered a member of the resident mission, administratively responsible to the resident representative."<sup>15</sup> Final responsibility rested, however, with the Bank's headquarters in Washington.

The Bank went to great lengths to reinforce and expand these arrangements with each successive project. In the late 1980s, when the Fourth Population and Health Project (FPHP) was being formulated, a new Task Manager (TM) took up the challenge with renewed vigour. At one stage, it appeared that he might convince 20 agencies<sup>¶</sup> to join the Consortium.<sup>16</sup> In a discussion between a Bank official and the afore-mentioned Task Manager, he reflected upon the effort to establish a large consortium as 'resource-intensive,' 'entrepreneurial' and 'time-consuming.' According to a memorandum<sup>17</sup> of the discussion, the TM "lobbied over a period of years with the numerous donors and forged a consensus that coincided with the GOB's; this involved hopping to the capitals in Europe and Japan and lobbying with every conceivable national agency that had any say..." He also "convinced his Division Chief and Department Director to finance his travel expenses, conference costs, etc. for quite a duration until the bilaterals began to chip in. [The TM] felt that allocating a reasonable 'war chest' to finance all the coordination work with the donors and the Government for at least two years (to ensure

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<sup>¶</sup> The agencies which were described as potential and current members of the IDA Consortium were AsDB, AIDAB, BWZ, CIDA, EC, DANIDA, ECB (Japan), FINNIDA, GTZ, ICDA (Belgium), JICA, KfW, DGIS, ODA, NORAD, SDC, UNICEF, UNFPA, and WHO.



continuity) was important.” It was also crucial that “the TM should be allowed to dedicate himself full-time on this enterprise. In [the Task Managers] case, [his Chief and Director] gave him the time and the resources necessary. It was clear that, in the case of Bangladesh, it was a labour of love from a TM who went beyond the normal boundaries of project design/initiation...” The memorandum provides an insight into the institutional support provided by the Bank to its staff in their pursuit of coordination through the Consortium arrangement.

The Consortium, which has evolved over a period of 23 years, still revolves around a cofinanced project, with common secretariat support and a regularised system of joint monitoring led by the Bank. Although alternative options have been proposed for the organisational arrangements,<sup>ε18</sup> the Bank has been remarkably successful at maintaining its position at the fulcrum of Consortium. As described below, intense differences have arisen among members over, for example, rôles and responsibilities. Tremendous effort has, however, been expended so as to overcome these difficulties through the incremental adaptation of practice, yet the basic elements of the Consortium approach have remained essentially unchanged.

### **5.3 The Consortium and its secretariat office in the 1990s: functions & functioning**

#### *5.3.1 The functions of the Population and Health Office*

The Terms of Reference (TORs) for the first Population Project Officer, written when the incumbent was to commence duties in March 1976, were established as four-fold: (1) to monitor project execution on behalf of the cofinanciers; (2) to assist the GOB in defining population policies and operational strategies; (3) to liaise with other donors participating in population-related activities; and (4) to perform demographic analyses.<sup>19</sup> It was therefore envisioned that through its Population Program Office (PPO) the Bank intended to play a significant coordination rôle both within the project and the sector as a whole. While each additional staff member recruited to the PPO worked according to a specific TOR, it was not until the FPHP was under preparation that a TOR was drafted for the office as a whole. The Staff Appraisal Report (SAR) for the FPHP framed the TORs as follows:

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<sup>ε</sup> For example, alternative organisational structures for the support unit were discussed between the Bank and WHO late in 1988. At that time they were seen to include: “(1) implementation unit in the MOHFP; (2) in RBM in Dhaka; (3) in the Bank in Washington; (4) a Bangladesh population and health consultative group or a consortium with annual meetings in Paris and a secretariat in Washington etc.”

The Population Program Office has operated since 1976 in the Bank Group's Resident Mission in Dhaka to monitor, report on and assist GOB in finding prompt solutions to issues of population and family planning. Because of the increased prominence of health care with the Consortium, the PPO will be expanded as a Population and Health Office (PHO) supported by a technical committee consisting of resident professional advisors from the Consortium members. The supervisory office at the Bank in Washington, DC which coordinates and oversees PHO's activities, will continue its function as under the Third Project. One of the lessons of the earlier projects was that this strong IDA presence provides a Consortium mechanism to promote a cohesive and consistent donor dialogue with the GOB on both policy and operational issues of the national population and health programs. Moreover, the IDA's presence helps to bring about project monitoring and provides technical assistance to the GOB.<sup>20</sup>

Although the TORs are rather vague a number of points bear drawing out: (1) the purpose of the PHO was to monitor, report on and assist the GOB to find prompt solutions, which could be interpreted as assisting the Government 'to get things done' or even 'doing things on its behalf'; (2) both operational and policy dimensions were envisioned; (3) there was a clear distinction between the Dhaka and Washington offices, with responsibility resting with the latter; and (4) the unit, by virtue of its Bank pedigree, provided a means through which to ensure a cohesive policy dialogue with the GOB.

The one-paragraph statement of mandate in the Staff Appraisal Report led to considerable confusion and dissatisfaction among the cofinanciers as to the rôle, accountability and ownership of the PHO (see section 5.8 below). Hence, the Bank drafted a more detailed TOR for the Dhaka-based support unit which, although not formally adopted, illustrates the Bank's view of the functions of the unit.<sup>21</sup> The TORs are set out in three sections: the first covering the rôle of the PHO in relation to the Bank; the second its functions vis-à-vis the Consortium; and the third the accountability arrangements. Under the function of the PHO in relation to the Bank, four tasks are delineated: (1) supervising procurement, disbursement and end use of IDA credits and cofinancier grants placed in World Bank Trust Funds (i.e., joint cofinancing); (2) monitoring compliance with project credit agreements, contracts and covenants; (3) facilitating implementation by helping Government respond to the donors' requirements; and (4) providing technical assistance to the Government in policy, planning and other priority areas. The Bank notes that the first two activities are mandatory as a function of its rules and/or agreements with the GOB while the latter two are discretionary and largely made possible due to financial support from the cofinanciers.

In terms of the PHO's function, as "the leader of the Fourth Population and Health Consortium," four areas are described in considerable detail. (1) Under the heading

‘coordination,’ a series of tasks are set out: the PHO is responsible for managing regular meetings and ensuring the necessary exchange of information at the country level to ensure that all parties are kept abreast of developments in the sector; liaison with agencies contracted by the GOB to implement components of the project (i.e., WHO, UNFPA and UNICEF) and with the numerous implementation offices established by the donors to execute the parallel-financed project components so as to seek information and communicate the agreed views of the Consortium; liaison with actors in the sector who are not members of the Consortium; and the conduct of two annual project supervision missions. (2) In terms of ‘steering,’ the PHO assists the GOB in developing and reviewing sector policy and strategy and acts as a ‘spokesperson’ for the Consortium in communicating with GOB; and undertakes analyses of sector issues to inform Consortium views. (3) With respect to ‘monitoring and reporting,’ the PHO reports on both the implementation of all aspects of the project as well as GOB compliance with covenants and agreements. (4) The PHO also had a mandate in ‘conflict management’ in relation to the affairs of the Consortium, provided that the parties concerned agreed to this rôle.

The section on accountability reaffirms that PHO staff are directly accountable to the Chief of the Resident Mission. Functional guidance was to be provided from Bank headquarters in areas where professional advice was not available in Bangladesh or where changes were required to existing agreements. Thus the TORs make no reference to the cofinanciers in relation to accountability. As discussed below, this arrangement led to frustration among the cofinanciers who, while largely financing the PHO, had no direct input in terms of providing guidance, reviewing its plans or assessing its performance.

The PHO was involved in all of the activities outlined in the draft TORs and thereby made a significant contribution to aid coordination and management. In terms of coordination, a large measure was achieved by engaging other donors in the Bank’s lending cycle. Subsequent to the First Project, project identification, appraisal and negotiation were led by the Bank, according to its procedures, but included the participation of all members and prospective members of the Consortium. Thus, for example, the pre-appraisal of the Fifth Health and Population Project (HAPP-5) included 73 participants representing 15 agencies.<sup>22</sup> During the preparation of HAPP-5, a Local Working Group consisting of representatives of the Consortium, donor agencies not present in the Consortium, as well as Government officials was convened by the PHO and met frequently and regularly. In addition, a log-frame exercise was conducted by the

PHO with 120 stakeholders to translate sector goals (as articulated in the HPSS) into HAPP-5 activities.

The PHO managed two, 2- to 3-week, supervision missions annually for each of the projects. Although one of the annual missions was composed entirely of Bank staff, the other was open to all Consortium members and often included donors not in the Consortium as observers (particularly USAID). Thus, for example, a typical supervision mission of the FPHP included 43 representatives from 13 donor agencies.<sup>23</sup> From the Bank's perspective, "large and frequent missions served as incentive to get on the spot decisions and actions taken that otherwise might have been delayed. And, given the number of donors involved in this sector, these missions were and are certainly effective in ensuring excellent aid coordination and avoidance of redundant, duplicative or interfering activities."<sup>24</sup> These missions were instrumental to the Bank in terms of advancing its corporate policy objectives and an explicit function involved building consensus among the cofinanciers.<sup>25</sup> The projects' mid-term reviews also included representatives from all the cofinancing and implementing donors. Multi-agency participation in Bank project cycles certainly contributed to increased integration of donors, at least around the cofinanced projects: consensus would have developed around project goals and strategies; some complementarity of inputs would have been achieved; and some coherence provided to what otherwise would have been a stream of independent appraisal and supervision missions.

Coordination was also served through the regular system of meetings established in Dhaka as an integral component of the Consortium approach. The first of these was held not long after the First Population Project commenced. Under the FPHP, the meetings were to be held every two months, yet they were often more frequently convened. The PHO managed the meetings, i.e., set the draft agenda, chaired the meeting and wrote the minutes. With the exception of two meetings held in late 1997, the Consortium met during the FPHP without Government representation and did not formally circulate meeting minutes to Government officials. Instead, the Bank would meet with the Government on a bilateral basis to represent the collective views of the Consortium. The meetings served primarily to share information and discuss project implementation issues although some limited attention was directed to policy issues.

The donors entrusted a wide set of aid management responsibilities to the PHO. The increasing use under the successive projects of World Bank Trust Funds resulted in

centralised disbursement according to common rules, GOB reporting only to the Bank (which in turn reported to the donors), centralised accounting and consolidated financial reports. In 1975, the Bank established a Project Finance Cell in the MOHFW to monitoring procurement and disbursement. The PHO supervised the work of the Cell which processed all claims for reimbursement from donors centrally for all components of the project.<sup>26</sup> Later the terms of reference for the cell were broadened to include the monitoring of all claims for reimbursement of expenditure and procurement under the IDA project as well as those made by the GOB with assistance from UNFPA and USAID. The Cell also provided a central facility for following up on the audit observations pertaining to the IDA projects. In the area of reporting, the PHO provided the donors with bi-annual reports on each sub-component of the project as well as statements on the GOB's compliance with legal covenants and agreements reached in the aide-memoires. Through the institutionalisation of these procedures, donors within the Consortium were enabled to utilise joint aid management systems for a proportion of their assistance to the FPHP. Nevertheless, some donors, notably the EU and GTZ provided parallel financing and relied on exclusive bilateral financial monitoring systems.

### *5.3.2 Staffing, costs and finance of the PHO: a 'fat and bloated bureaucracy'?*

The project office in Dhaka, first the Population Project Office (PPO) and later the Population and Health Office (PHO), was strengthened in line with the increasing size and complexity of the successive projects. During the First and Second Population Projects, the office consisted of one expatriate and one Bangladeshi professional. An MCH specialist was added in 1986, both to support the workload associated with the expanded volume of resources, and also to reflect the changed content of the Third Population and Family Health Project (TPFHP). For the FPHP, the staff complement increased significantly. There is, however, some ambiguity over who comprises the PHO staff. One definition, held by many cofinanciers, includes only those staff financed from the Consortium members resources, with the exception of the specific allocation from the Bank to the PHO budget under the FPHP. This would not, however, include the significant contribution made by Bank core staff to the project. At times, the Bank took the view that the PHO included all staff who were directly engaged by the Bank and working on the project irrespective of their funding source and location of duty. At other times, the PHO referred only to the project support office in the RBM. In 1997, there were eleven professional staff working in the Dhaka and Washington offices of the Bank on the FPHP (Table 10). In that the PHO is managed by the Bank, its staff are recruited, contracted and evaluated according to Bank procedures and rules.

**Table 10: Staffing of the Population and Health Office in 1997**

<b>Dhaka-based staff</b>	<b>Washington-based staff</b>
1. PHO Chief + FPHP Task Manager (international)	1. Task Manager for HAPP-5 Preparation
2. Population Specialist (international)	2. Population Specialist
3. Public Health Specialist (international)	3. Operations Specialist
4. Health Consultant (national)	4. Health Economist
5. WID Consultant (national and added late in FPHP)	
6. Operations Specialist (national)	
7. Senior Procurement Specialist (national)	
<b>Support Staff</b>	<b>Support Staff</b>
Three secretarial staff	Two secretarial staff

In contrast to the modest cost of the PPO for the TPFHP, budgeted at US\$ 1.3 million for its five year duration,<sup>27</sup> the cost of the PHO was set at US\$ 6.003 million for the envisioned five year life of the FPHP.<sup>28</sup> The budget of the PHO was, therefore, just over a million dollars per year, which represented approximately 1% of the total expenditure of the project. While the lion's share of the PHO's expenses were associated with salaries (i.e., US\$ 4.5 million), approximately US\$ 1.5 million consisted of 'discretionary costs' such as travel, consultants fees and communication. It is likely that the availability of this large pool of discretionary funds was of utmost importance to the relative effectiveness of the Consortium in that it provided the convenor with great flexibility in responding to crises as they developed.

As with earlier projects, the cost of the PHO during the FPHP was shared among the cofinanciers and the Bank. Table eleven presents the financing plan for the PHO at the time of pre-appraisal. The Bank's contribution was met out of its central administrative budget and fees earned from administering Trust Funds on behalf of the cofinanciers, while the cofinancier's contributions were apportioned from their grants to the GOB.

#### **5.4 Financial coordination through the Consortium**

Participation in the First Population Project was limited to the Bank and 6 bilateral agencies (see Annex 6 for a list of cofinanciers for each of the four projects). During the FPHP, nine bilateral donors were members of the Consortium. Two significant donors to the sector, USAID and AsDB, and a host of smaller ones did not cofinance the project and, therefore, did not affiliate themselves with the Consortium. None of the UN organisations channelled their regular funds through the cofinanced projects of the Consortium, although three of the major health-related agencies had some form of association with the Group. WHO gained membership by virtue of executing a number of sub-components financed by the bilaterals. UNICEF became involved as it was implementing and/or supporting a number of health programmes which received

assistance through the FPHP. The status of UNFPA's association with the Consortium, although unclear in the eyes of the Consortium members (see below), comprised assisting the Government to implement activities financed by the FPHP.

**Table 11: Financing of the PHO for FPHP<sup>29</sup>**

Donor	% of total cost
Australia (AIDAB)	3.0 %
Belgium (BADC)	1.6 %
Canada (CIDA)	20.0 %
EC	13.0 %
Netherlands (DGIS)	8.0 %
UK (ODA)	8.0 %
Norway (NORAD)	13.0 %
Sweden (SIDA)	5.0 %
Japan (JICA)	1.6 %
Germany (KfW)	13.0 %
Germany (GTZ)	--
IDA	11.0 %
TOTAL	97.2 % <sup>ξ</sup>

<sup>ξ</sup> Does not equal 100% due to rounding

The extent to which the Consortium managed to coordinate aid in the sector was far from complete. Table 12, although not providing a comprehensive picture, suggests that the Consortium coordinated the disbursement of almost US\$ 78 million per year but that other donors committed a large amount of aid to the MOHFW independently of the Consortium initiative. The Table only reflects, however, the resources of the major agencies and, therefore, does not take into consideration the aid of all 31 agencies known to have committed and/or disbursed funds to the MOHFW between 1992 and 1996. It proved impossible to obtain this data, as the funds provided by the smaller agencies were particularly difficult to ascertain. Even the Health Economics Unit of the MOHFW was frustrated in its attempt to paint an accurate picture of the flow of funds in the sector due to the lack of readily available information and the failure of certain donor agencies to provide the data when requested to do so.<sup>30</sup> It is important to stress that the Table also fails to include those resources provided by the Consortium members to the sector outside of the FPHP. In the case of a number of members, their support to the health sector, directly to the GOB or to NGOs, outside the FPHP was substantial. For example, DGIS provided approximately US\$ 4.1 million annually to the FPHP while it channelled US\$ 4.5 million annually through other mechanisms to the health sector.<sup>31</sup> In the case of Sida, only approximately 50% of its health sector aid was allocated to FPHP activities.<sup>32</sup> The ODA (DFID) provided approximately US\$ 3 million outside the FPHP over the course of the project (i.e., 10% of its support).<sup>33</sup> The EC,<sup>34</sup> JICA,<sup>35</sup> and CIDA<sup>36</sup> all provided some funds to the sector which were additional to the FPHP. Given these caveats to Table 12,

and in keeping with estimates provided by the MOHFW, the Consortium likely coordinated approximately one third of external resources in the sector.

**Table 12: Rough annual disbursement/commitment by major donors to MOHFW, through Consortium and outside Consortium (US\$ millions)**

Consortium donors (disbursements)		Non-consortium donors (commitments)	
World Bank	31.4	American USAID	30.0
German GTZ	2.1	UNICEF	14.0
German KfW	13.1	Asian Development Bank	10.0
Canadian CIDA	6.3	UNFPA	6.0
Norwegian NORAD	4.8	WHO	5.0
UK DFID	4.5		
Dutch DGIS	4.1		
Swedish Sida	2.5		
Australian AusAid	0.8		
European Community	8.3		
TOTAL	77.9		65.0

### 5.5 The World Bank's interests in the Consortium

As the founding member and lead agency within the Consortium, the World Bank believed that the benefits of the Consortium outweighed its costs. While the language used to describe these benefits changed over time and with respect to the intended audience, one can discern four distinct objectives sought by the Bank through the Consortium: (1) to maximise resource mobilisation; (2) to make more effective use of aid; (3) to promote a coordinated approach to policy; and (4) to reduce the burden of aid management devolving to the GOB. A fifth, largely unstated, benefit lay in the Consortium's ability to bestow upon the Bank leverage over the sector.

For the Bank, donor cofinancing of its successive projects provided a mechanism to ensure that more resources were available to support the policy objectives which it pursued in the population and health sector in Bangladesh. Population control has been a high priority corporate objective of the Bank since its leadership under McNamara<sup>37</sup> which coincided with the first two Bangladesh population projects. The consortium enabled it "to maximise external aid"<sup>38</sup> and to "increase the flow of funds for this field from small donors who would have been unable otherwise to formulate projects."<sup>39</sup>

Not only did the Consortium capture bilateral aid for deployment within Bank initiatives, it also provided tools to increase this aid's effectiveness and efficiency – thereby furthering the Bank's policy interests. The Consortium made 'aid go further' in five ways. First, there were savings to be made from pooling resources and operations. As the Bank argued, "having each donor pushing separate proposals is counter-productive,



leading to diffusion of financial and administrative resources.”<sup>40</sup> Second, through the arrangement, bilateral grant funds were combined with the IDA credit “allowing greater flexibility in project planning”<sup>41</sup> making possible what might have otherwise not obtained. Third, the deployment of aid from a large number of donors within one project avoided duplication of activities. Fourth, the Bank claimed that multi-party financing encouraged, to some extent, organising donor contributions on the basis of cost-effectiveness considerations.<sup>42</sup> Fifth, it prevented some competition among donors which would have otherwise inflated the costs of local resources, dissipated resources through duplication of some activities while less appealing ones remained without aid.

The third benefit of the Consortium to the Bank was its ability to filter conflicting donor signals and amplify those which it sought to advance to the Government. In reflecting on the first two population projects, the Bank maintained that it “has succeeded to considerable extent in harmonising the frequently conflicting views of cofinanciers regarding program emphasis and strategy. Through its leadership rôle, IDA has promoted better Bangladesh policies and a steadier national course than would have taken place if each cofinancier had sought to press its own views on the Government without regard to the broader perspective of other donor concerns and interests.”<sup>43</sup> Hence, the Bank enthused that the ‘continued’ use of the Consortium during the TPFHP would “ensure consistent, rather than mixed, signals to Government on important policy issues.”<sup>44</sup> The Bank suggested that policy consistency resulted from two factors associated with the Consortium. First, the PPO “provides a mechanism to promote a cohesive, consistent donor dialogue with GOB on the national population and family health program.”<sup>45</sup> Second, the Bank drew attention to the importance of cofinancing. For example, the Project Completion Report for the Second Population and Family Health Project concluded “Looking back, it is doubtful whether the commonality of approach now prevailing would have been possible, but for the cofinancing arrangements worked out by the Bank during the first project and continued thereafter for the subsequent projects. Coordination by other means, without cofinancing, might not have produced the same degree of results. It is quite possible that ideological considerations might have been the predominant factor governing the choice of their project, if the ten major donors had dealt with the Government separately.”<sup>46</sup> In the survey conducted for this research, two thirds of respondents agreed that policy dialogue and consensus building within the Consortium had resulted in a diminution in the amount of conflicting policy advice provided by donors independently to the Government.

The Consortium, and more specifically the overwhelming presence of the Bank therein, also served to influence donor thinking with respect to policy. For example, the Bank asserted that the Government “did not get conflicting advice from various donors [because] during IDA missions many of the donors get [a] proper briefing that changes their perspective. This would not be the case if they visited individually and did not have the chance of checking their perceptions with others [i.e., Bank staff] having knowledge and background of the program.”<sup>47</sup> In other words, the Consortium provided the Bank with the means to keep the cofinanciers ‘on message.’ It is important to bear in mind that while the Bank spoke in terms of the benefits extended by the PPO/PHO to the Government, achieving policy consistency among the donors served the Bank’s interests as well. In the words of one agency representative, which after protracted negotiations with the Bank decided not to finance the FPHP, the Consortium was used by the Bank to “exercise leadership” and “influence donors” with respect to policy in the sector.<sup>48</sup>

Lessening the burden of aid management which fell upon the Government was one of the objectives of the consortium approach<sup>49</sup> and the Bank often made assertions that it was successful in this regard. For example, the Bank claimed that “it saved a lot of time for Government officials in dealing with donors individually both in the formulation and implementation stages of the program.”<sup>50</sup> In particular, the Consortium “minimised GOB’s aid management burden” through, for example, the “drastically reduced number of supervision missions” the Government had to prepare for.<sup>51</sup> Indeed, a central function of the PPO/PHO entailed aid management. The cofinanciers were willing to channel funds through Bank systems (as opposed to through categorical ones they might have otherwise established or those of the GOB) because they presented the possibility of cost savings and because confidence could be placed in them. The arrangement also suited the Bank because, through the PPO/PHO, the cofinanciers subsidised a Bank lending programme, facilitated the deployment of a large number of Bank staff to the field and, thereby, increased the control the Bank had over a significant proportion of the finance available in the sector and, thus, its influence more generally. In the Bank’s words: “The Bank *led* the Consortium and coordinated the mobilisation of grant resources for the sector as also program planning and aid administration. Establishment of a cofinanciers funded PPO/PHO was necessary for the Bank to play this rôle effectively.”<sup>52</sup>

The four benefits of the Consortium described above were widely proclaimed by the Bank in a non-self-serving manner. According to the Bank, the effort represented “a sincere and honest attempt on the part of all the parties to work towards the common

good of Bangladesh.”<sup>53</sup> Although it can be inferred that the Consortium was of benefit to the health sector in Bangladesh, the arrangement was equally beneficial to the Bank. The Consortium bestowed leverage upon the Bank enabling it to steer developments in the sector according to its precepts and interests.

Although the Bank suggested that it sought a position of equality with other donors in the Consortium, in reality *premus inter pares* was its true objective. Thus, on the one hand, the Bank “explained that it was not part of IDA’s intention to play the rôle of coordinator... The only reason for our seemingly visible rôle has been the need to discuss the technical details of the project with various donors on the request of the Government.”<sup>54</sup> On another occasion, the Bank assured SIDA “that we certainly are not looking for pre-eminence of the Bank as such, but rather are working as a group of completely equal partners to increase the effectiveness of all our investments.”<sup>55</sup> In its correspondence with potential cofinanciers, the Bank spoke of assuming a share of the costs of the project “sufficient to carry respectable weight in total project financing.”<sup>56</sup> On the other hand, internally the Bank maintained that its “contribution should be sufficient enough to permit a leadership rôle in the project.”<sup>57</sup> When Bank management weighed in favour of a smaller Bank contribution for the First Population Project (i.e., US\$ 15 million as opposed to US\$ 20 million), project staff were anxious about a “possible reduction of leverage.”<sup>58</sup> Consortium leadership positioned the Bank at the epicentre of sector developments. As the Bank, for example, pointed out: “As leader of the Bangladesh Population and Health Consortium, IDA is in a strategic position to carry out the sector review... The review process can be used to continue the policy dialogue with the Government and thus is likely to strengthen the rôle of the Bank in the sector.”<sup>59</sup>

The Bank justified its rôle as leader of the Consortium in terms of its comparative advantages. The first advantage being the leverage it achieved through the volume of resources it had at its disposal. For example, the Bank argued that “as the largest donor,” it had the “capacity to help pull other donors together for a common stance in regard to program priorities and content.”<sup>60</sup> Second, the Bank suggested that if it did not organise cofinancing, the MOHFW would not receive the volume of funds that it did from other donor agencies. “Alternative mechanisms...[would be] possibly threatening to the resource needs of the program.”<sup>61</sup> Third, the Bank highlighted its alleged neutrality as a key factor differentiating it from other donors:

It is clear that no alternative to the Bank’s mechanism for donor coordination is acceptable to the GOB at this time: Senior GOB officers welcome the rôle of the Bank as a coordinator... The Bank, as a lending agency, is viewed less as a donor than as a collaborating agency. The notion that any donor could somehow replace

the Bank as a coordinator of donors is unacceptable, since donor coordination could evolve into a mechanism for external direction and control of the program. This is a reasonable concern given the fact that nearly all resources for the program derive from external assistance. The Bank style of relating to the GOB as a borrower makes its rôle as a donor-coordinator acceptable as a neutral partner in decision making. If the Bank did not exercise a coordinating rôle, some other less effective and less acceptable mechanism would emerge.<sup>62</sup>

Moreover, as noted above, there was no clear alternative among the Consortium members in terms of leadership. Consequently, the cofinanciers agreed to the Bank's leadership and hoped that it would continue under HAPP-5, should a donors-only coordination mechanism persist (see next Chapter).<sup>63</sup>

### **5.6 Concerns within the Bank over the Consortium**

Although the Bank successfully pursued a number of objectives through cofinancing and the Consortium, there were concerns within the Bank over the actual and potential costs associated with sponsorship of the arrangement. A Bank Vice-President, for example, reminded staff working on the Bangladesh programme that coordination carries costs in terms of administrative complications, staff time and relations with the borrower country.<sup>64</sup> Four distinct concerns were aired: (1) the possibility that Bank leadership of the Consortium might conflict with the principle of recipient leadership in aid coordination; (2) the possibility that the rôle of facilitator and honest broker might erode or conflict with Bank corporate policies; (3) the costs of maintaining the PHO exceeding Bank norms; and (4) the detrimental effect that reliance on the RBM for project implementation might have on MOHFW capacity.

In relation to the principle that recipient leadership be observed, staff preparing the Second Population and Family Health Project were instructed by their management that the Bank "is not to undertake any coordination on behalf of the Government in regard to program activities not directly associated with our project."<sup>65</sup> And although the Bank did not aim to provide coordination services for the entire sector, through its central position in the Consortium, it nonetheless assumed significant influence. Such was its pivotal rôle in the sector that a Division Chief in the Bank expressed his concern that the FPHP Task Manager "was replacing the Minister of Health in importance and clout in this area."<sup>66</sup> It is not clear if senior management was more concerned about the perception or the practice that its staff may be usurping the rôle of the chief executive in the health sector.

Another concern harboured in some Bank quarters was that the process of negotiation required within the Consortium to arrive at consensus decisions might dilute the Bank's

corporate objectives. As early as January 1974, in consideration of pre-negotiations for the First Population Project, the Bank raised the question of whether or not the cofinanciers would go along with the “tough stand” of the Bank and “whether their involvement in the project was more important than putting pressure on the GOB.”<sup>67</sup> The Operations Evaluation Department (OED) of the Bank maintained that the pursuit of cofinancing had led to trade-offs and the “sacrifice of program interests.” Although the nature of the “program interests” are not defined, it is likely that the OED interpreted these as Bank interests. Country-level donor negotiation and horse-trading raised another concern with Bank headquarters. This related to the possible impact of conflict within the Consortium on donor relations at the global level. Hence, it was argued that “...it is extremely important that we [the Population Projects Department in headquarters] coordinate from a central point. Any problems with respect to our donors will affect our ability to attract grant funds for Bank-supported population projects.”<sup>68</sup>

Questions also arose over the resource implications of the PHO. In considering whether or not the Bank should use the consortia approach to coordination more widely, the Task Manager of the FPHP warned that “Personally, I think the Bank has a fairly large problem on its hands in this respect, but doesn’t realise it yet.” He considered the need to “spell out the wider implications of the consortia approach for the Bank: hiring and recruitment, staff incentives, travel, cofinancing policy, etc.”<sup>69</sup> Due to the costs and strategic interests served by the Consortium, Bank management stressed that “improved coordination does not mean complete control over every possible externally financed population activity. What is important is to have a coordinated approach among the principal donors who are likely to have views on policy and management and whose programs could have a significant impact on the implementation of the national effort....and nothing we do should give the impression that we seek to involve every donor that expresses interest in family planning activities in our project.”<sup>70</sup> In effect, the Bank was concerned about the human resources required to provide coordination services in the context of the weak public sector in Bangladesh. In preparing the FPHP, Bank staff observed that “The Bank’s structure provides for supervision coefficients which truly reflects supervision needs and not implementation needs. Over the last 15 years, however, the Bank and the cofinanciers have become involved in implementation assistance; not as a plan or future commitment, but as a present-day matter of fact.”<sup>71</sup>

The impact of the day-to-day involvement of the PHO in implementation assistance on the development of Government capacity for aid management was the Bank’s fourth area

of concern. The Completion Report for the Second Population and Family Health Project concluded that “Bank leadership in project formulation, financing and donor coordination should be maintained; however, efforts should be made to transfer this responsibility to GOB in an increasing measure.”<sup>72</sup> Despite such recommendations, the Bank faced the dilemma that if it were to scale-back the level of supervision, it “would put the large investments made so far at risk.”<sup>73</sup>

Despite misgivings about the costs of the Consortium, the general attitude in the Bank was that “while cofinancing did place burden on our staff, the efforts were worthwhile considering the advantages accruing from a coordinated effort.”<sup>74</sup>

## 5.7 To join or not to join? Membership in the Consortium

Unlike that which might be expected from a Government-led aid coordination arrangement for the sector, the Consortium was not designed to include all donors which provided support to health-related activities. Its stated purpose was aid coordination and management for the Bank’s cofinanced projects. And whereas numerous donors were invited to join the Consortium over the course of successive projects,<sup>ψ</sup> a sentiment existed within the Bank that it should not seek to provide coordination services for all donors in the sector. Nonetheless, an exploration of the rationale for membership in the Consortium remains relevant to the study of coordination, for it offers insights into stakeholders’ expectations, objectives and concerns with respect to participation in coordination initiatives. The common and varied reasons for joining the Consortium are listed in Box 3 while the reasons for not so doing so are summarised in Box 4.

### 5.7.1 Reasons advanced for project cofinancing and Consortium membership

In addition to the ostensible reason for joining the Consortium, i.e., to improve aid coordination, donors hoped to pursue additional interests through membership. These ranged from increasing the effectiveness and efficiency of their aid transactions to enhancing their position in policy dialogue. The following examples provide the rationale, and sometimes the language, put forward by the bilaterals in their decision to join the Consortium.

#### **Box 3: Rationale provided by donor agencies for Consortium membership**

1. To place or keep corporate policy issues on GOB/donor policy agenda.
2. To strengthen policy influence vis-à-vis GOB and other donors.
3. To reduce costs of programming individual contributions (i.e., shared managerial & administrative

<sup>ψ</sup> Agencies which were courted by the Bank but declined from joining included at least the following: AsDB, BADC, DANIDA, ECB, FINNIDA, the Ford Foundation, the Population Council, the Government of New Zealand, SDC, UNFPA, UNICEF and USAID.

costs).

4. To improve the impact of bilateral contribution (e.g., complementarity of inputs).
5. To improve prospects for fund disbursement.
6. To improve the quality of monitoring and auditing of contributions.
7. To share responsibility in handling controversial issues.

Working through the Consortium enabled a number of donors to programme aid at a significantly reduced cost and with greater efficacy than would have otherwise been the case. By way of example, in reference to the First Population Project, a review of Norwegian aid to Bangladesh noted

For Norway, with its small ODA administration, a cofinancier rôle in this multi-bilateral arrangement was particularly attractive because it made it possible to commit large sums for family planning without tying down commensurate technical and managerial resources. IDA, in addition to lending a substantial share of the required funds under stringent auditing procedures, supervises the project and coordinates disbursements for the purposes specified by donors.” The report continued: “At the end of 1982, after the three, one-year extensions that were necessary to bring the first phase of the project to a close, one fifth of the original allocation of NOK 45 million still remained unspent. Throughout 1983, efforts were made to disburse that money. Finally it was allocated to...” a construction activity. “This experience nevertheless strengthened NORAD’s position concerning the choice of strategy for assistance to family planning in Bangladesh: what a multi-bilateral arrangement under the sponsorship and supervision of the World Bank could not achieve would be even less likely to be achieved through bilateral program support.”<sup>75</sup>

For the Norwegians, the primary interest in working through the Consortium lay in programming NORAD funds with a maximum amount of accountability for the lowest cost to the organisation. Other donors similarly spoke of the benefits of the Consortium to their agencies in terms of reduced costs for project planning and monitoring sector developments.<sup>76</sup>

Many donors put forward the view that because the consortium approach builds upon the comparative advantages of the distinct parties involved, it thereby improved the synergy of individual donor investments. Japan’s rationale for participation in the FPHP is a case in point. Japan informed the Bank that it had a large amount of funds available for construction, supplies and equipment for the health sector in Bangladesh, but lacked local knowledge about how best to utilise these. Through the Consortium it was able to “secure software support for Japan’s hardware input.”<sup>877</sup> At times, however, donor interest in improving the complementarity of inputs belied domestic motives. For example, NORAD

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<sup>8</sup> Japan did not become an active member of the Consortium as it was unable to conclude a bilateral agreement with the GOB under the umbrella of the FPHP and, therefore, did not disburse any of its committed funds.

described one of its objectives for working through the Consortium as: “to try to make Norwegian expertise available.”<sup>78</sup>

Perhaps donors’ foremost consideration was the effect that Consortium membership would have on their policy influence. NORAD’s TORs, for example, for participation in the Consortium explicitly established its intention to “influence the Consortium, World Bank, and the overall programme [i.e., sector] to be to the highest possible extent in line with the basic principles for Norwegian development assistance and NORAD’s strategy.”<sup>79</sup> According to a CIDA participant in the FPHP negotiations, membership “strategically allows CIDA to influence the GOB’s sector programming at a policy level, key for many of CIDA’s priorities.”<sup>80</sup> CIDA officials believed that the basis of their enhanced policy influence through the Consortium was two-fold: (1) “Because of [Canada’s] long-standing presence [in the Consortium], CIDA has now positioned itself to influence policy directions within the GOB and the Consortium; and (2) the activities selected for the proposed CIDA contribution are critical to achieving the goal of the overall cofinanced project, and would allow CIDA to further strengthen its policy influence.”<sup>81</sup> An ODA official suggested, “donors stay in the Consortium, despite its difficulties, because through its leverage, they can use it to push reforms.”<sup>82</sup> In effect, the Consortium provided its members with an instrument to affect ‘assertive multilateralism’ – to make bilateral concerns more widely shared and to enhance their influence with respect to advancing these.

Due to the Consortium’s influence over the policy process, membership provided a mechanism for getting and keeping corporate concerns and interests high on the policy agenda. Its potential was expressed by the Bank to James Grant, UNICEF’s former Executive Director: “participation in the project [TPFHP] would provide a powerful forum through which to keep Government attention focused on MCH development over the next five years and to ensure a cohesive donor approach to those issues.”<sup>83</sup> The Bank also suggested that as a formal cofinancier, UNICEF would enjoy “much more financial and political leverage” to realise its goals in the health sector.<sup>84</sup>

For some donors, membership provided a communal shield from behind which to advocate bilateral views as though they were widely held. The Bank acknowledged that the Consortium might be used in such a manner. “We might find that several donors would welcome an ‘IDA shield’ to bring some needed pressure on the GOB, pressure which they might be reluctant or powerless to bring individually and which they can



‘leave to the IDA.’ But presumably even sympathetic donors would resent our making it clear to the GOB that their aid (and its formal commitment) would be conditional on fulfilling certain IDA pre-negotiating conditions, even though they might privately go along with the action provided their approval of it were not revealed.”<sup>85</sup> The Consortium could also shield donors from special interest groups in their domestic constituency. For example, during the formulation of the TPFHP, “USAID expressed interest in considering a cofinancing rôle, particularly if the project were to include aspects of the voluntary sterilisation program currently excluded from project cost estimates.”<sup>86</sup> According to the Bank, USAID considered joining the Consortium so as to support sterilisation while simultaneously “reducing bilateral exposure” on this sensitive issue.<sup>87</sup> In effect, through the Consortium, USAID<sup>λ</sup> hoped to gain an international stamp of approval for a bilateral policy objective which was encountering hostility from critics at home and abroad.

After a lengthy involvement in the Consortium, some donors questioned the impact of stepping out of the project on their credibility in donor and Government circles – and therefore, indirectly on their influence. Thus CIDA staff recommended that their Minister approve the Canadian contribution to the FPHP, for not doing so “would jeopardise Canada’s credibility and influence within the donor community and with the Government of Bangladesh.”<sup>88</sup>

While donors may have been pursuing multiple objectives through their association with the Consortium, it is equally the case that the Bank invested considerable resources in making and reiterating the case for membership and applying pressure on donors to join and stick with the Group. When the Norwegians considered withdrawing from the FPHP, the Bank wrote that “despite obvious difficulties and costs....we all need to be as flexible as possible...rather than retreat to the inter-donor fragmentation and competition of earlier days.”<sup>89</sup> In part, Bank fear of donors leaving the Consortium was based on the impact which this might have on the membership of other donors. Such concern is reflected in a Bank memorandum: “a German withdrawal will undoubtedly have an unsettling effect on other donors.”<sup>90</sup> It was not an idle concern, for according to the Bank, “the Swedish decision [to pull out of the TPFHP] was followed by efforts to exert pressure on other donors to pull out and caused a number of them to reconsider their support to the Project.”<sup>91</sup>

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<sup>λ</sup> The Bank accepted USAID’s motivation for participation but ultimately USAID decided against joining the Consortium for other reasons.

In terms of encouraging new entrants, the Task Manager for FPHP reported “that our investments over the last two years to convince the Japanese Government to play a more active rôle in the population and health sectors in Bangladesh are starting to pay dividends.” After Japanese “participation in the pre-appraisal... decisions were made to (1) discontinue interest in the proposed hospitals;... and (3) seek participation modalities with the Bank-led Consortium.”<sup>92</sup> In other words, after Bank lobbying, the Japanese Government reversed its decision over the content of its assistance to Bangladesh and the bilateral nature of its provision in favour of participation in the Bank’s project.

#### 5.7.2 *Reasons for not joining the Consortium*

The rationale held, if not articulated, by some donors for their hesitation to join the Consortium arose from the leadership ambitions which they harboured. Chapter Two provided an account of the competition between the Bank and UNFPA to assume the pre-eminent position; each hoped to develop a financing plan into which other agencies would contribute and to establish a venue for donor coordination under its aegis. The Bank’s analysis suggests that similar aspirations held by WHO, USAID and later UNICEF account for their reluctance to participate as cofinanciers in the Bank projects.<sup>93</sup> The rationale offered by the dissenting agencies was not couched in the language of leadership but in terms of more palatable pretexts, such as those which follow.

#### **Box 4: Reasons advanced for not joining Consortium**

1. Membership would reduce agency’s visibility.
2. Membership would reduce agency’s autonomy.
3. Agency’s resources insufficient to influence decisions in Consortium.
4. Membership would reduce agency’s access to Government officials.
5. Agency dissatisfied with decision-making style in Consortium.
6. Agency dissatisfied with policy decisions taken by Consortium.
7. Agency concerned that World Bank uses leadership to advance its corporate agenda.
8. Concern that membership would reduce plurality of views in the sector.
9. Agency unable to fund and execute favoured project sub-components.
10. Agency sufficiently influential to effect policy agenda without Consortium membership.
11. Proclivities of individual staff.
12. Legal, administrative and/or accountability reasons.
13. Agency dissuaded from joining due to potential impact on dynamics within Consortium.
14. Reasons not associated with the functioning of the Consortium (e.g., domestic crisis).

The possibility that Consortium membership would reduce an agency’s visibility with the GOB and/or domestic constituency presented a problem for a number of donors. For example, with respect to the First Population Project, the Bank noted that after review of the appraisal document, USAID informed the Bank that it could not joint cofinance the project as USAID “required identifiable components ‘on which they could put their flag.’”<sup>94</sup> Similarly, part of UNFPA’s dissatisfaction with the FPHP and its desire to

disassociate itself from the Consortium in the 1990s arose from the perception that it lost visibility by virtue of participating in Consortium activities. In the words of the UNFPA Representative, “The efforts made by UNFPA to be visible as well as the trust given by the Government to it are not always greeted [favourably] by the Bank which would probably prefer UNFPA becoming a full and – indistinct – member of the Consortium under its leadership.”<sup>95</sup>

Over the life of the Consortium, numerous agencies decided against cofinancing the projects because they felt that they had had insufficient involvement in project formulation. The First Population Project was designed by the Bank before it approached other donors for funds. As a consequence, the Bank learned that in the case of the Americans, “USAID is lukewarm to participation in project on grounds that... [they] were not consulted enough.”<sup>96</sup> Chapter Four described how UNICEF, after unsuccessfully exploring the possibility of hiving off the health components of the TPFHP into a separate project, decided not to participate in the Consortium project. UNICEF informed the Bank, that “we are certainly keen to work with you, particularly when we can be associated together at the early stages of a project’s development and thus ensure that the project which emerges is one in which all parties have full confidence.”<sup>97</sup>

In a similar manner, the non-concurrence of some donors with the policy thrusts or certain objectives of the projects presented a barrier to their participation. Indeed, a USAID official argued that a mechanism which included most donors in the sector would be disadvantageous to the development of the sector.<sup>98</sup> The case was buttressed upon the assumption that submerging differences so as to arrive at a common donor position would result in a “puerile common thread ...and the Government would not benefit from the plurality of viewpoints of different donors.” In relation to the TPFHP, the Bank commented that “the main issue will be to maximise other donor participation while obtaining their commitment to submerge some of their particular preferences in favour of a unified cofinancier approach to the program.”<sup>99</sup> Dutch, Norwegian and Swedish support was made contingent upon an expanded maternal and child health focus; about which the Bank, CIDA and the Germans were less than enthusiastic.<sup>100</sup> Other contentious issues also led to threats of non-participation. For example, just after negotiations for the TPFHP, NORAD informed the Bank that there was a risk that Norway would pull out of the project because the Norwegian development minister “is a leading figure in the Christian People’s Party which opposes abortion.”<sup>101</sup>

A policy which led one cofinancier to withdraw from the Consortium was the decision to furnish family planning providers, motivators and clients with incentives in an effort to increase the contraceptive prevalence rate. During the appraisal of the TPFHP, the Bank was of the opinion that “The referral fees issue is a potential break-point with most of the cofinanciers. Germany, the Netherlands, Norway, Sweden and the UK are convinced that they have more negative than positive consequences...Making an assumption that a referral fee system is essential would not reflect our considered views and probably would lead to withdrawal of several prospective cofinanciers.”<sup>102</sup> SIDA eventually withdrew from the Consortium as the incentives debate was not resolved to its satisfaction. SIDA informed the Bank that “instead Sweden hoped to achieve a more direct impact by financing health care in Bangladesh on a bilateral basis.” Yet the Bank was also provided “less ‘open’ reasons including: (1) there were several African countries in which Swedish financing of family planning efforts would afford an opportunity for more leverage than possible in Bangladesh; and (2) recent negative publicity about the Bangladesh population program which had an effect on both public and Government in Sweden.”<sup>103</sup> The Bank considered that “the Swedish decision was based primarily on an unwillingness to face anticipated public criticism of the Project, whether merited or not.”<sup>104</sup> The foregoing suggests that SIDA, as a small contributor to the Consortium project, felt that it did not have sufficient clout in policy dialogue to ensure outcomes acceptable to its domestic constituency. Consequently, SIDA decided to pursue its corporate policy objectives on a bilateral basis; unfettered by the position adopted by the Consortium as a whole.

To some extent, the differences in policy orientation among Consortium members could be accommodated, and their fear over loss of visibility countered, by providing donors the opportunity to parallel finance, execute or be associated with those sub-components of the projects which appealed most closely to their mandates and values. For example, during the TPFHP, Germany provided parallel financing for capacity development of the National Institute for Population Research and Training<sup>105</sup> and during the FPHP, ODA parallel financed and executed the Health Economics Unit.<sup>106</sup> Where this type of accommodation was not possible, due to competition among the donors, the threat and eventuality of non-participation arose. For example, during appraisal of the TPFHP, the Bank commented on “an undercurrent of feeling among some donors, particularly NORAD and the Dutch, that the components earmarked to them for funding do not fit with their preferences.”<sup>107</sup>

The importance attached by some donors to the content and nature of their involvement in the project and the impact which this had on their decision to participate in the Consortium is illustrated by the circumstances which resulted in DANIDA and the Belgians backing out of the FPHP. According to DANIDA,<sup>108</sup> the scope and content of the TAPPs (i.e., the GOB's project planning documents) of sub-components of the FPHP which DANIDA was to have funded were changed by the Bank and Government without adequate consultation. In particular, DANIDA wanted to parallel-finance and execute two components, which, without the concurrence of DANIDA, had been assigned to WHO for execution with financial support from NORAD and SIDA (with joint cofinancing which was preferable to the Bank). DANIDA insisted that if the original TAPPs were not reinstated and the terms for participation not honoured it would withdraw from the FPHP.<sup>109</sup> The Bank deftly responded that the "GOB holds the primary responsibility for implementing all its activities. In areas where external assistance is felt necessary, GOB may choose agencies with relevant expertise to provide such assistance. In line with this practice, GOB asked WHO to be executing agency for this sub-component...Hence, transferring the rôle of executing agency from WHO to DANIDA is a decision that could only be taken by GOB, in consultation with the other donors involved." It went on to encourage DANIDA's participation in the Consortium under "the current arrangements."<sup>110</sup> For DANIDA, however, "The course of events in recent months has convinced us that there is no scope in the FPHP for Denmark to play the rôle of fully fledged partner within the parameters envisaged by the other partners for Danish support to the FPHP. In addition, the coordination and transparency of the preparation phase has been nebulous to an extent where we find the process to have become administratively just too burdensome...It is thus with regret that we now inform the World Bank...that ... DANIDA withdraws from the Consortium."<sup>111</sup>

The Belgian decision not to cofinance the FPHP also revolved around the perception that its freedom to support activities of its choice would be too greatly constrained. Subsequent to a request from the GOB that the Belgians (ADGC) finance specific activities in the sector under their existing framework of cooperation, the Bank invited ADGC to join the Consortium. Belgian officials responded positively to the idea of contributing to the FPHP and informed the Bank that the "problem now is to convince the GOB that Belgium could be most effective in aid provision by joining the IDA and existing cofinanciers."<sup>112</sup> Later Belgium learned from the ERD that if it wanted to join the FPHP, its contribution would have to be additional to the funds committed under the

existing bilateral country programme. The Belgians informed the Bank that they were unwilling to contribute to the FPHP on the basis of additionality and that the ERD remained the main 'hurdle' to their participation in the Consortium. The Bank responded that "this hurdle is not insurmountable"<sup>113</sup> and subsequently prevailed successfully upon the ERD to drop its condition.<sup>5</sup>

In terms of participation in the Consortium hinging upon the freedom of donors to finance activities of their choice, Belgian support to the FPHP raised a problem for the Bank. In the words of the FPHP Task Manager: "Strong preference was expressed for support to a specific geographical area. In view of the nature of the Fourth Project and its multiplicity of cofinanciers, I argued against this preference. I believe it may take some more convincing to have ADGC abolish the idea of 'a Belgium piece' of the project."<sup>114</sup> The Belgians eventually decided against participation in the project. The ERD was informed that the decision was the result of a "retrenchment policy" of the Government of Belgium.<sup>115</sup> Funds did, however, subsequently become available for a geographically-defined, integrated rural development project which included a health component as envisioned by the Belgians for the FPHP. This suggested that other factors influenced Belgian decision-making. According to the Belgian aid representative in Dhaka, the real reasons were: (1) the amount of aid Belgium was willing to place in the FPHP was too small to influence decisions within the Consortium; and (2) membership would have reduced the agency's flexibility and inhibited it from pursuing its favoured strategy.<sup>116</sup>

The fear of circumscribed autonomy conditioned the attitude of most donors with regard to joining the Consortium. Coordination would impinge upon donor control over project content, aid procedures and time horizons, *inter alia*. Hence, when asked why UNICEF did not join the Consortium, one of its staff baldly stated that it "wanted to retain its independence."<sup>117</sup> The attitude of the AsDB was similar. When the World Bank learned, for example, that the AsDB was considering financing a project in the health sector, the Bank asked the AsDB "if it would be profitable to explore systematically the possibility of a joint or more fully complementary approach to Bank and AsDB population/health assistance?" The Bank suggested that this would "simplify project preparation, negotiation and implementation for the Government while continuing to provide the advantages of a unified donor approach in respect of key policy and implementation

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<sup>5</sup> This raises two issues which are taken up elsewhere in this dissertation: (1) that donors have reinforced the difficulties faced by the Government in planning and coordinating aid by, in this case, clawing-back funds committed for specific activities; and (2) the power which the Bank could exercise over GOB decision-making.

issues.”<sup>118</sup> The AsDB responded that it preferred a ‘complementary’ approach which would allow it to pursue its own project ideas according to the time plan it had already established.<sup>119</sup> Later, when the appraisals of the AsDB’s second project and the FPHP coincided, both parties agreed that the projects would benefit from “parallelism in timing.” However, in terms of complementarity of substance, the Bank complained that “not much willingness to accommodate was forthcoming... The AsDB proposals simply remain unaware of the involvement of other donors.”<sup>120</sup>

In justifying USAID’s decision to remain outside of the Consortium, the Director of the Office of Population and Health in Dhaka conceded that although “USAID is driven by its own philosophy – it is for administrative, legal and accountability reasons that it wishes to work outside of the Consortium...All organisations should work within the broad parameters towards joint sector goals, but with their own modalities.”<sup>121</sup> An official from USAID’s headquarters provided different reasons including the perceived inability of the PHO to disburse funds and implement activities as well USAID’s interest in working outside of the public sector apparatus.<sup>122</sup> However, as the second most powerful donor in the sector, it is likely, as suggested by a number of informants, that USAID did not join the Consortium as it was sufficiently influential to affect the policy agenda without the backing of the Consortium.

It appears that, at times, the decision of whether or not to join the Consortium rested as much on the proclivities of individual officials with the authority to influence the decision as it did on organisational interests and needs. In reporting on SIDA’s renewed interest in joining the Consortium in 1987 (after dropping out of the TPFHP), the FPHP Task Manager intimated that the change in mind-set may have been partially a function of change in Directorship of SIDA’s Health Division at its headquarters.<sup>123</sup> In the case of UNFPA, its representative in Dhaka informed the Bank that: “I have, in principle, considerable hesitation about being a participant in a project with another funding agency. We have experienced a good deal of difficulty in the past in mixing our funds and other inputs with other donor agencies. For this reason, all things being equal, I would prefer to avoid such involvement in the future.”<sup>124</sup>

At other times, decisions on membership in the Consortium were taken on very different grounds. For example, the British dropped out of the Second Population and Family Health Project because the newly elected Conservative government was seeking spending cuts, and the Bangladesh population project became one casualty.<sup>125</sup> Another reason for

non-participation, which was similarly unconnected with the manner in which the Consortium functioned, resided in bilateral relationships between the donors and the GOB. Japan, for example, committed funds for the FPHP but was ultimately unable to join the Consortium as it proved impossible to reach a bilateral agreement with the ERD. Germany's rôle in the Consortium was almost scuttled for a similar reason. According to a Bank official, the "participation of Germany remains doubtful due to numerous conditions set by Germany appraisal mission which GOB can not realistically meet prior to negotiation. 'I have sent letter to German Charge d'affaires with the hope that he will encourage his Government to be more reasonable.'"<sup>126</sup>

Finally, it is instructive that the Bank did limit membership in the Consortium. In 1993, a communication between two CIDA officials records that it was "interesting that SK [i.e., the Head of PHO] would recommend a much smaller Consortium in the future. Does this suggest that only those who agree with the Bank would be invited? Certainly we get the impression out here that he is unhappy with the Consortium arrangement."<sup>127</sup> Earlier, the Bank made the decision to deny membership to USAID. Chapter 3 noted that the GOB requested that USAID's contribution to the sector be included in the FPHP. In a memorandum, the Task Manager for the project informed Bank management that "for the moment we declined this request; our management structure would not be able to run such a large operation."<sup>128</sup> In private, the TM stated that he feared that USAID would dominate and that, as a result, a number of smaller agencies would pull out of the Consortium.<sup>129</sup> The Bank was thus concerned about the possible influence of USAID and that the mechanism would not be able to withstand the policy differences among the donor agencies. These points raise important considerations regarding the potential for more inclusive aid coordination: (1) is it possible to reconcile the differences of all donors in the sector; and (2) what would be the administrative and managerial costs of attempting to coordinate their disparate aid delivery systems? We will return to these questions in the final Chapter, as well as to the possibility that an unstated reason for the Bank's reluctance to include USAID in the Consortium may have been its concern the balance of power would be tipped away from the Bank in an uncertain direction.

## 5.8 Problems internal to the Consortium

*It has been difficult to maintain donor coordination in the Consortium arrangement.*<sup>130</sup>

G. Roedde, CIDA, 1994



Any system seeking to submerge differences in policy objectives and accommodate the distinct procedures and accountabilities of large agencies operating in an international environment is likely to encounter difficulties. As such a system, the Consortium and its project office faced ongoing threats from within, which tended to be particularly acute during periods of project formulation yet could be precipitated by other events as well. According to the Task Manager for the preparation of the FPHP, the goal at the time was to maximise the amount of resources available for population control in Bangladesh. “The donors were brought in without sufficient and explicit agreement on the rules of the game; we were first interested in gaining access to their funds, difficulties would be resolved during implementation.”<sup>131</sup> This section examines some of the chronic problems which plagued the Consortium, because they portend the difficulties which will be faced by national authorities when they assume the mantle for aid coordination and because they may offer lessons for overcome such obstacles.

While somewhat arbitrary in categorisation, it is useful to consider these difficulties in terms of those arising due to: (1) conflicting policy objectives; (2) inadequate communication; (3) disputes over rôles, responsibilities and accountability; and (4) differences in expectations of the coordination machinery. In practice the concerns were often closely interwoven. Problems became particularly pronounced during the FPHP which resulted in a number of ameliorative actions: (1) the formation, at the instigation of cofinanciers,<sup>132</sup> of a sub-group of the supervision mission of April/May 1994 to perform a SWOT analysis on the Consortium;<sup>133</sup> (2) an externally facilitated retreat of Consortium members in August 1994;<sup>134</sup> (3) the preparation of a draft Terms of Reference for the PHO; and (4) a series of high level meetings in Dhaka in 1996 to reiterate and address the persistent grievances.<sup>135,136,137</sup> Pursuant to these discussions, and again at the request of a bilateral agency,<sup>138</sup> a ‘Code of Conduct’ for the Consortium was drafted by the PHO in 1996 (Box 5).<sup>139</sup> The Code was seemingly never subsequently discussed in the Consortium nor formally adopted and was considered, by some members of the Consortium, as simply ‘innocuous.’<sup>140</sup> It certainly did not resolve many of the dissatisfactions held by the Consortium members – perhaps because there was a perception that other parties were not abiding by it.

**Box 5: Code of Conduct for Donor Consortia in Bangladesh<sup>141</sup>**

1. All members will be treated as equal partners.
2. Rôles and responsibilities of each member of the Consortium will be defined and agreed by the Consortium and each member will endeavour to perform its rôles and responsibilities.
3. Consultation will be held within the Consortium before engaging in dialogue with the GOB on important issues.
4. Equal respect be shown for the views of each member of the Consortium; if there are differences in viewpoints, steps will be taken to resolve those. Final positions on issues where differences persist will be

taken on the basis of consensus.

5. Decisions arrived at on the basis of consensus will be supported by all members of the Consortium.

6. Transparency will be observed in dealings within the Consortium. Grievances will be first aired within the Consortium group at Dhaka.

7. All members will seek to promote cohesion within the Consortium.

#### 5.8.1 Policy conflict

*Often major differences of approach have occurred, particularly between the World Bank and the donors.*<sup>142</sup>

G. Roedde, CIDA, 1994

According to the Bank, “it would be divisive and counterproductive for individual donors to cofinance in the hope of using that leverage to steer the program toward their own particular objectives. The last several years have demonstrated how uncoordinated approaches can send mixed signals to the GOB, cause borrower confusion and impede effective coordination.”<sup>143</sup> Nonetheless, it was the very possibility that the Consortium would enable the cofinanciers to advance their individual corporate policy objectives more successfully that many sought membership in the Group. Over the course of the successive projects numerous policy differences arose and are far too numerous to record; these ranged from differences over appropriate institutional arrangements within the Government, to discord over priorities, to variance over strategies, etc. The point which bears making is that differences did exist and these created a host of problems for the participants. At the root of these problems lay three issues relevant to donor coordination, namely: (1) how policy dialogue was conducted in the Consortium; (2) how decisions adopted in the Consortium were communicated to the Government; and (3) if and how individual members should undertake bilateral policy dialogue on population and health issues independently of the Consortium. The TORs covering the PPO/PHO, as articulated in the SAR for the FPHP, provided scant guidance on these questions; and the resultant ambiguity created significant tension.

In relation to policy dialogue within the Consortium, it was envisioned that the annual project supervision missions as well as the regular meetings of the Consortium would provide a venue for the resolution of policy differences. In practice, these proved insufficient and tensions persisted. At the heart of the issue lay the question of how to weight the influence of each member. The Task Manager for formulation of the FPHP conceded that this difficult issue was not explicitly addressed. Three options existed: by contribution; equality; or by placing a premium on expertise. The attempted to invoke a

mixture of the latter two so as to appease the smaller members.<sup>144</sup> At the Consortium Retreat (1994), the issue was flagged by the cofinanciers who felt that the process of policy development within the Consortium was unclear, as was the origin of PHO policies communicated to the Government. It was recommended that more time be accorded within meetings of the Consortium to the consideration of policy issues so that consensus could be achieved. However, the underlying issue of how policy decisions were to be arrived at was not tackled.<sup>145</sup> In 1995, the Preparatory Review Group Report for the Mid-Term Review of the FPHP proposed an ideal approach to ‘policy development and coordination.’<sup>146</sup> This involved ‘an evaluation of the policies of different donors;’ ‘an assessment of their similarities and differences;’ the development of a ‘joint policy;’ and representation of this as ‘Consortium policy’ to the GOB. While it is not clear whether or not this process was seriously considered, it was certainly not formally adopted. In turn, the Code of Conduct proposed that “equal respect be shown for the views of each member of the Consortium; if there are differences in viewpoints, steps will be taken to resolve those. Final positions on issues where differences persist will be taken on the basis of consensus.”<sup>147</sup>

Frustration also presided over policy dialogue with the Government. While it was generally agreed (and formally proposed by the Bank in the draft TORs for the PHO) that the Bank, as leader, would represent the views of the Consortium to the Government (thus reducing the amount of time taken up in bilateral dialogue and also reducing the number of conflicting signals), ambiguity remained which bred suspicion. It was, for example, unclear whether or not the PHO presented to the GOB only the areas of agreement or also disagreement within the Consortium (i.e., played down differences to suit Bank interests) and whether or not the PHO communicated the Consortium’s agreed views or distorted these to reflect Bank thinking. While it was difficult for the donors to confirm or dispel their fears, they were aware of the tendency of the PHO to gloss over differences, even in official policy papers, and to misrepresent the views of the Consortium members in other ways. For example, a Norwegian delegation complained that “During the Paris meetings in 1985 several conditions for participation in the whole five year period of the project were specifically mentioned. This is not reflected in the official bank documents (credit agreement, report and Recommendation to the President of IDA).”<sup>148</sup> On a separate occasion, a member of the Consortium in Dhaka informed his agency’s headquarters that the “Minutes prepared by the World Bank of Consortium meetings frequently do not reflect accurately the discussions. Expressions of donors’ viewpoints, especially of dissatisfaction, are omitted or minimised.”<sup>149</sup> In discussions

convened to address the weaknesses in the Consortium, it was proposed that areas of agreement and disagreement within the Consortium should be recorded while the Code of Conduct suggested that “decisions arrived at on the basis of consensus will be supported by all members of the Consortium.” Adherence to these suggestions would have reduced the room the PHO had to manipulate the articulation of the Consortium positions to the Government.

Even if accurately communicating Consortium decisions could be resolved, there remained the dilemma of how donors could maintain their association with the Consortium when the group was advancing positions at odds with their particular corporate values. In addition to the option of withdrawing, donors could distance themselves from policy positions and/or articulate, in private, contrasting positions to the Government. The pursuit of three options was evident. As mentioned earlier, a number of donors reversed their decision to join the Consortium when the gulf in policy between themselves and other donors became apparent. The second option also entailed difficulties for donors. This was expressed by a CIDA official over support within the Consortium for NORPLANT research. CIDA did not agree with, nor fund such research, “but must spend considerable time and effort communicating the rationale of other donors in financing this activity.”<sup>150</sup> Although not formally a Consortium member, UNFPA provides the most consistent example of an agency participating in Consortium meetings while simultaneously advancing contradictory policy positions to the Government, an action which caused considerable resentment among Consortium members. For example, when UNFPA approached CIDA with respect to the possibility of the latter channelling additional support for health activities in Bangladesh through UNFPA, CIDA responded that “this could not be considered if UNFPA was not at the [Consortium] table and more importantly was in conflict with other partners.” CIDA went on to “express concern regarding the overt public criticism UNFPA was making about the Consortium and World Bank and that the dialogue should occur at the table.”<sup>151</sup>

The draft Code of Conduct proposed that “decisions arrived at on the basis of consensus will be supported by all members of the Consortium.” It remains to be seen how realistic this aspiration turns out to be. Differences among agencies over policy and strategy are, of course, inherent in the development enterprise, arising at times from uncertainty over best practice and at others to the pursuit of non-developmental objectives through the aid regime. Nonetheless, it is clearly in the interest of coordinated assistance to minimise these differences as far as possible. Consequently, it is necessary to develop ground rules

for discussing and communicating differences to the Government in such a manner that does not threaten the stability of the coordination arrangement. It would appear that more forethought was required with respect to the systems of communication within the Consortium as problems of communication remained a constant friction to the maintenance of good relations within the group.

#### 5.8.2 Communication difficulties

*Not surprisingly, the diversity of donors with disparate interests and philosophies has posed diplomatic challenges to the Bank.*<sup>152</sup>

World Bank, 1991

*Donors were annoyed with the style of the functioning of the Bank and its first among equals attitude.*<sup>153</sup>

N. Gerein, CIDA, 1996

It was asserted in the Completion Report for the TPFHP, that the success of the Consortium was “primarily attributable,” among other things, to “an effective leadership provided by the Bank, in an informal atmosphere facilitating frank discussion of issues leading to consensus solutions.”<sup>154</sup> Yet, it was also true that inadequate communication presented ongoing challenges to the maintenance of the Consortium arrangement. Despite the regular meetings, joint missions and the production of a biannual report on project implementation, donors held four concerns related to communication: (1) inadequate reporting on project implementation; (2) insufficient consultation by the Bank prior to decision-taking; (3) misrepresentation of donor viewpoints by the PHO to Bank headquarters and the GOB; and (4) suspicion that the Bank pursued its own objectives in the sector without transparency. At one point, donors demanded that “the communication problem be addressed urgently”<sup>155</sup> and one donor proposed that “a facilitator might be engaged to work with the donors and World Bank ... to develop processes to ensure improved partnership, participation and communication among the Consortium, PHO and World Bank, Washington.”<sup>156</sup>

The perceived inadequacy of reporting could be viewed simply as a question of expectations and level of detail required by the funding agencies of reports produced by the PHO, which it undoubtedly was. Nonetheless, the issue was also one of communication, in that it begged the question of how effectively the Consortium worked

to communicate expectations and resolve these. Agreement was not reached prior to implementation of the FPHP on reporting details and thus had to be negotiated in mid-stream. At the Consortium Retreat, the problem was identified as lack of agreement on reporting format and content. The meeting agreed that the reports would be recast to satisfy both Bank and donor needs, and in particular that these would be more analytic, devote greater attention achievement (instead of inputs) and to problems. Complaints from donors tapered off after amendments were made to subsequent reports and aide-memoires, suggesting that, with respect to some issues, communication was adequate to resolve differences of expectation of the coordination machinery.

The issue of consultation within the Consortium proved less tractable. In May 1996, at a meeting of heads of aid agencies of Consortium members, the donor's major concerns were described as "poor communication between the Bank's HQ and the donors representatives in the field; [and] the inadequacy of Bank's consultation with donors on key issues before engaging with GOB on such issues."<sup>157</sup> Even the World Bank acknowledged that the "Cofinanciers feel excluded from this dialogue [Bank and GOB] and unaware of critical exchanges until it is too late in the project cycle to contribute substantively to what is going on."<sup>158</sup> A subsequent meeting of heads of agencies suggested that "regular consortia meetings [be convened] locally with adequate notice, followed by accurate recording of minutes to be circulated for correction to participants. If the minutes do not adequately reflect any of the concerns raised in the meetings, this should be pointed out and the minutes amended."<sup>159</sup> This practice was adopted by the PHO but frustrations persisted. At one level, some Consortium members complained that the regular meetings did not allow for meaningful discussion of policy as they were mired in the minutiae of micro-management.<sup>160</sup> At a more substantive level, as argued by one of the cofinanciers, the problem of inadequate consultation or partnership was structural rather than procedural. "This level of inconsistency from the Bank is not occasional only. While the Bank has its own extensive document on participation, in practice it interprets participation as sharing with cofinanciers and GOB documents or TORs or scheduled events that have already been finalised by the Bank as part of an internal process... These internal processes are stopping the Bank from actually practising participation."<sup>161</sup> The bilaterals were frustrated by what they saw as the imperative within the Bank to disperse its loan and steer the policy agenda according to its corporate objectives which militated against consensus building with its 'partners.'

Where consultation within the Consortium elicited opinions contrary to those held by the PHO, cofinanciers feared that these were brushed under the carpet so that they would not come to the attention of Bank headquarters or the Government. The officer-in-charge of the PHO attributed tension in the Consortium in 1996 to a “lack of communication between [Bank] headquarters and the PHO which results in the cofinanciers receiving conflicting messages and becoming agitated.”<sup>162</sup> The minutes of a meeting of donor staff in June that year, confirmed that “insufficient communication...between the Dhaka offices and HQ, was mentioned as the key issue.”<sup>163</sup> Others suggested that it was simply a personality dispute between officials in the Bank.<sup>164</sup> Nonetheless, the “breakdown in communication” left the cofinanciers with two concerns: (1) that “the World Bank Washington is receiving an inaccurate view of donor activity and viewpoint,”<sup>165</sup> and (2) about who was ultimately responsible within the Bank for taking decisions regarding developments which were of concern to all parties. Consortium members were particularly frustrated when agreements reached in Dhaka were subsequently overturned in Washington.<sup>166</sup>

Bank misrepresentation of donor views to the GOB marked a longer-standing concern. The communication systems of the Consortium did not provide sufficient transparency to confirm or dispel donor anxieties. Donors were aware that the Bank did pursue its own objectives through the Consortium mechanism, in terms of its policy agenda and its concentration on disbursement. One member stated that “Cofinanciers experience the Bank pursuing its own activities and deadlines without transparency about its ultimate objectives. This leads to suspicion among cofinanciers about the Bank’s own agenda.”<sup>167</sup> It appears that the members had cause for concern. For example, upon completion of the first supervision mission of the First Population Project in 1975, the Bank proposed that “A sanitised version of the supervision mission report should be sent to donors.”<sup>168</sup> This set a precedent which was followed by subsequent Task Managers. Thus, with respect to a later mission, headquarters instructed its field staff: “please do not repeat not distribute supervision report of February 20. Separate donors report is near completion and we will despatch copies of it soon.”<sup>169</sup> This brings us back to the question of whether it is the systems which are inadequate or whether institutions will obviate these to pursue their individual objectives?

### *5.8.3 Differences of opinion over rôles, responsibilities and accountability*

*The Consortium has had many discussions on the issue of rôles and responsibilities but the ambiguity continues.*<sup>170</sup>

P. Thorpe, CIDA, 1995

As noted above, the TORs for the Consortium and its project support unit were not defined with any degree of precision until 1994. There is no evidence to suggest that the lack of specificity regarding rôles caused cofinanciers many difficulties until the early 1990s. Such may have been the case because the earlier projects entailed a greater amount of parallel financing than the later ones, which would have reduced donor reliance on the Bank for aid management.<sup>σ</sup> Alternatively, the relatively smaller number of donors in the arrangement may have caused less contention. Nonetheless, by 1989 the Task Manager for FPHP preparation commented with prescience: “it is quite clear that it will not be easy to find an organisational and administrative form that will be effective with so many donors and executing agencies in one project.”<sup>171</sup>

In light of the envisioned problems, a day was set aside during the FPHP start-up mission to address “the functional and organisational relationships of the Population and Health Office vis-à-vis the Government and the Consortium’s representatives in Dhaka.”<sup>172</sup>

Despite this effort, a considerable amount of confusion and dissatisfaction arose over the appropriate functioning and ownership of the Consortium and the PHO. Consequently, in November 1992, a special meeting of the Consortium was held to discuss rôles and responsibilities.<sup>173</sup> Minutes from this meeting record that the Bank described its rôle in similar terms to the draft terms of reference it proposed for the PHO in 1994 (see section 5.3.1). At the meeting, one of the complaints was that the PHO staff were involving themselves in issues unrelated to the implementation of the FPHP. The Dutch delegate stressed that the “PHO staffs are over-burdened, FPHP is not yet in place, and on the other hand PHO staffs are over-burdened with the Inter-sectoral Population Project and the Nutrition Project.”<sup>174</sup> CIDA, and perhaps other donors, felt that “as overall project coordinator, the PHO ought to: (1) increase their information sharing with donors; (2) set in writing their rôles and responsibilities; (3) consult with donors on PHO candidates and yearly staff appraisals; and (4) agree to PHO mid-term review and end-of-project evaluation of PHO.”<sup>175</sup> In response, the Bank agreed that as a supplement to the description in the SAR, “a written note on the functions of the PHO will be circulated.”<sup>176</sup>

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<sup>σ</sup> In the First Project all but one cofinancier channelled funds exclusively through parallel arrangements which entailed separate financial and operational reports and additional independent supervision missions. By the FPHP, seven of the cofinanciers channelled all or a part of their assistance to the project through Trust Funds held by the World Bank.



Later in the year, the head of the PHO in Dhaka told a meeting of the Consortium that the note “would be made available to the Consortium after consulting with World Bank headquarters.”<sup>177</sup>

The promised details on the functions of the PHO were not forthcoming and dissatisfaction resurfaced. Consequently, by early 1994 the bilaterals began to meet independently of the Bank on the issue of how the Consortium functioned. At one of these meetings, it was decided that a working group be formed to discuss, among other things, the rôles and responsibilities of Consortium members.<sup>178</sup> This recommendation was taken forward in the form of a SWOT analysis during a supervision mission.<sup>179</sup> The analysis drew attention to the difficulties caused by different agendas and expectations among the members, but also the power imbalance between the Bank and the cofinanciers. It was suggested that the problem lay in “a gap between the perceived and actual goals and objectives, rôles and responsibilities of each participant.” In turn, the working group recommended, among other things, that a retreat be convened so as to address the perceptions of the parties as the rôles and responsibilities of all members and, more specifically, to narrow the gap between what the cofinanciers expect and what the PHO delivers.<sup>180</sup>

The Retreat revealed a number of differing perceptions regarding ‘who should be doing what,’ and that a variety of expectations were not being met.<sup>181</sup> Participants were arranged into three groups according to their institutional affiliation (i.e., PHO, cofinancier, or executing agency<sup>\*</sup>) and asked to comment upon four questions: ‘how do we see ourselves?’; ‘how do we see others?’; ‘how do they see us?’; and ‘what do we expect?’ Some of the differences are illustrated by the following examples. The ‘executing agencies’ expressed their expectation that other members would have ‘greater confidence in their technical capabilities.’ In marked contrast, the PHO expected that the multilaterals would ‘execute more and advise less,’ while the donors noted a conflict between these rôles and expected that ‘clearer guidelines be developed.’ Both the Bank and the donors wanted the executing agencies to keep them better informed of their activities. The executing agencies, however, saw their responsibility for reporting to be primarily to the Government, not to the PHO or donors. Whereas the PHO understood itself to be accountable to the World Bank, the cofinanciers complained that this arrangement resulted in the PHO being “not accountable to the donors who fund them.”

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<sup>\*</sup> WHO and UNICEF were referred to as executing agencies at the retreat. UNFPA did not attend which led to criticisms of lack of cooperation.

The executing agencies reflected the prevailing ambiguity by reporting that they were accountable to the GOB, donors and to their Executive Boards.

While the bilaterals conceded that they constituted a diverse group with ‘inconsistent,’ ‘demanding’ and ‘unrealistic expectations,’ they charged that the Bank was ‘driven by disbursement’ and that its officials, although paid by the cofinanciers, were ‘busy with non FPHP matters.’ They demanded that the Bank be ‘more open in its dialogue with donors,’ ‘represent donor views as one voice,’ and ‘undertake more critical reporting’ so as to appraise the cofinanciers of the true situation. There was agreement on the need for ‘greater transparency,’ ‘greater information flows,’ and the development of a ‘Code of Conduct.’ It was acknowledged that part of the problem which they were experiencing arose from the fact that the expectations had not been clearly reflected in the formal agreements covering the project. A number of specific recommendations were put forward at the Retreat aimed at clarifying the rôles of the PHO and the executing agencies, and strengthening accountability, reporting and communication.

The Bank described the Retreat as “a useful starting point for further development and improvement in the unique coordination and collaboration being developed by the Consortium.”<sup>182</sup> At least one donor, however, complained that the Bank’s mode of participation had frustrated the resolution of a number of problems: “while cofinanciers were extremely frank in their exchange of views on the expected rôles and responsibilities of Consortium members, participants from the World Bank Dhaka were their usual cautious, guarded and polite selves. This inhibited development of the expected action plan from some of the working groups for strengthening the Consortium.”<sup>183</sup>

Although the Retreat may have served cathartic purposes, the underlying structural problems remained. The participants’ frustrations re-emerged when the Bank was perceived as riding roughshod over their expectations regarding donor and GOB participation in the preparation of the Health and Population Sector Strategy<sup>184</sup> and HAPP-5.<sup>185</sup> The Swedish Ambassador reflected the dominant mood among the bilaterals when he wrote to the Bank: “We frequently hear the FPHP referred to as a ‘World Bank project’ with a PHO reporting to Washington, whilst in our view, the proper terminology and order lines should have been, a ‘GOB project’ with the World Bank as the donor lead

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<sup>8</sup> This statement suggests that members themselves perceived that differences in corporate culture led to problems in coordination.

agency and as such responsible to the donor Consortium. It is, after all, cofinanciers who share the costs of the PHO. We would in no way argue for a change of the World Bank being the lead agency in the Consortium but would simultaneously encourage GOB's coordination rôle and responsibility...Is there a need for a 'new' PHO and, if so, what rôle and responsibilities should it be given?"<sup>186</sup>

Disagreements over responsibilities dragged into 1996. It was the Bank's opinion that due to the "diverse accountabilities and procedures of participating members, a certain amount of tension is inherent."<sup>187</sup> In May 1996, at a meeting convened to discuss concerns with the Consortium, the minutes record that "some donors felt that there was a conflict in the Bank's 'lending and leadership' rôle. One was driven by wish to come to closure quickly on lending decisions followed by prompt disbursements while the other required methodically building donor consensus and Government ownership which was inevitably a slow drawn out process. This resulted in the Bank "pushing projects on the borrowers without adequate consultation with relevant stakeholders in the planning process..."<sup>188</sup> Elsewhere donors had remarked upon the differences between the two approaches, particularly that, as grant-givers, they were concerned with 'accountability', whereas for the Bank, the "major concern is project implementation and loan disbursement. This 'cultural difference' in the institutions needs to be recognised and dealt with explicitly."<sup>189</sup> In reality, the PHO was wearing one additional hat which further complicated matters – namely that of advancing the Bank's corporate policy agenda.

The Bank proposed that "The most effective way to resolve the tension is to develop shared values and objectives, and a clear understanding (recorded in writing) covering respective rôles of the different partners, their responsibilities and the modalities for working together. Further, all aspects of the working relationship should be periodically revisited." It was, therefore, recommended that "the local heads of donor agencies meet to work out 'mutually acceptable rules of the game.'"<sup>190</sup> The rules of the game were subsequently unilaterally proposed by the Bank in its draft Code of Conduct. The point worth considering, however, is that despite considerable and ongoing attention to the delineation of rôles, responsibilities and accountability, the differences were never satisfactorily resolved. Thus the question remains as to whether or not it would be possible to draw up sufficiently detailed legal agreements to minimise differences of perception and interpretation and thereby militate against conflict over these issues. Or is it the case that the ambiguity, although at times frustrating to the participants, has been

purposely built into the system so as to allow the parties to pursue their individual interests through the arrangement?

Criticisms surrounding rôles, responsibilities and accountability within the Consortium were naturally primarily directed towards the Bank, as it was in the maelstrom. Yet there was also confusion and dissatisfaction over the rôle played by the multilateral agencies with respect to the project. The GOB entered into contractual arrangements with WHO, UNFPA and UNICEF to provide assistance in the implementation of almost half of the sub-components of the FPHP. Criticisms centred primarily around UNFPA and WHO and were essentially three-fold: (1) the quality of the support provided by these agencies to sub-component execution; (2) the nature and direction of accountability of the agencies; and (3) the manner and extent to which the agencies were able to bridge the gap between playing a normative rôle (i.e., providing technical advice to GOB) on one hand and of undertaking project execution on the other (i.e., ensuring implementation). The problems manifested themselves largely in the realm of aid management, not coordination.

The responsibilities which WHO assumed under the FPHP were far greater in scope, financial value, and complexity than had been the case for the TPFHP (essentially a family planning project); in that the organisation was commissioned by the GOB to execute 21 of the 66 sub-components of the project. It was suggested in confidence by both Bank and WHO officials that the Bank had put pressure on the GOB to seek the services of the WHO to execute such a large number of projects so as to provide a financial and substantive life-line to WHO which might otherwise have become marginalised in what was to become the world's largest externally financed health and population project.<sup>5</sup> Agreement was reached on the precise rôle of WHO prior to project start-up and detailed in agreements with both the World Bank<sup>191</sup> and the GOB.<sup>192</sup> As part of the arrangement, the managerial capacity of the local WHO office was strengthened so as to cope with the increasing work load.

Despite attempts to clearly specify WHO's rôle and to take steps to enable WHO to successfully discharge its commitments, dissatisfaction surfaced. Some donors were concerned with the ability of WHO to effectively execute some of the activities for which it took responsibility. For example, WHO was criticised for its inability to recruit suitable

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<sup>5</sup> According to the agreement, WHO received 4% of the actual cost of all supplies and procurements made and 14% for all other costs.

expertise for the components relating to Health Care Quality Assurance, STIs, Cancer and the Rational Use of Drugs, *inter alia*.<sup>193</sup> In addition, donors complained of inadequate monitoring and reporting, and delays in approvals and procurement. For example, an AIDAB review of its contributions to the FPHP executed by WHO found “that the biannual report from WHO to GOB, and shared informally with the Bank and relevant donors, inadequate in detail for AIDAB requirements.”<sup>194</sup> AIDAB also pointed to “inadequate human resources in the Dhaka office to manage the execution rôle effectively.” In more general terms, the reviewers argued that “a lack of financial and operational autonomy in the Dhaka office led to a major impediment to successful performance of WHO’s rôle.” The review recommended that the autonomy of the local WHO office be increased and that WHO report with greater specificity on project execution – failing this, it was recommended that an Australian contractor be appointed to manage the sub-components. The Preparatory Review Group Report for the Mid-Term Review of the FPHP also traced problems with WHO execution to the “organisational set up of WHO which does not allow for flexible operation... The response rate is impeded by their having to obtain approval through a series of administrative channels that are WHO standing procedures.”<sup>195</sup> Some criticisms were countered by the WHO Representative who wrote: “While we acknowledge some delays in the past... WHO rules and regulations, however, must be followed to implement these activities, which is also clearly stated in the GOB/WHO agreement.”<sup>196</sup>

The Government signed agreements with the Bank and WHO, indicating that it could comply with the procedures of both agencies. When contradiction arose, WHO found itself in a difficult position. For example, the Bank sought to ensure that WHO, when executing activities financed with funds channelled through its Trust Accounts, abide by rules to which IDA resources were bound and agreed by Government in the DCA. In one case, Bank rules specified that purchase orders worth more than US\$ 200,000 be put up for international tendering. According to WHO sources, WHO resisted the application of Bank procedures and only at the threat of its withdrawing from project execution was a compromise found through which large purchase orders be broken down into smaller units to circumvent the Bank’s rules.<sup>197</sup>

Another problem lay in the area of accountability. Whereas the project execution agreements made WHO directly accountable to the Government, donors were concerned about the limited accountability that the organisation had towards them as ‘funders.’ Although the agreements contained clauses about sharing information with donors, the

funding agencies considered this insufficient and demanded greater leverage over WHO in relation to sub-components which they financed. Was frustration over 'inadequate' accountability an inevitable outcome of the Consortium arrangement in which the cofinanciers had agreed to fund the project, but over which the GOB had ultimate responsibility for project implementation (including the subcontracting of project execution)? In other words, is it possible to set bench marks with respect to financial and operational reporting that will satisfy donors or will they only be truly satisfied in meeting their accountability requirements by directly managing aid themselves?

In the case of UNFPA, confusion about its responsibilities focused mainly around misunderstandings over what it had agreed to do with respect to implementation of the FPHP and over which rules and procedures should govern UNFPA actions. During project preparation, UNFPA, as well as WHO and UNICEF, were almost always referred to as 'executing agencies.' In April 1992, for example, at a meeting of the Consortium, not long after the FPHP start-up and at which three UNFPA staff were present, UNFPA was reported as undertaking project execution for two named sub-components of the project.<sup>198</sup> A supervision mission aide-memoire, from the same period, records that agreement had been reached in principle among all parties as to the rôle of UNFPA and that the mission would recommend that the MOHFW formally request UNFPA participation in sub-component execution.<sup>199</sup> Differences, however, arose over what would be involved. NORAD, the financier of one of the sub-components, wanted UNFPA to assume a purely administrative rôle (i.e., recruitment of personnel and payment of salaries), whereas UNFPA envisioned something more 'substantive.'<sup>200</sup> There were also differences over the fee provided to UNFPA for its services: the Fund wanted to charge 13%; while the Government was only offering 5%.<sup>201</sup> Negotiations got further bogged down over whose procedures would prevail. In the Development Credit Agreement,<sup>202</sup> the Government had committed itself to ensuring that all goods and services procured with IDA funds, or those of the cofinanciers passing through Bank Trust Funds, follow IDA procedures, whereas UNFPA insisted that its own rules apply.<sup>203</sup> While the Fund was able to reach an agreement with the Government on its rôle and remuneration, problems arose during project implementation due to the lack of understanding among cofinanciers of the nature of UNFPA participation; relating to their inflated expectations of what the Fund would deliver.

Misconceptions emerged, among other things, over monitoring and reporting channels. For example, when it surfaced that there were, and had for some time been, serious lapses

in the quality of oral contraceptives, financed by CIDA and procured by UNFPA, CIDA launched its own enquiry. A CIDA report noted: “unfortunately most of the UNFPA actions were unknown to the Bank or to CIDA...Between September and December minimal correspondence from UNFPA was copied to Bank or CIDA. The UNFPA Representative stated that he considered his rôle is to support Government, not the Bank or Consortium and, therefore, his responsibility is to communicate with Government. The current system for communication among the various parties involved may not be adequate when such serious issues arise.”<sup>204</sup> As was the case with WHO, donors were not satisfied with reporting and accountability systems to which they were only indirectly linked with the MOHFW as the intermediary. Where confidence in the GOB capacity to facilitate the linkage was found to be lacking, donor frustration was vented upon the executing agencies.

For much of the remainder of the project, UNFPA worked to portray its rôle as a supporting, as opposed to executing, agency, in part because the confusion over its responsibilities had resulted in it being “unfairly criticised and its reputation harmed vis-à-vis the donors.”<sup>205</sup> Hence, in response to a report issued by the Bank, the UNFPA Representative stressed to the RBM Chief that “according to the Memorandum of Understanding signed with the Government of Bangladesh, UNFPA is only ‘assisting the Government in the execution of financial and administrative aspect of the MDU sub-component’ and shares no responsibility in the implementation of the project. Therefore, the designation of UNFPA as *executing agency* will be deleted.”<sup>206</sup> The Representative reiterated the same position to the RBM later in the year, insisting that as the Fund merely assists the GOB it could, therefore, assume ‘no responsibilities for delays’ and had thus been criticised unfairly by Consortium members for what were essentially GOB (in)actions.<sup>207</sup> The Fund also convened a special meeting of the Consortium at which it provided a detailed explanation of its rôle according to its agreement with the Government, namely: (1) to procure commodities for a variety of sub-components; and (2) to ‘facilitate’ implementation of the two named sub-components.<sup>208</sup> As the donors continued to draw attention to what they saw as failures on the part of UNFPA project execution, it was necessary for the UNFPA Representative to restate the nature of the contractual arrangements at another meeting of the Consortium.<sup>209</sup> From the USAID perspective, UNFPA was characterised as a ‘unilateral actor’,<sup>210</sup> while a World Bank official less generously referred to the Fund as the “problem player... which does its own thing and manages to be damaging despite its small budget.”<sup>211</sup>

It is unclear if the Fund wished to stress its rôle as a mere ‘supporting agency’ so as to: (1) distance itself from the control the Bank exercised through the Consortium; (2) distance itself from perceived shortcomings with project implementation; or (3) to retain a greater normative rôle in the sector vis-à-vis the GOB than would be possible if UNFPA assumed a prominent part in project execution. As a UNICEF official remarked: “UNFPA has had a negative experience with execution, and now asks itself ‘why be subservient to the World Bank, cofinanciers and Government?’”<sup>212</sup>

The issue of the appropriate rôles of the UN technical agencies in the Consortium provoked considerable disagreement. The Bank encouraged the Fund to “function more as executing than advisory.”<sup>213</sup> In contrast, although the WHO Programme Manager for FPHP conceded that the WHO did not speak with a technical voice at the Consortium meetings, he thought that it ought to.<sup>214</sup> CIDA, among other agencies, agreed with the WHO position that the multilaterals should play a greater rôle in policy leadership in their respective areas of expertise within the project.<sup>215</sup> The DGIS officer for the Consortium consistently argued that all three multilaterals ought to make a greater contribution in terms of policy, with each assuming a leading rôle according to their mandates.<sup>216</sup> The Bank was said to be opposed to re-assigning rôles in such a manner, as it argued that the Bank had, or could access, technical expertise as needed.<sup>217</sup> ODA posited that the multilaterals were not in a position to take on leadership rôles as they did not possess the ability or influence to bring about the necessary reforms required of the GOB – “they would cave in to Government pressure.”<sup>218</sup>

The bilaterals expressed the need to develop clearer guidelines for the multilaterals which differentiated between these two possibly conflicting rôles: executing and advisory.<sup>219</sup> The WHO manager for the FPHP acknowledged the difficulty reconciling these two rôles as conflicts often arose between “the analysis of problems and recommendation of solutions based on WHO norms and procedures” on the one hand and the exigencies of project management on the other.<sup>220</sup> According to WHO headquarters officials this transpired when “the contractors asked WHO to perform tasks in a manner inconsistent with scientific best practice, which was often the case when, for example, WHO was asked to procure goods and services from the sponsoring country.”<sup>221</sup> The GOB hoped that the multilaterals could perform both tasks. According to a MOHFW view, expressed in a status report on the FPHP, “while it is felt that the executing agencies [i.e., the multilaterals] may still be required, their rôles should be clearly defined and be expanded beyond the existing boundaries of procurement, recruitment, training and fellowship



arrangement. Technical assistance from the executing agencies should not be just limited to the provision of consultants, it must include transfer of technology, provision of appropriate managerial assistance and capacity building.”<sup>222</sup>

The central questions raised by the involvement of the multilaterals in the Consortium were: (1) whether or not their rôle in project execution compromised their normative functions; (2) whether or not their rôle within the Consortium should have included acting as lead technical agencies for areas within their respective technical capabilities – a rôle often seen by the bilaterals to have been usurped by the World Bank; and (3) given the criticism levelled at the multilaterals for their alleged inability to manage funds properly on behalf of the bilateral organisations, was it simply the failure to adequately specify expectations, and if not, what prospects are there for the GOB to meet donor expectations in this regard?

#### *5.8.4 Different expectations of the Consortium arrangement: missions, meetings, monitoring*

*There are a variety of animals in the garden, each with a different expectation of the PHO.*<sup>223</sup>

K. Hagstrom, SIDA, 1996

Hagstrom was correct when he portrayed the differences among the Consortium members as the underlying factor for dissatisfaction with the arrangement. The different characteristics and distinct needs of the agencies made it difficult for the PHO to reconcile the cacophony of demands. The agencies differed in a host of ways. For example, in response to donor complaints over “slow and sometimes unclear processing of claims,” the Bank responded that it was “difficult presenting the true picture of expenditures and disbursements...of all seven cofinanciers and executing agencies.”<sup>224</sup> For they operated according to “9 different fiscal years and 6 different cash flow and Fiscal Year carryover systems... etc.”<sup>225</sup> The agencies also differed in relation to their representation at the country-level. KfW functioned without any resident staff,<sup>226</sup> the EU had one official covering health as well as projects in 6 other sectors,<sup>227</sup> while CIDA employed three professional staff to monitor its investments in the FPHP.<sup>228</sup> The authority vested in the resident representative also varied widely. ODA delegated almost total responsibility and decision-making authority to its aid management office in Dhaka,<sup>229</sup> while AusAid appeared to lie on the other end of the spectrum. Donors also

differed with respect to their interest in delegating responsibility for aid management to the GOB. SIDA, for example, advocated for ever increasing MOHFW participation and, therefore, against parallel financing (and its accoutrements such as project implementation units and dedicated financial and operational reporting systems) while the EU, GTZ and ODA took an opposing tack in principle and in practice. The Bank also noted that there were tremendous differences in the abilities and knowledge brought to the project by the individual officers of the different agencies which exacerbated problems arising out of institutional differences.<sup>230</sup>

To a remarkable degree, it proved possible to accommodate the divergent needs of the parties within the coordination arrangement. Thus, for example, the projects enabled some agencies (such as the EU) to parallel finance and execute components of their choosing; while simultaneously accommodating the wish of SIDA to joint-cofinance part of the project with the GOB. Nonetheless, despite general agreements to work collectively under the banner of the Consortium, at times the different expectations proved vexing to reconcile. Examples of the frustrated expectations are provided as they reflect the demands which the Government will face if and when it assumes a more pronounced rôle in aid coordination and management.

The focus of the supervision missions proved contentious as donors were interested in different aspects of performance. This pulled the PHO in opposing directions.<sup>231</sup> Some donors were concerned only with the sub-components of the projects which they financed while others, less concerned with micro-management, wanted to consider the implications of their investments on the macro-issues in the sector. According to one view, “the Consortium functions mainly to share information on what [donors] are doing and how ‘their’ sub-components are progressing. Ultimately each donor is mainly interested in the sub-components which they fund.”<sup>232</sup> Yet some agencies were interested in the bigger picture. The SIDA officer responsible for FPHP found it “odd that during supervision missions, each donor’s specialist digs deep into individual sub-components, yet no-body takes stock of overall progress of the project.”<sup>233</sup> In 1986, Norwegians complained to the Bank that a supervision mission was “less satisfactory than previously... It is essential that the annual reviews function as a useful instrument in the monitoring *sector* progress.”<sup>234</sup> One resident EU official found: “the missions too superficial.”<sup>235</sup> The official observed that due to the preoccupation with the sub-components, there was little time to deal with the policy issues. Yet because the “World Bank’s and the Mission’s understanding of the sub-components was shallow,” the missions were not able to make

insightful recommendations on these either. Such was the price of attempting to accommodate the divergent interests.

Similar discord presided over the regular Consortium meetings. An EU review noted that while the meetings may be useful to members, they are “particularly unsatisfactory for policy discussions” as they are too short and too focused on micro-issues surrounding implementation.<sup>236</sup> At the Consortium Retreat, it was recommended that the format be reviewed. Later the Consortium agreed that its “bimonthly meetings in the present form were observed to be inadequate for policy dialogue so they would be modified.”<sup>237</sup> The meetings were not recast, presumably due to the pressing day-to-day problems which kept the Consortium focused on micro-management.

The balance between monitoring process and impact was also controversial. Most donors complained that the Bank was more interested in disbursement than the quality and impact of its investments. Some observers suggested that this was a hypocritical charge; as many agencies were equally interested in disbursement. According to a WHO official, as there was “significant underspending in FPHP (and previous projects) the bilaterals were not pleased with the Bank which introduced an additional tension in the Consortium.”<sup>238</sup>

A litany of unmet expectations of the Bank emerged over the course of the projects. For example a KfW report recommended “stronger emphasis on sector dialogue and on program policy,”<sup>239</sup> while another considered “the Bank’s advisory rôle with respect to sequencing and timing not very strong, it should have been more proactive in coordination, a more analytical approach should have been adopted.”<sup>240</sup> More importantly, different views obtained over the PHO itself. Whereas some donors considered it insufficiently funded and staffed (e.g., NORAD),<sup>241</sup> it was also described as a ‘fat and bloated bureaucracy.’ Over the years, there were calls to evaluate the effectiveness of the PPO/PHO and at times plans as well.<sup>242</sup> According to SIDA, the issue was raised at the Consortium retreat, but was “not strongly supported by the cofinanciers and was in any event blocked by the Task Manager.”<sup>243</sup> The PHO was eventually subject to its first external review in 1998 which focused, however, more on the options for a project support unit for HAPP-5 than the problems associated with meeting the needs of donors under the FPHP.<sup>244</sup>

## **5.9 Performance of the Consortium with respect to aid coordination: excellent, but...**

*It is not correct to evaluate the Consortium against a theoretical gold standard which does not exist in reality.*<sup>245</sup>

J.S. Kang, World Bank, 1997

Despite Mr Kang's legitimate concerns over the validity of the exacting evaluative framework employed by this study, the Consortium performed very well with respect to aid coordination and management (Table 14). Although the financial costs of the PHO may seem high, as a proportion of the total volume of resources channelled through the mechanism, they were in practice modest. While the mechanism failed to incorporate some major donors and a significant share of aid to the sector, it should be borne in mind that the Consortium was ostensibly designed to coordinate donors around Bank projects, not to provide coordination services to the sector as a whole. The Consortium's most fundamental shortcoming lay in its relationship with the recipient administration; it reinforced the dependency of the MOHFW and did too little to make use of Government systems and to encourage recipient leadership.

### *5.9.1. Ownership, participation and periodicity of coordination through the Consortium*

Theoretically all the cofinanciers had a stake in the Consortium. In practice, it was owned by the Bank in whose institutions it was housed. Significantly, the Government had no ownership in the mechanism and there were no plans to enable it to assume any.

If one discounts the fact that the Government, two major donors and several smaller ones, as well as civil society, did not gain membership in the Consortium and, therefore, only rarely took part in events organised by it, participation by members of the Consortium in its activities was impressive. This is true for their involvement in the annual IDA-cofinanciers project missions and the meetings of the Dhaka-based representatives. The Bank and, with very few exceptions, all the cofinanciers were represented in all of the supervision missions during the successive projects, albeit some better than others. With respect to participation in the regular meetings of the Consortium, evidence is only available for the FPHP as minutes and a participant list were only produced from 1992 onwards. Between April 1992 and May 1997, at least 44 regular meetings of the Consortium were convened, which represents an average of about 9 meetings per year. For 41 of these meetings, a participant list was available. These records illustrate (see

Table 13) that the majority of the agencies participated in more than two-thirds of the meetings called; with the exception of the EC, Japan, UNFPA and KfW.<sup>™</sup> As noted above, occasionally other parties were invited to discussions of the Consortium.<sup>α</sup> The World Bank was well represented at all of the meetings and on one occasion sent 12 delegates. The other agencies sent only one or two officials each.

**Table 13: Participation of members in 41 meetings of Consortium 1992-1997**

Agency	No. of meetings attended	Average no. staff/meeting
World Bank	41	6.3
GTZ	40	1.2
WHO	38	1.3
CIDA	36	1.6
ODA	35	1.5
NORAD	34	1.0
SIDA	34	1.0
UNICEF	29	1.4
AusAID	28	1.2
DGIS	27	1.0
EEC	16	1.9
Japan	16	1.4
UNFPA	14	1.6
Federal Republic of Germany	7	1.0
KfW	2	2.0

There were mixed opinions over the desirability of Government participation in the Consortium. While donors such as Sweden called for “more direct participation by Government,” others questioned whether or not the time of Government officials should be expended in discussions among donors. Most GOB officials argued passionately for Government representation in the Consortium and that donor-only arrangements were not in the interests of the country. The Bank maintained that Government participation in supervision missions was inappropriate as their purpose was to review GOB performance.<sup>246</sup> As discussed in the next Chapter, under the SWAp there is wide-spread support for a Government-led aid coordination arrangement as well as Government leadership of annual sector reviews. Nonetheless, certain donors wish to maintain an arrangement through which they can meet independently of Government officials, as has been the case with the FPHP Consortium.

<sup>™</sup> KfW did not have country level representation in Bangladesh and relied on the missions for project monitoring.

<sup>α</sup> Of the 41 meetings: USAID, DANIDA and AsDB participated in three, officials from the MOHFW attended two, as did two consultants.

In that successive projects ran without interruption and the supervisory missions and meetings of the Consortium were frequent and regular, periodicity of coordination through the Consortium was excellent. There were complaints that activity levels in the MOHFW waxed and waned in response to the schedule of visiting Consortium missions. Yet the emergence of a ‘mission culture’ reflects less the intermittent nature of coordination through the Consortium than the overwhelming demands placed on the administrative machinery of Government by missions themselves.

#### *5.9.2 The realm, breadth and integration of aid coordination through the Consortium*

The Consortium provided tools through which to promote consultation over policy issues and strategies (through the missions and meetings), the Bank with some means to encourage the concertation of donor opinion and action, as well as opportunities for the pursuit of significant operational coordination through the cofinancing arrangement and use of common aid management systems. In terms of the breadth of coordination achieved, the Consortium focused mainly upon the sub-sector in which its projects were active. During the FPHP, this involved approximately 35% of aid in the health and population sector. With emphasis placed on the SWAp, the Consortium is taking an interest in systemic and cross-cutting issues beyond the confines of its investments.

The systems of aid coordination and policy dialogue established by the Consortium are only partially integrated with their indigenous counterparts. In aid management terms, although many common systems are used by Consortium members, these are often grafted upon or parallel to Government systems. More complete integration occurs in the policy dimension where the Consortium discussions are an integral and agenda-setting feature of the domestic policy process.

#### *5.9.3 Authority and adherence to decisions made in the Consortium*

The legal agreements governing the cofinanced projects provided the basis for donor adherence to commitments they made to aid coordination and management. Less explicit rules, for example those relating to the conduct of meetings of the Consortium, were gradually formalised as the need to do so arose. Even the formal agreements broke down on a recurrent basis where specificity was lacking and differences of opinion over interpretation came to light. Often it proved difficult to resolve these differences as limited authority was vested in the Bank as arbiter and no agreed or effective sanctions had been developed. The Team Leader of the Preparatory Review Group of the Mid-Term Review of the FPHP (a former staff of the World Bank’s OED) suggested that “the

problem with the Consortium is that the responsibility to coordinate has been vested in the PHO but it really doesn't have the power to fully carry out this responsibility."<sup>247</sup> This analysis was echoed by a PHO staff who complained that there are "no real sanctions over bilaterals who won't play ball."<sup>248</sup> Yet despite the absence of an entity which wielded absolute authority in the group, for the most part, decisions which were made with respect to project financing and implementation were subsequently honoured.

#### *5.9.4 Outcome criteria: efficiency, effectiveness and sustainability*

The efficiency of the deployment and management of aid in the sector was improved as the Consortium served to reduce the duplication of activities, to harmonise procedures, and to encourage donors to use common aid management tools. In the survey conducted for this study, there was support from all respondents for the proposition that the Consortium had reduced the burden faced by the MOHFW in relation to aid management. Respondents stressed the contribution of consolidated expenditure reporting and common disbursement in the case of Trust Funds. Donors were largely appreciative of the initiative to rely on single biannual reports prepared by the executing agencies and MOHFW, but Government officials did not agree that this reduced the reporting demands of the agencies. Whereas 5 of 8 donor officials suggested that joint missions had had a beneficial impact, only three of the five Government officials, which responded, agreed. Many cited the persistence of numerous additional missions fielded by donors, particularly by those providing parallel financing. The majority of respondents felt that the Consortium had satisfactorily reduced the number of bilateral meetings required between the agencies and senior Government officials. A third of donor officials felt that the Consortium had resulted in cost-savings and increased efficiency of resource use, while the remaining respondents were uncertain.

Two factors likely contributed to the Consortium playing a positive rôle in increasing the effectiveness of the deployment of aid. First, roughly two-thirds of donor respondents suggested that the Consortium had resulted in improved project design, a sentiment generally shared by Government officials. Second, in that conflicting policy advice was diminished as a result of consensus-building, the arrangement would have contributed to more coherent programme development.

While the Consortium may be financially sustainable in that its supporters appear willing to establish a comparable arrangement for HAPP-5 (see next Chapter), the mechanism would not flourish if it were transferred to the MOHFW for management. In relation to

the Third Project, the Government already noted that “a negative aspect is the possibility of the GOB’s growing dependence on IDA & cofinanciers for maintaining a vast complement of field staff on a permanent basis.”<sup>249</sup> Under the FPHP, the PHO was enlarged and little was done to develop indigenous capacity to assume the responsibilities performed by the PHO to manage aid and coordinate donors.

In addition to considerations of the performance of the Consortium according to the study’s conceptual framework, a couple of points deserve consideration. First, there were undoubtedly additional benefits of the Consortium in terms of aid coordination. For example, one Consortium member highlighted its utility in orienting new expatriate staff to the sector, providing continuity among the group of donor representatives, and, during the FPHP, providing an institutional memory of donor decision-making.<sup>250</sup> Yet, the experience also raises concerns which cannot be discussed within the conceptual framework. For example, did the Consortium encourage an unbalanced approach to reform of the aid relationship in that it was used to leverage changes in the MOHFW, while doing little to put pressures on donors to improve the effectiveness or efficiency of aid, through, for example, modifications of their procedures? In addition, the PHO and the numerous project offices established for project implementation undermined the line authority in the MOHFW. In the same vein, the scale of the Consortium had an overwhelming influence on policy development. While none of the donors surveyed rejected the idea that the Consortium had increased the leverage of their agency over the Government on policy dialogue, only half stated categorically that it had done so. Most Government officials took a contrary view. One official stated that as a result of the strength of the Consortium, the Government had “lost control over developments in the sector” and two-thirds of Government respondents felt that the Government was disadvantaged in the face of a united donor front on policy dialogue. One donor questioned the legitimacy of the Bank using the Consortium as a forum for policy dialogue as the Bank was not a neutral player and the Consortium does not include all donors and excludes the Government.<sup>251</sup>

**Table 14: Assessing the Consortium against the conceptual framework for aid coordination**

Process criteria	Remarks
Ownership	<ul style="list-style-type: none"> <li>◊ Belongs to cofinancing donors including the World Bank. In practice, as the manager of the Consortium and PHO, the Bank has greatest ownership.</li> <li>◊ No steps are being taken to institutionalise the Consortium, or the project support unit, in the MOHFW.</li> </ul>



Participation	<ul style="list-style-type: none"> <li>◇ While a significant number of donors are not part of the Consortium, all major bilateral agencies, with the exception of USAID, and the key health-related multilateral organisations, with the exception of AsDB, participate in the Consortium.</li> <li>◇ Excludes numerous donors, the GOB, and civil society, although there are formalised and increasingly regularised linkages with them.</li> <li>◇ Concern has been expressed that the specialised UN organisations and Funds do not contribute sufficiently to the group in their normative capacity.</li> <li>◇ High degree of participation in missions and bi-monthly meetings.</li> <li>◇ Decision-making is on a consensual basis, within the framework of a Code of Conduct. The World Bank brokers consensus-building and conflict resolution.</li> </ul>
Periodicity & continuity	◇ Regular, frequent and on-going.
Integration	<ul style="list-style-type: none"> <li>◇ Systems for aid management are partially integrated into recipient administration.</li> <li>◇ Consortium policy positions are very well integrated into the policy process - at times these set the pace and content of the sector agenda.</li> </ul>
Realm	◇ Promotes in equal measure consultation, concertation and operational coordination.
Breadth	<ul style="list-style-type: none"> <li>◇ Focuses mainly on those activities within the sector supported through the FPHP (i.e., approximately 35% of external investment in the sector).</li> <li>◇ The Consortium has had limited oversight of broader systemic issues. This changed with the preparation of a SWAp.</li> </ul>
Authority & adherence	<ul style="list-style-type: none"> <li>◇ Members generally abide by decisions taken in the group. However, many instances of the failure to do so have come to light and the Bank complains that it does not have the authority to prevent members from acting unilaterally.</li> <li>◇ Procedures established do not appear to be by-passed although certain arrangements are duplicated (e.g., appraisal and monitoring missions).</li> </ul>
Costs	◇ In addition to the significant human resources devoted by each member agency to participation in the Consortium, the cost of the PHO is approximately 1% of project investment. This appears to represent good value-for-money.
Outcome Criteria	Remarks
Efficiency	◇ Appears to improve the efficiency of aid in the sub-sector supported by FPHP by: (1) reducing duplication of activities; and (2) diminishing burden on recipient administration through harmonisation of procedures, etc.
Effectiveness	◇ Appears to improve the effectiveness of the sub-sector supported by FPHP by: (1) reducing conflicting policy signals sent to MOHFW; and (2) rationalising a proportion of external investments.
Equity	<ul style="list-style-type: none"> <li>◇ Unclear if the mechanism serves to correct inequities in targeting of assistance and in payment for services.</li> <li>◇ There is no evidence that it increases parity of benefits for aid-supported staff.</li> </ul>
Sustainability	<ul style="list-style-type: none"> <li>◇ The arrangement is well institutionalised within the donor community and it appears that staff (perhaps with the exception of the multilateral organisations) have adequate informal incentives to participate actively.</li> <li>◇ Costs appear sustainable while the mechanism remains under donor ownership.</li> <li>◇ Development of national skills and institutions to handle these tasks not evident.</li> <li>◇ Project support units and PHO undermine line management in MOHFW.</li> </ul>

## 5.10 Chapter summary

➤ The Consortium represents a remarkably long-lived initiative which has enabled disparate donors to accommodate differences in policy and operational practices so as to improve the coordination of a proportion of their aid. During the FPHP, this involved the

resources of ten donors covering approximately 35% of external investment in the sector as well as the participation of three health-related multilateral agencies.

➤ The ingredients which made the Consortium relatively successful appear to be: (1) an ongoing and concerted effort to address threats as they arose and to adapt practices and formalise procedures; (2) the availability of a significant amount of ear-marked funds for aid coordination as well as considerable flexibility in their deployment; (3) an explicit financial investment and, hence, ownership in the mechanism by all parties (save the multilateral agencies which may account for their erratic and problematic participation); (4) specific characteristics of the lead agency which included the perception of relative competence and neutrality (i.e., not belonging to any one donor country), institutional support and internal incentives for aid coordination coupled with the dedication of particular staff;<sup>a</sup> (5) tangible benefits for the lead agency (i.e., access to more aid and enhanced influence to pursue its policy objectives); (6) material benefits for all members (i.e., cost-savings and policy leverage); and (7) an operational component in the form of a project to coordinate around.

➤ Despite the achievements, there was significant disenchantment with the manner in which the Consortium functioned, particularly with respect to differences of opinion over policies and strategies as well as rôles, responsibilities, accountability, expectations and communication. The cofinanciers laid the blame on the dual and conflicting rôles of the Bank as lender and consensus builder.

➤ The persistence of difficulties raises the question of whether or not it would have been possible to mitigate against the possibility of dissatisfactions by providing greater specificity to agreements and placing greater emphasis on process issues? Alternatively, do specific and changing institutional interests of members override their general commitment to coordinate when differences arise? From the evidence provided by the Consortium, it would appear that the latter generally occurs.

➤ It was agreed that no donor in Bangladesh could have substituted for the Bank as leader of the Consortium. Yet, the lack of absolute authority and, consequently,

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<sup>a</sup> The rôle of personalities in the success of the Consortium is illustrated by the following concern: “some questions were raised [by SIDA officials] as to the long-term prospects of the Consortium, whether its nature would change drastically once other persons would staff the offices in Dhaka and in Washington...”

legitimacy of the Bank to lead donors in the sector provided donors with the option of whether or not to join the Consortium, to participate actively, and to abide by the decisions and rules of Consortium. Would donors vest the required authority in the Government if it were adequately strengthened to take on the rôle of aid coordinator? Similarly, if it has been difficult for the Bank, arguably well resourced, and seen by many observers as managerially competent, to provide coordination services with which the bilaterals are satisfied, what hope is there that the GOB or another donor could meet these?

➤ The establishment within the donor community of a large expatriate capacity for aid management and donor coordination is likely to have diverted resources from the task of developing recipient capacity for these tasks.

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## CHAPTER SIX

### Coordination and the sector-wide approach: a watershed or faddish chimera?

#### 6.1 Introduction

This Chapter analyses the introduction of a sector-wide approach (SWAp) in Bangladesh. As the SWAp remained more aspirational and theoretical than applied during this research, the Chapter begins with an explication of the concept. The manner and interests served by placing the SWAp on the health sector agenda are then explored. Given the limited application of the approach in practice, this Chapter does not provide an assessment of the results of the SWAp *per se*, but rather describes the intentions of the key players with respect to their participation in this innovative approach to assess the prospects that the SWAp may improve aid coordination. A number of reasons are given to suggest that the introduction of the SWAp may mark a potential watershed in relation to aid coordination in Bangladesh. However, despite the fact that the approach brings the need for aid coordination into strong relief and provides a number of powerful tools to facilitate aid coordination, the SWAp may simply be the latest in a history of donor-inspired fads in the sector.<sup>α</sup>

#### 6.2 What is a SWAp?

*We have been put under great pressure to adopt the SWAp, but have no idea what it is we committed ourselves to; each visiting consultant tells us something different.*<sup>1</sup>

Chair, MOHFW Task Force on Sector-wide Management, 1997

During 1996-97, disagreement over the meaning of a SWAp was not limited to visiting international consultants, but was shared by donor staff, stationed in headquarters and field locations. This resulted in considerable confusion among Bangladeshi officials, who obtained the bulk of their understanding of new aid management instruments from these sources. Given the nascency of the term and the nature of the ideas which it tries to capture, ambiguity over the attributes and aims of the SWAp was predictable. In January 1997, aid agency delegates to a global strategy meeting on SWAps in Copenhagen<sup>2</sup> employed varying terminology to describe the many characteristics and objectives which

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<sup>α</sup> Such as 'Health for All' through Primary Health Care; GOBI-FFF; UCI-90; etc.

they were seeking to achieve through changed practice at the aid interface. The World Bank used the nomenclature ‘Sector Investment Programs’ (SIPs) and ‘Sector Expenditure Programs’ (SEPs) to describe the generic attributes of a sector-wide approach as well as legal lending instrument of the Bank (in the case of the SIP). Both Sida and DANIDA used the term Sector Programme Support, with Sida placing emphasis on common implementation arrangements<sup>3</sup> and DANIDA according salience to recipient ownership of the programme.<sup>4</sup> USAID favoured the term ‘Sector Program Assistance’ in reference to budget support which sought to highlight the link between aid and host country policy and institutional reform.<sup>5</sup> According to Cassels, the term SWAp was adopted at the Copenhagen meeting to accommodate the plurality of approaches to sectoral development under consideration.<sup>6</sup>

A sector-wide approach centres around a medium-term partnership between various arms of the recipient government and donors. Current consensus holds that the SWAp’s aims are to bring about better health, in the context of a coherent sector (as defined by an appropriate institutional and financing structure), through concentration on four substantive areas of collaborative work: (1) the development of sectoral policies and strategies; (2) the preparation of medium-term and annual sector financing and expenditure plans; (3) the establishment of common management systems; and (4) institutional reform and capacity building in line with the policy framework and supportive of the proposed managerial and financial arrangements.

As framed, the definition of the SWAp touches on an enormous range of issues. In relation to aid coordination, the SWAp suggests a number of practical tools which could potentially improve coordination (such as jointly-held priorities, plans, budgets and management systems). Implicit, however, is the requirement of unprecedented levels of coordination among donors and between donors and government.

### **6.3 The introduction of the SWAp in the health sector in Bangladesh**

Although the term was not applied, the Bank promoted one element of the SWAp, the pooling of donor funds, as early as 1988. Preceding the Fourth Population and Health Project (FPHP), Bank staff visited the headquarters of existing and prospective cofinanciers to promote the idea of a “program approach...in which donors could make their contribution to a pool of funds on a proportional basis.”<sup>7</sup> Pooling was advocated because of “the complexities of current project financing with too many parties involved.” According to the mission aide-memoire, the Bank encountered “views which run counter” and “much scepticism” to the proposal.<sup>8</sup> Nonetheless, the Bank persisted by

asking the Government to formulate a paper on how it could handle “implementation of a program approach.”<sup>9</sup> At a meeting of Government and donors, held in Paris in 1990 to reach consensus on the FPHP, the program approach was again commended by the Bank and “received with mixed reactions.”<sup>10</sup> The idea of pooled resources was eventually dropped for the FPHP due to cofinancier concerns regarding accountability as characterised by the German position: “based on the Third Project implementation experience, participation in a ‘program finance’ arrangement for the Fourth Project cannot be recommended. Financing of distinct project components is recommended instead, so that appropriate implementation planning and monitoring procedures can be agreed upon a bilateral basis.”<sup>11</sup>

The Bank, however, did not lose sight of the program approach. The Completion Report for the Third Population and Family Health Project, published in 1993, concluded that the project “could perhaps have been designed better through a more complete pooling of resources towards commonly defined objectives, without individual donors being identified with separate sub-components.”<sup>12</sup> Paradoxically, and despite the fact that resources for the FPHP were not pooled, in March 1994, the Bank began to refer to the project as operating within a ‘program approach.’ By this it meant putting “the project activities in the holistic context of family planning and health programs rather than leaving them disjointed.”<sup>13</sup> The extent to which the FPHP achieved such distinction is debatable, yet it was certainly the intention of the Bank to shift investment in the sector in the direction of a programme approach. Approximately one year later, the Bank wrote to its Consortium partners “wondering if it would make sense to consider more a program approach” in any follow-on project.<sup>14</sup> Despite the nomenclature, what was envisioned was essentially a SWAp. “Under such an approach, we would reach agreement with Government on the whole program of the MOHFW - broad priorities and strategies, annual operational plans and policies, and annual expenditure programs and financing. This agreement would provide a framework within which donors would offer assistance according to their interests. This assistance could take the form of focused projects or of time-slice<sup>a</sup> (or program) finance, to help cover whatever the focused projects do not, in a flexible manner.”<sup>15</sup> This letter was followed by a visit to Dhaka by a senior Bank official who met with senior Government officials (MOF, ERD, and MOHFW) and with donors to discuss the merits of a SWAp and to address the many concerns which the various parties held.<sup>16,17</sup> Thereafter the Bank circulated a concept paper which set out the rationale and relevance of the SWAp to Bangladesh.<sup>18</sup> In a report on a GOB-donor

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<sup>a</sup> Time-slice finance is synonymous with budget-support.



consultation on the future of the population and health programme, held in Paris later that year, the Bank records “it was generally agreed that a sector-wide approach was appropriate for a program of this importance and size,”<sup>19</sup> (although the claim that agreement had been reached was later refuted by a participant at the consultation<sup>20</sup>). In early 1996, the Bank’s internal ‘Initial Executive Project Summary’<sup>δ</sup> for the Consortium’s Fifth Health and Population Project (HAPP-5) asserted that “the Bank is the only donor taking a sector-wide approach.”<sup>21</sup> By this the Bank presumably meant that other agencies had yet to commit themselves. By the end of 1996, the Bank was still asserting its leadership position in SWAp development. For example, the Bank memorandum on meetings of the Secretary, MOHFW, with Bank staff in Washington, records that “IDA was proposed [by the Secretary] to continue to work as the lead agency among donors for devising the sector-wide approach.”<sup>22</sup> Thereafter, discussions on the preparation of HAPP-5 and the sector-wide approach became intimately intertwined, and the Bank led both.

Although the Bank attracted allies, it remained the principle proponent of the SWAp until the end of this study, at which time considerable uncertainty persisted as to the nature and even whether or not a sector approach would be adopted. A variety of motivations could be imputed to the Bank to account for its support for the introduction of the SWAp in the health sector in Bangladesh (speculation on these is reserved for the next Chapter), but its own rationale proposed that the SWAp could facilitate two reforms.<sup>23</sup> First, that within the allocation of public-sector resources, priority be accorded to an Essential Package of Services (EPS) reflecting those interventions identified by the Bank as particularly cost-effective in an earlier global analysis.<sup>ε24</sup> It was argued that given the fungibility of resources, *ad hoc* external investment could not ensure such an allocation. The SWAp would provide the mechanism which would put all resources on the table for scrutiny and negotiation and thereby ensure that aid would not replace Government funding of priority activities. Consequently, the HAPP-5 appraisal mission aide-memoire specified that project negotiations would only proceed once assurances were received from the GOB that the EPS would constitute 60% of all public finance in the sector and that “donor funds do not substitute for Government funds during the life of the program.”<sup>25</sup> Second, the Bank wanted to secure sector reforms which could not be addressed in a piece-meal manner. Consequently, the preparation of implementation plans for a host of sector

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<sup>δ</sup> The IEPS is the document submitted to the Board for approval for project preparation.

<sup>ε</sup> The EPS in Bangladesh included low cost interventions in five categories: (1) Behaviour Change Communication; (2) Reproductive Health Care; (3) Child Health Care; (4) Communicable Disease Control; (5) Simple Curative Care.

reforms served as pre-conditions of negotiation for HAP-5.<sup>26</sup>

In that there was widespread dissatisfaction among powerful stakeholders over specific features of the health sector in Bangladesh, conditions for the introduction of a SWAp were ripe. First, a number of donors agreed with the Bank's reform objectives - even though they may have disagreed with the methods for introducing them or with particular details. Second, many donors, notably the European members of the FPHP Consortium<sup>27</sup> and USAID, were concerned that developments in the sector lacked direction; something that a policy framework could correct. Third, most donors,<sup>28</sup> but most audibly DGIS,<sup>29</sup> Sida<sup>30</sup> and CIDA,<sup>31</sup> were concerned with the lack of Government ownership of the programme and hence were apprehensive about its sustainability. Limited Government commitment was in part attributed to the lack of an agreed strategy, which was exacerbated in the face of donor-driven project investment. It was envisioned that consultation and negotiation of a sector strategy would engender greater Government commitment to the programme. Fourth, for many actors, it was thought that the sector approach would provide the opportunity to improve aid coordination. Moreover, numerous donors, the Bank and many Consortium members included, took the public position that the transition to a SWAp was an opportune time for the MOHFW to establish and lead some form of aid coordination arrangement. For the first time, USAID pushed forcefully for GOB leadership in aid coordination.<sup>32,33</sup> USAID may have seen the potential of shifting the locus of aid coordination not simply from the Bank to the MOHFW, but perhaps to an MOHFW mechanism over which it could exert control vicariously.<sup>λ</sup> While some MOHFW officials were threatened by the proposed changes (particularly Project Directors who were concerned about the loss of benefits and status), senior officials were persuaded that they stood to gain, not least keeping the next World Bank project on stream, and went along with preparatory work on the SWAp.<sup>β</sup>

#### **6.4 SWAp characteristics and coordination**

This section explores the perceptions of various stakeholders towards the collaborative programme of work, which is central to the sector-wide approach, so as to enable the formation of judgements about its utility to aid coordination. The findings are based on the survey described in the methods section of Chapter One, as well as documentary and interview sources.

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<sup>λ</sup> Although there is no direct evidence to substantiate this claim, it remains that it was not until the SWAp was floated that USAID publicly stated the need for MOHFW leadership over coordination.

<sup>β</sup> When asked what the MOHFW expected to from the SWAp, one official responded "more aid."

#### *6.4.1 Sectoral policy and strategy frameworks*

One of the features which distinguishes the SWAp from previous ways of doing business is that it “has demanded of new health policies that they be far more explicit than their predecessors, and that they be formulated to address real choices for the sector.”<sup>34</sup> The preparation of a sectoral policy or strategy framework was considered universally desirable by the stakeholders consulted in the study. Respondents expressed the potential for such frameworks to facilitate a comprehensive approach to decision-making for the entire sector. As a result of such an approach, it was felt that expenditure could be guided towards priorities established through evidence-based methods as opposed to political or economic expediency, which would in turn lead to reduced sectoral fragmentation and duplication of activities. MOHFW officials noted that in conflicts with interest groups, reference to a previously agreed strategy might provide them with a measure of leverage. Some donors shared this view, reiterating the much-used notion of putting the MOHFW in the ‘driver’s seat.’

Notwithstanding the recognition accorded in principle to the importance of a health policy to guide the SWAp (and donor activities therein), numerous anxieties were raised about what might happen in practice. A majority of donors were apprehensive about the possibility that they might not subscribe to the principles articulated in an ‘agreed’ policy. For example, both UNICEF and WHO expressed concern that a too narrow definition of the sector had been adopted in the Health and Population Sector Strategy (HPSS) which formed the basis of the SWAp. Other donor concerns were that: (1) their values, mandates and/or objectives may be incompatible with the consensus agreed to by other stakeholders; (2) they may have insufficient involvement or influence over the articulation of the strategy; and/or (3) their liberty to support specific activities and propagate closely held values may be circumscribed by the resulting accords. The majority of Government officials canvassed were concerned that donors might have too much influence over the sector policy.

It is understandable that respondents were anxious that they may not concur with the ‘agreed’ policy frameworks nor agree to buy into them. Chapter Three described the attempts to establish a formal and legislatively-based national health policy which were so fraught with difficulties that they were aborted. While donors could have opted to support the Government to evolve a national policy or plan which could have guided efforts for reform in the sector, the Bank instead embarked upon a parallel exercise. The annual IDA supervision mission of the FPHP in 1995 “informed the MOHFW that a well

thought out sector strategy needs to be developed and that the Bank will undertake to do the work in partnership with the Government.”<sup>35</sup> While the Bank’s motivations for bypassing the GOB’s established policy and planning procedures are not wholly clear, the Bank may have been concerned about: (1) associating itself with the overtly political process inherent in working with a national health policy committee; (2) slowing down the pace of preparing HAPP-5 and the sector-wide approach by tying them to a potentially protracted governmental exercise; and/or (3) relinquishing some influence over strategy direction and content. Whatever the mixture of motivations, the Bank opted to side-step the Government-led national health policy and planning processes by demanding that a sector strategy be in place prior to the pre-appraisal of HAPP-5.

The Bank’s intentions with respect to the HPSS included not only its desire to ensure a comprehensive approach to the sector, but also to enlist the support of other stakeholders for its reform agenda. According to the Bank, the strategy would provide the Government with “the analytical basis...which will guide the development of ... the sector over the next five years...and firm up GOB priorities.” For other donors, the Bank hoped the HPSS would “provide a common framework for their support to the health and population sector...”<sup>36</sup>

Although strategy preparation became a major focus of activity for a large contingent of MOHFW and donor officials, the exercise was overwhelmingly Bank-driven. Initially, political disturbances disrupted work on the sector strategy, at one point forcing the cancellation of a mission to Bangladesh which aimed to reach consensus on a draft strategy. To keep to project preparation schedules, in a letter to the Secretary, MOHFW, the Bank proposed “as a fall back, IDA could prepare a very rough first draft of the strategy paper.”<sup>37</sup> The Bank continued by suggesting that if it were not possible to field a mission by April, “and bearing in mind the need to continue the momentum of sector strategy and project preparation, it may be opportune to consider a 3 to 4 day meeting elsewhere.” Such an approach was resoundingly rejected by other members of the Consortium, many of whom argued in favour of allowing the Government to proceed at its own pace; both with its difficult reform agenda and with developing an indigenous and domestically owned strategy.<sup>39</sup> Opposition to the tactics adopted by the Bank was also voiced by USAID which reminded the Bank that: “design of the HPSS is an inherently governmental function which should be done in Bangladesh.”<sup>40</sup> USAID wanted to ensure that the strategy was “not only a World Bank or Consortium product but a document which represents the concerns and issues of all participants in the sector.”<sup>41</sup> Ultimately, the Bank postponed the HPSS preparation missions until it was feasible to field them in

Bangladesh and consented to a more inclusive and participatory process. For example, seven Technical Groups consisting of approximately 130 participants, comprising technical experts, NGOs, civil society, and a policy think-tank, were established to work with the multi-donor HPSS Reconnaissance Mission.<sup>42</sup> Yet even the participatory process was tightly managed by the Bank. The task manager of the FPHP emphasised “that whatever process we follow it should *not be seen* to be donor driven... Management and supervision of the process of stakeholders and beneficiaries being involved in the preparation...should be done by the JGF [Japanese Grant Facility]<sup>x</sup> staff rather than the PHO. GOB views PHO as World Bank but they are likely to see JGF staff more as belonging to them than to the Bank.”<sup>43</sup>

After a series of Bank-donor and Bank-only missions, a draft HPSS<sup>44</sup> was issued by the MOHFW, yet its formal adoption by the GOB was stipulated as a condition by the Bank for pre-appraisal of HAPP-5.<sup>45</sup> Consequently, although the HPSS was approved by the highest levels of Government in August 1997, in the eyes of many stakeholders, it remained a document with the distinct imprint of the Bank. DFID was “deeply concerned that the process of developing the HPSS has contravened two of the Bank’s own requirements for introducing Sector Investment Programmes, viz. that (i) local stakeholders, usually Government, should be fully in charge; and (ii) local capacity, rather than technical assistance, should be relied upon.”<sup>46</sup> A senior WHO official wrote that the preparation of the HPSS and HAPP-5 were “a matter for concern... there are so many opinions on so many health and health services issues that someone, i.e., WHO, needs to promote consensus.”<sup>47</sup> Stakeholder reluctance to buy into the HPSS can, therefore, be explained by the fact that: (1) the process was rushed; (2) not all positions were equally and adequately considered; (3) the views of the Bank predominated; and (4) the document did not adequately reflect the true intentions of the MOHFW. This example begs the question of whether or not and how it might be possible to design a process through which to arrive at a true consensus over sector development which can guide the most important parties investing in the sector?

#### 6.4.2 *Sector financing and expenditure plans*

The HPSS specified that it would be implemented through annual operational and related expenditure plans – encompassing the entire programme of work of the MOHFW, including revenue and development expenditures and inclusive of externally-supported activities. By August 1997, a draft HAPP-5 Project Implementation Plan (PIP) had been

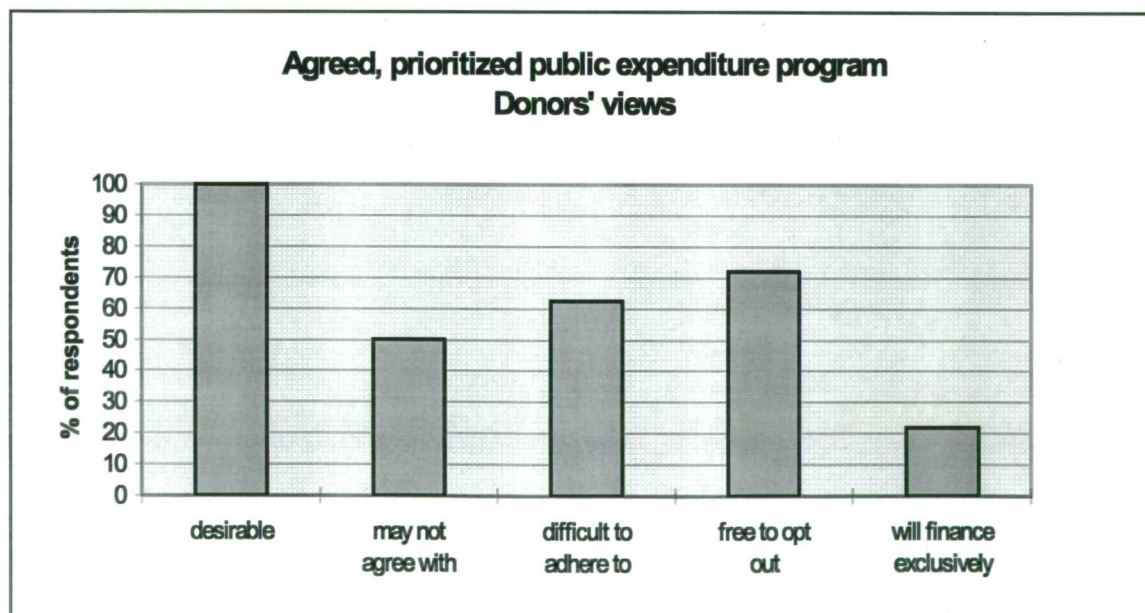
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<sup>x</sup> The JGF constituted a million dollar grant provided by JICA to the MOHFW for expenditures associated

prepared by MOHFW with estimated expenditure projections for the first year of the programme.<sup>48</sup>

All stakeholders consulted during the research provided enthusiastic support to the principle of developing agreed, prioritised, medium-term and annual budgets for the MOHFW which reflect the aspirations established in the sector strategy. Respondents commented that these might: (1) facilitate resource allocation in a more systematic, evidence-based and comprehensive manner than currently obtains; and (2) provide a common framework to guide the deployment of all resources – irrespective of their origin. Yet, in the survey both donors and Government officials voiced a number of problems. Donors were concerned that: (1) their agency may not agree with the chosen expenditure plans; (2) their agency may have difficulties supporting activities specified in the programme; and (3) their freedom to finance activities which were not specified in the PIP ought to be maintained under a SWAp (see Figure 1). Only two agencies committed themselves to funding exclusively those activities agreed to in the annual expenditure programme (i.e., the World Bank and Sida).

**Figure 1: Donors views on an agreed MOHFW expenditure programme (n = 11 donors)**



All Government officials surveyed indicated that ideally all expenditure, particularly aid, should support activities specified in the annual plans and expenditure programme. Nevertheless, a significant number of officials paradoxically suggested that ‘flexibility’

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with preparation of HAPP-5. The JGF was executed by the World Bank on behalf of the MOHFW.

should be maintained in practice and an open attitude adopted to '*ad hoc*' projects of a 'political nature.' Officials were worried about what would be on the table during annual review and budgeting exercises. As noted above, donors saw the procedure as overcoming the fungibility problem and consequently ensuring that external funds did not displace GOB funding for the Essential Package of Services. Government felt threatened not only by external scrutiny of the budget, and, by implication, matters of national sovereignty, but also by having its hands tied when dealing with the inevitable domestic politics surrounding resource allocation.

Although the SWAp can accommodate a variety of financing instruments, the intention is that over time, as accounting, auditing and other managerial systems within the recipient administration become more robust, and thereby gain greater donor confidence, project-specific investment will give way to budget-support. While the overwhelming majority of Government staff considered a shift to budget-support as desirable, this sentiment was shared by only about two-thirds of donor respondents. By the end of 1997, only three agencies had committed themselves to providing some of their assistance during HAPP-5 in the form of budget-support (i.e., World Bank, Sida, and DGIS), and the Bank was the only agency to specify that its entire credit would take this form.<sup>‡</sup>

Six of the seven agencies which responded to the survey indicated that they would likely earmark funds for certain activities in the sector. Given the response bias inherent in the survey, it is probable that it will be business as usual with project finance for the remainder of agencies (i.e., the majority) in the sector for the foreseeable future. From the donor's perspective, project-specific investment is the best way to protect those activities which they feel have not received adequate attention in the consensus agreements – but is also seen to safeguard tied aid and to support NGO operations under a SWAp. Moreover, there was some reluctance to commit to the use of pooling arrangements until the Government could demonstrate greater probity in the use, accounting and auditing of funds. Although projects are potentially problematic with respect to coordination, donors agreed overwhelmingly with three rules which ought to accompany the SWAp which might partially ameliorate some of the problems.<sup>×</sup> Whether or not such guidelines would be adhered to is a matter for speculation, but past experience suggests that some donors tightly guard information about their programmes.

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<sup>‡</sup> The Bank faces, of course, different corporate exigencies than do the bilaterals, with the former characterised by disbursement and the latter by financial accountability and attribution.

<sup>×</sup> Decisions regarding earmarked funds should be communicated to Government and donors well in advance of annual programme planning exercises; and agencies should make a commitment to

Ministry officials are more favourably inclined towards budget-support than their donor counterparts. In the case of senior MOHFW officials, this can be explained, in part, by the fact that they bore the brunt of the workload imposed by the projectised approach but also because they stood to gain from increased line authority with the SWAp. Nevertheless, projects had a strong lobby among Project Directors (who gained a wide range of benefits from them) as well as within the Planning Commission, where project approval and extensions provided the main source of influence.

#### *6.4.3 Common management systems*

According to Peters and Chao, “one of the main technical innovations of the SWAp is the concentrated efforts on building and using national management systems to plan, monitor performance, and undertake the day-to-day business of purchasing and delivering goods and services.”<sup>49</sup> Common management systems aim to facilitate more order and economy in handling of resources. This covers functions such as aid-related appraisal, disbursement, procurement, reporting, accounting, and auditing. The goal is to dispense with the multiple, distinct, bilateral arrangements between individual donors and recipients, in favour of the use of common, unitary systems. This may involve the harmonisation of donor procedures or, ideally, donor use of systems embedded in the recipient’s public administration. Precedents for common management already exist for a portion of resources managed under the FPHP. Donor procedures were harmonised for joint missions, common disbursement through the Bank Trust Fund accounts, etc., and there was limited use of government systems for aid management through, for example, consolidated reporting by the Project Finance Cell, MOHFW. A review of global experience with SWAps concludes that developing and using national systems presents the greatest challenge.<sup>50</sup>

Although the HPSS did not address the issue of common management systems explicitly (beyond the broad intention to use joint operational programmes and budgets) the aim was implied. The survey of stakeholders’ views found that almost all Government officials found the concept desirable. It was envisioned that the use of common arrangements might entail less ‘day-to-day interference’ and a ‘hands-off’ approach to aid management by donors. Nevertheless, Government officials recognised that, in reality, they were relatively powerless to enforce common systems on donors. Approximately seventy percent of donor officials reported that they found the notion of

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sustained funding for an agreed period.



common systems desirable in principle, yet cautioned that there is a major gap between what is desirable and what they regard as currently feasible. Over one-half of donor respondents anticipated having problems making use of common systems. Donors were concerned with three issues. First was the question of attribution – donors expressed the need to continue to be associated with specific inputs and outputs. The second problem related to accountability. Questions were raised about the Government's ability to spend funds on agreed purposes and account for them adequately. Third, and related to the first two concerns, was the issue of adequate Government capacity (particularly if the common management systems were to be managed by Government).

When respondents were asked who should take responsibility for specific management systems (if they were established), while there was only limited agreement on specifics, two clear patterns emerged: (1) Government should take on increased, and progressively increasing, obligations concomitant with a relinquishing of donor control – this sentiment is particularly strong among MOHFW officials, who no doubt felt empowered through their rôle in the HPSS and HAPP-5 PIP preparation; and (2) the need to establish modalities for joint GOB-donor management of a number of functions. The case of responsibility for communication and information provides an illustration. While the majority of respondents agreed in principle with the need for a central point of communication in the sector as well as a depository for reports and information, and an enhanced and leading rôle for the MOHFW in this area, there were grave reservations among donors over current capacity in the MOHFW to perform this task effectively. Weak institutional capacity was listed as the greatest threat to the SWAp by all donor respondents and three quarters of their Government counterparts. Consequently, capacity-building was underlined as having a central place in a successful SWAp.

## **6.5 Coordination architecture under the SWAp**

The SWAp literature stresses that a SWAp entails risks for donors and Governments alike and, consequently, that there is a need to develop processes and fora for dealing with problematic issues.<sup>51,52,53</sup> The SWAp, therefore, demands that the architecture for aid coordination be explicitly addressed.

### ***6.5.1 Government-led sector-wide management board***

In Bangladesh, the need for a Government-led arrangement for aid coordination had been mooted long before the advent of a SWAp. As discussed in Chapter 3, a Government-led initiative had been established in the 1970s but was abandoned. During the 1990s, the desirability of greater Government involvement and leadership was expressed by

individual donors working within the Consortium, by the Consortium as a group,<sup>54</sup> by the Preparatory Review Group which was commissioned by the Consortium to provide a semi-independent review of the FPHP prior to its mid-term review,<sup>55</sup> by a European Union situation analysis of coordination,<sup>56</sup> by the multilateral agencies,<sup>57</sup> by donors which were not members of the Consortium (such as USAID<sup>58</sup>), and by the Government itself.<sup>59</sup> Yet it was discussions concerning the SWAp which crystallised the perceived need and provided the impetus to place aid coordination on the health policy agenda.

Donors had different reasons for wanting a Government-led arrangement. For some agencies, the introduction of a SWAp provided a window of opportunity to establish a recipient-managed structure so as to redress past inadequacies in this area. Others were concerned about the influence the Bank would wield if it led the principal aid coordination forum in the sector under a SWAp. USAID frequently stressed that the sector strategy should address the issue of donor coordination and that “we strongly support the proposal to establish a single national coordination mechanism for health and population.”<sup>60</sup> USAID suggested that a number of apex-level committees could “be merged thereby bringing all parties under one coordinating mechanism.”<sup>61</sup> The proposed merger was discussed at a meeting of the Minister, MOHFW, USAID and the Bank in March 1996. According to Consortium meeting minutes, “the main point agreed upon was to have only one, widely representative, apex body for the entire sector for policy level decision-making” which would be chaired by the MOHFW.<sup>62</sup> USAID, never a member of the Consortium, proposed that a mechanism based on its own Future Challenges Committee<sup>β</sup> be established. As the Bank and other Consortium members had relatively little influence over the Future Challenges Committee, they pressed for the establishment of a new entity. As a result, a Government Task Force was convened on the issue. It met twice in 1996, and “recommended the establishment of one single Apex Advisory Committee on Health and Family Welfare, with the overall rôle of advising on policy and programme issues at the national level. The Apex Committee would be chaired by the Hon’ble Minister while the Secretary would be the Vice-Chairman.”<sup>63</sup> Yet the proposed Apex Committee was never established. According to Bank sources, this was not because agreement could not be reached on the Committee, but rather that the MOHFW had too many competing issues on its plate at the time and the discussion was simply overtaken by more pressing events confronting the sector.<sup>64</sup>

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<sup>β</sup> The Future Challenges Committee was established in 1994. It focused primarily on family planning issues and its membership consisted largely of those NGOs through which USAID operated as well as ministry of health and family welfare officials.

The position that the sector strategy and HAPP-5 preparations should address the modification of existing, or establishment of new, aid coordination arrangements was held not only by USAID,<sup>65</sup> but also by the Bank<sup>66</sup> and individual members of the Consortium, particularly by Sida,<sup>67</sup> CIDA,<sup>68</sup> DGIS<sup>69</sup> and DFID.<sup>70</sup> For reasons over which one can only speculate,<sup>8</sup> discussions during preparation of the HPSS side-stepped the issue, as did the HPSS document. Nevertheless, the architecture for aid coordination did feature during preparation of HAPP-5. The MOHFW Task Force on Sector-wide Management was mandated, among other things, with proposing aid coordination arrangements for the HAPP-5.<sup>71</sup> The survey of stakeholders' views found universal support for the position that a Government-led aid coordination arrangement be established. A range of views were expressed on questions of leadership, composition, organisation, functions, operating procedures, rules and secretariat support for such a body.

#### *Leadership and membership of the sector-wide management board*

Most stakeholders thought that the Government-led coordination arrangement, sometimes referred to as a 'sector-wide management board', should be chaired by the Secretary or Minister, MOHFW. Some respondents suggested that the chair rotate among participating government agencies (i.e., MOHFW, ERD, Finance, Planning Commission), while others proposed that it alternate between Government and donors. While it was agreed that the body should be as widely-inclusive as possible, so as to achieve greater understanding, participation and ownership in the SWAp instruments, opinions differed over membership and participation. A number of respondents, particularly members of the FPHP Consortium, indicated that, based on their experience, the larger the group the more difficult it would be to make it work effectively and reach consensus – thereby arguing for some limits to participation. A majority of Government officials were wary of including in the forum those donors who did not support activities outlined in the public expenditure programme (by these criteria, USAID, AsDB and a number of other agencies would have been excluded). The question of the involvement of NGOs, executing agencies and civil society was also divisive, particularly within Government circles. On the whole most respondents argued for a broadly representative body and a number of

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<sup>7</sup> The Bank was more concerned with the architecture than the rôle of the Government in aid coordination.

<sup>8</sup> The Bank was, by virtue of leading the Consortium, in a strong position to influence health policy and, specifically, to achieve the reforms it was seeking, through the status quo in coordination arrangements. While the Bank's medium-term ambitions included tighter and more encompassing aid coordination arrangements, and a central place within these, it is likely that the Bank took the strategic decision to press for reforms first through the HPSS and to deal with coordination architecture thereafter.

suggestions were made which would accommodate a large group of stakeholders.

### *Functions of the sector board*

Although discussions pertaining to the sector management board were very much in their infancy, proposals had been made on functions and *modus operandi*. The following sections touch briefly on these proposals, noting issues which are relevant in so far as they point to perceived short-coming of the existing coordination arrangements and challenges to establishing alternative mechanisms.

The board was envisioned as the primary forum for policy dialogue within the sector. There was near universal agreement that the board should take leadership of the Annual Programme Review (APR) process (i.e., the annual planning and review exercise for the SWAp). Donors stressed, however, that this should be done in close collaboration. It was suggested that: (1) the board lead the review, particularly, planning, monitoring and reporting on the health programme (i.e., the PIP) and on progress in implementing the reform agenda; (2) donors be closely involved with the MOHFW in preparing the Terms of Reference and aide-memoires for the APRs; (3) donors take particular responsibility for monitoring select performance indicators and programme conformity with aid pledge conditionalities. It was stressed that within the framework of the APR, the MOHFW should generate sufficiently comprehensive information so that donors could abstract what they require to meet their individual reporting requirements, thereby obviating the need for the MOHFW to prepare multiple donor-specific reports.

### *Board secretariat*

There was agreement that the board would require a secretariat, yet opinions differed over its institutional affiliation, staff composition and its physical location. Four options for institutional affiliation of the secretariat were proposed: (1) within an upgraded and strengthened Planning Cell of the MOHFW; (2) within the secretariat established by the donors to service their Consortium (i.e., a modified PHO); (3) a new cell in either the MOHFW or Planning Commission; (4) a semi-autonomous organisation independent of either Government or donors but accountable to the sector-wide management board.

Options three and four had only minimal support. Although the idea of semi-autonomous entity was desirable to a number of respondents, others thought that it would not have the entrée and force to overcome the many obstacles which it would likely face. The option of establishing a new structure within the Government was viewed by many respondents as unnecessarily expensive and counter to the principle of strengthening existing

organisations. Those who suggested utilising the Consortium secretariat to support the sector-wide management board stressed that they would only recommend this option if its staff were functionally responsible to a Government official representing the sector-wide management board and not to the World Bank. A variant on this option entailed establishing a twinning/mentoring relationship between PHO staff and their counterparts in a MOHFW sector-wide secretariat along functional lines to strengthen institutional capacity and enable it to undertake functions currently the responsibility of the PHO.

Strengthening the existing Planning Cell in the MOHFW garnered the most support. It was suggested that the Cell should include line MOHFW staff as well as externally financed technical assistants, and/or staff seconded from donors, accountable to a line MOHFW official. Most respondents felt that the Cell would only be effective if its position in the organisational hierarchy were elevated. This might include establishing a higher level post at its helm (i.e., Additional Secretary). This would allow for day-to-day interaction between the Cell and the Secretary and, thereby, ongoing and more substantive involvement of the Secretary in policy development and donor coordination. While a number of respondents felt that the physical location of the secretariat was immaterial, others demurred. Officials working in the MOHFW suggested that housing the secretariat in the present MOHFW premises would reduce its effectiveness due to the constraints associated with the operating environment (e.g., passes to enter premises, poor facilities, etc.). Yet, a number of respondents felt strongly that the secretariat had to be located in the MOHFW, for symbolic as well as more practical reasons of economy, ease of access to decision-makers, etc. It was revealing that although there was universal agreement that the MOHFW should play a greater rôle in aid management and donor coordination, there was considerable opposition among donor agencies to the suggestion that donors which were not providing budget-support (i.e., those which continue to operate within a project framework) contribute towards the costs of aid management in the sector.

#### *6.5.2 A donor-only aid coordination arrangement under the SWAp: supporting the Board?*

The support of a number of donors, particularly members of the present Consortium, for a Government-led aid coordination arrangement in the sector was conditional upon the continued co-existence of an additional group consisting solely of donors. A dual arrangement was also favoured by a minority of Government officials. The rationale behind the proposition for parallel structures included: (1) a number of donors argued that they require a forum where they can engage without potentially negative consequences in

sensitive discussions ranging, for example, from perceptions of Government capacity to debates on substantive policy issues; (2) some donors stated that a venue was required in which mundane operational procedures relating mainly to aid agency bureaucracy could be addressed. It was felt that involving Government representatives in such exercises was not an efficient use of civil servant's time; (3) some donors were averse to having aid coordination wholly dependent on a newly established, yet untested, Government-led forum which may prove ineffective and/or inefficient. The donor-only group was seen as a fall-back position, at least over the medium-term; and (4) in light of the capacity in the PHO, it was contended that a modified version of the present arrangement could provide technical assistance and guidance to the Government's sector-wide management board and secretariat until it was no longer required. Some donors argued that it is unrealistic for Government to expect donors to dismantle exclusive aid clubs – and if they are abolished, informal arrangements would be established in their place.

The establishment of a donor-only coordination arrangement was opposed, at times vociferously, by more than half of the Government respondents. MOHFW officials argued that: (1) GOB had been party to decisions pertaining to the preparation of the HPSS and PIP and, thus, should be fully involved in discussions concerning its implementation; (2) the success of the SWAp demands greater transparency between Government and donors – not discussions behind closed doors; and (3) it did not make sense for donors to take decisions independently of the Government which may subsequently need to be rejected when presented to the ministry for implementation.

The opposing differences are likely reconcilable, for opposition to a donor-only group presumably rests with Government dissatisfaction over the present FPHP Consortium. The Consortium could be modified to accommodate GOB concerns and, indeed many members agreed with the need for its reform under a SWAp. The Swedish Ambassador to Bangladesh, summed up the opinions of his colleagues when he wrote to the Bank in early 1997, “a related issue is the rôle and responsibilities at present and for the future of the PHO...Is there a need for a ‘new’ PHO?”<sup>72</sup> In addition to reform of the Consortium, the establishment of a sector-wide management board could assuage some Government antipathy towards a donor-only group. For example, in contrast to prevailing situation, the board would provide a forum for policy dialogue to which Government would be party.

#### *Consortium leadership and secretariat support: a Bank prerogative?*

The only donor which was explicitly named by respondents in relation to suitable

leadership of a modified Consortium was the World Bank, a proposition which was supported by a number of agencies and by some Government officials as well. The Bank was seen as having the necessary resources, influence and experience to perform this demanding task effectively. Other respondents suggested that leadership should be determined either on the basis of: (1) the size of financial contribution to HAPP-5; (2) through elections held annually; or (3) rotation according to criteria not made clear.

All respondents commented on the need for the Consortium to be serviced by a secretariat. Of those donor respondents who felt that the staff of such a secretariat should be drawn from one of the member agencies, operating in line positions and accountable to its management, all favoured the World Bank (one Government official concurred). However, an equal number of donor respondents, and a majority of Government officials, stated a preference for the Consortium secretariat to exist independently of any of the donors. The desire for an independent entity likely stems from donor reluctance to continue to rely on the Bank without seeing the viability of another donor taking over this responsibility. It was proposed that those agencies might be appeased by an arrangement which allowed members to second staff to the World Bank to work in the proposed secretariat.

While the Bank foresaw the need to modify the Consortium under the SWAp, the Bank did not envision a diminution of its rôle therein.<sup>73</sup> Thus, in the Initial Executive Project Summary for HAPP-5, Bank staff wrote for the Board audience: "The GOB and donors want it [the Bank] to continue to lead a population and health Consortium, with its proven track record."<sup>74</sup> At times, the Bank presented its justification for leadership in sweeping *non sequiturs*: "There was a consensus [in a Dhaka heads of agencies meeting] that regardless of the financing mechanisms of different donors, formulation of a single, coherent strategy for each sector is the most effective approach to support an investment program. For that purpose, the present consortia arrangement led by the Bank in the education and health sectors is appropriate and should continue."<sup>75</sup> Therefore, while the Bank acknowledged the need for, and desirability, of reform of the Consortium and its secretariat, the Bank established fixed parameters, including its intention to remain *primus inter pares*.

#### *Consortium membership under a SWAp*

A number of options were presented for membership of a modified donor Consortium: (1) those agencies which cofinance in support of HAPP-5; (2) a limited group of donors which provide budget-support for the public investment programme of the PIP; (3) a

larger group of agencies which support the PIP (with financial or technical assistance) irrespective of mode of financing; (4) an even larger group of agencies which support health sector activities but may not have their contribution (entirely or in part) reflected in the PIP (i.e., USAID, AsDB, UNFPA, UNICEF and a host of smaller agencies); or (5) a very large group of donors, NGOs and executing agencies which finance and/or deliver services in the sector irrespective of their participation in the PIP.

At the time of the survey, it appeared that arrangements represented by options (1) and (2) would include too few players to achieve any real measure of aid coordination. A question arose as to whether or not those donors which do not support activities in the PIP should be allowed membership in the Consortium? Although the survey suggested that approximately one-third of donor, and two-thirds of Government, officials found the existing FPHP Consortium imperfect because it did not include all of the major external agencies, a number of officials in the Consortium stressed the need to keep the group sufficiently small to enable it to work effectively.

If most, or all, donors become members of a large, modified Consortium, there is a risk that the group would become the sector's central coordination arrangement *de facto*, with the following potential results: (1) the sector-wide management board could be rendered less powerful than the Consortium (through emasculation or ceremonialisation) thereby undermining attempts to encourage GOB leadership of aid coordination; and (2) the leader of the Consortium (most likely the World Bank) would become even more influential in the sector. Such considerations run counter to allowing full membership to all donors in the sector.

#### *Consortium functions under a SWAp*

In terms of functions, there was agreement that a secretariat supporting the donor Consortium should: (1) devolve some responsibilities which the PHO presently performs to the MOHFW; (2) continue to perform those tasks which are presently carried out by the PHO and which the MOHFW can not or will not perform; and (3) play a rôle in supporting the MOHFW with those functions newly devolved to the secretariat of the sector-wide management board and other entities taking on new responsibilities for aid management. Generally, it was felt that the Consortium secretariat should have exclusive responsibility for: (1) organising and participating in meetings of the Consortium; (2) facilitating member dialogue on sector strategy and expenditure policy; (3) monitoring GOB compliance with donor conditionalities and sector-wide performance indicators; and (4) providing technical and steering support to the MOHFW sector-wide management



board and its executive office.

## **6.6 Assessing the SWAp against the conceptual framework for aid coordination**

The SWAp, as defined by Cassels,<sup>76</sup> stands up very well according to this study's conceptual framework for good aid coordination and management practice. The concept would also fare favourably if stakeholders' views of what is desirable in a SWAp were to materialise in Bangladesh. The SWAp performs less well if stakeholders' actual and probable intentions with respect to their participation in the initiative are considered. While it remains a moot point as to how effectively any eventual SWAp, once implemented, will actually contribute to aid coordination in Bangladesh, Table 15 presents an assessment according to the findings in this Chapter.

From the assessment it might be concluded that the SWAp is indeed a chimera with respect to aid coordination. Few stakeholders intend to be bound by the policy and expenditure frameworks developed for the SWAp and the use of common arrangements for the management of aid resources is far from assured. Sixty percent of donors surveyed were concerned, with good reason, that other donors would operate outside of SWAp and thereby undermine its potential. Moreover, in that some form of a modified donor Consortium is likely to persist, it is likely that the Government's aid coordination rôle (as envisioned under the sector management board) will fall victim to decisions pertaining to aid deployment taken in the donor Consortium.

The SWAp does, however, mark a watershed in that it provides an invaluable service to the cause of aid coordination. It has, for example, forced most stakeholders to consider the bigger picture and may, as a result, lead to better and more coordinated investment practices. Second, it has highlighted the problem of agencies acting unilaterally and independently of commonly accepted frameworks. Third, it has led, at least rhetorically, to a consensus on the need for greater Government leadership in aid coordination, and thrown up some proposals on how it might be achieved in practice. Finally, it has drawn greater attention to some of the limitations of the PHO and Consortium arrangements and will likely, therefore, contribute to their reform.

The shape and performance of the SWAp remains to be seen. Successful implementation depends upon the Government establishing common management arrangements in which donors can and will place their confidence. Experience with donor use of common arrangements, even those established within the UN and the Consortium, suggests, however, that donors are not sanguine when it comes to other institutions managing their

resources. The SWAp will also demand processes through which partners establish a level of trust which can lead to consensus among a wide constituency of stakeholders on policy and resource allocation. The analysis of policy making and planning in Bangladesh as well as relations within the Consortium suggest that the environment is marked more by competition and mistrust than by cooperation. Finally, as Peters and Chao conclude, “if government shows no interest in taking leadership for the health sector, a SWAp would not make sense.”<sup>77</sup> In Bangladesh, the health sector agenda has been primarily set by donors, particularly the Bank. Although the Bank cultivated interest in the SWAp in certain Government quarters, the notion of Government leadership remains fanciful.

**Table 15: Assessing the SWAp against the conceptual framework for aid coordination**

Process criteria	Remarks
Ownership	<ul style="list-style-type: none"> <li>◊ The theoretical SWAp is predicated upon Government ownership and leadership.</li> <li>◊ In Bangladesh, the SWAp was externally driven, mainly by one agency. A hand-full of senior MOHFW bought into the exercise, as did the key donor agencies.</li> <li>◊ It is not clear that the Government fully owns the sector strategy document, nor that all donor agencies completely agree with it.</li> <li>◊ Greater Government ownership will be manifest in the annual spending plans, as these have to be agreed to by the finance ministry.</li> <li>◊ Donors are concerned that they may disagree with spending plans and want the right to 'disown' them.</li> <li>◊ It is not clear whether or not a Government-led coordination forum will be established nor, once established how broad participation and ownership will be.</li> </ul>
Participation	<ul style="list-style-type: none"> <li>◊ The theoretical SWAp proposes a partnership between various arms of Government and donor agencies – the greater the number of participants; the greater chances are that the SWAp will achieve its intended aims.</li> <li>◊ In Bangladesh, at the time of the survey, the MOHFW had committed itself to a SWAp, but the ERD, Planning Commission and Finance Ministry remained largely outside the process.</li> <li>◊ The World Bank, Sida and DGIS were strong proponents. Other members of the Consortium were to varying degrees on board. Other donors were taking a wait-and-see attitude to full participation.</li> <li>◊ Agencies which will likely operate outside of the PIP, such as USAID, AsDB and to some extent UNFPA, were nevertheless involved in preparation of the SWAp.</li> <li>◊ Very limited stakeholder involvement beyond the agencies listed above.</li> </ul>
Periodicity & continuity	<ul style="list-style-type: none"> <li>◊ In theory, once functional, the SWAp is a sustained partnership across a number of programmes of work, hence it is regular and continuous.</li> <li>◊ In practice, in Bangladesh, since the SWAp activities were largely Bank-driven, there obtained a 'mission culture' to cycles of activity and inactivity with regard to the preparation of the SWAp.</li> </ul>
Integration	<ul style="list-style-type: none"> <li>◊ In theory, the SWAp provides tight integration between domestic and external funds as these are pooled for budgeting, spending and reporting.</li> <li>◊ In Bangladesh, the PIP and HAPP-5 conform to the principle of integration.</li> <li>◊ How many donors will work within the PIP and submit to use of national management arrangements remains unclear.</li> </ul>
Realm	<ul style="list-style-type: none"> <li>◊ The SWAp covers consultation, concertation and operational coordination.</li> <li>◊ In practice operational coordination may be limited as donors will programme funds outside the PIP.</li> </ul>
Breadth	<ul style="list-style-type: none"> <li>◊ The SWAp is one of the widest coordination arrangements conceivable at the sector level, in that it attempts to coordinate all activities which fall under the purview of the MOHFW.</li> <li>◊ Regulation of the private sector, including NGOs, is not considered under the SWAp in Bangladesh, thus limiting its breadth in practice.</li> </ul>
Authority & adherence	<ul style="list-style-type: none"> <li>◊ The GOB strategy, plans and budgets should confer authority and legitimacy on the SWAp. Limited adherence to the HPSS and PIP remains a serious threat to the SWAp.</li> <li>◊ Although all stakeholders agreed to the broad principles of the SWAp, very few wished to be bound by its instruments.</li> </ul>
Costs	<ul style="list-style-type: none"> <li>◊ Difficult to calculate.</li> <li>◊ Clearly one of the most resource intense of the various mechanisms.</li> </ul>
Outcome Criteria	Remarks
Efficiency	<ul style="list-style-type: none"> <li>◊ The ideal SWAp would improve both allocative and technical efficiency.</li> <li>◊ In Bangladesh, it may achieve efficiency savings in practice, but this depends on the proportion of donor agencies which adhere to its instruments.</li> </ul>

Effectiveness	<ul style="list-style-type: none"> <li>◇ Theoretically, the SWAp can improve effectiveness through agreement on strategy direction, promotion of best-practice and systems strengthening.</li> <li>◇ Yet to be seen if these obtain in practice.</li> </ul>
Equity	<ul style="list-style-type: none"> <li>◇ In theory, the SWAp could improve equity in the sector. For example: in that the SWAp is to be based on a holistic approach to sector development, it could reduce inequities which arises from disparate donor-driven schemes (correcting inequities in targeting of assistance); evidence-based approaches to decision making and improved transparency could result in pro-poor resource allocations; joint management frameworks could increase parity of benefits and perks for aid-supported staff.</li> <li>◇ The extent to which these are realised depends on the manner and extent to which the SWAp is put into practice.</li> </ul>
Sustainability	<ul style="list-style-type: none"> <li>◇ In that a central component of the SWAp involves capacity development and working through indigenous systems, the SWAp should be a sustainable model for aid coordination.</li> <li>◇ While stakeholders strongly endorsed capacity development for the SWAp in Bangladesh, over the short term, it would appear that parallel (and unsustainable) systems will remain the norm.</li> <li>◇ The SWAp will only achieve its aims if effective incentives/sanctions are established for compliance, participation and non-participation of donors and GOB. This area had yet to receive attention in Bangladesh.</li> </ul>

## 6.7 Chapter summary

- The introduction of the sector-wide approach resulted in the preparation of the HPSS as well as the Programme Implementation Plan for HAPP-5. Although limited, the participatory nature of their preparation provided a valuable process through which Government and donor priorities and strategies were made explicit and a level of agreement on these was reached. While marking a feat in the context of Bangladesh, the achievement is tempered by the fact that numerous donor agencies as well as Government officials are concerned that they may not agree with the strategic framework and did not have enough say in its development. Moreover, the Government is concerned that unprecedented levels of donor coordination may result in undue leverage exerted by donors over policy direction and resource allocation.
- The PIP includes expenditure plans which provide an umbrella framework to guide all external investment in the sector under the purview of the MOHFW. However, many donors indicated that they wish to retain the right to operate outside of this framework and will do so in practice. The Government also indicated its preference for a flexible approach to working outside of the agreed expenditure plans.
- The SWAp makes provisions for and aspires to the use of common management arrangements for resource deployment in the sector. While Government, and to a lesser extent aid, officials described this as desirable, many donors indicate that they will continue to rely on separate management arrangements. They will do so because they are concerned about attribution, accountability and Government capacity.
- Under the SWAp, the need for a Government-led, aid coordination arrangement has

been agreed by all stakeholders. Nevertheless, its establishment has not been viewed as a priority by Government nor donors.

- Despite the possibility that a donor-only Consortium may usurp Government leadership as well as the authority and effectiveness of the Government-donor sector management board, many donors made their support for a Government-led aid coordination arrangement conditional upon the coexistence of a donor-only Consortium. The Bank stated its intention to remain at the helm of a modified donor-only Consortium.
- The idealised SWAp performs well according to the conceptual framework for aid coordination. Nevertheless, over the short-term, it will not fulfil its potential because too few stakeholders wish to be bound by its instruments. This is the case either because they are concerned that the Government lacks the capacity to manage the SWAp adequately or because the SWAp is seen to usurp the agencies of their autonomy.
- The process of the introduction of the SWAp has benefited health sector aid coordination by bringing attention to certain failings and possibilities with respect to prevailing arrangements.
- While it is difficult to predict what will happen over the next 5-10 years, given experience with coordination arrangements in Bangladesh, it appears unlikely that the systems for aid management and coordination will be established which match those envisioned by the SWAp in its idealised form.

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## **CHAPTER SEVEN**

### **Summary and conclusions: room for optimism?**

#### **7.1 Introduction**

This Chapter begins with a recapitulation of the rationale for the study, and speculates why, based on the experience of conducting the study, aid coordination and management has remained neglected in the literature. The following sections summarise the major findings of the study with reference to the objectives set in the introduction. The limitations of the conceptual framework are reviewed with the aim of suggesting refinements and, reflecting the importance of power in the coordination equation, the validity of the ‘technocratic’ approach is reconsidered. Thereafter, the prospects for improved coordination are weighed. Given past experience and the intentions of the stakeholders with respect to coordination arrangements under the SWAp, the prospects are at best mixed and contingent upon major changes to ways both donors and Government do business. Based on the analysis, a list of principles which ought to govern the management and coordination of aid are proposed and areas for further research identified.

#### **7.2 Purpose and process**

The literature reviewed for this study suggested that although there has been an intense scrutiny of development assistance over the past decades, there has been relatively little documented consideration (empirical or theoretical) of the processes of aid coordination and management at the country-level, and little relating to these issues specifically in the health sector. Nonetheless, the grey literature and discussions with actors in the development community emphasised that, for a range of reasons, concern over inadequate aid coordination in the sector was assuming an increasingly prominent place in policy discussions. There remained, however, many unanswered questions concerning the motivations and practice of aid coordination, not least the views, concerns and behaviour of recipients. Consequently, I developed a conceptual framework for assessing aid coordination in practice so as to provide a starting point for a more critical examination of the processes at play. This study sought to evaluate specific aid coordination mechanisms against the criteria proposed in the conceptual framework based on documentary evidence as well as the views of stakeholders. It sought especially to elucidate the views of the recipients, who, according to an agreed set of principles governing aid coordination, were to be at its centre.

Bangladesh was an excellent case study for empirically testing the evaluative framework and for exploring unanticipated factors governing aid coordination. Not only had the country attracted considerable developmental assistance from a broad range of international agencies, but additionally, in the health sector, a long-standing effort to coordinate donors provided a rare opportunity to learn lessons from this complex dynamic. Conducting the research, however, proved difficult as the stakeholders were reluctant to discuss openly the manner in which the mechanisms work, and to present their views on the rationale for their participation in, and perceived effectiveness of, coordination arrangements. For example, when this research was initially discussed with World Bank officials in Dhaka, they did not see the need to document nor distil lessons from the experience.<sup>1</sup> Later, an official from Bank headquarters expressed his anxiety that the Consortium would not be able to “withstand an academic scrutiny” as “it risked flying apart” and, therefore, counselled me not to undertake the study.<sup>2</sup> Once in Bangladesh, it took nine months to reassure the donor community, and principally the Bank, that the exercise could be constructive and mutually beneficial and, consequently, that documentation should be made available (see Annex 3 for a synthesis of the field research process). In the end, I was given access to material, yet the reluctance of donor and government officials to allow any scrutiny of their practice goes some way to explaining the gap in the published literature on aid coordination.

### **7.3 A synthesis of the major findings**

#### *7.3.1 Aid coordination and management in Bangladesh: a summary*

Since independence, aid from a large number of external agencies has formed an integral component of the country’s public expenditure programme. This has provided donors with an influential voice in the Government’s policy orientation, resource allocation and institutional structures. From the perspective of donors, it appears that the political and administrative arrangements prevailing over the course of the country’s history lent credence to the view that the Government did not know its own affairs best, that it served other interests and objectives than those sought by the aid agencies, and/or could not be trusted to use the external resources placed at its disposal to their most judicious advantage. These beliefs have influenced donor thinking in relationship to the desirability and feasibility of relinquishing leadership in the management and coordination of aid to the Government. Moreover, the perception of Government as weak, lacking capacity as well as questions over its legitimacy and integrity provided an ongoing and disingenuous

justification for external leadership over aid management and to some extent, aid coordination.

Strong, effective control over the deployment of aid has not been exercised by the Government. There has not been a great deal of political, public or external pressure to improve or support the Government's coordination of aid. Attempts which have been made to augment Government capacity were not sufficiently effective to displace the apprehensions of donors. Moreover, there is a perception among some donor officials that the Government is not only unable to provide effective leadership to aid coordination, but may also be unwilling to do so. This is the case, it is argued, because effective coordination, and the transparency it implies, would reduce the room for political manoeuvring and limit opportunities among civil servants for rent-seeking through the aid regime. Donor concerns were substantiated by the position which MOHFW officials adopted in relation to the SWAp.<sup>β</sup>

This research suggests that some culpability for the relative absence of GOB leadership, and the weakness of its institutions, in aid management rests with donors themselves. This is due, in part, to the enthusiasm with which donors have established and maintained independent and exclusive aid management and coordination systems which usurped many of the Government's responsibilities. Moreover, the weak and reactive pattern of Government decision-making can be partially explained, and was likely exacerbated, by the proclivities of donors to inundate Government officials with foreign visitors and other demands, to induce confusion through advocacy of contradictory policy prescriptions, and perhaps, most importantly, to orient the development agenda towards external priorities and, thereby, weaken domestic ownership and support of it.

### *7.3.2 Aid coordination and management in the health sector: the Government's machinery*

The Government has concluded that "in the absence of a well planned and systematic aid negotiation and coordination arrangement for the health and population sector, piecemeal aid allocation and donor pressure for assistance in particular areas have resulted in duplication of efforts in some areas and inadequate attention to other areas..."<sup>3</sup> An argument was made in this thesis that the absence of an over-arching sector policy and,

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<sup>β</sup> It will be recalled that a Project Implementation Plan (PIP) was prepared to provide an umbrella framework to guide all investment in the sector under the purview of the MOHFW. The reluctance expressed by Government officials to insist that all external assistance be deployed with reference to the PIP signalled their interest in maintaining maximum flexibility.

until very recently, an agreed strategic plan setting out the Government's priorities, provided donors and interested domestic parties with a virtual *tabula rasa* for imposition of their priorities and independent action. As a result, external funds tended to be allocated on a project-by-project basis, in an *ad hoc* manner, largely uncoordinated from other activities in the sector. Broad policies which were endorsed by the Government, such as the population policy and the health and population sector strategy, were largely driven by parties within the donor community. Minimal stakeholder involvement in policy development resulted in shallow commitment and ownership. Consequently, few stakeholders were willing to deploy their resources with reference to these 'government' frameworks (e.g., only two of the 31 donors would fund exclusively those activities jointly agreed and specified in the implementation plan for the SWAp).

The national level, over-arching, institutional arrangements for Government-led aid coordination were found by both donor and Government officials to be inadequate for sector level coordination. In particular, the Economic Relations Division could not provide meaningful oversight because: (1) its organisational structure is not sector-related but corresponds with source of funds; (2) it has become largely severed from the planning process; and (3) it aims to maximise aid mobilisation (which may occur at the expense of rationalisation). The Planning Commission can no longer play a strong rôle at the sector level because: (1) it has been gradually emasculated; (2) many of its responsibilities devolved to the ministry; and (3) donors have tended to operate relatively independently of its five-year and annual plans.

While donors acknowledge that the Government's plans are intended to rationalise the deployment of aid, plans have not, at least according to the donors, proven particularly effective. This is said to be the case because: (1) the planning process places excessive emphasis on project formulation and approval to the detriment of sector planning; (2) there exists an inability, or unwillingness, on the part of high-level decision-makers to delegate lower-level decisions to lower-level managers which results in the former being preoccupied with routine tasks at the expense of strategic planning; and (3) at the sector level, planning skills are in short supply, inadequately developed, and overwhelmed by the exigencies of project processing and administrative demands.

The non-availability of GOB sponsored and donor supported plans served as just one of a number of factors which subverted GOB-led aid management and coordination. There was also the problem of limited capacity within government institutions to manage

external resources in such a way that inspired donor confidence. In addition, there existed ambivalence on the part of MOHFW officials, due in part to their lack of confidence, but also to the impact which coordination might have on their influence, patronage and opportunity to seek rents. These limitations to government involvement in aid coordination were compounded by the absence of a government-led, sector-level, apex body for interaction among government and donor officials.

### *7.3.3 Aid coordination and management in the health sector: the donor's machinery*

Even prior to the resumption of health services after the war, competition among the major donors (i.e., World Bank, UNFPA, WHO, USAID and later UNICEF) over the leadership of aid coordination in the sector led to a schism between the agencies which, among other contributory factors, has obviated against substantive coordination amongst them to this day. Great differences between agencies, in mandates, perceived authority, financial and technical capacity, approaches, and operational autonomy at the country level often frustrate attempts which are made to coordinate. As a result, each of these donors (which remain prominent actors in the health sector) mount relatively independent programmes and, to a large extent, manage these through relatively independent means.

Some attempts have been made to coordinate assistance, but these have been piece-meal and, with the exception of the Consortium, largely ineffectual. Hence, for example, some coordination tools have been introduced in Bangladesh under the aegis of the Resident Coordinator System (RCS). While these tools provide, to varying but limited degrees, a measure of increased consultation, concertation and a modicum of operational coordination amongst the UN organisations, they remain constrained by a host of factors. The constraints include the lack of clarity among UN staff on the rationale for coordination; differing perspectives and priorities among agencies; differing (frequently negative) perceptions among agencies of one another; the lack of familiarity of operational procedures of other agencies; concern among staff that coordination will increase bureaucracy and reduce action; and a lack of time and resources for coordination (i.e., other higher order priorities crowd out coordination). A major barrier to coordination was found to be the significant degree of competition among these agencies for leadership, resources and visibility. It appears that officials are often provided with insufficient direction and incentives from their respective headquarters to support the RCS. Consequently, the system remains dependent on personal interests and chemistries, which constantly change due to the turn-over of staff. In reality, the Resident Coordinator lacks adequate authority over a system in which participation remains essentially

voluntary. The system is further weakened by a lack of resources and the perception that, as an off-shoot of UNDP, it lacks impartiality.

Hence, while a system exists through which to achieve improved coordination of UN agencies, insufficient authority and resources are vested in it to make it work. This casts a shadow over the prospects of inter-agency coordination more generally. For if these agencies, which (1) form part of a loosely configured system with one, albeit weak and distant, central authority; (2) pursue increasingly integrated goals; (3) have some commonalities in terms of operating procedures; and (4) do not need to pursue narrow domestic agendas through the aid regime, cannot coordinate amongst themselves, is it possible that the bilateral agencies which do not possess these facilitating characteristics will be able to do much better? The case of the Consortium has provided some tentative answers.

In contrast to the UN agencies, a striking amount of effort has been expended by bilateral donors to coordinate their efforts through the Bank-led Consortium. To a considerable degree, the arrangement has enabled donors to submerge and accommodate differences in policy and operational practices so as to improve the coordination of a proportion of their aid to the sector. During the FPHP, this involved the resources of ten donors covering approximately 35% of external investment in the sector as well as the participation of three health-related multilateral agencies (although the latter's membership took the form of implementation assistance). It appears from this study that these donors<sup>δ</sup> chose to channel some of their assistance to the sector through the Consortium principally because they thought that it would save costs and magnify their policy leverage.

The ingredients which made the Consortium relatively successful appear to be the following: (1) an ongoing and concerted effort to address threats as they arose, to adapt practices and formalise procedures; (2) the availability of ear-marked funds for aid coordination as well as considerable flexibility in their deployment; (3) an explicit financial investment, and hence ownership, in the mechanism by all parties (save the multilateral agencies which may account for their erratic and problematic participation); (4) specific characteristics of the lead agency which included the perception of it as relatively competent and neutral, institutional support and internal incentives for aid coordination coupled with the dedication of particular staff; (5) tangible benefits for the

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<sup>δ</sup> That these agencies were predominantly from middle-ranking powers, and thus held many similar values and priorities, may partially account for their proclivity to coordinate with one another.

lead agency (i.e., the availability of more aid and enhanced influence to pursue its policy objectives); (6) material benefits for all members (i.e., cost-savings and policy leverage); and (7) an operational component in the form of a project around which to coordinate.

Despite the achievements, this research found that there was significant disenchantment among participants with the manner in which the Consortium functioned. This was particularly the case with respect to differences of opinion over appropriate policies and strategies for the sector, as well as rôles, responsibilities, accountability, expectations and communication among Consortium members. The persistence of difficulties within the Consortium raises the question of whether or not it would have been possible to mitigate against dissatisfactions by providing greater *ex-ante* specificity to agreements and placing greater emphasis on process issues. Alternatively, might the specific and changing institutional interests of members take precedence over their general organisational commitment to coordinate and thereby perpetuate conflict? Three findings may suggest that up-front agreements will not suffice when differences arise. First, conflict persisted despite the progressive specification and institutionalisation of rules and procedures to guide working arrangements, due to the tendency of stakeholders to transgress the codes outright or to interpret rules so as to suit their interest. Second, those donors which envisioned that coordination may result in a conflict with the values or interests of their agencies, refrained from even attempting to cooperate (only 10 of the 31 donors supporting the MOHFW were members of the Consortium). Third, when conflict arose within the Consortium, the cofinanciers apportioned the greatest amount of blame to the conflicting rôles of the Bank as lender and consensus builder, suggesting that organisational interests do over-ride attempts to compromise when differences arise. In the case of disparate views, presumably inevitable in the development enterprise, the prospects for coordination are not encouraging unless much greater attention is paid to the process of achieving consensus and the development of incentives and sanctions.

Findings demonstrated agreement that no donor in Bangladesh could have substituted for the Bank as leader of the Consortium. Yet, the lack of absolute authority,<sup>6</sup> and consequently legitimacy, of the World Bank to lead donors in the sector provided donors with the option of whether or not to join the Consortium. As a result, the majority demurred. While fourteen reasons were postulated by donor officials for the reluctance of their agency to acquire membership, they could be grouped into two basic themes: (1)

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<sup>6</sup> In light of the domestic objectives which the agencies pursue, as well as the fact that they are often imbued with different values, it is difficult to imagine that they would ever vest absolute authority in any one agency.

due to perceived differences in policy and strategy; and/or (2) the constraints which membership would entail for their operational autonomy. The latter is particularly the case for agencies which must maintain a high profile (such as UNICEF) but was of concern to the other agencies as well. The lack of authority of the Bank (i.e., “no real sanction over bilaterals who won’t play ball”<sup>4</sup>) also provided members with the option of whether or not, and how, to participate in activities of the Consortium and whether or not to abide by the decisions and rules established by the group. The fact that most donors did not join and that member-donors were only willing to cede partial authority to the Bank raises a fundamental question with regard to this research. By virtue of its national sovereignty the GOB enjoys a certain legitimacy (albeit undermined due to concerns regarding integrity and accountability) not enjoyed by the Bank. Given that legitimacy, would donors be prepared to vest the required authority in the Government to lead on aid coordination arrangements if it were adequately strengthened to take on such a rôle?

Disregarding for the moment the question of how to augment the capacity of the GOB to assume a greater rôle in aid management, it is worth considering the experience of aid management in the Consortium. It was difficult for the Bank, arguably well endowed with technical and financial resources, and seen by many observers as managerially competent, to escape bilateral criticisms over the aid management services it provided. Indeed, donor criticisms suggest that the bilaterals sought, through their concerns regarding accountability, a pretext for maintaining their own management structures. If the Bank could not meet the exacting standards laid down by the donors, is it likely that the GOB will be in a position to do so in the near future?

Some of the questions raised through the experience with the Consortium are partially answered by the short-lived experience with the sector-wide approach. The introduction of the SWAp resulted in the preparation of a Health and Population Sector Strategy document as well as a Programme Implementation Plan (PIP) for the first five years of the SWAp. Although limited, the participatory nature of the preparation of these two documents provided a valuable process through which Government and donor priorities and strategies were made explicit and a level of agreement on these was reached. In particular, it marked the first time that most donors worked together with different arms of Government (albeit mainly the MOHFW) to consider the activities in the sector in their entirety.



While representing a feat in the context of Bangladesh, the achievement of producing working documents for the SWAp is tempered by the fact that numerous donor agencies as well as Government officials are concerned that they may not agree with the strategic thrust or particular aspects of the PIP.<sup>6</sup> This is ostensibly the case because of the perception held by many stakeholders that the SWAp, and the reform agenda encapsulated within it, was predominantly articulated by the Bank and that other constituents did not have enough say in its development. Perhaps, however, donors will never feel that they have had enough input into the preparation of a document unless they are its principle authors. Nonetheless, as a result, many donors indicated that they wish to retain the right to operate outside of this framework and will do so in practice. The Government also indicated its preference for a flexible approach to working outside the agreed public expenditure plans. Officials in the MOHFW argued that they have taken this position because the Government is concerned that unprecedented levels of donor coordination could result in undue leverage exerted by donors over policy direction and resource allocation. It may equally be the case that civil servants wish to retain a degree of non-transparency which would permit them to continue expropriating resources or to retain control over a particular programme or other fiefdom.

The SWAp makes provisions for and aspires to the use of common management arrangements for all resources deployed for public sector activities, irrespective of their source. While Government, and to a lesser extent aid, officials described this as desirable, many donors indicate that they will continue to rely on separate bilateral aid management arrangements. They are concerned about attribution, accountability and the Government's capacity to manage the common arrangements.

During the preparations of the SWAp, the need for a Government-led aid coordination arrangement was agreed to by all stakeholders. Nevertheless, its establishment was not viewed as a priority by Government nor the influential donors and it has, therefore, not yet been created. Many donors made their support, for a MOHFW-led, Government-donor coordination arrangement conditional upon the maintenance of a donor-only Consortium. But the very existence of a donor-only Consortium (even one that is partially reformed), particularly if it is led by the Bank, threatens the authority and effectiveness of any eventual Government-donor coordination arrangement.

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<sup>6</sup> For example, there were differences of opinion over the emphasis which should be placed on cost-recovery, regulation of the private sector, reorganisation of the MOHFW, etc.

The process of the introduction of the SWAp has benefited the cause of health sector aid coordination by bringing attention to certain failings and possibilities with respect to the prevailing arrangements. Although the idealised SWAp performs well according to the conceptual framework for aid coordination, over the short-term it will remain business as usual. The SWAp will not fulfil its potential because too few stakeholders wish to be bound by its instruments. It may be the case because donors are concerned that the Government lacks the capacity to manage the SWAp. It is, however, also likely that for many stakeholders the SWAp instruments reflect too closely the signature of the Bank as opposed to that of the Government. Alternatively, donor hesitation may arise due to the perception that the SWAp, irrespective of its sponsorship and leadership, would usurp the agencies of their autonomy. Nevertheless, as is the case with the Consortium, it remains a case of coordination by persuasion and not by the command of the authority of an agreed and legitimate leader.

#### **7.4 Limitations to the conceptual framework**

The conceptual framework proposed in Chapter 1 for the assessment of aid coordination instruments and empirically tested in the health sector in Bangladesh was useful in terms of identifying key characteristics which determine the effectiveness of specific arrangements and passing judgement on them. It also provided a prism through which to understand the complex relationships among donors and Government. Nonetheless, the framework was subject to limitations which operated on three levels.

On one level, the conceptual framework can be criticised on the basis of its foundations. First, the principles upon which it rests were espoused through fora in which the donor community has greater influence than recipient nations and, consequently, the framework is biased in favour of donor values, interests and priorities. It was, however, beyond the scope of this enquiry to validate the universality of the conceptual framework in this manner. Second, as the indicators were extrapolated from first principles, as opposed to being culled from actual experience in the field, existing mechanisms are evaluated against a hypothetical gold-standard. It is unlikely that any mechanism will excel in light of the exacting criteria. Nonetheless, the criteria, irrespective of their genesis, biases and high expectations, do provide a basis for considering the effectiveness of aid coordination within a given context.

A more substantive problem with the evaluative framework lies in the unit of analysis adopted by the study. The unit consisted of the aid coordination instrument, whose

definition was intentionally broad and included every conceivable activity which served to increase the integration of aid. As noted above, aid coordination tools in Bangladesh included processes within the recipient administration, those established by the United Nations, the Consortium arrangement as well as the SWAp. The emphasis on aid coordination instruments, although conceptually helpful, contributes to the separation between the management and coordination of aid and the management and coordination of domestic resources and programmes. While this distinction has a significant basis in reality in Bangladesh and elsewhere, ultimately, sustainable aid coordination should be viewed as inseparable from the coordination and management of domestic resources. The implications of failing to take this distinction into consideration include the very real possibility that a coordination arrangement which performs well according to the conceptual framework, such as the Consortium in Bangladesh, is provided with ever more resources and responsibilities. This may divert attention and resources from the development of national capacity and systems and thereby usurp important national functions with respect to aid management. A case could be made for assessing the efforts of donors to coordinate aid from a more holistic perspective. The unit of analysis could be the government systems themselves (e.g., for policy making, resource allocation/budgeting, reporting, auditing, etc.). Aid coordination would be measured by the extent to which external resources are integrated into these indigenous processes – with the goal of comprehensive integration.

The foregoing scenario suggests that although the individual variables within the conceptual framework consisted of valid and necessary indicators (e.g., proportion of donors active in the mechanism), they were insufficient and inadequate in an important respect. The problem lay not in the indicators themselves but with the need to prioritise (or place greater weight on) those indicators which are deemed of greater importance. The argument advanced in this thesis was that a premium should be placed on those mechanisms which are managed by the recipient administration (or contributes to achieving such an end). By extension, those mechanisms which are in many respects exemplary but which undermine the capacity or willingness of the recipient to provide leadership on aid coordination services should be considered flawed. In terms of the conceptual framework, this raises the question of subjectivity and values.

The study has provided evidence that the motive held by some donors to coordinate aid (or become involved in an aid coordination arrangement) related to the potential of coordination to confer leverage in a competitive arena. This suggests that the objectives

pursued by stakeholders through their involvement in aid coordination instruments do not necessarily coincide with the implied aim of such mechanisms (i.e., to rationalise external investment in the sector in accordance with recipient priorities and strategies). The conceptual framework, however, failed to capture this dimension of coordination as it emphasised technical over political factors, suggesting objectivity and neutrality over subjectivity and power. The evaluation of the effectiveness of aid coordination is not simply a technocratic exercise but is also inherently value-laden. Different weights would likely be placed by different analysts on the individual indicators. Thus, for example, those donors which sought to advance their corporate policy positions through an aid coordination arrangement would presumably consider favourably the ability of a mechanism to engineer a common donor front for forcefully influencing Government decision-making, but they might rate recipient leadership as less desirable. This does not detract from the value of the conceptual framework *per se*, but does complicate the issues. In particular, it suggests that, although it is useful to consider the strengths and weaknesses of the mechanics of the various arrangements to coordinate aid, and whether they are effective according to specific benchmarks, it would be facile to consider the arrangements without giving consideration to the objectives sought by the stakeholders through their involvement. This is an important consideration when addressing the prospects for coordination more widely. The case has demonstrated that only the minority of donors are willing to accommodate the costs of coordination so as to contribute to the goal of aid rationalisation, and that this is most likely explained at least partially by their desire to enhance their policy leverage.

## **7.5 Prospects for health sector aid coordination**

Experience with health sector aid coordination in Bangladesh over the past quarter century suggests that the prospects for improved practice are at best mixed. The Consortium demonstrates that, given certain facilitating and demanding conditions, some donors are willing to devote considerable resources to coordinate a proportion of their aid, even when the process is fraught with tension, unmet expectations and acrimony. However, most donors found it preferable to pursue bilateral and independent relationships with the Government for the deployment and management of their assistance.

Four principal obstacles were proposed as having accounted for the very constrained extent to which aid was coordinated. (1) In the absence of GOB leadership, there existed

no alternative authority which commanded sufficient legitimacy to coordinate aid on behalf of donors. The UN agencies neither vested such authority in the Resident Coordinator System nor in the sovereign Government. The bilateral agencies involved in the Consortium only partially acknowledged the need for a first-among-equals in their group. As a result, most donors pursued independent action on the basis of the authority of their respective governing bodies and mandates. (2) Donors, with to some extent the exception of those in the Consortium, were not prepared to delegate the responsibility for aid coordination and management to other institutions. Although this was purportedly for reasons of accountability, it appeared equally plausible that this provided a convenient justification for independent and unfettered action. (3) The Government did not provide an adequate framework for the deployment nor management of aid resources. While this was an objective reality, there are indications that not enough was done by the donors to address and correct the limitations so that the Government could have assumed a more central position. There was also, however, evidence to suggest that the GOB would not readily assume this rôle even if it were enabled to do so (discussed in Chapter Six). (4) This dissertation has provided a number of examples, and strong supporting evidence, which suggest that both the aid agencies and the Government of Bangladesh understand that aid coordination presents a powerful tool with which to exercise leverage over the development process. Indeed, it is not difficult to interpret the successive coordination initiatives of the Bank (i.e., from project cofinancing to donor Consortium to SWAp) as attempts to increase its influence over an ever larger sphere of aid, donors and activities and policies for the sector. The consideration that aid coordination provides the coordinator with influence has coloured the desire of stakeholders to lead coordination processes and conditioned the extent and manner in which they took part in various coordination arrangements.

The prospects for improvements to aid coordination in Bangladesh are thus dependent on at least three preconditions. First, the Government would need to assume a position of authoritative leadership so as to fill the current vacuum. Clearly leadership will not be conceded to the Government on the basis of sovereignty alone. Government will have to 'earn' it. This will require vision, resources and a very different approach to work from the one which currently prevails. Second, common management systems would need to be established by Government in which donors could and would place their confidence (i.e., meet donor expectations in terms of accountability). Experience elsewhere (e.g., Zambia) has been frustrating in this regard.<sup>5</sup> Third, processes would need to be established through which donors would have some opportunity to influence the

Government's policy and expenditure frameworks within the context of Government leadership and management. The fulfilment of each of these conditions appears to be very unlikely.

## **7.6 Proposed principles of aid coordination and management**

Although the prospects for improved coordination are diminished in practice by the political dimensions of the processes in question, the Consortium demonstrates that under certain conditions donors are willing to sacrifice some autonomy and self-interest in the interest of coordinated action. Based on the foregoing discussion, a number of principles which ought to govern such initiatives suggest themselves as follows:

- (1) The provision of foreign assistance within the framework of a single, unifying health sector strategy, and comprehensive operational and expenditure plans, provides the basis for effective coordination of aid;
- (2) Government leadership in preparing strategic, operational and expenditure plans, and harnessing foreign resources within the framework of these instruments, is essential to effective and sustainable management of external resources. This is the case because it confers authority on these instruments (and thereby encourages the donors to buy in) and it encourages Government commitment and ownership;
- (3) The primacy of Government leadership in providing the framework for deployment of external assistance does not imply that the Government needs to lead, nor be involved, in all aid coordination fora: there are important areas of aid coordination which should not involve Government - either because this would represent an unnecessary burden on the Government machinery (e.g. harmonisation of donor procedures) or because Government officials may resist external agency initiatives (e.g. harmonising benefits for Government staff). While multiple aid coordination mechanisms may be both necessary and desirable, it is crucial that effective arrangements for communication between the Government and the donors'-only groups are established;
- (4) Aid coordination is a process which seeks increasing levels of integration between Government and its development partners in terms of: (1) policy and strategy; (2) expenditure programme; and (3) programme implementation (including financing) and monitoring. Therefore, the sector-wide approach represents a desirable goal in

terms of aid management. In light of the various areas in which integration needs to take place, distinct and different aid coordination arrangements may be required for each of these three processes;

- (5) To the maximum extent possible, the mechanisms for aid delivery and monitoring should support and strengthen existing Government systems and procedures, instead of circumventing or establishing new systems to accommodate short-term development partner concerns for accountability, disbursement or impact. Capacity development for resource management must be part of any aid coordination strategy;
- (6) The pursuit of increased integration of external and Government resources in the health sector should proceed on an incremental basis which builds on past experience, relationships and existing structures as opposed to implantation of imported and/or idealised notions of best-practice;
- (7) Increased coordination entails risks as it is premised on changes on the part of Government and donors in the way they do business. Therefore, to make headway on coordination, individual programme officers and their Government counterparts will have to push and challenge their organisational boundaries. Secondly, new ways of doing business may initially result in confusion and conflict and may set back progress and impact temporarily;
- (8) Effective coordination is dependent upon the timely availability of a range of reliable information to guide the decision-making processes of all parties active in the sector. Communication channels and networks which involve all agencies supporting health sector activities and encompass Government must be systematically established and adequately maintained. These channels should be formalised and should not duplicate those which Government may have already established for other purposes;
- (9) Aid coordination and management is dependent on the availability of considerable resources which are ear-marked for coordination but can be deployed in a flexible manner. All donors which do not provide budget-support should be required to contribute to the costs of aid coordination and management so as to increase their interest in these coordination processes.

### **7.7 The study's contribution to knowledge**

The study has contributed to knowledge in a number of ways. For one, it provided the first contributions to the published literature on the characteristics of health sector aid coordination as well as a methodology for analysing and assessing the effectiveness of aid coordination arrangements.<sup>6,7</sup> Second, it made a unique contribution to the understanding of aid coordination because it provided an analysis of the issues from a third-party perspective. Other studies of health sector aid coordination which are in press, while benefiting in many ways from the fact that they were not undertaken by outsiders, demonstrate biases leading to undue optimism or undisguised donor interests.<sup>8,9</sup> In contrast, this study, whose results have been validated through triangulation and peer-checking, provides a balanced view of the actions and behaviour of both parties to the process. Moreover, given the depth and breadth of the study, which covers over 20 years and is based on a wide-range of sources, the analysis provides a realistic assessment of the practice and prospects of aid coordination. Third, it provides a useful addition to the meagre store of policy analyses centred on the health sectors in low income countries. In particular, its political-economy approach may help to explain how and why certain policies are on the agenda and the rôle of policy coordination networks therein. Picking up on the last point, an account of the World Bank's interests and mode of operations, although somewhat specific to Bangladesh, is important as the Bank has assumed a prominent place in the health policy arena in countries of low- and lower-middle income. Finally, the analysis of the determinants and limited effectiveness of aid coordination provide further empirical data with which to improve understanding of the broader issue of aid effectiveness.

### **7.8 Research questions in the field of aid management and coordination**

Although this exploratory research has contributed to the store of knowledge on aid coordination and provided some tentative positions on the prospects for better practice based on experience in Bangladesh, it could not provide definitive answers nor properly address a number of issues. Perhaps, the central question which arises from the conclusions drawn in this study relates to whether or not most donors are truly averse to the coordination of their assistance at the country level. It was argued that in Bangladesh, three obstacles would have to be addressed before the type of aid coordination envisioned in the conceptual framework could realistically obtain: (1) real government leadership to assuage concerns of legitimacy, commitment, etc.; (2) sufficient government capacity to assuage concerns of accountability; and (3) the establishment of fora for negotiations aimed at building consensus. How best to enable these facilitating factors remains a



matter for operational research. However, the central question relating to aid coordination remains that if recipient capacity were strengthened to the extent that it no longer provided a pretext for external management, and if the recipient assumed ownership of the coordination instruments, and if some sort of process were evolved to handle the politics of consensus development, would the donors continue to act independently of the Government and one another? It would appear that this could be tested through a case study of experience with a SWAp in a country in which government capacity were not a limiting feature. The paradox arises, however, that it is in the most aid-dependent countries that capacity is most lacking and where the integration and coordination of external resources is most urgently required.

## 7.9 Chapter 7 references

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- <sup>6</sup> Buse K, Walt G. An unruly melange? Coordinating external resources to the health sector: a review. *Social Science and Medicine*. 1997; **45**(3): 449-463.
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## **ANNEX 1:**

### **LIST OF PERSONS CONSULTED AND INTERVIEWED**

#### **Government of Bangladesh Officials**

##### **Ministry of Health and Family Welfare**

Mr Md. Abdullah, Assistant Chief  
Mr Luqueman Ahmed, Joint Chief  
Mr Osman Ali, Deputy Chief  
Mr Muhammed Ali, Secretary, MOHFW  
Mr Abdus Samad Bhuiyan, Additional Secretary  
Dr Zakir Hussain, Director Primary Health Care  
Mr Azizul Karim, Joint Chief Planning  
Mr ABM Kawnine, Joint Chief and Project Director, Health Economics Unit  
Prof. James Killingsworth, Team Leader, Health Economics Unit  
Mr Meszbahuddin, Deputy Chief  
Mr Stephen Thomas, Associate Economist, Health Economics Unit

##### **Ministry of Social Welfare**

Mr Abul Kalam, Deputy Chief

##### **Planning Commission, Ministry of Planning**

Dr Faisal Islam, Research Officer, Health Wing  
Ms Nargis Islam, Deputy Chief, Health Wing  
Mr Md. Shahiduzzaman, Joint Chief, Health Wing

##### **Economic Relations Division, Ministry of Finance**

Mr ABM Golam Mowla, Deputy Secretary  
Mr Ehsan Shamim, Deputy Secretary

#### **Dhaka-based Donor Officials**

##### **Asian Development Bank**

Mr B Horayangura, Resident Representative

##### **Australian Agency for International Development (AusAid)**

Ms Roushan Akhter, Senior Development Officer  
Mr Jason Reynolds, First Secretary

##### **Canadian International Development Agency (CIDA)**

Dr Nancy Gerein, Director, Technical Advisory Unit  
Mr Tom Schatzky, First Secretary

##### **Department for International Development (DfID ex-ODA)**

Ms Adrienne Brown, Programme Officer  
Ms Sofie Forman, Programme Officer  
Dr Mehtab Currey, Senior Advisor, Health and Population

##### **Embassy of Belgium**

Mr Vital Kellens, First Secretary

**DANIDA**

Dr Shireen Huq, Programme Officer

**Embassy of the Federal Republic of Germany**

Dr J Lewerenz

**Embassy of France**

Mr Romain Vuillaume, First Secretary

**European Commission**

Ms Laila Baqee, Programme Officer

Mr Nick Roberts,

**GTZ**

Dr Hans-Otto Baum, Head of Project Administrative Services

Mr Habibur Rahman, Associate Advisor

Dr Heide Richter, Team Leader, NIPORT

**Royal Netherlands Embassy (DGIS)**

Ms Rita Imanuel, former First Secretary

Ms Marjan Kroon, First Secretary

**Sida**

Mr Karl Hagstrom, First Secretary

**UNAIDS**

Dr Lisa Messersmith, Country Programme Advisor

**UNDP**

Mr Khondker Hafiz, Assistant Resident Representative

Mr Osman Ghani, Chief, Programme Support Unit

Mr David Lockwood, Resident Representative

Ms Eimi Watenabi, former Resident Representative

**UNFPA**

Mr Alain Mouchiroud, Representative

**UNICEF**

Mr Rolf Carriere, Representative

Dr Kamal Islam, Programme Officer, Health

Dr T.O. Kyaw-Myint, Project Officer, Health and Nutrition

Dr Eric Laroche, Chief, Health and Nutrition

Dr Monika Sharma,

**USAID**

Mr Richard Greene, Deputy Director, Office of Population and Health

Mr Ali Noor, Director of Research, Office of Population and Health

Mr David Piet, Director, Office of Population and Health

**World Bank**

Mr Faruque Ahmed, Population Specialist

Dr Gay Alexander, MCH Specialist

Dr Humanyun Hye, Consultant

Mr JS Kang, Population Specialist

Mr SK Sudhakar, Task Manager FPHP and Chief Population and Health Office

**World Health Organization**

Dr Shambhu Archarya, Programme Manager  
Dr BD Chataut, Consultant, Coordination and Management  
Dr Wit Hardjotanojo, Representative

**Headquarters Agency Officials****Canadian International Development Agency**

Ms Sarada Leclerc, Health and Population Specialist  
Ms Peggy Thorpe, Health and Population Specialist

**UNFPA**

Ms Catherine Pierce, Deputy Director, Technical and Evaluation Division  
Dr Seth Rao, Director, Technical and Evaluation Division

**USAID**

Dr Constance Carrino, Chief, Health Policy and Sector Reform Division  
Ms Sharon Epstein, former Country Director, UNFPA, Dhaka and

**UNDP**

Mr Niky Fabiancic, Management Officer, OUNS  
Mr Gary Gabriel, Director, OUNS

**WHO**

Dr John Martin, Associate Director, ICO  
Dr Nick Dragger, Consultant for Aid Management and Coordination, ICO  
Dr Malingo Fernando, Desk Officer for FPHP, ICO

**World Bank**

Mr Edward Elmendorf, Health Advisor  
Dr Philip Gowers, Team Leader for HAPP-5, former Task Manager FPHP  
Ms Laura Kiang, Operations Specialist, FPHP  
Dr Tom Merrick, Senior Population Advisor  
Dr Ok Pannenberg, former Task Manager for POP-3  
Mr Chris Walker, former Task Manager for Pakistan SAP  
Dr Abdo Yazbeck, Health Economist, FPHP

**Other**

Mr Shamim Ahsan, former Secretary, MOHFW  
Dr Andrew Cassels, Health Systems Development Consultant, involved in HAPP-5 preparation  
Ms Cathy Deane, Consultant on Organization and Management for HAPP-5 preparation  
Dr Ken Grant, lead Consultant on Organization and Management for MOHFW reorganization  
Prof. Moshraff Hossain, former Member, Planning Commission  
Dr Andreas Lenel, Health Economist and Consultant for KfW, member of PRG of FPHP - MTR  
Dr Petra Osinski, Chief Technical Advisor, Project Preparation Cell for HAPP-  
Dr John Phillips, Population Council, Senior Associate, wrote BD case for OED eval of pop projects  
Mr Ron Ridker, formerly OED World Bank and team leader of PRG of FPHP MTR  
Dr Ubaidur Rob, Programme Associate, Population Council

## ANNEX 2:

### QUESTIONNAIRE ADMINISTERED TO GOVERNMENT OFFICIALS

#### MOHFW Sector Programme Management Task Force 1997

#### Aid & Donor Coordination under Sector-wide Programme Management

#### QUESTIONNAIRE FOR DEVELOPMENT PARTNERS IN BANGLADESH

##### PLEASE NOTE

1. This questionnaire does not seek definitive positions nor any commitments from your agency. It aims to solicit your interpretations, views and concerns so as to inform the dialogue on aid/donor coordination under the proposed sector-wide approach. Responses are confidential in the sense that they will not be linked to respondents nor agencies in the analysis nor report.
2. Please complete this questionnaire by 20 August 1997 and return it to Kent Buse c/o the World Bank Resident Mission in Dhaka. Fax no. 880-2-863-220.
3. If clarifications or elaboration of your responses is deemed desirable, Kent Buse, the consultant undertaking this work on behalf of the Task Force, will request to meet with you in late August.
4. Separate questionnaires are being administered to Government and Headquarters officials.

##### ACRONYMS

FPHP	Fourth Population and Health Project
GOB	Government of Bangladesh
HAPP-5	Fifth Health and Population Project
HPSS	Health and Population Sector Strategy
MOHFW	Ministry of Health and Family Welfare
PEP	Public Expenditure Programme
PHO	Population and Health Office
SWAP	Sector-wide Approach
TORs	Terms of Reference

##### IDENTIFICATION

1. Name of Respondent:
2. Name of Agency:
3. Position of Respondent:
4. Length of time in Bangladesh (in months): \_\_\_\_\_ Length of time in Position (in months): \_\_\_\_\_

##### AGENCY PROFILE

Structural characteristics of development agencies influence their needs and concerns with respect to participation in sector-wide approaches. This section builds a quick profile of your agency in the context of the Bangladesh health and population sector.

5. In which year did your agency become active in the Bangladesh health and population sector?  
19 \_\_\_\_

6. Please comment on the current autonomy of country-level decision-making in your agency as follows:

(a) Rank and describe the decision-making power of your agency's country office in relation to programme resource allocation decisions:

(from 1 = no authority to 5 = full authority): 1      2      3      4      5

Comments:

(b) Rank and describe the flexibility of your agency's country office in making alterations to the programme during implementation:

(from 1 = no authority to 5 = full authority): 1      2      3      4      5

Comments:

(c) Describe and attempt to quantify the influence of the following entities in setting funding priorities for your agency in the sector at the country level (percentages should add up to 100):

headquarters: \_\_\_\_\_%

country office: \_\_\_\_\_%

other donors: \_\_\_\_\_%

MOHFW: \_\_\_\_\_%

other: \_\_\_\_\_% (please specify): \_\_\_\_\_

Comments:

7. Please specify the current complement of human resources in your agency's country office with responsibility for health and population sector programme management:

(a) Total	_____ Full-time	_____ Part-time
(b) Expatriate	_____ Full-time	_____ Part-time
(c) Local	_____ Full-time	_____ Part-time
(d) Health Professionals	_____ Full-time	_____ Part-time
(e) Administrative/Managerial	_____ Full-time	_____ Part-time

8. Please specify the **approximate** budgetary commitment your agency made (will make) to the sector in the table below (in US\$ millions and percentages as appropriate):

	1994/95	1995/96	1996/97	1997/98	1998/99
(a) Commitment to health and population activities					
(b) % of (a) for MOHFW expenditures/activities					
(c) % of (a) in Consortium FPHP					
(d) % of (a) as budget support to MOHFW					
(e) % of (a) in technical assistance					
(f) % of (a) disbursed in practice				N/A	N A

## AIMS AND CHARACTERISTICS OF SECTOR-WIDE APPROACHES (SWAPs)

In the health sector, SWAPs have been defined as a sustained process of collaboration between different arms of Government and one or more donor agencies with the common goal of improving people's health, which involves four key components: (1) the articulation of sectoral policies and strategies; (2) preparation of a prioritised public expenditure programme for the sector; (3) design and use of a common management framework for programme implementation; and (4) a programme of work in institutional development to strengthen Government capacity for components 1-3. Donor provision of direct budget (programme) support, as opposed to project-specific investment, is also sometimes associated with a SWAP.

9. From your point of view, what are the most desirable components of a SWAP, and therefore the most worthy of attention? Please choose and circle as many components as desirable:
- (a) agreed sector policies and strategies;
  - (b) agreed and prioritized public sector expenditure programme;
  - (c) the use of a common management framework for programme implementation (e.g. common technical assistance pool);
  - (d) institutional development of MOHFW for sector-wide management;
  - (e) provision of direct budget support to MOHFW as opposed to project-specific investment?
  - (f) other (please specify):
10. What does your agency see as the major advantages of operating within a SWAP framework in the health sector in Bangladesh?
- (a)
  - (b)
  - (c)
  - (d)
11. What are your principal concerns about working within a SWAP framework in the health sector in Bangladesh?
- (k) do not ascribe to the sector strategy which guides the SWAP? *Yes / No / Perhaps*
  - (l) may not agree with the prioritized public expenditure programme? *Yes / No / Perhaps*
  - (m) may find it difficult to channel your agency's aid within the expenditure programme? *Yes / No / Perhaps*
  - (n) foresee organizational barriers to participating in the common management framework for programme implementation? *Yes / No / Perhaps*
  - (o) unsure of how to manage the transition to the SWAP? *Yes / No / Perhaps*
  - (p) fear that other agencies might not support the SWAP, thereby undermining its potential benefits? *Yes / No / Perhaps*
  - (q) Government may lack adequate management capacity to operate a SWAP? *Yes / No / Perhaps*
  - (r) project-specific investment has advantages over SWAPs? *Yes / No / Perhaps*
  - (s) other (please specify):

## PARTICIPATION IN THE SWAP IN THE HEALTH SECTOR IN BANGLADESH

This section does not seek definitive positions from agencies. It seeks to explore preferences and where agencies are at in terms of making decisions about their potential participation in a SWAP for the health sector in Bangladesh.



12. Will your agency likely finance the SWAP public expenditure programme (PEP)? *Yes / No / Perhaps*
13. If your agency should finance the SWAP - PEP, has any thought been given to funding modalities? *Yes / No / Perhaps*  
 If yes, will your agency use any of the following modalities?  
 (a) earmarking funds against specific activities/projects? *Yes / No / Perhaps*  
 (b) providing programme budget support to the MOHFW? *Yes / No / Perhaps*  
 (c) co-financing with World Bank through Trust Fund? *Yes / No / Perhaps*  
 (d) co-financing with Government on parallel basis? *Yes / No / Perhaps*  
 (e) other (please specify):
14. If your agency is likely to earmark funds for particular activities/projects:  
 (n) what is the approximate proportion of funds to be earmarked? \_\_\_\_%  
 (o) what criteria would determine activities to be earmarked?  
 (i)  
 (ii)  
 (iii)  
 (c) what modalities would govern monitoring and reporting on earmarked funds? Please comment:
15. If your agency is likely to finance health sector activities outside of the Government's public expenditure programme, what is the likely approximate proportion of the funds? \_\_\_\_%
16. Will your agency likely participate in the annual SWAP planning and review processes? *Yes / No / Perhaps*  
 If yes, would your agency be represented by:  
 (a) headquarters? *Yes / No / Perhaps*  
 (b) field office? *Yes / No / Perhaps*  
 (c) consultants? *Yes / No / Perhaps*
17. In your opinion, should being a financier of the SWAP public expenditure programme be a pre-condition for participation in the annual review processes? *Yes / No / Perhaps*
18. In your opinion, which stake-holders, in addition to GOB and its Development Partners, should participate in the SWAP planning and review processes and how?

Stake-holders to be involved in SWAP	The manner in which to involve stakeholders
(a)	
(b)	
(c)	
(d)	
(e)	

#### MODALITIES FOR AID & DONOR COORDINATION UNDER SWAPs

This section seeks to solicit the range of views on possible modalities for aid and donor coordination under the proposed health sector SWAP. Multiple choice options are listed below some questions, they are intended to save time in responding. Please feel free to include other possibilities as required.

19. Which aid coordination responsibilities should the MOHFW bear under the SWAP?
- (s) lead on annual SWAP programme planning and review processes? *Yes / No / Perhaps*
  - (t) chairing regular meeting of all donors for information exchange? *Yes / No / Perhaps*
  - (u) nodal point for communication in sector? *Yes / No / Perhaps*
  - (v) depository for information on activities in sector? *Yes / No / Perhaps*
  - (w) other (please specify):
20. Which common programme implementation arrangements should Government manage and which should be managed by donors? Please choose and circle your preferred choice:
- (t) coordinated and joint appraisal of donors' inputs? *GOB / Donors*
  - (u) planning, monitoring and performance evaluation of sector programmes? *GOB / Donors*
  - (v) procurement and contracts? *GOB / Donors*
  - (w) reporting? *GOB / Donors*
  - (x) accounting on expenditure? *GOB / Donors*
  - (y) auditing? *GOB / Donors*
  - (z) technical assistance pool? *GOB / Donors*
  - (aa) others (please specify):
21. If the Government is to take on increasing responsibility for sector management, will a Government SWAP secretariat be required? *Yes / No / Perhaps*
- If yes, should it be distinct from the MOHFW Planning Cell? *Yes / No / Perhaps*
- If it is situated in the Planning Cell, should the Cell be strengthened? *Yes / No / Perhaps*
22. Should those agencies which are not providing budget support (i.e., those that are earmarking funds) to the MOHFW be obliged to earmark a percentage of their health sector contribution to defray aid coordination costs by the MOHFW? *Yes / No / Perhaps*
23. Should a Government - donor coordination mechanism, chaired by Government, such as a Local Consultative technical sub-group on health and population be established? *Yes / No / Perhaps*
24. Should a donors-only coordination arrangement exist (e.g. Consortium)? *Yes / No / Perhaps*
25. Should a set of 'rules of the game' for coordination accompany the SWAP? *Yes / No / Perhaps*
- If yes, what should they involve?
- (a) no donor expenditures outside of SWAP - PEP, except for specified one-off activities undertaken by GOB (e.g., pilots) and those activities consistent with HPSS carried out by the voluntary and private sectors? *Yes / No / Perhaps*
  - (b) funds for ear-marked activities specified well in advance of annual planning processes? *Yes / No / Perhaps*
  - (c) commitment to sustained funding for agreed period? *Yes / No / Perhaps*
  - (d) participation in key and specified events? *Yes / No / Perhaps*
  - (e) agree to common donor voice on conditionalities, sanctions and how to implement them? *Yes / No / Perhaps*
  - (f) draft and final TORs and reports concerning appraisal, monitoring and evaluation of parallel financed activities shared with sector information nodal point to ensure all stakeholders are apprised of developments in the sector? *Yes / No / Perhaps*
  - (g) others (please specify):

## CONDUCT OF ANNUAL SWAP REVIEWS

It is generally envisioned that the SWAP be implemented through annual operational programmes, budgets, and subsequent reviews of performance. The key to monitoring is the development of agreed indicators, covering both impact and process. The section seeks to understand your agency's requirements and concerns in relation to indicators and monitoring responsibilities.

26. Who should lead the SWAP review, prepare the TORs, Aide Memoire, etc.? *GOB / Donors / Other*

If other, please specify: \_\_\_\_\_

27. What financial and operational information would your agency likely require to monitor its investments?

Financial information required	Operational information required
(a)	(a)
(b)	(b)
(c)	(c)
(d)	(d)
(e)	(e)

28. Would a standard reporting format be acceptable to your headquarters if it incorporated the annual operational plans for the main programme components, their planned mile stones, indicators for results obtained, and expenditure data? *Yes / No / Perhaps*

29. What external verification would be required, and how should it be provided?

Type of verification	Means of verification
(a)	(a)
(b)	(b)
(c)	(c)
(d)	(d)

30. Would the timing of the annual review in February be acceptable to your agency (i.e. to coincide with GOB reviews)? *Yes / No / Perhaps*

## ADAPTATION OF THE DONOR CONSORTIUM AND INSTITUTIONAL ARRANGEMENTS ASSOCIATED WITH IT TO MEET NEW NEEDS UNDER HAPP-5

In 1992, the GOB and a Consortium of donors embarked on the Fourth Population and Health Project (FPHP). A project support unit (PHO), financed with project funds and staffed by the World Bank, was established to act as a secretariat to the Consortium and to coordinate donor inputs. While this approach has served its members well, there is a recognition that modifications may be required to address donor coordination needs for HAP-5 and the SWAP. This section seeks to explore options and preferences for modification of this arrangement.

31. Which agencies should participate in a Consortium?
- (ee) only joint co-financiers of HAPP-5? *Yes / No / Perhaps*
  - (ff) all financiers of the SWAP PEP? *Yes / No / Perhaps*
  - (gg) SWAP financiers and multilateral technical agencies? *Yes / No / Perhaps*
  - (hh) SWAP financiers, interested donors and multilateral technical agencies? *Yes / No / Perhaps*
  - (ii) (d) and major NGOs? *Yes / No / Perhaps*
  - (jj) should the Government be included? *Yes / No / Perhaps*
- Comments:
32. If the Government is not a participant, how should the Consortium interface with GOB?
- (ff) minutes of meetings shared with GOB? *Yes / No / Perhaps*
  - (gg) GOB attends tail end of meetings for briefings and dialogue? *Yes / No / Perhaps*
  - (hh) other (please specify):
33. Which agency and/or official should provide leadership to the Consortium?
- \_\_\_\_\_ For what period of time should the leader serve? \_\_\_\_\_?
- According to what criterion should the selection be made? Please choose and circle one option:
- (gg) largest investor in the SWAP PEP;
  - (hh) elected by members;
  - (ii) rotating basis;
  - (jj) other (please specify):
34. What should be the rules of the game and the roles and responsibilities of membership in the Consortium?
- (hh) leader has sole responsibility for liaison with GOB on Consortium issues? *Yes / No / Perhaps*
  - (ii) leader chairs regular meetings of members? *Yes / No / Perhaps*
  - (jj) leader circulates draft agenda and minutes of meetings for comment prior to finalization? *Yes / No / Perhaps*
  - (kk) leader circulates draft TORs and Aide-memoires for joint missions in relation to appraisal, monitoring and evaluation of Consortium support to SWAP? *Yes / No / Perhaps*
  - (ll) members agree to attend certain minimum activities of Consortium? *Yes / No / Perhaps*
  - (mm) decision-making by consensus? *Yes / No / Perhaps*
  - (nn) decision-making by majority vote? *Yes / No / Perhaps*
  - (oo) reports from all sector work supported by agencies shared in Consortium? *Yes / No / Perhaps*
  - (pp) agreement to abide by similar rules and regulations (e.g. for engaging consultants, incentive payments, etc.)? *Yes / No / Perhaps*
  - (qq) others (please specify):
35. In your opinion, should a secretariat exist to support the Consortium? *Yes / No / Perhaps*

36. If you agree that a Consortium secretariat should exist, which functions should it fulfil that are not undertaken by GOB?

<p><b>SWAP Management</b></p> <ul style="list-style-type: none"> <li>(a) planning, monitoring and performance evaluation of sector programmes? <i>Yes / No / Perhaps</i></li> <li>(b) maintaining data base on sector activities/outputs? <i>Yes / No / Perhaps</i></li> <li>(c) reporting? <i>Yes / No / Perhaps</i></li> <li>(d) accounting on expenditure? <i>Yes / No / Perhaps</i></li> <li>(e) auditing? <i>Yes / No / Perhaps</i></li> <li>(f) organize and participate in annual SWAP review? <i>Yes / No / Perhaps</i></li> <li>(g) monitoring GOB compliance with donor conditionalities? <i>Yes / No / Perhaps</i></li> <li>(h) steering and technical support for GOB SWAP secretariat? <i>Yes / No / Perhaps</i></li> <li>(i) others (please specify):</li> </ul>
<p><b>Donor Coordination</b></p> <ul style="list-style-type: none"> <li>(a) coordinated and joint appraisal of donors' inputs? <i>Yes / No / Perhaps</i></li> <li>(b) management of Consortium procurement and contracts? <i>Yes / No / Perhaps</i></li> <li>(c) technical assistance pool for Consortium members? <i>Yes / No / Perhaps</i></li> <li>(d) facilitate member dialogue on sector strategy and expenditure programme? <i>Yes / No / Perhaps</i></li> <li>(e) organize and participate in Consortium meetings? <i>Yes / No / Perhaps</i></li> <li>(f) undertake conflict management? <i>Yes / No / Perhaps</i></li> <li>(g) others (please specify):</li> </ul>

37. Would your agency be likely to finance a Consortium secretariat as a proportion of its costs?  
*Yes / No / Perhaps*

38. In your opinion, what should be the institutional affiliation of the staff of such a secretariat?  
Please choose and circle one option:

(ll) from one of the Consortium member agencies, operating in line positions and accountable to its management? *Yes / No / Perhaps* If yes, which agency?

(mm) seconded from member agencies to a semi-autonomous entity? *Yes / No / Perhaps*

(nn) recruited on the open market to a semi-autonomous entity? *Yes / No / Perhaps*

(oo) other (please specify):

39. Where should the secretariat be located? Please choose and circle one option:

(mm) in a MOHFW premises? *Yes / No / Perhaps*

(nn) in one of the member agencies? *Yes / No / Perhaps* If yes, which? \_\_\_\_\_

(oo) elsewhere (please specify):

**THE RELATION BETWEEN THE EXISTING DONOR/AID COORDINATION MECHANISMS AND THE GOVERNMENT'S OWN CAPACITY FOR A SWAP**

40. How would you define aid and/or donor coordination?

41. Could you please comment on the present health sector aid coordination patterns and mechanisms?

42. How would you describe the present role of GOB agencies in health sector aid coordination?  
Please choose one option and comment:

(pp) MOHFW *adequate / inadequate*

(qq) Planning Commission *adequate / inadequate*

(rr) ERD *adequate / inadequate*

43. In your opinion, did the FPHP undermine the ability of the Government to lead on aid coordination? *Yes / No / Perhaps*  
If yes, how?

44. What have been the key benefits of the FPHP donor Consortium for Government? Please circle those benefits below:

(rr) reduced burden on MOHFW through:

- (i) joint donor appraisal and supervision missions? *Yes / No / Perhaps*
- (ii) common disbursement through World Bank? *Yes / No / Perhaps*
- (iii) consolidated financial expenditure reporting mechanism? *Yes / No / Perhaps*
- (iv) single bi-annual reporting requirement? *Yes / No / Perhaps*
- (v) fewer meetings with FPHP donors on an individual basis? *Yes / No / Perhaps*
- (vi) provision of project management support? *Yes / No / Perhaps*
- (vii) other (please specify):

- (b) reduction of conflicting policy advice from Consortium members because policy consensus was reached within the Consortium and communicated to Government by the PHO? *Yes / No / Perhaps*
- (c) useful mechanism through which to communicate Government views to donors? *Yes / No / Perhaps*
- (d) other (please specify):

45. What have been the key benefits of the Consortium for donors? Please choose and circle as many benefits as appropriate:
- (ss) increased leverage of your agency over GOB strategy and expenditure? *Yes / No / Perhaps*
  - (tt) increased aid efficiency and cost savings through common programme implementation arrangements? *Yes / No / Perhaps*
  - (uu) improved coordination of donor inputs? *Yes / No / Perhaps*
  - (vv) improved project design and implementation through information sharing? *Yes / No / Perhaps*
  - (ww) other (please specify):
46. In your opinion, what have been the major drawbacks of the Consortium?
- (tt) imperfect aid coordination instrument since it does not include all major donors? *Yes / No / Perhaps*
  - (uu) imperfect aid coordination instrument since it excludes participation of MOHFW? *Yes / No / Perhaps*
  - (vv) inadequate in reducing the burden of aid management on MOHFW since FPHP co-financiers persist in:
    - (i) fielding individual appraisal, supervision, and review missions? *Yes / No / Perhaps*
    - (ii) arranging numerous meetings with senior Government officials on a bilateral basis? *Yes / No / Perhaps*
    - (iii) funding numerous distinct projects? *Yes / No / Perhaps*
    - (iv) requiring additional information for project monitoring ? *Yes / No / Perhaps*
  - (a) imperfect because members advanced conflicting policy advice to GOB? *Yes / No / Perhaps*
  - (b) other (please specify):
47. Do health sector aid coordination activities currently occupy a significant proportion of your time? *Yes / No / Perhaps*
- Could you estimate how much? \_\_\_\_% Is this too much time? *Yes / No / Perhaps*

## ANNEX 3:

### FIELD WORK MILESTONES

Date	Event	Activities/Comments	Outcome
Dec 10-15 1995	Reconnaissance trip to Dhaka	* met with key donors and Government officials to discuss proposed study	* opposition from Dhaka office of World Bank * support from some donors: particularly those outside Consortium and those dissatisfied with Consortium * Government officials were non-committal
April 1996	Commence field work	* affiliate as research fellow at the Centre for Health and Population Research (ICDDR,B)	* although seen as a relatively apolitical, the Centre does not have the resources nor expertise in policy analysis to provide the prestige nor influence required to gain collaboration from aid coordination actors
May 1996	Introductory letter and synopsis of research	* letter sent to all major donors supporting health activities and to Planning Unit of MOHFW * followed-up with phone calls	* some officials agree to meetings
May - Aug 1996	Meetings with select donor and Government officials	* 9 donor officials, mainly those critical of coordination arrangements, agree to informal meetings * meet with hand full of GOB officials	* some donor concerns with Consortium and aid coordination are gleaned from officials * basic documents from some donors as well as GOB planning documents are collected
June - Aug 1996	Donors divided over study	* local office of World Bank leads opposition to study - but other officials also concerned with 'non-stakeholder' scrutiny of process * I lobby supportive donors to argue my case in Consortium	* access to documents and officials temporarily blocked as donors decide how to handle my request to undertake research and have access to documents and officials
23 June 1996	I request meeting with Consortium	* letter sent to World Bank * follow-up with several meetings with World Bank staff	* World Bank agrees to idea of presentation which is subsequently agreed in meeting of Consortium on 21 August
9 Sept 1996	Formal presentation of research proposal to Consortium	* presentation made to about 60 officials of Consortium and visiting donor mission	* I requested documents, observation of Consortium meetings and collaborative approach to research (i.e. Consortium members could sit on steering committee and input into design)
14 Sept 1996	Consortium response to my proposal/ request via World Bank	* Consortium requests that I: (1) prepare historical review of donor involvement in health sector; (2) obtain clearance of GOB for review; (3) re-approach Consortium for cooperation once historical review completed and reviewed by Consortium	* research delayed until Government agreement to historical review obtained * compelled to pursue relatively fruitless line of research as documentation for review not readily available among donors * World Bank makes eventual release of donor documents subject to (1) Consortium of approval of the historical review as well as (2) restrictive Bank policy on 'disclosure'



Date	Event	Activities/Comments	Outcome
Sept - Oct 1996	Historical review	<ul style="list-style-type: none"> <li>* GOB clearance requested</li> <li>* TORs drafted, shared with, and cleared by Consortium</li> <li>* Consortium members requested in writing and with follow-up calls to collaborate by sharing required historical documents</li> </ul>	<ul style="list-style-type: none"> <li>* GOB clearance communicated to Consortium on 28 November</li> <li>* very few donors respond to request for documentation to prepare historical review</li> <li>* those donors who do respond positively, do not have historical documentation required</li> <li>* assignment is forgotten by donors</li> </ul>
Nov 1996	Case study for UN Inter-Agency Task Force on Basic Social Services	* Task Force commissions me to prepare case study on health sector aid coordination in Bangladesh	* assignment will eventually provide patronage required for access to (1) officials and documentation among the UN agencies; and subsequently to (2) other relevant officials
17 Dec 1996	Dhaka office of World Bank offers limited support to research	* given GOB clearance for historical review, local office of World Bank agrees to sharing some limited documents if I sign waiver regarding use	* I ignore offer as documents offered by the Bank are largely in my possession already (e.g. Staff Appraisal Reports, mission aide-memoires but not meeting minutes)
Jan 1997	Visit to UN agency Headquarters	<ul style="list-style-type: none"> <li>* interviews with officials of World Bank, UNICEF, UNFPA and UNDP</li> <li>* gain access to World Bank archives in Washington</li> </ul>	<ul style="list-style-type: none"> <li>* first useful data obtained</li> <li>* examine correspondence relating to Bank health projects in Bangladesh from 1972-1996</li> </ul>
Feb - Jun 1997	Increasing access to documents	* supportive Dhaka-based donor officials (CIDA, Sida, UNFPA) make files available to me	* able to collect most minutes of Consortium meetings, as well as other useful documents
Feb 1997	Interviews with officials in Dhaka		* my elevated status results in broader range of GOB and donor officials agreeing to meet with me
Mar 1997	Draft report for UN Task Force	* draft report circulated among interested parties for comment	* feedback from donors and GOB officials provides relatively honest views on aid coordination
July - Aug 1997	Survey of stakeholder views on aid coordination under a sector-wide approach	<ul style="list-style-type: none"> <li>* World Bank HQ commissions me through a MOHFW HAP-5 Task Force to prepare survey</li> <li>* with difficulty, I convince sponsors to include views of GOB in survey</li> <li>* questionnaire administered to officials of GOB and donors locally and at HQ levels</li> </ul>	<ul style="list-style-type: none"> <li>* allows for collection of standardized data from a significant proportion of donors as well as some GOB officials</li> <li>* some follow-up interviews</li> </ul>
Aug 1997	Field work completed		
Sept 1997	Draft report on aid coordination and sector-wide approach	<ul style="list-style-type: none"> <li>* survey results are interpreted according to my conceptual framework</li> <li>* draft report widely circulated for comment</li> </ul>	<ul style="list-style-type: none"> <li>* feedback on report provides further refinement of donor and GOB officials views on aid coordination</li> <li>* feedback used as validation technique on interpretation of results</li> </ul>
Dec 1997	Follow-up visit to Dhaka	* meetings with key informants to verify findings and interpretations	

## ANNEX 4:

### ADMINISTRATIVE ARRANGEMENTS OF GOVERNMENT

The Prime Minister is Chief Executive, and the President the Head of State. The apex of government is formed by 36 ministries which are responsible for policy formulation and oversight functions. Political leadership of each ministry is vested in a Minister, while chief executive and accounting responsibility is assigned to the Secretary, a senior permanent civil servant. Moving down the hierarchy is the Joint Secretary followed by the Deputy Secretary. Other officers, such as the Senior Assistant Secretaries and Assistant Secretaries, have little decision-making responsibility. Within the ministries, power struggles between the minister and secretary provide an ongoing dynamic. Given the turmoil in Bangladeshi politics, the turn over of ministers is very high which allows the Secretaries to wield considerable control.

Territorially, the country is divided into six divisions, 64 districts, 487 sub-districts (Thanas), 4422 unions, and over 68,000 villages (see Table ). The union currently forms the lowest tier of elected government. Since independence, a variety of systems of local government have been introduced following changes of leadership at the national level. It has been argued that the implicit purpose of all local government reforms have been to serve the political ends of national leaders, as successive local governments have never been accorded economic or political autonomy.<sup>1</sup>

#### Bangladesh's sub-national administrative structure

Type of unit	Number
Divisions	6 Average population 20.5 million
Districts	64 Average population 1.92 million
Thanas	487 Average population 252,000
Unions	4,422 Average population 27,800
Villages	68,000 Average population 1,800

The Ministry of Health and Family Welfare is responsible for the formulation and implementation of national health and population policies and the overall administration, coordination and management of health care and family planning service delivery. The task of implementing health policy, including its technical aspects and service delivery,

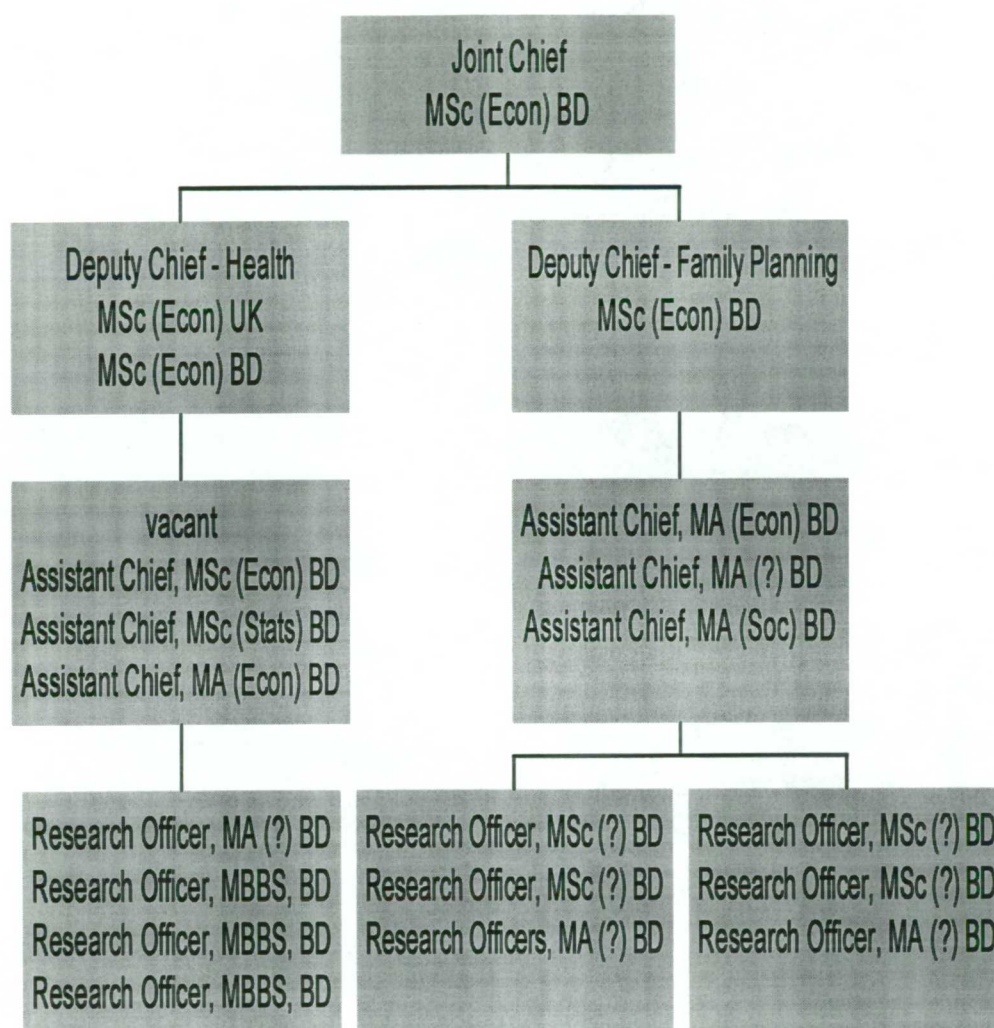
lie with two Directorates (often referred to as wings), that of Health Services and that of Family Planning, each headed by a Director-General. Programme management is highly centralised in Dhaka, the capital. The Directorates operate relatively independently of one another. Each has specialised cadres of staff and training institutions, a separate chain of command, and largely independent facilities and information management systems. There have been halting attempts to integrate service delivery in a 'functional' manner at the Thana local government level and below.

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<sup>1</sup> Westergaard K, Alam MM. Local government in Bangladesh: past experiences and yet another try. *World Development*. 1995; 23 (4): 679-690.

## ANNEX 5:

### MOHFW PLANNING UNIT PERSONNEL 1997: QUALIFICATIONS AND SPECIALISATION



BD Bangladesh  
 MA Master of Arts  
 Msc Master of Science  
 Econ Economics  
 Stats Statistics  
 Soc Sociology  
 MBBS Medical Degree

# ANNEX 6:

## THE FINANCING OF WORLD BANK POPULATION AND HEALTH PROJECTS IN BANGLADESH

(in US\$ millions)

Project	Total Value	GOB	IDA Credit	Cofinanciers	Grant
First Population	45.7	5.3	15.0	1. Norway	8.5
				2. Germany	6.1
				3. Australia	2.6
				4. UK	3.2
				5. Canada	2.0
				6. Sweden	3.0
Second Population & Family Health	110.0	10.8	32.1	1. Norway	20.0
				2. Germany	18.2
				3. Australia	4.0
				4. UK	4.0
				5. Canada	5.0
				6. Sweden	8.0
				7. Netherlands	7.9
Third Population & Family Health	263.1	34.6	100.9	1. Norway	27.9
				2. KfW	28.2
				3. GTZ	16.9
				4. Australia	6.5
				5. UK	12.5
				6. Canada	27.7
				7. Netherlands	7.9
Fourth Population and Health	774.7	306.5	188.3	1. Norway	28.7
				2. KfW	78.4
				3. GTZ	12.6
				4. Australia	5.1
				5. UK	27.1
				6. Canada	38.1
				7. Netherlands	28.8
				8. Sweden	15.0
				9. EEC	49.9

