Developing Policy for Improving Effectiveness and Harmonization of Aid to the Health Sector in Sudan

2010

Dr. Amjad Idries

Table of contents

Developing policy for improving effectiveness and harmonization of aid to the health sector in Sudan

1 Introduction

The donors have their agenda and preferences, but the manner they would like to see the results of their assistance to the countries has changed over time. In 1970s, the increasing concern was about whether aid made any difference in promoting development in general, and that would countries be better without aid? This trend continued till 1990s, when the aid givers became more structured in their approach to assessing the impact of aid to the countries. For example, in 1992 the OECD-DAC produced its first manual on aid impact assessment (*Development assistance manual: DAC principles for effective aid*), followed in 1999 by a manual on assessing the impact of humanitarian aid (*Guidance for evaluating humanitarian assistance in complex emergencies*). After millennium development goals that were set out in 2000, in order to improve aid effectiveness for achieving MDGs, Paris declaration for aid effectiveness was adopted at a high level forum in 2005. This declaration calls for the following measures, both from the donors as well as from countries in receipt of aid or official development assistance:

1. **Ownership**: partner countries exercise effective leadership over their development policies and strategies and co-ordinate activities;
2. **Alignment**: donors base their overall support on the partner countries' national development strategies, institutions and procedures;

3. **Harmonization**: donor actions complement each other and are more harmonized, transparent and collectively effective;
4. **Managing for results**: managing resources and improving decision making for results by a common M&E framework; and
5. **Accountability**: donors and partners are together accountable for achieving the development results.

However, to what extent the Government as well as the donors comply with the covenants of Paris Declaration? This study is aimed at responding to this question. But, first we see how the health services are financed in Sudan.

1.1 Financing of health

National health accounts for Sudan are not available. Therefore, the figures quoted are mostly projected from whatever data is available and are estimates. Sudan had gone through years of war and as a result social services, including health received low priority in resource allocation. But, with peace in the South and oil exploration bring good signs and the expenditure on health has been growing in the recent years.

It is subject to debate, what should be the ideal figure for health? A low figure suggests that not enough resources are mobilized for health, that access to health care is insufficient, and that the quality of services is poor. Likewise, a high expenditure on health may be consequent to a widespread use of advanced technology and likelihood of inefficiencies. According to WHO, the minimum per capita total health expenditures of US$ 34 (at average US$ exchange rate) for 2004 (US$ 38 for 2008) is needed to cover essential health services[1]. However,

[1] Commission on Macroeconomics and Health, 2001

Sudan's total health expenditure as a percentage of GDP was 3.80% in 2006. This is less than the average for countries in Sub Saharan African average of 5.3% and the lower middle income group average 6.1%. In 2006, as result households in Sudan financed 62.08% of total health expenditure through out-of-pocket spending at the time of service. This compares with an average 39.05% in Sub Saharan African countries and 37.51% in the lower middle income group[2].

While the health sector is under financed, health spending is skewed towards hospital care, i.e. most of the public budget allocation is for salaries and major hospitals. As a consequence, the primary and first-referral care, particularly in the poorer states, suffers from lack of resources. The development budget for the health sector is quite small in most states. Primary and first-referral care, particularly in the poorer states suffers from under-financing and inequitable allocation of resources. For example, in 2005 the public expenditure on health in Blue Nile State was US$ 3 per capita, allocated mostly on salaries and largely to the secondary hospitals in capital. As a result, particularly in rural areas and conflict affected states, the staff has low morale, services are limited and of poor quality, insufficient and poorly-maintained infrastructure and equipment, and inadequate pharmaceutical supply – as well as the user fees and high drug prices that deter the poor from accessing health services.

1.2 Donor assistance to Sudan

Sudan receives modest official development assistance (ODA), particularly following the Comprehensive Peace Agreement (CPA) signed in January, 2005 between the Government of Sudan and Sudan People's Liberation Movement (SPLM). This assistance is provided by bilateral as well as multilateral agencies and other actors, including the government, UN agencies and national and

[2] http://healthsystems2020.healthsystemsdatabase.org accessed on 30 November, 2009

international non-governmental organization are involved in its implementation in a range of sectors, including health.

In health sector, donor spending as a percentage of total health expenditure in 2006 was 6.40% in Sudan, compared with the Sub Saharan African average of 22.39% and the lower middle income group average of 11.13%[3]. However, most of this assistance is dedicated to humanitarian assistance, recovery and rehabilitation of health services. But, whatever the amount and nature of assistance, the question is to what extent the Government as well as donors comply with covenants of Paris Declaration? This study is aimed at responding to this question. A similar study was done in 2005, and in the following excrepts from the same is presented.

1.3 Compliance to Paris Declaration

Following the adoption of Paris Declaration, to monitor progress, the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD) undertook a survey that was administered by the World Bank. Sudan was one of the 55 countries that participated in survey; and an overview of the findings is given as below:

[3] *ibid*

Table 1: Status of adherence to Paris Declaration in Sudan

Dimensions	Status (2007)	Challenges	Priority Actions
Ownership	Low	Coordination of development objectives between north and southern parts of country	At GoNU level, ensure that policy objectives feed into the budget processes; at GoSS level, prepare national development strategy
Alignment	Low	Low capacity of country systems	Build capacity for PFM country systems, better estimation of budget inflows; better tracking of donor support
Harmonisation	Moderate	Lack of government capacity	Increase use of programme based approach
Managing for results	Low	Lack of statistical information	Build capacity to generate statistical information; conduct poverty baseline survey
Accountability	Low-moderate	Lack of capacity	Build integrated monitoring and evaluation systems in the GoSS and GoNU.

Source: OECD (2008) Better aid: 2008 survey on monitoring the Paris Declaration, Making aid more effective by 2010, Organization for Economic Cooperation and Development Organization

From the results of the survey, it is clear that adoption in Sudan, whether by the government or by donors, of different covenants of Paris Declaration are from low to moderate. In hindsight, this indicates to the low effectiveness of aid or the money is not getting its value! Therefore, there is a need to understand the level of aid effectiveness in the current scenario and to develop a framework and a plan for health development, assuring a coordinated donor actions and measures by the ministries of health to improve aid effectiveness.

1.4 The rationale

The aforementioned survey results that are based on data collected following the indicators paid down in Paris Declaration, although informative and valuable in highlighting the need for a variety of interventions for making the aid more effective, it is generic and concern all sectors. But, there is no such document that could provide specific picture of aid and aid effectiveness in the health sector.

Therefore, with the overall purpose to improve aid effectiveness, the Federal Ministry of Health launched this initiative of developing a framework and a plan for health development, assuring a coordinated donor actions and adoption of appropriate measures by the ministries of health to improve aid effectiveness. In this manner, it will be possible to and rally donors for scaling up health services as envisaged in national health policy and 5-year strategic plan for health sector.

In the following, the detail about this initiative will be described.

2 Developing a framework and a comprehensive plan for improving effectiveness and harmonization of aid to the health sector

At the national level Humanitarian Aid Commission, Ministry of Humanitarian Affairs coordinates all aid that flows into the country, while at sectoral level in the Ministry of Health, the Secretariat of International Health acts as a gateway. That is, it is well placed to coordinate donor actions and measures by the ministries of health to improve aid effectiveness in order to achieve MDGs. But, amongst others, the question remains how and what mechanisms to bring in to realize the objectives of Paris declaration, i.e. among others aid harmonization, reducing the aid fragmentation?

Apparently, however in Sudan, at least in the health sector, no formal mechanism for such purpose exists. It is therefore intended to develop one with the overall aim to harmonize and rally donors around a nationally organized and agreed framework linked to the measurable results and plans for scaling up health services in the government leadership.

2.1 Tasks

1 To review the relevant literature and discuss modalities for undertaking the assignment;

2 To discuss and agree on the workplan for accomplishing the assignment within the stipulated time schedule;

3 To develop a framework to harmonize and rally donors around measurable results and plans for scaling up health services as envisaged in national health policy and 5-year strategic plan for health sector in the government leadership;

4 To develop a comprehensive plan for health development, assuring coordinate donor actions and measures by the ministries of health to improve aid effectiveness in order to achieve MDGs; and in this regard task force will inter-alia undertake following tasks:

4.1 To draw boundaries of the health system, drawing on its building blocks, at the national, state and locality levels;

4.2 To map the donors as well as the government contribution to the different building blocks of the health system at the national, state and locality levels;

4.3 To identify gap in the adequacy of resources and coverage of interventions defined in national health policy and strategic health sector plan;

4.4 To develop a comprehensive plan with measurable results for scaling up health services in the government leadership;

4.5 To develop mechanisms and operational guidelines for rallying up donors and partners in health, including the private sector for supporting the comprehensive plan for the development of the health sector in Sudan.

5 To submit report according to the agreed format and schedule

3 Understanding the terms of reference

A focal person has been assigned to coordinate the assignment. In this regard, he has been tasked to set up a task force drawn from stakeholders (donors and partners in health, including private sector) and act as its secretariat. The task force will deliberate and undertake the assignment essentially guided by the national health policy, strategic plan and principals laid down in Paris declaration (2005) and the follow up guidelines agreed in Accra (2007).

In order for setting a task force, a meeting of the senior management in the Federal Ministry of Health was held in the office of the Assistant Undersecretary, International Health. Medical Officer, WHO Representative Office Sudan and Dr. Amjad Idries of International Health Directorate presented the issue and the following points came up in the meeting (copy of the presentation is at **Annexure A**:

1. Participants agreed on the importance of this issue considering the situation in Sudan and the considerable number of donors providing different types of aid using a variety of mechanisms, their funding requirements and methodologies.
2. MOH officials emphasized the importance of Paris declaration on aid effectiveness and harmonization and the need for implementing the concepts in health sector in Sudan. This was seen in line with Ministry of Health policy and regulations.
3. The participants ask to make use of previous efforts in this area considering the experience in different projects in health sector.

4. It was clear from the discussion the importance of involving the main donors and organizations representatives in this process both at higher level and at technical level.
5. Situational analysis about the current status was crucial for developing comprehensive plan/policy and defining of any subsequent step.
6. The work was divided into two components:
   6.1. Situational analysis and assessment
   6.2. Framework and action plan development.

Accordingly, 2 taskforces: one to undertake situation analysis; and the other to develop a framework for a policy to improve aid effectiveness has been set up and are defined below.

3.1 Task force to undertake situational analysis of aid effectiveness

In order to steer the process for analyzing the current situation of donor assistance and assessment of compliance to Paris Declaration, a taskforce comprising the following members was set up:

1. Dr. Isameldien Mohamed Abdalla – chair
2. Dr. Amjad Mohammed Idries - secretary
3. Dr. Ehsanullah Tarin
4. Dr. Sara Awadellah
5. Dr. Mohamed Hussien
6. Representative of UNDP
7. Representative of UNICEF
8. Representative of Sudanese AIDS Network

This task force will work to address the assignment in two parts: assessing the current situation of donor coordination; and analyzing the aid effectiveness, using the five sets of indicators laid down in Paris Declaration. The two parts of the assignment are defined in the following.

3.1.1 Part one: Donor coordination

Sudan receives a modest amount of ODA, which is often unpredictable and of a short-term nature. Further, country being in crisis a large number of agencies, national and international, including UN agencies operating in the field creates a serious challenge for the MOH to coordinate their input. This coordination is important to maximize impact of the overall health investments, including by the donors.

This part of the assignment will therefore focus on assessing the level of donor coordination in the following manner:

1. Stocktaking exercise of all health supporting agencies, including UN agencies, donors, national and international NGOs, Civil society associations, community structures to:
   1.1. Define area of expertise for each organization, existing collaborative programs with Ministry of Health, geographic location and delivery capacity
   1.2. Define type and duration of each stakeholders' business in the health sector
2. On the basis of this analysis, define existing coordination structures at various levels, membership, existing ground rules, TORs, scope of responsibility and decision-making
3. Describe existing communication systems within and between coordinating bodies at national and sub-national level

4. Review existing high level joint monitoring boards responsible for policy guidance and for overseeing effective coordination
5. Review scale and scope of coordination for Global health partnership, namely GFATM and GAVI.

3.1.2 Part two: Aid-effectiveness

A reference was made earlier to the low to moderate level of compliance in Sudan to the Paris Declaration. This implies in retrospect the donor support is not having impact, as it should have. In this part of the assignment, looking at five selected indicators, the effectiveness of overall health investments, including by the donors as well as by the government will be gauged. The five selected indicators are described as below:

1. Alignment: Assess if all donors support the national health sector strategic plan which clearly states the national priority program and identifies common health goals agreed by all donors and provide data and information on the existing independent health expenditures by donors;
2. Use of procurement systems: Assess the level of commitment by donors to use partner country procurement systems. Describe the concerns surrounding with the use of country procurement systems for example on quality of medicines, counterfeit drugs and access to essential medicines;
3. Aid predictability: Review the level of financial commitments to national priority programs for the last five years and for the coming three to five years;
4. Use of common arrangements or procedures under aid harmonization domain: to review the aid given based on programme-based approach; and

5. Results-oriented frameworks: Analyze existing common approach to monitor health sector performance, and is there an independent way to assess impact of sector support.

3.2 Taskforce to develop a framework for MOH policy on aid effectiveness and harmonization

In Sudan, at least in the health sector, there exists no formal mechanism or policy for improving the aid effectiveness. The country, with the health system that is fragile and disrupted on account of years of civil strife, had no capacity to coordinate the huge number of donors. One outcome, as indicated by the results of DAC/OECD survey was that the aid effectiveness was low to moderate for different measurable indicators.

While the aforementioned task force will assess the current situation of donor coordination and in that context analyze the aid effectiveness, this task force is assigned to design a framework for developing a policy for assuring compliance to different covenants of Paris declaration with the overall objective to improve aid effectiveness and harmonization of all investments in health. For this purpose, a task force with following members has been identified:

1. Dr. Mohamed Ali Yahia Elabbassi - chair
2. Dr. Amjad Mohammed Idries - secretary
3. Dr. Ehsanullah Tarin
4. Dr. Mustafa Salih Mustafa
5. Dr. Sara Hassan
6. Dr. Mohammed Hassan
7. Dr. Igbal Elbashir Ahmed
8. Representative of UNFPA

9. Representative of National NGOs

This task force will work to address the terms of reference as set forth for this assignment. However, in order to contextualize the issue a brief overview of the major categories of aid agencies is provided.

4 Major donors and partnerships

At the national level Humanitarian Commission, Government of Sudan coordinates all aid that flows into the country, while at sectoral level in the Federal Ministry of Health, the Directorate General of International Health, since sits at the inlet, in principle should act as a gateway for aid to the health sector. However, the country with its federated constitution, the constituent states/provinces are autonomous the aid agencies often work directly with them. This situation is facilitated by the fact that country has been in crisis and the health systems as a result is fragile and disrupted. Therefore, often aid is fragmented and there is no or ineffective coordination by the government.

The international aid flow for Sudan ranges from humanitarian aid, recovery to development. It is provided by bilateral as well as multilateral agencies and actors, including the government, UN agencies and national and international non-governmental organization are involved in its implementation. In the following, a brief account of the major donors is given.

4.1 Multi-Donor Trust Fund

A Joint Assessment Mission, led by the World Bank and comprising UN agencies and representatives of the government of Sudan and SPLM defined the immediate, short term and long terms need for the rehabilitation and development of social sector, including health. A multi Donor Trust Fund was set up, after signing the CPA with World Bank assigned its administrator. For every one dollar donated by the donors, the government was to contribute two dollars.

For northern Sudan, comprising 15 states, this fund focuses on supporting humanitarian action, recovery and development in four states affected by the conflict: South Kordofan, Blue Nile, Kassala, Red Sea, and the three areas –

Abeya, Blue Nile and South Kordofan. In addition, certain interventions are made at national level to address cross cutting issues.

4.2 Global Alliance for Vaccines and Immunization

The Global Alliance for Vaccines and Immunization (GAVI) has been supporting immunization in Sudan. As a result, more than 8 million children were vaccinated against poliomyelitis and measles that led to the circulation of wild poliovirus was interrupted and the number of measles cases reduced significantly, contributing to reducing the child morbidity and mortality.

There has been growing realization at global level that for any intervention at programme level, in this case Expanded Programme on Immunization, to be sustainable it was essential to support strengthening of health system. Accordingly, country submitted a proposal to GAVI, which committed to support interventions aiming to strengthen health system during 2007-12.

4.3 The Global Fund to fight AIDS, Tuberculosis and Malaria

Sudan was granted a total of approximately US$ 183 million in four grants for HIV/AIDS, malaria, and tuberculosis. While UNDP is the principal recipient, WHO is sub recipient for an amount of US$ 21.7 million out of the US$ 58.3 being disbursed for the first two years. South Sudan has also benefited from an additional US$ 95.5 million over five years for fighting the three diseases, of which US$ 36 million has been allocated for the first two years.

4.4 The United Nations in Sudan

Since 2005, United Nations and partners have been engaged in the formulation and implementation of work plan covering both humanitarian needs and development programming. The plan encompasses contribution of 13 UN

agencies with WHO as lead agency for health sector to work closely with agencies, mainly UNDP, UNFPA, UNICEF and UNAIDS.

However, as the country is moving from a humanitarian crisis to recovery and development, the United Nations in consultation with the Government has formulated a four-year (2009–2012) development assistance framework (UNDAF). The UNDAF is aimed to enhance synergy and coherence among all UN agencies in support of efforts to achieve the MDGs through building national capacity for development planning and management, including capacity for policy analysis, monitoring and evaluation and for coordination. The UNDAF aligns with government plans and policies and guide collaborative programming. It brings greater coherence to the input of various UN agencies and reinforces the partnerships for development in the country. The UNDAF is based on UN-supported country analysis of existing documents such as the Sudan Household Health Survey 2006 and the joint assessment mission and has adopted a region-based structure to reflect the decentralized system of government.

4.5 The Common Fund for Humanitarian Assistance

A common fund for humanitarian assistance, which is consistent with the principles of good humanitarian donorship and works on a needs-based approach with flexible, timely, predictable and adequate funding, has been created as a tool to coordinate the inputs to fund priority humanitarian needs. Under this umbrella, through this fund administered by the UN Resident Coordinator, the donors, UN agencies, NGOs and other partners in consultation with nationals decide what projects and activities should be funded. However, the focus of input through this fund has mainly been the three Darfur states and war affected states.

4.6 The World Bank

After an absence of 12 years, the World Bank opened offices in Khartoum. Its involvement in the Sudanese health system started with an assessment of the health sector and a report that was published in 2003. Then, as co-leader of the joint assessment mission, it worked closely with the UN agencies including WHO. After the signing of the CPA, the World Bank has played a key role as administrator for the MDTF, particularly in implementing decentralized health system development projects designed for the recovery of the transition states and executed by the federal and state ministries of health.

4.7 Nongovernmental organizations

The role of nongovernmental organizations in building peace in Sudan has been vital. There are over 250 national and international nongovernmental organizations and community-based organizations, including 85 in northern Sudan (Darfur excluded), 65 in south Sudan and 65 in Darfur, that are active in different fields of humanitarian assistance, providing support in emergency relief and rehabilitation, education, orphan sponsorships, mother and child care, health services, environment, water supply and sanitation among other development activities. In addition, there are several more working in Eastern Kassala state and the three areas. A list of organizations, maintained by the office of Humanitarian Commission is available at Annexure A.

4.8 Bilateral agencies

A number of bilateral agencies, including USAID, TIKA, JICA, SKICA, DFID, European Commission etc are working in Sudan. Mainly focused on humanitarian assistance, providing support in emergency relief and rehabilitation in the three Darfur states, these provide also development assistance.

5 Framework for aid effectiveness

The Paris Declaration on aid effectiveness guides this framework, with certain additions. This is due to the focus of the Paris Declaration is on monitoring the progress towards Millennium Declaration and the Millennium Development Goals (MDGs).

The MDGs although aimed to raise awareness about the overall human development; those related to health indicate selectivity for certain killer diseases in their approach, essentially at the expense of other health problems. The three health related MDGs are: reduce child mortality; improving maternal health; and combat HIV/AIDS, malaria, tuberculosis and other diseases. As a result of this narrow focus, the broader health system issues are likely to be ignored.

Therefore, the proposed framework for aid effectiveness should be seen go beyond MDGs and the Paris Declaration (PD). That is, the tenets of the PD will be interpreted and used for addressing the broader health system issues, including the three health related MDGs. Also, as certain elements of PD are not compatible with and unlikely to work in Sudan, these will be adapted. In the following, different components of the framework for aid effectiveness in Sudanese context are explained, noting however there are many overlaps between those:

5.1 Ownership

The donors work to address the needs of the country – a task requiring engaging with the recipient country. But, who and how the priorities should be set and what should guide this process? This consideration is important in order to establish the country ownership of the programmes and projects implemented with donor

assistance. This is important for sustainability that interventions are funded even after the donor's assistance had dried up.

To answer the above question, the recipient country – the ministries of health should lead the process for need identification and setting the priorities. However, what should guide this process? It should be the national health polices and or national strategic or operational plans for health sector. Any program, project or intervention should be drawn on these documents. In case the intervention is made, for example, in reproductive health (RH), it should be in line with the national RH policy and or strategy or operational annual plan. The objective is that the donor's input should compliment and form part of the bigger picture and is not implemented as an isolated activity.

However, in order to realize the above, while designing programmes, projects and interventions, donors need to accept and respect the leadership of the ministries of health, they have the obligation to also strengthen the latter's capacity to exercise leadership. The capacity building should extend to assisting the counterpart ministries and sub national authorities in designing/updating the national and or sectoral polices and or national or sectoral strategic plans.

In brief, with a bi-prong approach aiming at establishing the recipient country's ownership:

- The ministries of health should take lead with donors' close collaboration in translating national development strategies into prioritized result oriented programmes, project and or interventions that are complimentary to those envisaged in the short (annual) to medium (3-5 years) term plans.
- The donors should include as part of their input, the activities aiming at building capacity, including designing/ updating the national development

strategies and developing prioritized result oriented programmes, project and or interventions.

- Donors to ensure the aid is not conditional and tied with varying strings, like imposition of user fee, increasing the tariffs, reducing subsidies etc. Tying aid infringes on priority setting and in addition to increasing transaction cost, impacts negatively the ownership and alignment of aid.

5.2 Alignment

Donors have their interests, priorities and procedures for administering, management and monitoring and evaluating their assistance. This aspect of the framework (alignment) aims at assuring the donors' interests, priorities and procedures are aligned with those of the recipient, i.e. ministries of health. This would require agreement on a framework for assessing country's systems and procedures, particularly the financial management and procurement system that these are up to the donors' acceptance.

In case, as a result of the assessment undertaken jointly by the donors and the country, deficiency or weakness is found, the donor should invest part of its assistance in strengthening country's systems, *albeit* in the remits of the country's strategies for capacity development. If the assessment identified need for reforms, the country should institute such reforms, ensuring that the national systems, institutional procedures managing aid are effective. However, while the two interventions could be made simultaneously, the donor may still use country's system with additional safeguards, essentially not creating dedicated structures (commonly called PIUs) for day-to-day management of aid.

In brief, with a bi-prong approach focusing on donors as well as the recipient country, the following are the elements of the alignment component of the framework for improving aid effectiveness:

- Both donor and the country work together to design a performance assessment framework for country's systems, institutions and procedures involved in managing aid.
- Conduct a joint assessment of the country's systems, institutions and procedures involved in managing aid, and define needs, if any, for capacity building, within the remits of national strategies.
- Donors use country's systems, institutions and procedures if up to mark, and in case weak invest part of assistance in capacity building, and may use them, *albeit* with certain additional safeguards.

5.3 Harmonization

This tenet of the framework is about how the donors amongst themselves and with the country compliment their inputs to avoid or reduce fragmentation, duplication and cost of transaction and harmonize mechanisms for aid delivery. Particular attention is needed in Sudan with a fragile health system, and where like any country there is a need for environmental protection.

The multiplicity of donors poses challenge for coordination. Particularly, it is so given the weak capacity in the ministries of health Sudan. The donors therefore have the responsibility, essentially with the ministries of health on board, to devise and implement common arrangements for joint planning (UNDAF), funding (e.g. common humanitarian fund), disbursement, monitoring, evaluating and reporting to the government on aid flow. The common platform can also be used for joint assessment of the country's systems (alignment).

Joint planning for health planning is a real challenge, specifically given the complexity of the health system and the variety of functions that are performed at different levels of hierarchy. Also, the epidemiological account, demographic profile and geographic and climatic characteristics contribute to shaping the health system. This situation requires coordinated action while planning for health. There has to be division of labor amongst donors and between donors and the country. **NB**: this part of the 'harmonization' component of framework will be dealt with in detail in section on recommendations.

In brief, with a bi-prong approach focusing on donors as well as the recipient country, the following are the elements of the harmonization component of the framework for improving aid effectiveness:

- The donors establish a common coordination platform with government leading the process for joint planning for health development, avoiding fragmentation and duplication of aid, geographically as well as between different functions (provision of personal health care and goods, collective health care, and other health related functions) of the health system.
- Donors to use the common coordination platform, with government as leader, for joint assessment of country's systems, institutions and procedures and introduce reforms in the procedures and incentive regimen for working towards harmonization, alignment and results.
- Donors and the country to jointly work for building institutional capacities and establishing governance structures, essentially within the remits of the national policies and strategies. While a part of aid may be allocated for this purpose, merely engaging government has its dividends.

5.4 Managing for results

Linking the planning of any programme, project or intervention, whether big or small, with national policies and strategies will ensure that the input by getting into the bigger picture, yields results. In this manner, it will also be assured that indicators are same and consistent with the national monitoring and evaluation framework. Unlike health related MDGs however, this M&E framework will encompass the health system in its entirety with all its functions at different governance levels.

In order to manage the aid for better results, using a bi-pronged approach of intervening at donor and government level, following are the elements of this component of the framework:

- The interventions made into the health system for any of its functions are result-oriented and use indicators that are consistent with those selected for country's national policies and strategies.
- Country's capacity for setting up and operating monitoring and evaluation system be built and that M&E for a specific programme, project or intervention should link to the national M&E system.

5.5 Mutual accountability

Sudan receives a modest amount in assistance, yet accountability and transparency in its administration is a key to its acceptance and support by the people for the national policies and strategies. The accountability envisages also that value for money, whether from donor or from public sources, is realized. This underlines the importance of setting up participatory mechanisms for a greater role of communities and their elected representatives in the need identification, planning, managing and monitoring and evaluation of the programmes, project and interventions made in the public sector.

- While it is essential for the donor to provide timely and complete information on aid flow, the involvement of the common coordination platform in preparing and submitting such reports could cut the transaction cost and assist the country in developing budget.
- The common coordination platform can be used to periodically review the progress towards compliance with the covenants of Paris Declaration.

6 Methodology

This assignment is undertaken in three steps: (i) mapping the donors and their assistance vis-à-vis the government contribution; (ii) determining the effectiveness of health investments, including donors as well as by the government; and (iii) developing policy for improving aid effectiveness.

This section deals with how the mapping of the donors and their assistance vis-à-vis the government contribution was conducted. Other two steps are dependent on the findings of this mapping exercise.

6.1 Mapping of donors' assistance vis-à-vis the government contribution

At the national level Humanitarian Commission coordinates all aid that flows into the country, while at sectoral level in the Federal Ministry of Health, the Secretariat of International Health acts as a gateway. But, there could be a number of agencies, particularly national and international non-governmental organizations that do not coordinate with FMOH and work directly in states.

Also, while UN agencies like World Health Organization works in close collaboration with the FMOH and its plans for technical assistance are mutually agreed and implemented. Similarly, certain international organizations like Carter Foundation would work closely with FMOH for the eradication of guinea worm. But, many other agencies develop and implement workplans in their own authority, and FMOH is not closely involved. The situation with bilateral agencies like USAID, TIKA, JICA, SKICA, DFID, European Commission etc the FMOGH is often a passive recipient. Likewise, the international NGOs often respond to situation on ground and focus their activities on humanitarian assistance,

providing support in emergency relief and rehabilitation, mainly in three Darfur states and internally displaced people (IDPs).

Given the myriad of agencies and the manner they operate in different parts of Sudan with a focus on a variety of sector – and health is one. Also, within health sector these agencies have their preferences in terms of diseases, e.g. Malaria, Guinea Worm etc and the geographical areas, like many organizations would prefer working in Darfur, although similar rather higher level of poverty and suffering could be in other parts of the country. The health system, according to WHO has six building blocks: health service delivery; health information, medicines and health technologies, health financing, human resources for health, and leadership and governance. But, for example the GAVI and Global Fund till recently would focus on certain diseases. Likewise, whereas the government funding is skewed towards hospital care, the NGOs tend to work in primary care and certain special programmes, e.g. guinea worm eradication.

Therefore, in order to coordinate the activities in the health sector and to have a greater impact of investment it is intended to map the players working for health in Sudan.

6.2 Variables for mapping

The variables for this study are divided into four categories:

1. General
    1.1. The identity of aid agencies operating in Sudan (North)
    1.2. The type of agencies (e.g. bilateral, multilateral etc)
    1.3. The duration for which agency has been working
    1.4. Type of counterparts/collaborating partners
2. Area of expertise/specialization

2.1. Expertise and area of operation (health, agriculture etc)

2.2. Geographical location

2.3. Specific services provided

3. Capacity to support

3.1. Strength of organization

3.1.1. Financial

3.1.2. Human resource

3.1.3. Logistics

3.2. Major inputs into health sector

4. Compliance with Paris Declaration

4.1. Coordination structures (to work with counterparts)

4.2. Communication mechanisms within and without organization with counterparts

4.3. Planning process

4.4. Financial cycle – of government and aid agency

4.5. Strategies for health development

4.6. Aid administration mechanisms

4.7. Procurement procedures

4.8. Financial and performance audit

4.9. Technical assistance to building the capacity

4.10. Role in local capacity building

4.11. Monitoring and evaluation system

6.3 Data collection tools

Two sets of data collection tools are developed for: (i) government departments; and (ii) aid agencies. But, there is a significant overlap between the two questionnaires. This is due to the one being aid giver and the other as receiver, and *per se* both have signed Paris Declaration. These tools draw on the variables given above and the indicators identified in the Paris Declaration for monitoring the aid effectiveness and measuring compliance to different covenants of the declaration.

Both the questionnaires with slight variation had four parts as below:

1. General information
2. Area of expertise and collaboration in health sector
3. Capacity and planning/implementation cycle expressed in budgetary terms
4. Compliance of the agency to Paris declaration by measuring the indicators that form part of the Paris declaration

A complete set of questionnaire is available at **Annexure B** and **Annexure C**.

6.4 Study sample

The population for this study comprises two sets of respondents: (i) the government departments; and (ii) the aid agencies. The former include the Federal Ministry of Health; the State Ministries of Health for 15 Northern states and the health programmes at federal level. The latter will include the UN agencies, bilateral agencies, multilateral organizations, and national and international non-governmental organizations. A list of organizations maintained by Humanitarian Commission is available at **Annex A**.

All organizations included in the aforementioned list will be asked to provide data and fill in the questionnaire, meant for donor agencies. Likewise, the Federal Ministry of Health, the State Ministries of Health for 15 Northern states, and the health programmes at federal level will be asked to provide data and fill in the questionnaire meant for government counterparts.

6.5 Data collection – fieldwork

The Directorate General of International Health, Federal Ministry of Health requested the Humanitarian Commissioner to write a letter to all UN agencies and national and International organizations working in the health sector to fill in the questionnaire. This questionnaire was hosted on the website of the Federal Ministry of Health, and could be filled in online.

The Humanitarian Commissioner wrote a letter to UN agencies and national and International organizations working in the health sector. These organizations were requested to access the website of the Federal Ministry of Health and fill in the questionnaire and submit within the prescribed schedule.

Likewise, the questionnaire for the government organizations was also hosted on the website of the Federal Ministry of Health and the state ministries of health and different programmes were asked to fill in the questionnaire online and submit with the prescribed schedule.

6.6 National health accounts

The Federal Ministry of Health with support from World Health Organization is currently engaged in developing first national health account (NHA) for Sudan. The NHA is a framework for measuring total – public, private and donor – the expenditure on health at national level. Sub health accounts can also be

generated for sub national levels, like state and also for a specific disease, e.g. HIV/AIDS.

In order to construct NHA the flow of funds will be tracked through different entities: financing sources, i.e. who are funding health and include public (ministry of finance), private (households), and rest of the world (donors including UN agencies). These sources channel funds to financing agents. These agents in return provide (ministry of health) or purchase (health insurance) pay (household) for health services. In return to the payment, the providers (public and private) render different health services or functions (personal health care, preventive and public health, health administration and others).

Through this exercise for developing NHA, it will be possible to track funds and map entities involved in financing together with the amount or level of funding and provision of health services at national as well as sub national, i.e. state level. It will not be possible to have locality health accounts.

6.7 Data management and analysis

The data collected was both quantitative as well as qualitative. The quantitative data was tabulated and analyzed for different variables drawn from the indicators of this study.

For qualitative data, the common emerging themes were categorized according to the variable drawing on the indicators for measuring the aid effectiveness and progress towards implementation of Paris declaration. These were discussed and formed the tenets of the framework policy for aid effectiveness.

7 Findings

Out of the 64 non government agencies contacted to provide information on a standardized questionnaire, only 16 responded. Likewise, out of the seven UN agencies, only one agency responded.

Based on the information provided by the responding agencies, the findings from quantitative and qualitative data are organized following study variables, as below:

7.1 General

All the agencies were international organizations and were of multilateral in nature. More than half of the agencies established their operation after 2000, and the majority of those after 2004. There are some, mainly religious organizations, that existed before 2000, and oldest was here since 1946 followed by another in 1974 and 1978.

One agency worked exclusively with federal ministry of health, while another had counterparts from NGO sector. Almost half of the remainder agencies worked with state ministries of health, and about a quarter with both state and federal ministries of health. Only one agency worked at three levels: federal, state and locality of health sector.

Majority of the aid organizations work in the Darfur region or those parts of North Sudan, e.g. South Kodofan, Blue Nile and Kassala that are affected by civil war between Sudan People's Liberation Army/Movement and the government of Sudan in Khartoum. Only one of the agencies that responded worked in Khartoum state, and that also with the internally displaced peoples. Half of the agencies that reported worked in a single state in Darfur region, while others

operate in more than on states. One agency worked through health sector programmes: Sudan National AIDS, National Tuberculosis, and National Reproductive Health programme. Another agency worked through village health committees, which were set up as part of its interventions.

While all agencies that responded worked in the health sector, more than half worked exclusively in health. Out of the remaining half, the majority work, in addition to health, in water sanitation and hygiene and food and agriculture sectors. One of the respondent agencies, which is faith based, works in a variety of areas like health, water and sanitation, education, emergency response, agriculture, psychosocial and peace building, gender and capacity building. Within the health sector, these agencies provided a range of services, including primary health care, support to the midwifery schools.

7.2 Aid effectiveness

Following the covenants of Paris Declaration for aid effectiveness, this study found the following:

7.2.1 Coordination structure

The existence of coordination structures was reported by all the agencies. It comprises mainly weekly and monthly coordination meetings organized at federal and state level, depending on where the particular agencies operated and or their respective headquarter was. In some cases, at operational level, the village health committees were used as a coordination tool. For example, an agency noted:

> *At national and state level, weekly coordination meeting are held between health partners to discuss operational issues, emergency preparedness, gaps, procedures, etc… At the project level, regular meetings are held with village*

health committees to increase community participation and ownership of the project.

Likewise, another agency representative responded as below:

At the national level the country office is responsible for coordination with the federal ministry of health (through country director, program development manager and technical advisors); at the State level there is area coordination team which plays the key role of coordination and at the locality level the program unit team takes the lead; and at the community level, the community development committees participate through consultations and feedback.

This set up of weekly and monthly coordination meetings was used to update, collect and exchange information with the partners. In a number of cases, a technical agreement and or memorandum of understanding signed by the partners governed the coordination between parties and to outline and clarifying the respective responsibilities related to the services given to the people in need. Likewise, at operational level, for a number of agencies, the community development or village health committee governs the coordination mechanisms. For example, an agency reported:

The technical agreement signed with the state ministry of health and the humanitarian aid commission in state as well as national level forms the main guideline for the project and covers responsibilities, activities, goals, budgeting, etc.

Another agency had much comprehensive coordination mechanism, as seen from the below response:

A Technical Agreement signed on a yearly basis between the agency and State Ministry of Health stipulates the terms of collaboration between the two parties with clear roles and responsibilities. The Technical Agreement also stipulates

the roles and responsibilities of the national non-governmental organizations collaborating with international non-governmental organization.

The State Ministry of Health responsibilities include: provision of authority to implement activities in the identified areas of operation, facilitation of project implementation and joint monitoring activities, secondment of staff to agency facilities, participation in interviews during recruitment of new staff, provision of the treatment standards guidelines and protocols...etc.

The responsibilities of partner agency include: provision of the necessary personnel in accordance to the ministry standards, provision of incentives to the SMoH seconded staff. Provision of free services, submission of weekly surveillance reports, monthly, quarterly and final reports to the SMoH. Participation in the weekly coordination meetings and any other meetings called for by the ministry…etc.

Dialogue is maintained with SMoH through collaboration meetings or a one to one basis, depending on the need. The collaboration meetings are held at both, the state headquarters and field levels. The coordination meetings offer also a forum for enhancing partnership with other NGOs.

The agency signs also a partnership agreement with the national partners stipulating the terms of funding as well as the roles and responsibilities of each party during project implementation. It is the responsibility of the agency to build the capacity of the local partner and enhance close working relationship and collaboration through regular meetings.

7.2.2 Communication mechanisms

The weekly and monthly meeting was also used as a forum, as mentioned above, to exchange information and as a communication mechanism between different agencies operating at a particular level, federal and or state, and between agencies and the ministry, state or federal. The memos, emails, telephone, minutes of meetings, and sharing of regular reports were main means for communication. Within a specific agency, usual top to bottom as well as bottom up approach of communication was used. The former for conveying decisions and polices and the latter for feedback and reporting on the implementation monitoring. But, there seems to be no standardized mode of communication, as is evident from the following examples, an agency noted:

> *Communication between the two levels (national and state levels) is maintained through sharing of coordination meetings minutes, occasional visits by the National Team, especially represented by the FMoH and Cluster leads to the Sub-National level and vice versa and through joint training forums and monitoring visits.*

> *In South Kordofan State, there is the monthly coordination office chaired by the undp resident coordination office where all different sectors meet and share information. The health sector is led by the WHO.*

Another agency responded in a different note, however as below:

> *Face to face meetings, being a small organization we depend on close professional networking with key personnel with the SMoH in order to guarantee smooth project implementation.*

In another instance, following was the response:

> *The communication is usually done at each level based on the coordination structure…and also the technical advisors under the supervision of the program*

development manager coordinate the technical support at the federal, state and locality levels. This is in collaboration with the technical government officials at different levels of authority.

7.2.3 Joint body for policy guidance and monitoring

The above situation whereby there is disjointed communication system, it is due to the absent or non functional high level joint monitoring board/committee that could provide policy guidelines and for oversight assuring the effective coordination. This was confirmed by an agency as the following:

There is no official monitoring board existing, but the monitoring is usually done through participatory aspect (including Plan staff, MOH staff and community representatives), and it depends on the nature of the project. If the project is at the local level then the technical government official at that level will be part of the monitoring board for that specific project, if the MOH staff participated in that project then they will be part of the monitoring board also. In case the project or program is under the national umbrella, then all levels will be part of the monitoring board. In case of evaluation; usually there is an external body that will lead the process in addition to the other members of the board and HAC representative staff as well. During the annual participatory program review (APPR), there is an opportunity for each level to see the experience of the others at different levels and know what kind or programmatic work is going on. This meeting is conducted on annual basis and the participants are from all levels from different stakeholders, starting from community up to that of federal level.

But, contrary to the above, another organization observed, “Yes, there is a joint monitoring committee which compromises of members of various government ministries including the FMoH, SMoH and HAC”.

However, while some agencies would follow the national protocols and health sector guidelines at state level, another agency would look towards its own structure for policy guidance and monitoring of its activities, as is evident from the following:

> *Our HQ in … provides various support i.e. monitoring, evaluation, finance and narrative support including policy guidelines in the health sector and our work in Sudan which strongly reflect WHO standards. …*

7.2.4 Planning process

There seems to no single pattern adopted by the aid agencies for planning in the health sector. The modalities vary from some that follow national strategic plan and standards to those who undertake the needs assessment to the others who are guided by the coordination meetings, where issues are brought for discussion. The planning process is conducted either solely by the organization and or in consultation and partnership with fellow agencies and the ministries of health at state or federal level. The following examples would highlight this variation ion planning for health by the aid agencies.

> *We undertake needs-assessments (with MoH permission and participation) and, in conjunction with Health authorities, we find areas with greatest needs. When the situation changes or when need arises we adjust our programmes where possible.*

> *Preliminary remote assessments serve to identify potential areas in need of further investigation. In coordination with partners, an on-ground assessment is then conducted to identify needs and possibilities for intervention. In case of positive findings, a project proposal is then drafted and validated by all partners, prior to the start of any intervention*

In Darfur, the planning process is at two levels; one at the cluster level through the health and nutrition coordination forum where priorities for the year are identified collectively and each partner submit its plans and budgets based on the overall priorities. The other level of planning, is at the field level where needs are identified with involvement of the beneficiaries and plans/budgets formulated based on the actual scenario on the ground. In South Kordofan,it is based on the plan of the SMoH which includes the health sector priorities and gaps.

Based on strategic planning of FMoH, Identified priorities by SMoH, HAC, UN/Cluster leads, donors , results of assessments in field level and in coordination with community leaders/representatives the proposed activities are presented to partners and signatories of technical agreements for review, endorsement and approval, simultaneously submission of proposals to HQ level and communication with donors followed by provision of financial support for respective activities.

7.2.5 Aid administration

How the aid is administered by the aid agencies varies, and a range of options, including agency specific to a joint mechanism between aid agency and recipient organization, are exercised. The aid agencies work at different levels in health system, and there seems to be no set pattern adopted in Sudan. This inference is drawn from the following examples, illustrated by responses from different agencies recorded as below:

Funding is received from a number of donors. … is the main implementing agency. However, on the ground, close collaboration is established with village health committees (VHCs), who are given maximum involvement and ownership of the project as part of the administration of aid. As such, the VHCs are closely involved in such things as recruitment, planning, and development of facilities.

We have technical staff who partner with health officers and work together to improve the health service delivery in area identified by ministry of health

Each program unit (in the organization of the aid agency) has community development coordinators. They facilitate the process between community (ultimate recipient) and other implementers. After project approval, community representatives take responsibility of administrating the project in collaboration with the MOH authority and with the facilitation of planning staff. So generally the MOH authority provides the technical lead and actual implementation whereas the community and Plan facilitate the process.

Based on the value of identified needs for interventions and received financial support most cost effective and sustainable implementation model is used with aim to strengthen the capacity of MoH and community to cope with future implementation of health activities.

Donor funding provided to the agency is administered based on donor and agency financial protocols.

7.2.6 Guiding principles and strategies for health planning

The usual planning cycle is followed. Mostly, it starts with needs assessment to drawing priorities and then designing interventions as projects/programmes. Yet, there were others that were guided by their headquarters and agency specific priorities. Only few aid agencies mentioned that in their planning process, they would be guided by the national health policy or national health sector strategic plan. The following examples will elaborate how the health planning is undertaken:

Guidelines of (State) MoH, needs-assessments and feedback of beneficiaries and communities guides us in developing our plans and proposals

In Darfur is guided by the humanitarian needs (gathered through assessments/surveys) in the targeted communities and observations lessons learnt during the implementation of the activities in the previous year. In South Kordofan State, (the planning process) is guided by the south Kordofan State Five Years Plan, and the Ministry of Health Planning document.

The community development plans and MOH consultations … are the main guidelines to develop Plan's health program. There are also strategic documents such as Country Strategic Plan (CSP), Country Program Outlines (CPOs) and operational plan (annual planning) that guide the program development. These documents also developed based on the consultation with different level (National, State, local).

Strategic objectives of Federal and State Ministry of Health, situation on ground and identified priorities by communities, signatories of technical agreement and readiness of partners and donors to support presented activities in health sector

Health development planning is a continuous process. After a health program is initiated, activities are discussed and prioritized with the State Ministry of Health. Local Village Health Committees are formed and Community Health Workers are trained to help educate communities on health services. In consultation with these stakeholders, services and activities are planned, executed, evaluated, and sustained with consideration of donor resources, institutional capacity, and security access.

7.2.7 Selection of indicators for monitoring and evaluation

Different agencies used indicators of their choice. That is, there wasn't a uniformly agreed set of indicators for monitoring and evaluation of donor assistance. Some agencies used indicators drawn on the ministry of health indicators, while others devised their own. Yet, others were guided by WHO (and other agencies, e.g. UNICEF) requirements for reporting morbidity and mortality. There were some agencies that used indicators provided by their principals (donors). The following examples will elaborate this diversity in the selection and use of indicators for monitoring and evaluation.

> *Sources of indicators used for monitoring include: - MoH-indicators; - SPHERE Minimum Standards (as appropriate in the context of the programme); - standard indicators from our donors; - indicators chosen by our INGO to use for Monitoring and Evaluation*

> *The following 5 indicators are used to monitoring programming: a) The number of patients benefiting from curative services; b) The number of women benefiting from ANC per week; c) The number of persons vaccinated per week; d) The number of home visits per week; e) The number of persons informed about health issues per week.*

> *There are two levels of indicators used for the monitoring, at the project level (short term), there are specific project indicators developed based on the technical design and the situation at the start of the project, and at the program level (long term) there are the CPO indicators and Country indicators which are developed based on the last cycle of the CPO evaluation and the secondary data. So the evaluation and the secondary data are considered as the main source for the indicators.*

Indicators used are derived from the Federal Ministry of Health, WHO, UNICEF, institutional donors, and Sphere standards.

All our projects are linked to a yearly logical framework including objectively verifiable indicators. Based on expected results, medical indicators are formulated (i.e. >85% measles vaccination coverage for children < 5 years old, CMR<1/10,000/day, U5CMR<2/10,000/day…) and monitored on monthly basis through medical reports done by the field.

7.2.8 Monitoring and evaluation system

There seems to have been no organized effort by the donor agencies for devising and operating a standard monitoring and evaluation system. Instead, like the selection of indicator, each agency devised and adopted its own system for monitoring and evaluation. While some agencies have elaborate system, others are building their system. Also, there seems no endeavor on behalf of aid agencies to harmonize their system with that of the national counterparts. This assumption is clear from the following responses, which are picked as representative.

The implementation of health and nutrition are monitored at various levels to ensure earmarked resources are used for the intended purpose which is primarily to quality services to the intended beneficiaries. Health and Nutrition Officers supervise/monitor activity implementation at the clinic level on daily basis; the Health and Nutrition Officers are supervised by the Medical Officers who reports to the Health and Nutrition Supervisor at the field level. The Health and Nutrition Manager in turn provides supervision to the entire health and nutrition sector and provides the necessary technical, administrative and programmatic support accordingly. The Health and Nutrition Manager is in turn supervised by the Head of Program who reports to the Director. Monitoring field visits are undertaken by the Health and Nutrition Manager, Head of Programs and the

Director, either together or separately on regular basis. The donors also visit project areas occasionally to monitor activity implementation. The SMoH monitors closely activities implementation at the field level and undertakes regular joint monitoring missions on quarterly basis. … provides monthly, quarterly and annual activity implementation reports to the SMoH, HAC, OCHA and Donors.

From the perspective of INGO, we make sure that our plans are published through the UN-Workplan and updated progress reports are given to the Health Sector mechanism and to our individual bilateral donors regularly.

The technical government authority (MOH), usually participate in the planning process and present the budget which is supported by plan in the specific geographical area. Most of the implementation is done by the government officials under the direct supervision of the MOH. They are supported by the community volunteers and representatives. Moreover there is annual and biannual report submitted to HAC on regular basis which contains the detailed information about the projects\programs. Then all parties are taking the accountability to monitor the project\program since they are participating in the planning, monitoring and implementation.

Administration of aid is monitored by regular monitoring/evaluation of implementation of activities, shared results and progress flow with community representatives, UN/INGO/NGO partners, signatories of Technical Agreement, Emergency Committee in state level, local authorities, internal audit, donors visits and external audit. Joint assessments/surveys conducted with participation of Officials from Government and respective Ministries technical staff members. Reports shared with above mentioned entities

7.2.9 Effort at national capacity building

Sudan having been through a long conflict and in chronic emergency which is attended periodically by acute emergencies it is important the aid agencies build national capacity to enable it plan, manage, and account for the achievements of the objectives. For this, the aid agencies have to harmonize their efforts. But, from the responses received from agencies for the question, what technical assistance was provided to strengthen the recipient's financial and accounting system, it is unclear whether there was any such effort. For example, the responses from different agencies are:

> *… Staff provides capacity building to … in terms of accountancy and logistics, such as monthly support in closing and controlling the accountancy, validation of expenses before purchase, etc.*
>
> *In most cases Plan provides the financial support for the community health workers and community leader's capacity building, and the MOH takes the responsibility of providing the technical support for the recipients. As well, other public sectors such as universities and institutions contribute.*
>
> *The present donor does not allow any capacity building / strengthening of recipient accounting – finance system. However and as contribution of sustainability, revolving funds have been established at some of the primary health care units. A small fee is charged for each visit which then goes into a fund, which then is used – possibly later used to pay for various running costs not covered by MoH*
>
> *As medical support is given directly to the targeted population, there is no exchange of money between our beneficiaries and our organization. All support is given as a service to the population and therefore doesn't need a strengthening of the recipient's financial and accounting system.*

7.2.10 Financial and accounting and procurement procedures

It is desirable to rely on and to the extent possible use recipient country's budget and accounting mechanisms and procurement procedures. In this manner, the capacity of the financial and accounting and procurement system of the recipient country would be built. However, in the survey conducted, all aid agencies that responded used their agency specific procedure, be it the budget and accounting or procurement system. The financial reports generated are also not shared with the host government. In the following are some representative responses:

> *… (Agency's name) follows Swiss accounting procedures with annual external audits and is ISO9000 compliant*

For another agency the system was like:

> *Monthly accountancy reports prepared at mission level*
> *Budget follow-up prepared at HQ level*
> *At end of budget year, audit done at HQ level*
> *Additional audit and accounting procedures according to donor requirements*

Likewise, another agency reported as below:

> *1. The organization has introduced worldwide guidelines for its representations accessible through web for anyone to look at and benefit from.*
> *2. Each representation has local financial and administrative guidelines to cater for any situations or particular issues which are country/regional specific.*

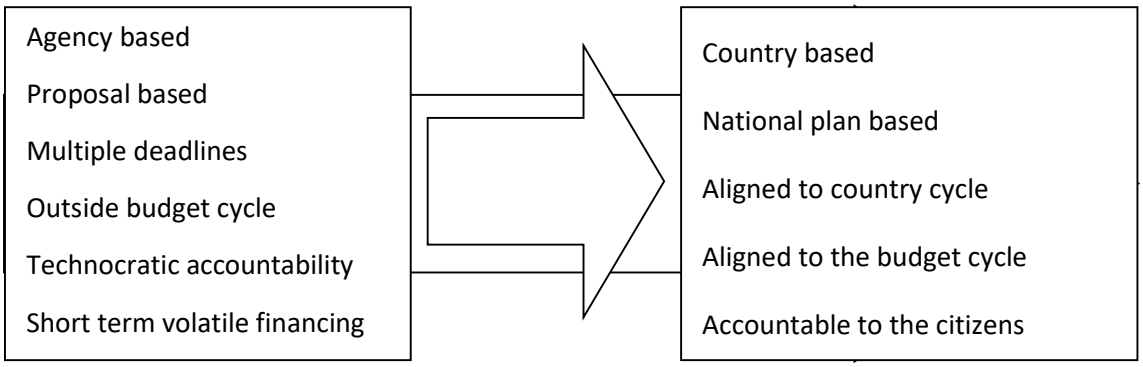
Not different was the case with another agency, which was following its principal's procedures.

Country of origin agency specific admin and finance procedures designed to satisfy country of origin accounting procedures

8 Discussion

The developed nations, on the pretext that developing countries cannot, from their own resources, achieve the MDGs, committed in the Millennium Declaration to provide development assistance, particularly in the area of health and to reduce poverty. However, it is equally true that aid has not been effective in achieving efficiently its objectives. That is, it underperforms, due mainly to it being un-coordinated, fragmented and overlapping, and above all it is also believed by many that aid does not lead to sustainable results. Nevertheless, there is a need for improved aid effectiveness, but for that a paradigm shift is required.

Aid effectiveness – a paradigm shift



That is, the aid, hitherto agency based presented as a standalone proposal, should follow the country's national plan. Furthermore, instead of the multiple deadlines given by different aid giving agencies for different plans, these should be aligned to the country's planning cycle. This alignment should extend to financing mechanisms, i.e. instead of short term volatile financing it should be planned well ahead and aligned to the country's budgetary cycle. Accordingly, in

order to bring in the above paradigm shift in aid administration, at a High Level Forum on Aid Effectiveness, the ministers of developed and developing countries and heads of the multilateral and bilateral development institutions, resolved on 2 March, 2005 as Paris Declaration for Aid Effectiveness to reform the way the aid is delivered and managed.

In the following we will discuss how efficiently the aid is delivered and managed in Sudan, but first we look at the nature of the aid agencies. This study found that majority of the aid agencies landed in this country around 2004, following the Darfur crisis. **NB**: since the southern states are not included in this study, the aid agencies working in that part of the country are not accounted for. Those agencies that were present since 2000 and continued their existence in addition to working Darfur region had their presence in Blue Nile, South Kordofan and Kassala. These areas are affected by the civil war between Government of Sudan and Sudan People's Liberation Army/Movement. The aid agencies in the northern states, from the data available, prior to 2000 and the major influx of aid agencies in 2004, were religious in nature, mainly from church.

Sudan receives foreign assistance, but there seems to be problems of the efficiency and effectiveness of this aid. These problems are both from the aid agency as well as from the government in receipt of the aid. Drawing on the findings of this study in the following we discuss the extent to which the covenants of Paris Declaration are adhered to in Sudan.

In order for the aid to be aligned with country's systems, there are a number of pre-requisites. The support should be in line with country's national policy and development strategies. However, in case of Sudan, not many agencies followed

this principle while planning their aid. Many followed own or their principal's priorities, but others were guided by the national strategic plan. The need assessment was often conducted jointly by the aid agency and the recipient, i.e. ministries of health, although there were instances where the agencies worked on their own. For example:

> *Based on the assessment carried on by our teams and health indicators (i.e. morbidity rate, mortality rate, vaccination coverage, access to safe water…), programs are proposed to headquarter in …. Within a certain limit of time, if indicators are not showing good results, a feasibility study is then carried on and a proposal for an intervention is done. If the program is agreed by headquarter, a proposition is given to the Ministry of Health and to respective authorities at federal, state and local level. If agreed by authorities, coordination team in Al Fasher with the help of the Khartoum support base is responsible to start and to develop the program according to the objectives set by the project documents.*

The above situation can be attributed to aid agencies as well as to the government. While the latter did not brought in place systems, the former were, in order to show their efficiency, forced to continue to work on their agenda. Both the donor and the country should have worked together for designing a performance assessment framework for country's systems, institutions and procedures involved in managing aid. The results of this assessment would have in turn guided the interventions.

As a result at a number of instances there was a joint assessment, but what guided this assessment was unclear. Such an assessment of the country's systems, institutions and procedures involved in managing aid, would have led to defining of needs, particularly for capacity building, within the remits of national strategies for capacity building. That is why; this study did not find tangible

efforts by the aid agencies for capacity building at different levels of the health system.

Capacity building can be at systemic, organizational and at individual levels. While a number of respondent agencies invested in the training of individuals, there was not much done at organizational and systemic level. The weak organization and systems perpetuated that led to the aid agencies contrary to the covenant of Paris Deceleration did not use country's systems, institutions and procedures. As otherwise, using the country's systems, *albeit* with certain additional safeguards, would have assisted in capacity building. Specifically, there was not, in a single case, that donors used country's budgeting and accounting system. Instead, they designed their own processes, which are quite elaborate, as is evident from the following example.

> *The country finance team consists of an expatriate Finance and Admin Director, one national Senior Finance manager, 2 national Finance Managers and site-based national Finance Officers. The country finance team works under close support and guidance of the HQ-based finance desk officer. … uses the ACCPAC accounting system. … has a rigorous internal control system which serves as the foundation of our field program and financial management. Internal controls are in place to ensure a visible mechanized system, ensuring that every cost to be incurred is aptly documented as being allowable, allocable and necessary for both program and project implementation. Given specific country contexts, … may need to tailor its policy and procedure manuals to meet the specific program needs. These modifications are reviewed and approved directly by …'s Field Comptroller and …'s VP of Finance. The Finance and Admin Director meets with the department heads (Operations) to discuss monthly pipelines, including monthly expenses, cash flow needs, sub-grantees, contract funding, staff requirements, and all program needs. The department heads address any issues that might arise during the previous month and plan*

for the upcoming periods. These meetings are a precursor to the Sr. Management meetings between the Sr. Management in the country office and department heads.

Similarly, there were no efforts by any aid agency in developing and strengthening the country's system for procurement; they installed their own procedures, as is seen from a response by an aid agency:

The budget is released under the supervision of the technical and finance department in the organization. Generally there should be initial request by the community and it should be approved by the authorized person. If this request is for equipment or construction, then there should be technical specification from the technical department in the government authority. Based on the amount of goods or services the quotation and procurement will be done by the purchasing committee from the recipient's representatives facilitated by Plan staff. Then the selection of the vender will depend on the application and specifications made before for the goods and the purchasing committee will screen the applicants and select the winner and notify him to deliver the services within specific period in specific location. When the vender delivers the good it should be checked by the technical person to ensure that it meets the specification identified in the quotation. In some case the services itself is delivered by the technical department from the government. In this case the community requests the services. Then after the approval of the services, the community committee will make an agreement with government department to deliver the services and after the service delivery and then committee will give good receiving note to the person who delivers the service and this note is one of the main documents to release the budget for the service provider.

The study showed that there is no results-oriented framework to guide the monitoring of health sector performance, and there was no formal independent way of assessing impact of sector support, although some agencies organized some systems for performance monitoring and evaluation. But, for such a system to design and install the country should have taken the lead. However, it is still struggling for establishing such a system. The donors have assisted, but their efforts were directed to establishing parallel system, thus fragmenting the already weak monitoring and evaluation system.

But, the core issue lies at the coordination and communication between, within and without, particularly with government partners. There is no uniform and standardized system for coordination and guidelines on communication. It comprises mainly weekly and monthly coordination meetings organized at federal and state level, depending on where the particular agencies operated and or their respective headquarter was. In some cases, at operational level, the village health committees were used as a coordination tool. The sharing of the minutes of these meetings is considered as a means of communication between the agencies and the government partners.

9 Conclusions

In Sudan health sector, donor spending as a percentage of total health expenditure in 2006 was 6.40% compared with the Sub Saharan African average of 22.39% and the lower middle income group average of 11.13%[4]. However, most of this assistance is dedicated to humanitarian assistance, leaving little for the recovery and rehabilitation of health services. There is almost negligible input in development, and even from government it is directed at the urban areas and mainly for tertiary care.

Notwithstanding the amount of development assistance it s delivery and management is flawed. The aid agencies operate with inadequate and weak coordination mechanisms and communication structures. The planning of input into the health sector is situation based and ad-hoc. This is primarily due to, there is no comprehensive plan for rehabilitation and development, covering all aspects of the health system[5], at any level in the hierarchy, and the aid agencies have not exerted enough to develop such a plan or build the capacity of the ministries of health, national as well as state or locality health administration, to develop on their own. The ripple effect of this situation is that there is no agreed common framework for monitoring and evaluation and accountability.

The government, i.e. the ministries of health at national and state levels has to take the lead and the aid agencies, particularly the UN agencies, in drawing a

[4] *ibid*

[5] The components of the health system are: health care delivery, human resources for health, health information, health financing, medicine and other health technologies, and leadership and governance

common framework for aid effectiveness following the covenants of the Paris declaration. The ministry of humanitarian affairs, together with the ministry of finance and national economy, has a pivotal role in coordinating this process, while federal ministry of health has to perform proactively.

That is, in essence, for the aid to be delivered and managed effectively and efficiently, it is imperative to develop a plan with an overall aim to harmonize and rally donors around a nationally organized and agreed framework linked to the measurable results and plans for scaling up health services in the government leadership. This is discussed in the next section.

Annexure A: List of Organizations and Development Agencies Working in Sudan Health Sector

9.1 UN agencies

1.	World Health Organization. WHO
2.	United Nations Children Fund. UNICEF
3.	United Nations Population Fund. UNFPA
4.	UNDP - United Nations Development Program
5.	United Nations Educational, Scientific, and Cultural Organization (UNESCO)
6.	World Food Program .WFP
7.	World Bank

9.2 International organizations – bilateral

1.	Turkish International Development Agency (TIKA)
2.	US Agency for International Development (USAID)
3.	Japan International Cooperation Agency (JICA)
4.	South Korea International Cooperation Agency
5.	European Commission
6.	Department for International Development (DFID - UK)
7.	Egyptian Mission

9.3 International organizations – multilateral

1.	Islamic Development Bank (IDB)

9.4 International non-governmental organizations

1.	Médecins Sans Frontières - Belgaum
2.	Médecins Sans Frontières -Spain
3.	Médecins Sans Frontières -Swiss
4.	Humedica
5.	Planned Parenthood
6.	GLRA
7.	Near East Organization
8.	CONCERN
9.	Emergancy-Italy
10.	Samaritan's Purse International
11.	Malteser International
12.	Fellowship of African Relief .FAR
13.	Medair
14.	Médecins du Monde. MDM
15.	Patients' Help Fund .Kuwait
16.	Infants Du Monde
17.	AMI *(*Association Montessori Internationale)
18.	Cymbidium Orchid Society of Victoria (COSV)
19.	International Medical Corps
20.	OVCI (Offshore Voluntary Compliance Initiative)
21.	Plan

22.	DATA
23.	Vision World Charity Organization
24.	Medical Aid Commission
25.	Elnusra Charity Organization
26.	Maarij Charity Organization
27.	World Vision
28.	Nordic Charity Aid
29.	RELIEF International
30.	Services along the Nile International
31.	Islamic Relief
32.	Tear Fund
33.	Cordaid
34.	Global Health Foundation
35.	Leprosy Mission
36.	IDRB
37.	Africa Humanitarian Aid (AHA)
38.	Mercy Malaysia
39.	Goal Ireland
40.	Saudi Red Crescent
41.	ACORD
42.	ALISEI
43.	Human Charity Organization
44.	Development Alternatives
45.	Global Hope Network
46.	Together For Sudan
47.	Adventist Development and Relief Agency Sudan (ADRA)

48.	Peace and Relief Organization
49.	Eritrean Red Cross and Red Crescent Association
50.	GOHANTEIR
51.	COPI
52.	Help Age
53.	Merlin
54.	Turkish Red Crescent

9.5 National non-governmental organizations

1.	Sudanese Red Crescent

10 Annexure B: Mapping Government's Progress on Compliance to Paris Declaration 2005

NB: this questionnaire is for completion by the government organisations receiving aid in their health related programmes/projects from the donors.

10.1 Part 1: General information

1. Organization name:

   ……

2. Category (please tick as appropriate): A. Federal Ministry of Hea ☐

   B. State Ministry of Health: ☐

   C. Health programme/project: ☐

   D. Other/allied health sectors (please specify, e.g. Ministry of Environment): ☐

---

3. Address (current):

   ……

……
……

4. Phone: ……..……
5. Fax: ……
6. Web address (if any):
   ……
7. E-Mail: ……..……
8. Contact/focal person (name):
   ……..……
   Phone: …….. E-mail: ……..…….

Instruction: in case the organization falls in category A, B or C go to part 3; and in case the organization is in category D, continue.

10.2 Part 2: Area of expertise and collaboration of organizations

Instruction: this part is for organizations in category 'D', i.e. allied to health sector, whose main area of work could be other than 'health'); the organizations in category A, B, and C go to Part 3.

1. What is organization's the main area of work? ----------
   ----
2. In case, the main area of work is 'other than health', does the organization work for health, directly or indirectly (e.g. provision of clean water and good

sanitation), please specify ----------

3. If response to question 2 is NO, i.e. organization is not involved in activities related to health, please don't respond to this questionnaire any further. If response to question 2 is YES, i.e. organization works for health, directly or indirectly, continue.

4. Whether organization for its work related to health collaborates with following? (Please tick √ as appropriate, and there can be multiple responses)

   a. Federal Ministry of Health: ☐

   b. State Ministry of Health: ☐ Which states? (Please provide details) ----------

   c. Locality health administration: ☐ Which localities? (Please give details) ----------

   d. Other (government medical and health institutions): Please give details) ----------

e. Other (private sector medical and health institutions/organizations): Please provide detail— ----------
---

---

5. Is there a formal mechanism by which you collaborate and coordinate with partners (identified in the above question)? Please (tick √): ☐ ----

6. If response to the above question is 'yes' please explain using the below guideline:

   a. What coordination structures exist at various levels, and what are their memberships, existing ground rules, TORs, scope of responsibility and decision-making processes? Please provide detail—----------
   ---

   ---

   b. What are communication systems within and between coordinating bodies at national and sub-national level? Please provide detail—----------
   ---

   ---

   c. Is there any high level joint monitoring boards/committee responsible for policy guidance and for overseeing/assuring effective coordination? Please give detail: ----------

---

NB: more pages can be added, and in that case please indicate in the questionnaire and refer to the question number in the additional notes.

10.3 Part 3: Capacity and planning/implementation cycle

Instruction: for organizations in category 'D', please provide the budgetary/ expenditure figures that are related to its work on health, directly or indirectly.

1. What is the organization's budget cycle?
   a. Biennial: ☐
   b. Annual: ☐
   c. Other (please specify): ☐

---

2. What was the total budget, from its own sources, for the last financial plan/year (specify, e.g. 2007-8) ….SDGs
3. What was the major budget lines/expenditure, **from its own sources**, with amounts for the last financial plan/year?

Category	**Budget items**	**Amount allocated**	**Amount spent**	**Comments**
Capital	Building (construction)			
	Equipment			
	Vehicle			
	Supplies (drugs etc)			
	Services (technical			

Category	Budget items	Amount allocated	Amount spent	Comments
	assistance)			
	Other			
Operational	Staff cost • International • National			
	Communication			
	Office rent			
	Travel (local and international)			
	Services (bills etc)			
	Repair and maintenance			
	Other misc			

NB: please add row if some expenditure type/budget item is not covered.

4. What is major budget lines/expenditure, **from its own sources**, with amounts for the current/ongoing plan?

Category	Budget items	Amount allocated	Amount spent	Comments
Capital	Building (construction)			
	Equipment			
	Vehicle			
	Supplies (drugs etc)			
	Services (technical			

Category	Budget items	Amount allocated	Amount spent	Comments
	assistance)			
	Other			
Operational	Staff cost • International • National			
	Communication			
	Office rent			
	Travel (local and international)			
	Services (bills etc)			
	Repair and maintenance			
	Other misc			

NB: please add row if some expenditure type/budget item is not covered.

5. What was total amount **received from donors** in the last financial plan/year (specify, e.g. 2007-8) ….SDGs

6. What was major budget lines/items **received from donors**, with amount in the last financial plan/year?

Category	Budget items	Amount allocated	Amount spent	Comments

Category	Budget items	Amount allocated	Amount spent	Comments
Capital	Building (construction)			
	Equipment			
	Vehicle			
	Supplies (drugs etc)			
	Services (technical assistance)			
	Other			
Operational	Staff cost • International • National			
	Communication			
	Office rent			
	Travel (local and international)			
	Services (bills etc)			
	Repair and maintenance			
	Other misc			

NB: please add row if some expenditure type/budget item is not covered.

7. What is the major budget lines/items **received from donors**, with amount in the current financial plan/year?

Category	Budget items	Amount allocated	Amount spent	Comments

Category	Budget items	Amount allocated	Amount spent	Comments
Capital	Building (construction)			
	Equipment			
	Vehicle			
	Supplies (drugs etc)			
	Services (technical assistance)			
	Other			
Operational	Staff cost • International • National			
	Communication			
	Office rent			
	Travel (local and international)			
	Services (bills etc)			
	Repair and maintenance			
	Other misc			

NB: please add row if some expenditure type/budget item is not covered.

8. What were major areas of expenditure (based on health system components), **from organizations sources**, with amount in last financial plan/year?

Expenditure Category	Expenditure areas	Amount allocated	Amount spent	Comments
Capital	Governance and leadership of health system			
	Health service delivery			
	Supply and management of medicine and technologies			
	Health information system			
	Human resources for health			
	Sustainable financing of health services			
	Other misc			
Operational	Governance and leadership of health system			
	Health service delivery			
	Supply and management of medicine and technologies			
	Health information system			
	Human resources for health			
	Sustainable financing of			

Expenditure Category	Expenditure areas	Amount allocated	Amount spent	Comments
	health services			
	Other misc			

NB: please add row if some expenditure type/budget item is not covered.

9. What are the major areas of expenditure (based on health system components), made **from donor aid**, with amount in the current financial plan/year?

Expenditure Category	Expenditure areas	Amount allocated	Amount spent	Comments
Capital	Governance and leadership of health system			
	Health service delivery			
	Supply and management of medicine and technologies			
	Health information system			
	Human resources for health			
	Sustainable financing of health services			
	Other misc			
Operational	Governance and			

Expenditure Category	Expenditure areas	Amount allocated	Amount spent	Comments
	leadership of health system			
	Health service delivery			
	Supply and management of medicine and technologies			
	Health information system			
	Human resources for health			
	Sustainable financing of health services			
	Other misc			

NB: please add row if some expenditure type/budget item is not covered.

10.4 Part 4: Compliance to Paris Declaration

NB: Paris declaration binds both donors as well as partner countries in receipt of aid, to all its covenants, concerning ownership, harmonization, alignment, results and mutual accountability, for assuring aid effectiveness.

The following questions are for the organizations (all categories, whether A, B, C or D) that are in receipt of the aid in order to assess their compliance to different covenants of the Paris declaration.

1. What is the framework (e.g. health policy, strategic plan etc) used for guiding the assessment of health needs as the basis for planning health interventions/reforms supported through aid? Please elaborate!----------
2. How the assessment of performance by different health system components (health service delivery, supply management of medicine and technologies, human resources for health, health information system, sustainable financing of health services and governance and leadership) is done? Please elaborate for each!----------
3. What is the process for planning health interventions? Please elaborate, including on how and who sets priorities!----------

---

---

4. What measures are taken and what mechanisms are there for building the capacity of the organization (in receipt of aid) to effectively utilize donor's assistance? Please elaborate, with particular reference to organization's capacity in financial management and procurement and supplies management!----------

---

---

5. How the organization assures that while planning for health, identified health needs and the results of performance assessment are taken into consideration, i.e. all health needs (epidemiological, demographic etc) and all components of health system get equal attention in all geographical regions of the country? Please elaborate!----------

---

---

6. While planning for health interventions, how organization assures complementarity of its own resources with that of donor's assistance? Please elaborate!----------

---

---

7. While planning for health interventions, how organization assures complementarity of its input (from donors as well as from its own sources) between different regions of the country? Please elaborate!----------
---

---

8. While planning, how organization assures complementarity of interventions from donors as well as from its own sources for health development? Please elaborate!----------
---
---

9. How is the administration of aid to the country monitored, in terms of performance, transparency and accountability? Please elaborate! ----------
---

---

10. What indicators are used for monitoring the performance of aid? Please elaborate, with particular reference to how the indicators are selected and the mechanisms for measurement!----------
---

---

11 Annexure B: Mapping the donor's Progress on Compliance to Paris Declaration 2005

11.1 Part 1: General information

1. Organization name:

   ……

2. Category (please tick as appropriate):

   a. UN agency ☐
   b. National Non-Governmental Organization: ☐
   c. International Non-Governmental Organization: ☐
   d. Governmental agency: ☐
   e. Other (please specify, e.g. GF): ☐

---

3. Presence in Sudan (please write the year when it was established):

   ……

4. Address (current):

   ……

5. Phone: ……

6. Fax: ……

Web address (if any):

……

7. E-Mail: ……

8. Contact/focal person (name):

   ……

   Phone: …… E-mail: ……

11.2 Part 2: Area of expertise

1. Sector the organization works with (health, agriculture, education, culture etc.): ---------- ---------- (respond as appropriate, and there can be multiple responses)

NB: The purpose of this question is to determine the specialized area, the responding organization works and is engaged in Sudan.

2. If not health, does the organization collaborate with health sector (tick √): ☐

3. If response to the above question is 'yes', then in what way: ----------

---

NB: if response to above question is 'no', please do not respond to this questionnaire and don't fill it any further.

4. Does the organization collaborate with? (Please tick as appropriate, and there can be multiple responses)

   a. Federal Ministry of Health: ☐

b. State Ministry of Health: ☐ Which states? (Please provide detail)

---

c. Locality health administration: Which localities? (Please provide detail)

---

d. Other (public sector medical and health institutions): Please provide detail)

---

e. Other (private sector medical and health institutions/organizations): Please provide detail— ----------

---

---

5. Is there a mechanism by which you collaborate and coordinate with partners (identified in the above question)? Please (tick √): ☐

6. If response to the above question is 'yes' please explain using the below guideline:

   a. What are the existing coordination structures at various levels, membership, existing ground rules, TORs, scope of responsibility and decision-making processes? Please provide detail—

---

   b. What are the communication systems within and between coordinating bodies at national and sub-national level? Please provide detail—

---

   c. Is there any high level joint monitoring boards/committee responsible for policy guidance and for overseeing/assuring effective coordination? Please provide detail—

NB: more pages can be added, and in that case please indicate in the questionnaire and refer to the question number in the additional notes.

11.3 Part 3: Capacity and planning/implementation cycle

1. What is the budget cycle for the organization?

   a. Biennial: ☐

   b. Annual: ☐

   c. Other (please specify): ☐

2. What was total budget for the last financial plan (specify year, e.g. 2007-8) ….US$

3. What was major budget lines/expenditure with amount for the last financial plan?

Budget items		**Amount allocated**	**Amount spent**	**Comments**
Capital				
	Building (construction)			
	Equipment			
	Vehicle			
	Supplies (drugs etc)			
	Services			

Budget items		**Amount allocated**	**Amount spent**	**Comments**
	(technical assistance)			
	Other			
Operational				
	Staff cost International National			
	Communication			
	Office rent			
	Travel (local and international)			
	Services (bills etc)			
	Repair and maintenance			
	Other misc			

4. What is major budget lines/expenditure with amount for the current/ongoing plan?

Budget items		**Amount allocated**	**Amount spent**	**Comments**
Capital				

Budget items		**Amount allocated**	**Amount spent**	**Comments**
	Building (construction)			
	Equipment			
	Vehicle			
	Supplies (drugs etc)			
	Services (technical assistance)			
	Other			
Operational				
	Staff cost International National			
	Communication			
	Office rent			
	Travel (local and international)			
	Services (bills etc)			
	Repair and maintenance			
	Other misc			

11.4 Part 4: Compliance to Paris Declaration

1. What is the planning process for health interventions? Please elaborate! -------
   ---

   ---
2. How is the aid administered to the health sector? Please elaborate the process! ----------
   ---

   ---
3. What guides the developing of plans for health development? Please elaborate! ----------
   ---

   ---
4. What is the source of indicators used for monitoring the plan? Please elaborate! ----------
   ---

   ---

5. How the administration of aid to the country is monitored, in terms of performance, transparency and accountability? Please elaborate! ----------
---

---

6. What is the technical and other assistance provided to strengthen the recipient's financial and accounting system? Please elaborate, explaining also in what way! ----------
---

---

7. What financial and accounting procedures (government or agency specific) are used in administering aid? Please elaborate! ----------
---

---

8. How much aid was administered during the last plan through recipients' financial channels, and how (e.g. budget support, Swap etc)? ----------
---
---

9. How and using what procedures are used for financial and performance audit of the aid disbursed to the recipient? Please elaborate! ----------
---

---

10. What procedures are used for the procurement of (tick √ as appropriate)?

Item	**Recipient's procedures**	**Agency's procedures**	**Comments**
Goods (drugs)			
Goods (equipment)			
Services (technical assistance)			
Civil work (construction)			
Others			

11. What is the technical and other assistance provided to strengthen the recipient's procurement and supplies management system? Please elaborate on all types of procurements! ----------
---

---

12. What is the commonly used management structure for aid administration (tick √ as appropriate)?

a. Agency's structure

b. Recipient's structure ☐

c. A specially developed structure ☐

d. Joint implementation: please elaborate ----------

e. Other: please elaborate ----------

13. How is the aid linked in terms of timing/period to the recipient's financial cycle? Please elaborate ----------
---

---

14. What consideration is given in planning interventions and making inputs for health development to other partner's, including recipient's inputs? Please elaborate ----------
---

---

15. What mechanisms are brought in place during planning and implementation for assuring the complementarity of aid, geographically and programmatically, between different agencies working in health sector? Please elaborate ---------
---

NB: this question is meant to avoid duplication and to compliment input from other partners, including the government, for efficient utilization of resources from different sources.

16. How and in what manner monitoring of aid (e.g. launching of common monitoring missions) is coordinated with other partners providing support in health development? Please explain ----------

---

---

17. What is the mechanism for monitoring of aid administration (please tick √ as appropriate?

    a. Agency's specific ☐

    b. Recipient's specific ☐

    c. A specially developed system ☐

NB: in case of specially designed system, please elaborate ----------

---

    d. Joint implementation: please elaborate ----------

e. Other: please elaborate ----------

18. Whether any mechanisms are in place in the aid community (in Sudan) to learn lessons from each other experience of aid administration? If yes, please quote one example concerning your agency ----------
---

---

19. Is there coordination between different aid agencies or a common arrangement, working for health development for the following (please tick √ if yes):

a. Planning ☐

b. Financing ☐

c. Disbursement ☐

d. Monitoring ☐

e. Evaluating ☐

f. Reporting ☐

NB: in case of yes to any of the above questions, please explain how the coordination and common arrangement, in each particular area has been working? ----------
---

---

a One way of While the other components of the framework for aid effectiveness are it has implications for

---

Who are the donors? Are UN agencies donors?

How to apply the framework for donor assistance channeled through UN?

Which donors the framework is applicable? Bilateral, multilateral, international nongovernmental organizations, national nongovernmental organizations

What is the eligibility of donors to work in the health sector?

Registration with HAC for INGO and GNGO, with foreign ministry for Bilateral, multilateral, including UN agencies

Harmonization for creating synergy and complementarity of input including aid – a real agenda