



German Foundation for World Population (DSW)

HEALTH SPENDING IN INDIA

THE IMPACT OF CURRENT AID STRUCTURES AND AID EFFECTIVENESS



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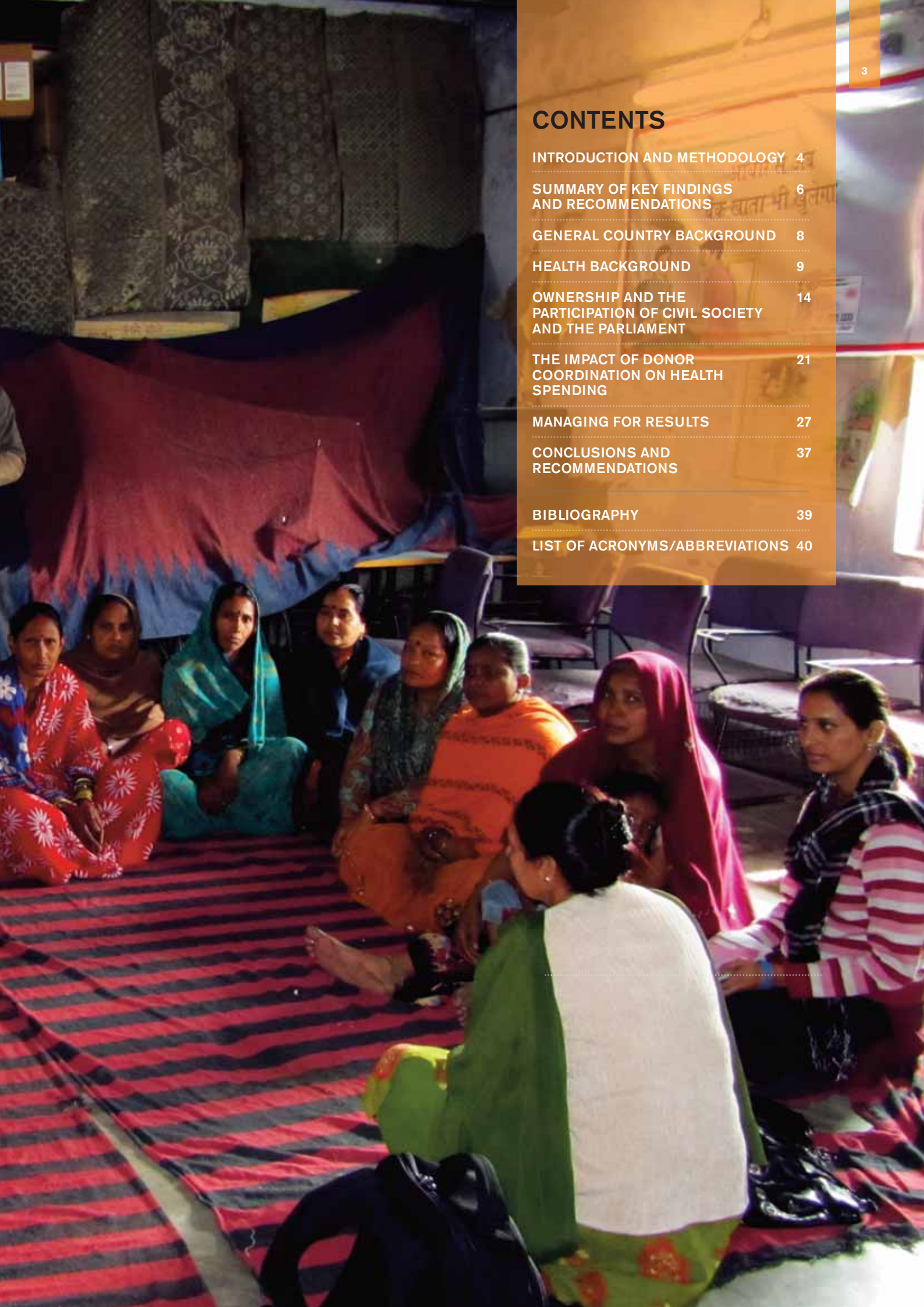
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Front Cover Photograph: Indian doctor in Mother and Child Hospital. Photo: DSW

Page 2 Photograph: Women's group in village outside the Indian capital, New Delhi. Photo: DSW

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INTRODUCTION AND METHODOLOGY

BACKGROUND AND METHODOLOGY

In recent years the EU has shown positive commitments to reforming its external aid instruments according to aid effectiveness principles established by the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008) – in particular to increasing ownership of developing countries development assistance.

However, during the very same period of time, key social sectors such as health have suffered significant decreases and gaps in EU funding. Official Development Assistance (ODA) spending in health worldwide decreased by USD124 million between 2006 and 2007, mainly due to a decrease in European health ODA. Compared to total ODA disbursements, European donors contribute relatively less to health than other international donors. In 2008, the aggregate share of the EU, its Member States and other European donors accounted for only 39% of health ODA, whilst accounting for 69% of global ODA.

As a result of such trends, the perceived need to reassess aid effectiveness principles against sector-specific funding for health became evident. For these reasons, Action for Global Health (AfGH), a network of European health and development organisations, commissioned the German Foundation for World Population (DSW) to carry out six fact-finding and advocacy visits to developing countries in 2010 and 2011 aimed at assessing the impact of current aid structures and aid effectiveness principles of health-spending in those countries. DSW is an international NGO (INGO) empowering young people and

communities in low- and middle-income countries by addressing the issues of population dynamics and by improving health as a way to achieve sustainable development.

This report on India is one of six country-specific briefings resulting from the fact-finding visits. The purpose is to provide health and development stakeholders at all levels, including policy and decision-makers, donors, NGOs and civil society organisations (CSOs), working in-country and externally, with concrete recommendations, alongside evidence and experience drawn from a broad cross-section of key stakeholders in the case-study countries, in order to support European advocacy for global health.

COUNTRY SELECTION FOR FACT-FINDING VISITS

On the basis of a number of criteria listed below, the AfGH network jointly selected Uganda (February 2010), Tanzania (April 2010), El Salvador (July 2010), Mozambique (September 2010), Vietnam (November 2010) and India (February 2011) for its fact-finding and advocacy visits. The criteria for selection included:

- Countries from different continents, including Latin America;
- Countries which are, or were until recently, major recipients of EU health ODA;
- Countries where AfGH has some kind of support, either from country offices or strong partnerships;



Community Health Worker (ASHA) training in Mother and Children's hospital near New Delhi.

Photograph: DSW

- Avoiding countries, if possible, where missions on health/aid effectiveness had recently been carried out;
- Some non-English-speaking countries; and
- Not taking into consideration conflict or immediate post-conflict countries given the visits' objective to assess development aid channelled to existing health systems.

INDIA COUNTRY CHOICE

India was chosen because of its particularly interesting and developing situation. India is one of the fastest growing economies in the world – consistently experiencing annual growth of at least 7% for many years. As a middle-income country (MIC), India has recently become a donor country itself and aid allocations to the country have seen drastic cuts.

However, it is a country of extreme economic inequality, characterised by the dual realities of an increasingly wealthy middle class and over half the population surviving on less than USD 2 a day. According to the Human Development index 2010, India ranks only in 119th place in terms of human development.

Despite accounting for a very small percentage of the country's national budget, the overall aid portfolio annually channelled to India is still one of the biggest in the world – mainly due to the sheer size of the country and the high share that the Indian population is accounting for within the global population.

The fact-finding visit to India involved interviews with the following stakeholders:

GOVERNMENT

Ministry of Finance
Ministry of Health

BILATERAL AND MULTILATERAL DEVELOPMENT PARTNERS

DFID
Global Fund
USAID
World Bank
European Commission
German Embassy
UNFPA
WHO

MEMBERS OF PARLIAMENT

Health Committee Member

INGOs

Terre des Hommes
Family Health International
International Planned Parenthood Federation

CSOs

India HIV/AIDS Alliance
Delhi Network of Positive People
Swasti
MAMTA – Health Institute for Mother and Child

THEMATIC AXES

All interviews held focused in particular on the following three thematic axes related to health aid effectiveness:

1. Country ownership and the participation of civil society and the national parliament in the health sector;
2. Impact of donor coordination on health spending in developing countries; and
3. Managing for Results: the role of aid for country progress towards the Millennium Development Goals (MDGs) and in universal access to primary healthcare.

Poor urban areas outside New Delhi: Inequities in India are striking.

Photograph: DSW



AfGH chose these themes on the basis of the findings from its first mission to Uganda that had focused on all the Paris Principles in order to test which of them were still topics of major concern to developing countries. The interviews revealed that these three topics were considered particular challenges by a variety of stakeholders in developing countries. Moreover, these issues had received insufficient attention within other evaluations on aid effectiveness undertaken. In addition to that, AfGH could see its own extensive expertise in carrying out research and advocacy for increased health funding, progress towards the health MDGs and universal access to primary healthcare, as well as CSO and community participation, as being an added value when addressing these issues.

ADDITIONAL RESEARCH AND CONCLUSIONS

The results of these interviews have been complemented by previous and subsequent desk research in order to provide a comprehensive perspective on the effectiveness of health aid in India, based on the principles of the Paris Declaration and Accra Action Plan on aid effectiveness. However, as the primary objective of this country briefing is to reflect the views of the stakeholders involved, some of the statements do not necessarily reflect the views of AfGH.

SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

OWNERSHIP

- In a country with the size and complexities of India, ownership is almost a given as assistance can only have an extremely limited impact. However, donors do have a role to play in **capacity-building** and promoting good practices in terms of **governance, participatory democracy, transparency and respect for human rights**. They should also promote and support country progress towards achievement of the **MDGs**.
- In order to ensure true country – as opposed to government – ownership, both the national government in India and the donor community need to actively promote **genuine participatory democracy** by involving a representative diversity of stakeholders in policy processes.
- The **Global Fund Country Coordinating Mechanism (CCM)** is seen by many Indian stakeholders as an interesting example of good practice in engaging all the stakeholders around certain health issues

and could be applied to the broader health and other sectors.

- In addition to a **country-wide mapping of CSOs** to be jointly undertaken by development partners, NGOs and the government, the latter should look at providing a formalised common focal point for local organisations as well as, crucially, simplifying, streamlining and levelling the registration process for all, no matter the individual focus of activity.

DONOR COORDINATION

- There seems to be a clear **link in India between the strength of the national approach to a policy issue and the ability of donors to coordinate** around that agenda. The HIV/AIDS agenda is one where coordination is high thanks to the Global Fund CCM and the Indian National AIDS Control Programme. Lessons learnt should be replicated in other areas.
- Whilst **coordination** between donors – especially between multilaterals and bilateral – remains an important task, it also needs to be enhanced **between vertical and horizontal levels of Indian government and service planning and delivery mechanisms**. Donors then need to coordinate with the most appropriate level of activity.
- **Coordinated technical assistance should focus on** clearly agreed deliverables requiring specific expertise at **state and district levels**, instead of overcrowding national ministries with foreign staff.

MDGs AND MANAGING FOR RESULTS

- The national government needs to **increase spending on public health** to ensure access to primary healthcare for the large number of poor in India. Levels of public spending on healthcare in India are amongst the lowest in the world.
- **The private sector** has an important role to play in the delivery of health services in India, however it is essential that **there is effective monitoring of these by government and not a simple passing of responsibility**. It is not acceptable that 35% of Indian families fall below the poverty line if a family member has to go to hospital.
- European donors can and should play a crucial role through know-how transfer, by

building on their countries' long-standing experience with social security and health insurance schemes to enable the Indian government to choose the best option for the country.

- Considering the size and complexities of a country such as India, interventions by donors at district level would also ensure a greater impact and higher visibility of health aid. However, such efforts need to be accompanied by measures improving accountabilities, incentivisation and results-based management at district level.
- To achieve the MDGs in India will require coherent and integrated approaches that address not only pure health systems, but also strategically related sectors such as sanitation, hygiene, education and water. These integrated approaches might be more easily and most successfully developed at local levels, and hence the need for donor and government support to such efforts at the local levels, by also involving and supporting Community Based Organisations (CBOs).
- Donors have a responsibility not to undermine any development results of external assistance with their policies in other sectors. The international community needs to monitor bilateral trade agreements, such as the Free Trade Agreement (FTA), and prohibit clauses with potentially adverse effects for the development of recipient countries in general and for universal access to healthcare in particular.

GENERAL COUNTRY BACKGROUND

INDIA'S ECONOMIC SITUATION

India is one of the world's fastest expanding economies, growing by 7% between 1997 and 2007. India – together with Brazil, Russia and China – is one of the BRIC countries, which have been identified as taking on greater political and economic influence on the world stage. India's increasing wealth has led many donors, including the European Commission to consider withdrawing from the country.

However, another reality persists: it has been estimated that over half India's population survive on less than USD 2 a day.¹ The vast majority of the rural population remain impoverished.

INDIA'S POLITICAL SYSTEM

India is the world's largest democracy and a federal state, sharing power between a parliamentary form of central government, 28 states and 7 Union Territories. The states and union authorities are responsible for health, as well as public order, agriculture and education.

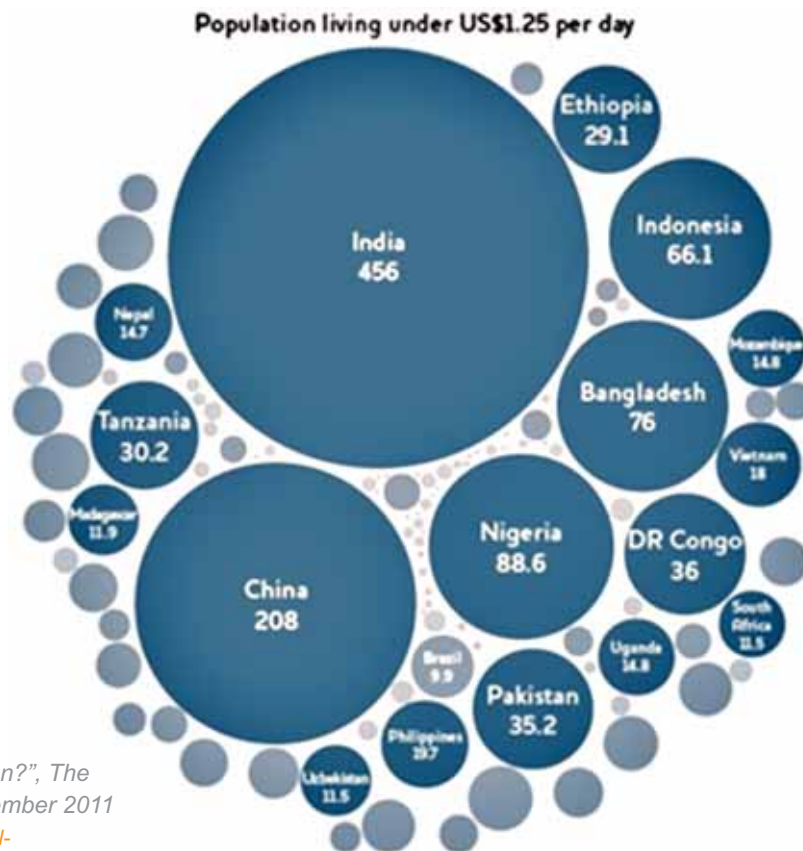
COUNTRY DEVELOPMENT PRIORITIES

Strategic five-year plans for the economic and social development of India are developed by the Planning Commission – an institution of the Indian

national government. The first five-year plan (FYP) was established in 1951 soon after independence. The 11th FYP runs until 2012.

Objectives to tackle issues of poverty and income over the FYP include raising the real wage rate of unskilled workers by 20%, increasing the agricultural GDP growth rate, creating 70 million new work opportunities and accelerating the overall GDP growth to 10%.

India is also one of the few countries that recognised the link between poverty and population growth, by establishing a national population policy and making the issue a priority in its development strategy. There are also objectives about improving focus on women and children, and girls in particular.



Figures are in millions of people. Graphic courtesy The Guardian
www.guardian.co.uk/global-development

Source: "Which Bottom Billion?", *The Guardian*, Tuesday 14 September 2011
<http://www.guardian.co.uk/global-development/datablog/2010/sep/14/bottom-billion-poverty>

¹ Source: A Thomson Reuters Foundation Service AlertNet: www.trust.org/alertnet/country-profiles/india

HEALTH BACKGROUND

INDIA'S HEALTH SYSTEM STRUCTURE

At national level, the Union Ministry of Health and Family Welfare has four departments covering:

1. Health and Family Welfare;
2. Medicine and Homeopathy (Ayush);
3. Health Research; and
4. Department of AIDS Control.

There is a Secretary of State for Health and Family Welfare and another for the Indian System of Medicine and Homeopathy². The Department of Health is supported by a technical wing, the Directorate General of Health Services.

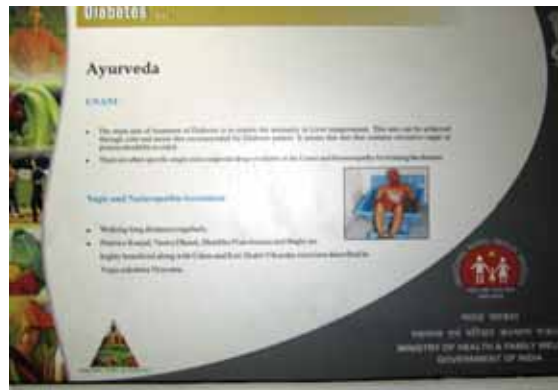
States have brought all healthcare programmes in a district under unified control. District level health management is responsible for linking policies laid down at higher levels with local realities. Community Health Centres (CHCs) have been established for every 80,000 to 120,000 population, providing basic specialty services in general medicine, paediatrics, surgery, obstetrics and gynaecology.

There is one Primary Health Centre (PHC) per 30,000 population (20,000 in areas of difficult terrain). Each has one medical officer, two health assistants (one male, one female), health workers and supporting staff. There is one health sub-centre per 5,000 population (3,000 in areas of difficult terrain), each manned by one male and one female multi-purpose health worker.

HEALTH CHALLENGES AND PRIORITIES

The 11th FYP highlighted that India still faces considerable health challenges: "Malnutrition affects a large proportion of children. An unacceptably high proportion of the population continues to suffer and die from new diseases that are emerging; apart from continuing and new threats posed by the existing ones. Pregnancy and childbirth related complications also contribute to the suffering and mortality."³

Apart from the dramatic emergence of HIV/AIDS over the past 20+ years, India is also seeing increases in mortality from so-called "lifestyle" diseases, including diabetes, cancer and cardiovascular diseases. The increasing burden of trauma cases and a growing population of older people are also presenting new and different public



Poster in the Indian Ministry of Health informing about Ayurveda.

Photograph: DSW

health challenges. The share of water-borne diseases among the poverty-related diseases is also relatively high compared to other developing countries, with diarrhoea being one of the most common causes of death in children under 5 in India, according to the National Health Survey.

India's economic divisions are strongly reflected in the health service. There has been underinvestment in state hospitals and most are overcrowded and understaffed. For many of India's poor, accessing the health system requires out-of-pocket expenditure which leads to increased poverty. However, at the same time, a number of world-class facilities have sprung up in the past two decades in India's biggest cities, catering almost entirely to the rich. So well equipped and well staffed are these hospitals that India has become a leading destination for medical tourism.

INDIA'S HEALTH POLICY FRAMEWORK

The first National Health Policy for India was drafted in 1983. It aimed to achieve the goal of "health for all" by the year 2000. It focused on: the creation of primary healthcare infrastructure; coordination between health-related services and activities (such as nutrition, water and sanitation); active involvement and participation of voluntary organisations; provision of essential drugs and vaccines; qualitative improvement in health and family planning services; provision of adequate training; and medical research aimed at common health problems.

² For more information, access MoH website: <http://mohfw.nic.in/>

³ Source: Planning Commission, Government of India, 11th Five Year Plan 2007-12, Social Sector p.57 http://planningcommission.nic.in/plans/planrel/fiveyr/11th/11_v2/11th_vol2.pdf

The National Health Policy was revised in 2002. This aimed to achieve an acceptable standard of good health among the general population of the country and has set goals to be achieved by the year 2015. The major policy prescriptions are as follows – most of them addressing key areas of concern affecting the Indian health system, with some of them (in bold) being rather controversial:

- Targeted increases in public expenditure on health.
- Convergence of all health programmes, barring exceptional issues such as HIV/AIDS, and reproductive and child health.
- Regulation of private clinical establishments.
- Accreditation procedures for public and private health facilities.
- Decentralising the implementation of health programmes to local self-governing bodies.
- Introduction of **user charges** for some secondary and tertiary public health services, for those who can afford to pay.
- Encouraging setting up of private insurance instruments to cover secondary and tertiary sectors.
- Mandatory two-year rural posting before awarding the graduate medical degree.
- Establishing two-tier urban healthcare system – PHCs and Government General hospitals.
- Co-option of NGOs in national disease control programmes.
- **Promotion of medical services for overseas users.**

The 11th FYP, 2007-12 contains a specific focus on health issues. It aims to “facilitate convergence and development of public health systems and services that are responsive to health needs and aspirations of people. Importance will be given to reducing disparities in health across regions and communities by ensuring access to affordable healthcare.”⁴ Achieving coordination between individual healthcare, public health, sanitation, clean drinking water, access to food, hygiene, and

good feeding practices remains a major challenge for Indian policy delivery.

The 11th FYP has had the following detailed objectives in the health field:

- Reducing Infant Mortality Rate (IMR) to 28 per 1,000 live births.
- Reducing Maternal Mortality Ratio (MMR) to 100 per 100,000 live births.
- Reducing Total Fertility Rate (TFR) to 2.1 per woman.
- Reducing malnutrition among children in the age group 0-3 years to half its present level.
- Reducing anaemia among women and girls by 50%.
- Raising the sex ratio for the 0-6 age group to 935 girls per 1,000 boys by 2012.
- Providing clean drinking water for all by 2009 and ensuring no slip-backs.

INDIAN HEALTH PROGRAMMES

Key programmes of India’s national health system are:

1. **The National Rural Health Mission (NRHM)**⁵ – launched in 2005 and working through a network of Accredited Social Health Activists (ASHAs) – one per village or roughly one for every 1,000 population. The ASHA is given a drug kit and basic training and carries out home visits covering all aspects of health delivery to people living in often isolated areas, particularly women and children. ASHAs are also trained by the government to undertake awareness-raising activities about the links between water, sanitation and health issues at district level.
2. **Reproductive and Child Health Programme (RCH) – RCH II (under NRHM)** aims to comprehensively integrate interventions to improve child health and reduce infant, under-five and maternal mortality. Key components include: antenatal care for mother and child; immunisation; and detection and treatment of

4 Source: Planning Commission, Government of India, *11th Five Year Plan 2007-12*, Social Sector p.58 http://planningcommission.nic.in/plans/planrel/fiveyrf/11th/11_v2/11th_vol2.pdf

5 Ministry of Health and Family Welfare: <http://mohfw.nic.in/NRHM.htm>

problems.

3. **National AIDS Control Programme (NACP) –** NACP III aims to integrate programmes for prevention, care, support, and treatment as well as addressing the human rights issues specific to people living with HIV/AIDS. It targets reaching 80% of high-risk groups including sex workers, men who have sex with men, and injecting drug users. It contains a Prevention of Mother-to-Child Transmission Programme.

HEALTH EXPENDITURE

Total healthcare expenditure in India was around 5% of GDP in 2008. This is more than in neighbouring countries such as Pakistan, Sri Lanka, and China, but far less than the E7 average of around 12%. However, this figure only tells part of the story.

The mid-term appraisal of the 11th FYP recognised that, “while total expenditure on health in India as a percentage of GDP was broadly in line with the level achieved in other countries at similar per capita income levels, it was skewed too much in favour of private expenditure. Public expenditure on health in India [...] was less than 1 per cent of GDP.”⁶

TABLE 1: PUBLIC EXPENDITURE ON HEALTH AS PERCENTAGE OF GDP

Year	National-level spending (% of GDP)	State-level spending (% of GDP)	Total (% of GDP)
2005-6	0.29	0.67	0.96
2006-7	0.29	0.67	0.96
2007-8	0.32	0.70	1.02
2008-9	0.35	0.71	1.06
2009-10	0.39	0.70	1.09

Source: Mid-term appraisal of the 11th Five-Year Plan⁷



ASHA training in a hospital for women and children, outside New Delhi.

Photographs: DSW

⁶ Planning Commission, Government of India, *Mid-term Appraisal of the 11th Five Year Plan* p.1 http://planningcommission.nic.in/plans/mta/11th_mta/chapterwise/chap7_health.pdf

⁷ Idem. p.2

The World Health Organisation (WHO) country profile describes public health spending in India as “abysmally low in a country where about 26% of people living below poverty line are critically dependent on public health services and the range and complexities of health issues are substantial with the equal presence of both communicable and non-communicable diseases.”⁸

AID LEVELS AND MAJOR DONORS

Net ODA has continued to increase in India, although the expansion of the national economy means that it does not account for any more than 0.2% of gross national income (GNI).

TABLE 2: OVERSEAS DEVELOPMENT ASSISTANCE TO INDIA

Receipts	2007	2008	2009
Net ODA (USD million)	1 391	2 114	2 453
Bilateral share of gross ODA	62%	66%	59%
Net ODA/GNI	0.1%	0.2%	0.2%

Sources: OECD, World Bank⁹

The share of bilateral aid has decreased significantly in the past few years.

India is no longer reliant on humanitarian assistance such as food aid and is directing its received external assistance towards infrastructure projects, social sector projects and building up the institutional capacity in line with its commitments to fulfil the MDGs.

Most bilateral assistance has been based on lending. Since independence to 2002, loans accounted for 90% of bilateral assistance. However, in recent years, India has prematurely repaid a significant part of both multilateral and bilateral loans raised under external assistance programmes. This fact led some donors to wonder why donors (and actually a good number do) continue to provide grants to the Indian government, if the latter has been able to prematurely repay loans in recent times. One could even wonder whether they have managed to do so partly through the grants they get from the same, or other donors.

Poverty levels in different Indian states vary greatly, and so does the amount of development assistance. In 2008, a paper on external assistance to India drew attention to the fact that a small number of states receive nearly 90% of support, whilst eastern and special category states account for just a little over 3% of the total disbursements.

FINANCIAL RESOURCES FOR HEALTH

Total external assistance to health in India is less than 2% of the budget and falling. The UK and World Bank (International Development Association – IDA) have been the major funders for health, accounting for nearly 70% of all ODA for health recently. India has also notably been one of the few countries in the world where the European Commission has been providing earmarked budget support to the health sector.

8 Source: WHO Regional Office for South East Asia - India country health system profile: www.searo.who.int/en/Section313/Section1519_10852.htm

9 www.oecd.org/dataoecd/62/30/1877912.gif

TABLE 3: AID FOR HEALTH TO INDIA. 2006-2008 AVERAGE. USD MILLIONS

Donor	Aid for health (USD millions)	Share of donor's total aid to India	Share of total aid for health to India
UK	503.2	54.5%	35.2%
IDA	481.8	35.1%	33.7%
Global Fund	128.3	100%	9.0%
USA	80.8	52.5%	5.7%
Norway	67.0	61.9%	4.7%
European Commission	65.8	34.2%	4.6%
Germany	59.1	13.6%	4.1%
UNFPA	12.2	100%	0.9%
GAVI	7.9	100%	0.6%
UNICEF	7.9	20.9%	0.6%
Total	1429.2	26.3%	100%

Source: OECD Health Charts¹⁰

The WHO sets out that typically, “most of the donor agencies provided aid for primary healthcare and immunization programmes with focus on projects related to strengthening of service delivery, capacity building, training and IEC. Multilateral and bilateral donors such as UNICEF, UNFPA, WHO, USAID, DFID, SIDA, and CIDA provided assistance for specific programmes in family planning, leprosy, malaria control, HIV/AIDS, etc.”¹¹



Women's group in village outside the capital, New Delhi.

Photograph: DSW

¹⁰ www.oecd.org/dac/stats/idsonline

¹¹ WHO Regional Office for South East Asia, *India country health system profile*: www.searo.who.int/en/Section313/Section1519_10852.htm

OWNERSHIP AND THE PARTICIPATION OF CIVIL SOCIETY AND THE PARLIAMENT

DONOR INFLUENCE OVER HEALTH SPENDING

The fact that India is one of the major growth economies in the world makes its relationship with the wider donor community significantly different to other developing countries. India is now in the position of being a donor of aid to Africa. Several donors are considering significant reductions to the aid disbursements to India.

India has felt strong enough to remove many donors from the country and to pay back a number of development assistance loans early. In 2003, India's Bilateral Development Cooperation policy agreed to accept bilateral assistance only from the G8 countries – namely the USA, UK, Japan, Germany, France, Italy, Canada and the Russian Federation – as well as from the European Commission. It also decided to no longer accept tied aid.

Total external assistance to health in India is less than 2% of the budget and falling. Indeed, the interviews conducted during the fact-finding visit to India show that the issue of donor influence over health spending is not a major concern for stakeholders in India. One co-operation partner goes so far as to say: "ownership is not a question in this country, where 98% of funding is controlled by government".

Other stakeholders also commented that the government is in a strong position to decide which donor should be working where and on what and that the government has made it clear that donors are supposed to feed into national plans. For example, one interviewee highlighted that the "EC [European Commission] does not publish calls for proposals without consulting with the government. [They are] in line with national policies".

However, it is not yet true that India can do without external assistance altogether. In its country profile, the WHO concludes that, "India will continue to be dependent on donor aid, and external assistance

will continue to serve as a catalyst to the improvement of systematic efficiencies and universal access to healthcare."¹²

Whilst this external assistance remains necessary, there are likely to be continued concerns about the influence development partners exert. It was not true that all the interviewees were happy with the influence donors have. Many were frustrated that donors would not simply support national health priorities, but instead sought to pursue their own agendas. As one government representative put it, "**Donors are not flexible – they have their own priorities and targets.**" Two examples provided were of two European donors, one of which only wanted to provide a loan specifically to tackle polio so that they could "show taxpayers they had done something on polio"; and another one, which only wanted to work on HIV/AIDS and contagious diseases.

Interviewees highlighted that there had been a particular stand-off for more than a year over vaccines when donors wanted to import them, but the Indian government wanted to purchase from local suppliers. The donor agenda was clashing directly with the preferred national policy direction, with donors trying to force policies onto the government.

Another issue mentioned was that it is sometimes hard to find information on funds entering the country and what they are for. In such cases it is impossible for there to be ownership or for people to be held to account. An example given was when the West Bengal government took a hard loan – with high interest rates – from the World Bank for strengthening hospitals. The Member of Parliament (MP) interviewed highlighted that "this was only uncovered by the local Parliamentary Committee."

On the issue of transparency, there is a **centralised database for ODA flows** in India, part of which is open to public access. However, the system – which has been in place for four years

¹² WHO Regional Office for South East Asia, *India country health system profile, Millennium Development Goals Annex 2* www.searo.who.int/en/Section313/Section1519_10857.htm

now – is far from well-functioning, as observed when trying to access the link provided by interviewees¹³.

Donor reporting should go beyond the overall envelope and allow for project disaggregation of funding, as for example, DFID does on its website. This would help enable full accountability by stakeholders.

A POSITIVE SIDE TO DONOR INFLUENCE?

Whilst there was recognition that donors should not be dictating national policies, there was a feeling that **donors can engage in promoting positive change** that domestic actors do not always have the power to create. In a context where national policies are not always seen to respond to community-specific needs, donors can play a role, for example, in promoting participatory approaches or the respect of human rights. One donor felt that development partners at least made a useful contribution to “increasing transparency of decision-making in India”, despite the relatively small amount of funding.

Some CSOs clearly wanted donors to exert more influence, not less, over government policy-making. For example, one CSO representative bemoaned the fact that **“Europe has been one donor that has not taken any stands**. And we would like to change that [on issues such as] same sex marriages [and] good harm reduction policies. The US and UK do the most, all the other countries stay quiet.”

Another issue was that donors could bring specific skills and experience to bear on Indian problems, adding value to the government and other national, regional and local stakeholders. One INGO interviewee stressed that whilst the government is “good at doing facility-based work, building hospitals and health centres, they are very poor at mobilising communities, advocacy and rights-based approaches.” These are areas where co-operation partners can add value and where support to civil society can be so important.

This INGO representative also felt that donors could play an important role in promoting the achievement of specific development targets: “We need external funds [but] don’t duplicate what the government is doing. **Act where there is added value [and] have your own say in what your funding will achieve in respect to a specific MDG.**” The conclusion seems to be that where there are clear and agreed overall principles or

objectives, such as the MDGs, donors are within their rights to push towards their achievement even if the national government is not as proactive.

In this context, some donor-funded programmes have had real positive impacts, including UNICEF-funded immunisation programmes and a maternal and child health programme, which turned into a comprehensive national strategy. Funding on HIV/AIDS has been substantial – particularly through the Global Fund to fight AIDS, tuberculosis and malaria – and had significant benefits to the national approach to tackling these diseases. Whilst some spoke of their frustration that donors did not provide more general budget support, there was also some understanding from INGOs that “as a donor, you also need to know what your money has contributed to.” It seems clear that the needs of donors cannot totally be ignored.

CO-OWNERSHIP OF KEY HEALTH PROGRAMMES

An important issue in the context of ownership in India is the division of responsibility between national and state levels. One key development partner put it thus: “States are 80% in charge of health, whereas the central Ministry of Health only has 20% control. Does it make sense to talk about national ownership [in this context]?” Clearly the issue of ownership is not limited to the level of the national government. It must also incorporate parliaments, state-level authorities, local level authorities and civil society.

The issue is not, therefore, just about how donors influence policy-making, but the attitude of the national government to participatory democracy. As one CSO interviewee said, **“co-ownership should be important**. The government should accept that....”

A key activity for many CBOs is raising community awareness about the government programmes and support available to them. For example, one organisation has done a lot of work to increase enrolment in health “smart cards”. Another has carried out a specific project funded by a pharmaceutical company that aims to “bridge the gap between existing government services and the people who don’t know about them.”

However, co-ownership means the government, donors and other stakeholders, including CSOs, CBOs and parliament, being engaged within the creation as well as the delivery of Indian health programmes.

¹³ <http://cdssindia.gov.in/cdss/rc?sessionid=131866061171854343> (public user access)

CSO PARTICIPATION IN HEALTH POLICY-MAKING

There were positive indications from some CSO representatives that they had been invited to consultations on state health programmes. An INGO highlighted that the Planning Commission “involves CSOs in consultation” on its FYPs. There was evidence from interviewees that this Commission had asked for specific input from certain organisations in the context of the 12th FYP.

NATIONAL RURAL HEALTH MISSION AND REPRODUCTIVE AND CHILD HEALTH PROGRAMME

The National Rural Health Mission (NRHM) was launched in 2005 by the Government of India as its flagship health programme, with minimal input from donors. Its official goal is “to improve the availability of and access to quality healthcare by people, especially for those residing in rural areas, the poor, women and children.”¹⁴

The largest sector of NRHM is focused on reducing child and maternal mortality. The second Reproductive and Child Health Programme (RCH II) aims to bring coherence to all the interventions for fertility regulation and maternal and child health with reproductive health programmes for both men and women.

The general feeling, as expressed by a development partner, was that “there is strong ownership around these programmes. Donors cover less than 5-10% of the whole RCH budget, [so] it’s not such a big financial involvement.” Review missions under NRHM were not initially open for donors, but now donors can participate once a year.

A different donor praised the fact that NRHM review has brought in CSO groups and other development partners. Also, one can now “download NRHM reviews and any district plan from the web, [so there is] high transparency”. Other interviewees commented that CSOs were consulted on the NRHM, whilst another development partner expressed the view that the “NRHM has a huge part for CSO participation and monitoring.”

However, there were seen to be structural problems in the conducting of these consultations. One NGO representative revealed that “[We are] participating in the new National Health Plan elaboration. Right now, it is about ‘who knows whom’. [There is] **no formal procedure to select participants in this process**. It is your proximity to the bureaucracy that opens your doors.” Consultation therefore remains patchy and not systematic and many CSO representative lack clarity and certainty about these processes and their value.

Another CSO representative highlighted that they had direct contact with government officials and highlighted problems with service delivery. However, this did not lead to a process of consultation by the government officials. “They never invite us to join if they have meetings with the Global Fund and donors.”

The evidence was that CSOs are **selected, not elected** to take part in consultations and those invited tend to be academics and CSO experts, rather than grassroots organisations. Government was felt to be sceptical about the legitimacy and representativeness of many CSO spokespersons. There was a fear from a government representative that civil society representation is “a very elite system which can be manipulated by the influential.”

One donor representative spoke of their “shock” when seeing the level of civil society engagement in India 10 years ago. “There was a lot of resistance from government offices to civil society participation. They regarded civil society as a threat, as nosy [...] but I think that’s changing now, probably because the younger officials in the ministry, they recognise that there is an added value.” Nevertheless, the latter are also **quite limited in their influence** and are not usually able to take a stand on issues important to CSOs.

A government official, on the other hand, felt that “the good people doing the work on the ground will not apply for participation in policy-making – they do not have the time for that.” Indeed, the capacity of CSOs is clearly an important issue if effective co-ownership is to emerge in India. One CSO representative whose organisation was part of many advisory groups with the government of India felt that not all CSOs were competent to play such a role. The quality of participation is significantly hampered by a **lack of capacity**.

14 Ministry of Health and Family Welfare, Government of India, National Rural Health Mission – Mission Document Preamble
www.mohfw.nic.in/NRHM/Documents/Mission_Document.pdf

On the other hand, many CBOs do not see their primary role as being to engage in policy consultations. According to one interviewee: “We only work on treatment and the discrimination of not having treatment.” Whilst there are some NGO representatives involved in technical advisory committees or meeting government representatives to advocate on health issues, the traditional role of CBOs is implementation and service-delivery.

Many organisations are “fire-fighting” to save lives and obtain, for example, anti-retro viral drugs for HIV patients. Some of the higher level political discussions and policies around health education, prevention and so on can seem too far removed from this reality for some CSOs. “Even if the Global Fund would give millions, for example for fighting stigma, what can you do with the money if people can’t stay alive?”, says one CBO member.

One important political voice was of the opinion that “voluntary organisations are the true good-doers as they do not have to follow donor priorities – they survive by collecting funding from the communities. If you are working for the community you will be able to survive with their support.” However, it is not clear that this logic applies to advocacy. Even NGOs from the Global North know that it is not so easy to get community funding for political advocacy work, which often requires support from external funders.

Where advocacy was taking place, there was clearly a feeling that **NGOs in India find it easier to engage on policy at district level**. An INGO pointed out that “only few NGOs influence the state level.” One CSO interviewee went even further to suggest that “in a country like India, it makes no sense to try and influence very high levels of decision-making – [it is] too complex, too big. It is the district-dynamics that are making the changes in the individual life.”

Another issue that might need to be overcome for true participatory processes to emerge is that so many **CSOs depend on government money** for the delivery of their programmes in communities. One development partner interviewee noted that, for example, compared to European CSOs, the “amount of funding received by CSOs from government is incredible. Some receive about 50% of their funding from government!” This means that they can be afraid to criticise.

One CSO representative clearly saw a danger in many organisations simply “doing business and becoming contractors” either to the government or donors just for the implementation of programmes rather than their conception. This particular CSO had also taken a strong stand on **increasing CSO ownership over their projects**, despite having to cope with the related consequences: “We are not

against donors, and want to have funding, but people should be happy to fund what we are doing. I am not going to go and ask for funding, if somebody wants to they can come to us. We are not doing donors work, it’s purely for the community and for treatment. That’s why we are poor.”

DONORS AND CSOS

One of the key areas where donors could make a positive difference – recognised by CSOs and development partners alike – was in supporting an increased advocacy and policy-monitoring role for civil society in India. Notably, the focus of several views was not that donors should fund small-scale local projects run by CSOs, but that efforts should be focused on **increasing the capacity of civil society to engage in district-level planning**. For example, a prominent development partner saw a role for “civil society [as] an independent third party monitor to facilitate programme improvement.”

There was some evidence of donors supporting such capacity building. One interviewee had two projects to build CBO capacities funded by international donors. However, donor-funded programmes promoting CSO involvement in policy-making processes were very much seen as “work in progress,” as a CSO put it.

Some INGOs aimed to take on a role in between government and local CBOs. Some received funding from various donors to do a mixture of work with government, technical assistance and community-based capacity building. “We mobilise communities to access government services, and then we work with the government to improve the quality of the services. We want to leave behind a legacy when a project ends and one component is better advocacy skills.”

Donors were also seen to have a role to play in **improving the legitimacy of civil society**. This could be done through procedural support to strengthen management systems, such as audits, to improve the legitimacy and transparency of CSOs – important for creating trust from government.

Moreover, CSO accountability to their communities can be encouraged and supported by donors. Lessons learnt from the Global Fund’s CCM in India should be considered for replication at health sector level.

GLOBAL FUND COUNTRY COORDINATING MECHANISM

The India Country Coordinating Mechanism (CCM) for the Global Fund to fight AIDS, tuberculosis and malaria was seen as one of the better examples of a CCM and a positive step forward in terms of country ownership. One development partner interviewee stressed that it was particularly positive because it is “100% Accra [whilst], let’s be honest, everybody [else] is working much more within the Paris Declaration framework than within the Accra agenda.”

Out of the 40 members, there are six seats for donors – bilateral and multilateral – eight NGOs, plus three people living with or affected by HIV. One CSO representative is a vice-chair. There are also seats for the WHO, UNAIDS and the United Nations Resident Coordinator. Total non-governmental representation is about 40%. Furthermore, many of the CSO representatives are umbrella organisations; community-based organisations are thus represented.

The eight current NGO representatives were elected, after 1,200 NGOs voted electronically via a website run by a CSO. There are significant challenges with organising this process, since civil society is so diverse and it requires an independent facilitator. Whilst earlier election attempts had failed, the latest round went relatively smoothly. Nevertheless, there are still significant challenges around raising awareness about the elections and ensuring organisations can access the Internet to vote. NGOs standing for election have to meet certain criteria and standards, and their mandate lasts two years before they have to stand for re-election. Some people are still not convinced that this is a feasible approach in such a big country as India.

On the positive side, the CCM is a platform for conflict resolution and the CSOs are active in this process. The CSO representatives now have preparatory meetings before each of the 5-6 CCM meetings each year so that they can coordinate their messages and interventions. There are specific funds available to support civil society participation.

However, despite the varied membership, the chair of the CCM remains the Health Minister and it is government led. The National AIDS Control Organisation (a division of the Ministry of Health and Family Welfare) is seen as a dominant force, putting everything together on the funding rounds at the last minute, with little time for the other stakeholders to influence. This means, as one CSO observes, that “the government dominates the agenda” and CCM money is seen as government money, rather than the money of all stakeholders.

Criticism of this lack of co-ownership came from all sides. A CSO representative complained that “everybody contributed [but] the national AIDS response is seen as government-owned. [There is] no appreciation for CSO input. Why should CSOs see themselves as partners then?” A development partner also reasoned that “the ‘I am in charge’ attitude of the government is sometimes not very constructive.” Thus the concept of CCM is good, but the practical implementation is imperfect. “You need genuine participation, not token participation.”

Nevertheless, the overall feeling seemed to be that the process is improving and levels of participation are increasing, even if civil society remains quite powerless. One CSO commented that: “It’s a bit better. Now it’s more transparent than before. But civil society does not have much influence.” Some stakeholders suggested a bias towards HIV above TB and malaria, which could be traced to some extent to donor priorities. There are also important challenges for CSOs to decide to what extent they should try to speak with one voice or recognise their differences.

Generally, the CCM model was seen to have a lot of potential. As one donor highlighted: “I am very convinced by the CCM model. It could work in the health sector in general. [There are] also more donors looking into CCM-like possibilities.” However, it was not clear to the stakeholders interviewed that the government was so convinced of the value of such participatory approaches. A development partner remarked, “I’m not sure the government would be interested in setting up a CCM-type mechanism to cover the whole of the health sector.” Indeed, a government official felt that CCM was in many ways a Western model, and not appropriate for the rest of the health sector.

Suggestions were made to support co-ownership of key health policies by introducing such coordination mechanisms at regional level and for efforts to be made to raise understanding and awareness about the nature and the functioning of the CCM. However, the voices were not currently loud enough to influence the government.

In terms of **consultation of civil society by donors themselves**, the principle was seen as having value by both sides, however such interaction tended to be limited to cases where there was a specific funding relationship between a donor and a CSO.

A civil society representative saw important differences between donors, with European, UK and US donors ranked in that order for their performance on participation. Their detailed analysis saw: an “American pattern of top-down, pre-decided structures” from USAID and the Bill and Melinda Gates Foundation; DFID providing “very low” funding for NGOs and focusing on the national and state levels; whilst the European Commission – despite the witnessed good will and openness of EU delegation officials – is too often tied by its own regulatory framework with “little possibility of adapting funding to the changing realities or context.”

Nevertheless, one organisation said it had been invited to two EU consultations on calls for proposals, whilst two others talked of good working relationships with an EU official. USAID spoke about the work that it does conducting “stakeholder interviews when going to the field” to understand the local situation and how US policy favours part of USAID being to “fund CSO/NGOs – encouraging the involvement of local organisations.”

CSO NETWORKING

Networking and coordination of civil society in India is difficult because of the sheer number, scope and variety of CSOs in India. A CSO remarked that “The Voluntary Health Association of India traditionally used to take the lead of organisations working on health broadly. I don’t think they do that anymore. It’s not possible to have them all under one umbrella.” There are some sector-based national networks however, such as on disability and on sexual and reproductive health and rights (SRHR). HIV is one of the most dominant issues and the AIDS India network one of the most active.

One CSO representative suggested that **virtual networks**, such as the mailing list created under the DSW Euroleverage Project, can be seen as a way forward in a country the size of India. However, co-operation between CSO partners tends to be project related. “We work together with other NGOs depending on the project. We do have partners, but no clear umbrellas. We can have consultative roundtables and invite other organisations and institutions. This always depends on the particular project and its topic.”

Another CSO talked about the work they are doing on political empowerment for people and organisations to advocate on local and state level.



AfGH fact-finding team meeting with local Civil Society organisations, in poor urban areas outside New Delhi.

Photograph: DSW

“The people are organising themselves to demand what they are entitled to.”

Once again, interviewees highlighted the need for support of such efforts. An INGO commented that “civil society is so vibrant in India, especially in their work with the communities. However, the size and complexity of a country like India makes it sometimes challenging to cooperate.” Another INGO spoke about work they are doing “supporting a [thematic] national-level advocacy network. We are helping them to build a secretariat and become an established platform.” More support is needed.

PARLIAMENT

There is a parliamentary Health Committee, which has the power to challenge government representatives, including through emergency questions, private members bills and the standing committee. There is also a specific parliamentary committee on HIV – which is coordinated by UNAIDS – and similar committees in several states. This has been useful in bringing different ministries together around the issue of HIV and provides a focus for HIV CSOs to carry out advocacy.

However, it was felt that there was still a certain scepticism from MPs about engaging with NGOs. It seems there are question marks from parliamentarians about the independence of some NGOs from their funders. One interviewee commented that “NGOs receiving funding from either government or others are biased – they cannot speak out freely.” For example, it was suggested that NGOs are more vocal about HIV/AIDS than TB because there is less funding around TB even though it is a huge problem in India. This called the integrity of the NGOs into question.

In general, the health committee has more experience working in co-operation with humanitarian INGOs, such as Medecins Sans Frontieres and the International Red Cross in the context of disasters striking India, rather than with Indian NGOs on ongoing health policy. It was clear that there are opportunities for mutually advantageous co-operation between MPs and CSOs in promoting the change they want, but both sides need to understand and trust the other more.

The better informed NGOs are about political debates and the workings of parliament, the more pressure they can exert on governments through MPs. Similarly, as MPs recognise the good work and expertise offered by many NGOs, they can call on them to provide information and opinions on matters they are dealing with. Both sides are likely to need support to take full advantage of these opportunities.

MEDIA

A final point that was raised was the potential role of the media in India. Compared to many developing countries the Indian media was seen to be strong enough to play an important role in holding the government and potentially donors to account by highlighting good and bad practice. One interviewee commented that, “at this point of time democracy is [sufficiently] far advanced that media have acquired immense powers. They are largely taking over the watchdog role on the government.”

There could increasingly be important links to be made between CSOs and the media in the future in ensuring democratic ownership of health spending in India. Important examples on how media is being influenced to play a impactful role through advocacy and awareness among the mass already exist¹⁵ and CSOs try to strengthen this tendency.



Fact-finding team (three women, right) meets Members of the Parliamentary Health Committee (left).

Photograph: DSW

¹⁵ For example: <http://www.ndtv.com/album/listing/news/jeene-ki-aasha-facts-about-women-and-children-10459#/slide/7>

THE IMPACT OF DONOR COORDINATION ON HEALTH SPENDING

DONOR COORDINATION OVERVIEW

There were differences of opinion about the extent of donor coordination in India. Similarly to views around ownership, some interviewees thought that the limited amount of donor funding in India meant that donor coordination in health spending was not a massive issue. A government official said that “the share of aid in the total budget is minimal so we do not spend much time on coordination issues.” The government was seen by some to have enough power to “demand that everybody works together on certain core principles,” as an INGO put it.

However, others highlighted that the Paris and Accra donor commitments around coordination had not been implemented in the country. An area where donor coordination could make a big difference is in **harmonised reporting**. Writing different reports for each donor is a big administrative burden and not at all necessary, particularly if a donor is only giving a small percentage of the overall budget – and even more particularly when these are only loans.

At least one donor representative was of the opinion that whilst there are still challenges, “there’s been a huge improvement in donor coordination. There’s much more dialogue between donors. It used to be that donors would pick their pet areas. That’s not the case anymore. We coordinate not to overlap and waste money.”

Another donor saw co-operation between EU and non-EU donors as being quite good. “We are all more or less talking the same language, except for the area of nutrition and on issues of convergence between the Health Department and the Department for Women and Child Development.” They argued that **donor forums need to be more sensitive towards the different “vertical cultures and responsibilities” between the different ministries**.

A challenge of increased coordination is that whilst it seeks to reduce transaction costs for the government, it increases them for donors. One representative remarked that coordination “takes work and it is work that is not programmed into the original programme plan and it takes a lot of time and patience. You have to manage different points of view and try to get everyone to converge rather

than just do their own bits and pieces.”

On the other side of the coin, a donor spoke of the need for coordination to come from the inside out. There **must first be “coordination among government ministries and in co-operation with civil society in the large sense. They [should] set up a body, which donors can then join as outsiders.”** The importance of the private sector in the Indian health system also means they need to be involved in effective coordination processes.

It can be imagined that it is hard for donors to coordinate effectively around a health policy in a situation where “there is not ‘one government’ – there are so many inter-ministry conflicts and departmental fights within ministries”. This implies that where there are clear policies and programmes in place, it is relatively easy for the donors to coordinate around those. Where the government is weaker, there are more alternative approaches emerging from donors. More than one donor felt that the government sometimes preferred to “divide and rule” rather than promoting donor cooperation.

An increasing issue with external assistance to India is potential incoherence with the economic wealth of the country and the fact that India has started to take on the role of a donor in Africa. Many donors are looking at decreasing their role in India. It is thought likely that India will have to look increasingly to investment banks for finance and that it is going to have to think perhaps more clearly and strategically about what it wants money for and why. In this sense, India will have to take full responsibility for coordinating the external finance coming into the country.

NEGATIVE ASPECTS OF COORDINATION?

Whilst coordination of donors is a key principle to be worked towards, care needs to be taken to ensure that this coordination is positive. There are dangers that coordination can be misused or misinterpreted, for example, such that instead of ensuring different donors adopt complementary approaches, it forces donors to adopt the same approach. One donor observed that there are risks that “it becomes a really specific framework where nobody can move.” Too much donor coordination can reduce options for governments, CSOs and other potential aid receivers.

Similarly, efforts to coordinate can **lead to a number of donors agreeing to join forces to tackle one issue, whilst other issues are ignored**. More than one interviewee expressed that this danger had become a reality in India where it had “become fashionable to support HIV”, whilst other important health issues such as TB and malaria are relatively neglected. Whilst benefits are seen in tackling the priority issue, there can be costs elsewhere in the health agenda.

A similar issue emerges where donors all decide to stop funding a particular priority or programme at the same time. One co-operation partner warned: “Caution though: many European countries intend to pull out of the Global Fund. [This could be] dangerous as funding to the Indian national HIV programme from the Global Fund is substantial – we need to be careful that the national programme does not end up being underfunded.” Again, **coordination needs to mean ensuring effective synergies and complementarities, not simply funding or not funding the same national programmes**.

Coordination can also increase the risks that donors join forces in order to exert inappropriate policy influence on the government. For example, whilst the donor partner platform of RCH II was seen to have many positive sides, a government representative still felt that it had the consequence that “donors sometimes want too much of a role in policy-making, [even though only] 11-12% of our funding in this programme is from donors.”

Another problematic example was given around the World Bank’s strict procurement rules, which have conflicted with national procurement policies. Whilst the government does not comply with these rules, they are not eligible for related World Bank finance. Furthermore, it also blocks funding from other donors who are trying to coordinate their approaches around the same rule.

The other side of this picture is that donors see the importance of, for example, following the WHO procurement guidelines on vaccines. Donors cannot afford bad headlines about funding “dodgy vaccines”. “There is consistency here among donors. The government has been taking risks in the past but when something goes wrong, the government tends to blame donors,” stressed one such donor. Both sides, however, seem to agree with the donor assertion that “we spend far too much time in health talking about procurement rather than health.”

DONOR COORDINATION MECHANISMS

WHO sets out that typically, “most of the donor agencies provided aid for primary healthcare and immunisation programmes with focus on projects related to strengthening of service delivery, capacity building and training. Multilateral and bilateral donors such as UNICEF, UNFPA, WHO, USAID, DFID, SIDA, and CIDA provided assistance for specific programmes in family planning, leprosy, malaria control, HIV/AIDS, etc.”¹⁶

Some of these disease specific donor-funded programmes have had a real impact, including UNICEF-funded immunisation programmes and HIV/AIDS and RCH funding programmes which have turned into comprehensive national strategies. Some of these approaches also led to specific opportunities and mechanisms for donor coordination.

NATIONAL AIDS CONTROL PROGRAMME (NACP) AND THE GLOBAL FUND

The Global Fund for fighting HIV/AIDS, tuberculosis and malaria offers one tool for all donors and has made increased efforts to align with country policies. This has led to a highly coordinated approach, with the Global Fund supporting the Indian National AIDS Control Programme (NACP) following the UNAIDS model.

The Indian government sees the NACP as one of the biggest donor successes in India. This HIV programme was also seen as positive by different stakeholders in the way it pooled funding from donors such as the EU, World Bank and DFID into the same programme. Now, 65% of NACP funding is external and the National AIDS Control Organisation (NACO) is a separate department.

The Country Coordination Mechanism (CCM) of the Global Fund has 40 members, of which eight are donors – bilateral and multilateral. Furthermore, donors have six-monthly meetings to discuss CCM issues and how they can support the Global Fund in a coordinated way. As one donor participant pointed out, “when the 44 Global Fund donors meet, we only talk about Global Fund processes and government policies. There is no realistic option for different donors to raise their own priorities.” The World Bank also told a positive story about recognising the respective areas of expertise amongst donors. For example, it saw that “DFID is excellent at delivering independent technical expertise, so we are trying to go into a state and work with them, maybe on separate projects, but at least acknowledging what each of us is trying to do and trying to complement each other. We do this on malaria at the moment.”

16 WHO Regional Office for South East Asia, *India country health system profile*: www.searo.who.int/en/Section313/Section1519_10852.htm

The main challenge to effective coordination around HIV/AIDS through the NACP and CCM was the extent to which donors can coordinate around one “policy” when the strategy is in reality extremely complex and multi-dimensional. One donor highlighted that: “Some countries have a simple [HIV/AIDS] strategy – not India. [It is a] 140-page document with 140 indicators.” Moreover, this highly bureaucratic structure is set up for one disease only – thus undermining coordination efforts in other health areas.

RCH II

The Reproductive and Child Health II programme is another programme that has a donor partner forum. Donors including the World Bank, UNFPA, USAID, DFID and UNICEF agreed to pool their funding mechanisms, whilst other partners provide technical assistance around the RCH plan.

The forum often, although not always, includes the government. A donor expressed the view that it was not entirely necessary for the government to be always present in donor coordination meetings, as long as the links with government and government policy were clear.

The forum meets once a month and has a six-month rotating chair. Discussions cover financial and programme management – operationalisation of facilities – drugs, equipment and skills. One donor explained that it “provides a platform to maintain common language and objectives in the sector. We are all following the government policies.” Another donor recognised that “it does not stop donors doing what they are doing in terms of small programmes, but at least there is coordination.”

One donor argued that there is more freedom of expression in the RCH II group, since it is not government led. Another observed that “there is strong ownership around these programmes. Donors cover less than 5-10% of the whole RCH budget, [so] it’s not such a big financial involvement. This is why donors also really have to think what their value added is in terms of technical support etc. The role of donors has changed a lot.”

On a positive note, there was some talk from CSOs of village-level committees in the context of NRHM and “similar coordination mechanisms” in the context of RCH II and social welfare. However, the functionality of all these is still very limited.

A SWAp IN INDIA?

SWAp (Sector-Wide Approach) is an approach that “brings together governments, donors and other stakeholders within any sector. It is characterised by a set of operating principles rather than a specific package of policies or activities. The approach involves movement over time under government leadership towards: broadening policy dialogue; developing a single sector policy (that addresses private and public sector issues) and a common realistic expenditure program; common monitoring arrangements; and more coordinated procedures for funding and procurement.”¹⁷

However, interviewees were quite critical of the possibility of introducing a Health SWAp in India, due to the bureaucratic nature of the instrument and the low share of external funding to the health sector. Instead, one interviewee called for more CSO and community involvement in existing coordination mechanisms.

AND HOW ABOUT IHP+?

The International Health Partnership (IHP+)¹⁸ seeks to increase coordination and alignment among a variety of health donors and different aid modalities, by following three key principles: one health plan; one budget; and one monitoring and evaluation framework. In theory, it should have some potential for bringing together the different coordination groups that exist in India – such as CCM, NACO, RCH II – into one platform.

However, the reality is also that there is a great breadth and diversity among these groups – one interviewee estimated there are hundreds of these groups in the country stating that it would be extraordinarily difficult to bring all these mechanisms together. One development partner questioned the appetite for such a process in India. “There does not seem to be a real demand from the government for IHP+. What is the added value for India? It is only a burden on the institutions here.”

Another donor felt that IHP+ discussions should restrict themselves to trying “to agree on broader principles/directions and stop there”. Anything more would create more problems and work than it would solve. For example, conducting a Joint Assessment of National (Health) Strategies (JANS), for example, was seen to be massively complex when responsibility is so heavily in the hands of states and districts.

¹⁷ Source: WHO, World Health Report 2000 p.123 www.who.int/whr/2000/en/whr00_en.pdf

¹⁸ www.internationalhealthpartnership.net

Again, the **challenge of coordination is the complexity and diversity of the Indian situation.**

More than one donor felt that the ball was very much in the court of the Indian government and whether they wanted to move towards one big coherent national plan to encourage convergence. However, it was also felt that donors could do more to hold more specific discussions on coordinating funding mechanisms on certain states or issues.

CHANGING AID MODALITIES

Interviewees highlighted that whilst the Indian economy is growing, it is not yet true that aid is not needed to help develop the public health system. One INGO interviewee urged that: "Health reform is one issue, but [just] in terms of upgrading equipment etc. we certainly need to have more funds. The health budget is too small. Sometimes you are shocked by the facilities in the state hospitals."

Since much of India's economic expansion is concentrated in a few hands, growth will not necessarily translate into improved basic services for the ordinary person in the short term. In its country profile, the WHO concludes that: "India will continue to be dependent on donor aid, and external assistance will continue to serve as a catalyst to the improvement of systematic efficiencies and universal access to healthcare."¹⁹

Whilst donors are likely to continue being active in health spending in India, the changing situation of India will also change the approaches they look to adopt.

FROM PROJECT/DISEASE FOCUS TO TECHNICAL ASSISTANCE

Donors have traditionally funded disease-specific programmes, leading to coordination through the mechanisms outlined above. However, the dominant opinion on aid was that because India is experiencing strong economic growth, support is needed less in strict financial terms and more on technical assistance, capacity and expertise. As one development partner expressed it, "the non-financial aspects of aid are more important than the financial ones in India. We need to work with the government and support them [...] the good will is there and the donor expertise is needed."

The European Commission Country Strategy Paper (CSP) for India (2007-13) identifies that: "As India continues on [its growth] path, as most observers expect it to, the need for development assistance will gradually decrease [...] This CSP

should therefore be regarded as transitional, showing a progressive shift from development assistance towards support to pro-poor sector reform policies and other areas of mutual interest, including economic co-operation."²⁰

Donor lending has already started to shift gradually from more passive programme assistance, to a more direct, active role in influencing and building the capacity of the government to initiate health reform, reflecting the shift in the international environment from disease control to systems, issues and governance.

UNFPA has gradually moved away from projects and more towards aspects such as capacity building, where their expertise is valued. Technical assistance is now the main approach of what is the biggest UNFPA country programme in the world – USD 65 million – bringing in experts and consultants to work with Indian authorities. For example, UNFPA will help in the process of conducting the 2013 National Health Survey. Nevertheless, UNFPA has already committed to vastly reducing its spending in India over the coming years as the perceived financial needs diminish.

USAID, Sida and others provide only project support. Sida do a lot of training. However, USAID is looking to do a lot more technical assistance. Donor-funded research has also been important in improving understanding of the health system and its challenges

In the case of Germany, these days 95% of German bilateral co-operation goes to bank credits – there is no longer a traditional aid relationship with India. Funds are no longer called "aid", but rather "economic co-operation". Yet it still counts towards German ODA figures. What remains as "aid proper" in the health field is a German-funded polio-eradication programme (vaccination), which has been a traditional area of work for Germany and India is one of only five countries in the world where polio is still a problem. In addition, there is still German Humanitarian Aid which tackles issues such as leprosy and German charities are active in the country. The German GIZ is providing specific technical expertise to the Indian "smart card" system of health insurance.

The issue has already been raised above that donors withdrawing from disease-specific spending could have a serious impact on the continued delivery of these programmes. There were additional criticisms of a shift to technical assistance at national level, particularly that it often

19 WHO Regional Office for South East Asia, *India country health system profile, Millennium Development Goals Annex 2* www.searo.who.int/en/Section313/Section1519_10857.htm

20 Source: www.eeas.europa.eu/india/csp/07_13_en.pdf, p.1

involves overcrowding Indian ministries with foreign staff. A government representative who followed the issue closely questioned whether that money would not be better spent on local consultants, allowing money to be saved and used for service delivery. A development partner interviewee said: "Placing people within the ministries does not work in any case in India. So, we have to use other ways of giving technical assistance." Technical assistance should focus on clearly agreed deliverables requiring specific expertise, not used to create more civil servants.

INCREASED MULTILATERALISM

An important way in which India has encouraged donor coordination is by significantly reducing its bilateral co-operation relationships and favouring multilateral assistance. Coordination is then ensured through the multilateral bodies, such as the International Development Association (IDA of the World Bank), the Global Fund to fight HIV/AIDS, tuberculosis and malaria, United Nations Population Fund (UNFPA), the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunisation) and UNICEF (the United Nations Children's Fund).

In 2003, India's Bilateral Development Cooperation policy agreed to accept bilateral assistance only from G8 countries and the European Commission. Other countries falling outside of these criteria were advised to continue providing their development assistance to NGOs, universities or through multilateral development agencies, with the aim of strengthening civil society. In 2008, multilateral assistance accounted for nearly 70% of the total assistance to India.

The World Bank (IDA) has been an increasingly important funder for health in India – contributing in excess of 30% of the total external aid for health.



Director of Health Centre outside New Delhi:
"Donor money does not reach us – we are lacking everything".

Photograph: DSW

Its primary focus has been on constructing sub-centres, post-partum facilities and family welfare centres. It has lending programmes, a policy research programme and has also been involved in task managing the RCH programme.

Nevertheless, whilst the multilateral bodies themselves guarantee coordination of their own members, it remains the case that **coordination is needed both between the different multilateral bodies providing development assistance and with the remaining bilateral donors**. This coordination should not be used to limit opportunities to support long-term health objectives in India.

DE-CENTRALISED ASSISTANCE AND REGIONAL PRIORITISATION

One CSO interviewee highlighted that "technical support is one big area where the donors can help. But the implementer has to be the state. Rather than picking up specific themes, the donors should pick states to focus on." Several stakeholders thought that donors should focus on those states where the indicators are worst and use targeted interventions which can show results. As pointed out by one CSO interviewee though, it is noteworthy that even within states there is variation in terms of performance. So-called better performing states also have pockets of poor development and health indicators.

A particular issue that was raised in this context was the absorption capacity of the Indian health system. A government representative recommended that donors should "prioritise capacity building and improving governance structures at state level" as this would increase the capacity to receive and manage more funds. India should be focused on domestic funding for health, with technical support from donors.

A CSO representative was also clear that donors should not engage so much in budget support, but rather they should "fund and support areas that are ignored by the government/ national level." There is a fear here that budget support means giving the money away and forgetting about it, rather than engaging in promoting positive change in a context where national policies are not always seen to respond to community-specific needs.

Europe has had a particular presence in the health sector, with India being one of the few countries in the world where the European Commission has been providing earmarked budget support to the health sector. The only geographical prioritisation the European Commission had previously had was through the Backward Region Grant Fund, which supported 200 out of 600 districts classified by the government as "backward".

However, the Commission representative highlighted that whilst it has until now funded the central ministry through budget support, “the government has recently asked some donors to shift from national government support to district (not even states) support because of the massive size of the country. They asked us to choose some districts, because states are still massive.” The donors had a meeting to discuss this demand before answering the government. UN organisations have already adopted this approach.

Focusing on the district level was seen to have several advantages in India, not least because an amount of money which would be a drop in the ocean at national level can have real impact at district level. “Moreover,” as one development partner said, “districts have more time for it.”

There was evidence that donors were starting to do this. For example, DFID is going to focus its efforts on the eight poorest states, rather than nationally. This approach will seek to work with state governments to increase their systems and capacities – on procurement, quality assurance, education etc – so that they can increase their resources for health. The structure for this is bilateral agreements with each state and the funding going through the state budgets. The

support is thematically focused on issues such as safe institutional deliveries, malaria, family planning and malnutrition.

CSO FUNDING

Also in the context of national versus local approaches, CSOs would often prefer more innovative community approaches, including supporting advocacy towards the government.

The European Commission has held project calls for proposals aimed at CSOs. For example, the first local call for proposals, around 2008, was focused only in priority districts and at reproductive and child health, TB and HIV. In 2010, there was a call for CSOs at local level working on water for health and sustainable livelihoods.

DFID is also moving towards offering more support directly to the very local levels. They are funding CSOs in three states to promote advocacy capacity to make government accountable. This sees the key role for CSOs in India as being a watchdog rather than in implementation or service delivery. By promoting advocacy-specific organisation, this will remove issues around conflict of interest that currently exist for organisations trying to do both advocacy and service delivery.



Measure taken by a hospital for mothers and children to fight discrimination against girls.

Photograph: DSW

MANAGING FOR RESULTS

THE ROLE OF AID FOR PROGRESS TOWARDS THE HEALTH MDGs AND UNIVERSAL ACCESS TO PRIMARY HEALTHCARE

The overall goal of government health policy is a basic one: to achieve an acceptable standard of health among the general population. The provision and availability of primary healthcare and the achievement of the MDGs are key government objectives in this context.

However, many challenges remain before these are achieved. WHO's analysis is that: "India's performance in reducing mortality rates, compared

to similar Asian developing countries like China, Indonesia and Thailand, is poor."²¹ Although there have been long-term reductions in mortality rates and disease prevalence, these are often insufficient to meet the MDG targets. These challenges are linked to a number of factors, including gender inequality and prevailing discriminatory practices against certain population groups affecting the lives and health of such groups.

TABLE: MDG PROGRESS

MDG	2015 target	Base-line	Mid-term	Latest	Assessment of progress
Under-5 deaths per thousand live births ²²	42	116 (1990)	94 (2000)	69 (2008)	Insufficient (Countdown to 2015) ²³
Under-1 deaths per thousand live births ²⁴	26	80 (1990)	60 (2003)	53 (2008)	Poor compared to similar Asian developing countries (WHO) ²⁵
Maternal deaths per 100,000 live births ²⁶	106	437 (1990-1)	301 (2001-3)	254 (2004-6)	Poor even among low-middle income countries of region (WHO) ²⁷
% of population (15-49) living with HIV/AIDS ²⁸	Halt and reverse increase	0.5 (2001)	0.39 (2005)	0.29 ²⁹ (2008)	India continues to be in the category of concentrated epidemic (2009 Country Report) ³⁰
TB prevalence per 100,000 population ³¹	Halt and reverse increase	500.9 (1999)	362.5 (2003)	299.1 (2006)	The TB burden in India is still staggering. (WHO) ³²
Incidence rate of malaria (% of population) ³³	Halt and reverse increase	1.74 (2005)	1.59 (2007)	1.52 (2009)	MDG target largely achieved (WHO) ³⁴

21 Source: WHO Regional Office for South East Asia, *India country health system profile, Millennium Development Goals Annex 2* www.searo.who.int/en/Section313/Section1519_10857.htm

22 Source: Countdown to 2015, *Official Progress Report (2010)* p.8 www.countdown2015mncn.org/documents/2010report/CountdownReportAndProfiles.pdf

23 Ibid.

24 Source: Government of India, Ministry of Statistics and Programme Implementation, Central Statistical Organisation, *India MDG country report 2009*, p.51 www.indiasanitationportal.org.in/sites/default/files/ssd04_2009_final.pdf

25 Source: *India country health system profile, Millennium Development Goals Annex 2*

26 Source: *India MDG country report 2009*, p.61

27 Source: *India country health system profile, Millennium Development Goals Annex 2*

28 Source: UN Development Programme, *MDGmonitor.org*, www.mdgmonitor.org/map.cfm?goal=&indicator=&cd=356

29 Estimates - http://www.nacoonline.org/National_AIDS_Control_Program/

30 Source: *India MDG country report 2009*, p.66

31 Source: *MDGmonitor.org*

32 Source: *India country health system profile, Millennium Development Goals Annex 2*

33 Source: *India MDG Country Report 2009*, p.72

34 Source: *India country health system profile, Millennium Development Goals Annex 2*

MDG GOAL 4: REDUCE CHILD MORTALITY RATES

A major MDG health target is to reduce by two-thirds, between 1990 and 2015, the under-five mortality rate. This establishes a target rate in India of around 40 deaths of children under five per thousand live births by 2015. There has been some progress towards this goal, with the official rate dropping from around 116 in 1990 to around 70 by 2008. However, this average annual percentage reduction of 2.9 has been deemed “insufficient” by the Countdown to 2015 Report.³⁵

Another key indicator is the infant mortality rate – the number of children dying each year before reaching their first birthday. WHO figures highlight that “infant mortality has declined significantly in India from 129 in 1970 to 57 in 2005-06”.³⁶ Official Indian Sample Registration System (SRS) figures show a further fall to 53 in 2008.³⁷ Nevertheless, this rate of improvement needs to increase dramatically if the MDG target of around 27 per 1,000 live births is to be achieved by 2015.

MDG GOAL 5: IMPROVE MATERNAL HEALTH

An MDG target on maternal health is to reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio. This creates the target rate in India of around 109 deaths of mothers per 100,000 live births by 2015. Again, whilst achieving the MDG target rate seems unlikely, there has been some positive progress, with the official mortality rate falling from 437 in 1991 to around 254 by 2005.³⁸

Another important indicator for improvements in reproductive health is the proportion of births attended by skilled health personnel. This has been continuously increasing, from about 33% in 1992, to 42.4% by 1998 and 46.6% by 2005.³⁹ This is another positive, yet insufficient development. Furthermore, according to the third National Family Health Survey (NFHS III), only 51% of mothers received an antenatal check-up in 2005-6.⁴⁰

A significant caveat when assessing progress towards the MDG targets on maternal health is the likelihood that official figures are a significant underestimation of the real situation. Both WHO and UNICEF are of the opinion that women’s lesser standing in Indian society means that not only are maternal health issues not addressed with sufficient zeal, but that maternal mortality is underreported and misclassified. Current official estimates are taken from the NFHS I, II & III, and the SRS. Research by WHO, UNICEF et al. remarks that “the reported MMR [in India] was accepted as the lower uncertainty limit, twice the observed value was taken as the upper uncertainty limit,”⁴¹ such is the perceived risk of undercounting in the country. WHO estimates that achieving maternal mortality targets “is largely dependent upon socio-economic conditions of women, besides efficient implementation of programme interventions.”⁴²

Doctor in women’s and children hospital explaining infant and child growth.

Photograph: DSW



35 Source: *Countdown to 2015 Official Progress Report (2010)* p.8

36 Source: *India country health system profile, Millennium Development Goals Annex 2*

37 Source: *India MDG country report 2009*, p.51

38 Idem, p.61

39 Idem, p.62

40 Source: *India country health system profile, Millennium Development Goals Annex 2*

41 Source: WHO, UNICEF, UNFPA and The World Bank, *Maternal Mortality in 2005* www.who.int/whosis/mme_2005.pdf

42 Source: WHO Regional Office for South East Asia, *India country health system profile, Millennium Development Goals Annex 2* www.searo.who.int/en/Section313/Section1519_10857.htm

MDG GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

Key targets under this MDG are to have halted by 2015, having begun to reverse the spread of HIV/AIDS and the incidence of malaria and other major diseases. There has been important and valuable progress on reducing the incidence of many major diseases in India. Yet, significant challenges remain.

On **HIV/AIDS** there seems to have been some progress. Official figures show the percentage of the adult population (15-49) living with HIV to have reached its peak and started to decline. The percentage dropped from 0.5% in 2001 to 0.39% in 2005, before falling to 0.3% by 2007. The high-level of donor coordination provided by the Global Fund and country ownership through the CCM and NACP seem to have contributed to positive outcomes towards this MDG.

There was concern when the prevalence of HIV among pregnant women went up from 0.74 per thousand pregnant women in 2002 to 0.86 in 2003⁴³. The 2005 MDG Country Report observed that "This increasing trend needs to be reversed to achieve MDG 6."⁴⁴ However, the 2009 Country Report found that the prevalence had indeed dropped down to 0.49% by 2007.⁴⁵

The second phase of the NACP (1999-2006) introduced the prevention of mother-to-child transmission (PMTCT) programme and the provision of free antiretroviral (ARV) treatment. However, by 2004 still only 5% of pregnant women living with HIV received ARVs to prevent PMTCT in India.⁴⁶ By 2009 it was estimated that 17 to 48% of pregnant women living with HIV and 27% of HIV exposed infants received ARVs for PMTCT.⁴⁷ As a result of such low coverage, thousands of children are still infected every year through mother-to-child transmission.

WHO also highlights two significant issues of concern when considering disease prevalence in India. First, it sees AIDS figures as being under-reported – the number of cases of full-blown AIDS reported to NACO in 2004 was only a fraction of AIDS morbidity in the country.⁴⁸ Secondly, major risk factors for a future and devastating AIDS epidemic include "widespread poverty, illiteracy, poor nutritional and health status, social inequalities based on caste and gender, inadequate health infrastructure, taboos about sex, lack of political commitment, and a persistent denial of the AIDS epidemic in many states."⁴⁹

On **malaria**, the 2005 country report on the MDGs states that "prevalence and death rates associated with malaria are consistently coming down."⁵⁰ WHO assesses that: "Malaria has been effectively controlled in vast areas covering almost 80 percent population of the country in spite of increased population, rapid and unplanned urbanization, increased migration and population aggregation. The present performance levels suggest that the targets of MDG have largely been achieved but should strive for consistency in the declines."⁵¹ The remaining challenge as highlighted in the 2005 Country Report is that "80% of malaria reported in the country is confined to areas consisting 20% of population residing in tribal, hilly, difficult and inaccessible areas."⁵²

On **tuberculosis**, the 2005 country report also tells a positive story, stating that "the death rate associated with TB has come down from 67 deaths per 100,000 people in 1990 to 33 per 100,000 people in 2003. The proportion of TB patients successfully treated has also risen from 81% in 1996 to 86% in 2003."⁵³

On **measles** there has been progress towards immunising children. The proportion of one-year-old children immunised against measles increased from around 42% in 1992 to 56% by 2003 and 69.6% by 2008.⁵⁴

43 Source: Ministry of Statistics and Programme Implementation, Government of India, Central Statistical Organisation, *India MDG country report 2005* p.67 www.unicef.org/india/ssd04_2005_final.pdf

44 Source: idem. p.19

45 Source: Ministry of Statistics and Programme Implementation, Government of India, Central Statistical Organisation, *India MDG country report 2009* p.18 www.indiasanitationportal.org.in/sites/default/files/ssd04_2009_final.pdf

46 Source: International AIDS charity www.avert.org/aidsindia.htm

47 Source: UNICEF, *Factsheet on the status of PMTCT responses, 2010* www.unicef.org/aids/files/IndiaFactsheet_PMTCTFactsheet_2010.pdf

48 Source: WHO Regional Office for South East Asia, *India country health system profile, Millennium Development Goals Annex 2*

49 www.searo.who.int/en/Section313/Section1519_10857.htm

50 Ibid.

51 Source: Ministry of Statistics and Programme Implementation, Government of India, Central Statistical Organisation, *India MDG country report 2005* p.19 www.unicef.org/india/ssd04_2005_final.pdf

52 Source: *India country health system profile, Millennium Development Goals Annex 2*

53 *India MDG country report 2005* p.68

54 *India MDG country report 2005* p.19

55 Ministry of Statistics and Programme Implementation, Government of India, Central Statistical Organisation, *India MDG country report 2009* p.57 www.indiasanitationportal.org.in/sites/default/files/ssd04_2009_final.pdf

THE SIZE CHALLENGE

An important aspect to remember when looking at these percentages and rates is the sheer number of people being talked about. Recent estimates put the Indian population at over 1.2 billion. Thus, even if only 1% of the country is affected by a health problem, the actual size of the health challenge is 12 million people. A problem affecting 5% of the population is the equivalent of the whole population in a country such as France, Italy or the UK being affected.

On tuberculosis, for example, the WHO country profile highlights that "India accounts for one-third of global TB and has more TB cases than any other country in the world. Every year about 2.2 million persons are added to the existing load of about fifteen million active TB cases; of these, about 800,000 are smear positive (infectious), and about 450,000 die. TB is the leading cause of death among women in the reproductive age group of 25-44 years, more deaths than those due to all the causes of maternal mortality. Since every sputum-positive case has the potential to infect 10-15 individuals in a year, and since TB is one of the important opportunistic infections of HIV, it is feared that deaths due to TB can go up to four million in the next decade if not controlled."⁵⁵

According to the international AIDS charity Avert, in 2006, India had the largest population of people living with HIV in the world.⁵⁶ In 2006, UNAIDS estimated that there were 5.6 million people living with HIV in India. Following the first survey of HIV among the general population, in 2007, UNAIDS and the Indian National AIDS Control Organisation agreed a broad estimate of between 2 and 3.1 million people. For 2009, the figure was estimated to be 2.4 million, which equates to a prevalence of 0.3% and makes the Indian population living with HIV the third largest in the world.

THE REGIONAL CHALLENGE

Related to the size challenge facing India are the significant differences and disparities between the health status and condition of different states and districts. India is in a sense not really one country, but 35 very different states, and no one-size-fits-all approach will work.

The MDG data reflects the significance of this regional challenge:

- The infant mortality rate (IMR) in 2007 varied from as low as 13 per 1,000 live births in Kerala to as high as 72 in Madhya Pradesh.⁵⁷
- The maternal mortality rate (MMR) in 2004-6 ranged between 95 per 100,000 live births in Kerala and 111 in Tamil Nadu to 440 in Uttar Pradesh/Uttaranchal and 388 in Rajasthan.⁵⁸
- For 2005-6, the proportion of births attended by skilled health personnel was 75.2% in urban areas, but only 39.1% in rural ones.⁵⁹ Vulnerable castes and tribes are the least likely to have skilled health personnel present at a birth.
- The WHO cites 2003 figures which show that 59.9% of HIV/AIDS cases are in rural areas and 61.75% of all HIV infections were in just six states, with greater prevalence in the south and far north-east.⁶⁰
- The immunisation coverage [for children aged 12-23 months] against measles ranged in 2005-6 from highs of 92.5% in Tamil Nadu and 91.2% in Goa to as low as 27.3% in Nagaland and 37.7% in Uttar Pradesh.⁶¹

THE HEALTH INFRASTRUCTURE CHALLENGE

Tackling these health challenges and regional disparities is a major issue for a big country such as India. The capacity of state and district health administrations is a significant barrier to achieving optimal results on the ground.

One senior interviewee highlighted that states often underuse funding, sending money back to central government that they have not been able to spend. There are still questions about absorption capacity. If the health budget is increased, would the states currently be able to utilise it?

Several interviewees highlighted that this is exactly an area **where donors and co-operation**

55 Source: WHO Regional Office for South East Asia, *India country health system profile, Millennium Development Goals Annex 2* www.searo.who.int/en/Section313/Section1519_10857.htm

56 www.avert.org/aidsindia.htm

57 Source: Ministry of Statistics and Programme Implementation, Government of India, Central Statistical Organisation, *India MDG country report 2009* p.54 www.indiasanitationportal.org.in/sites/default/files/ssd04_2009_final.pdf

58 Idem, p.61

59 Idem, p.63

60 WHO Regional Office for South East Asia, *India country health system profile, Millennium Development Goals Annex 2* www.searo.who.int/en/Section313/Section1519_10857.htm

61 *India MDG country report 2009* p.59

partners could play a key role in supporting the ability of states and districts to absorb these potential budgets.

One donor opined that the key health challenge for India was how to get effective management for results between the national and state levels. The issue is how the national level can encourage the state level to achieve “improvements on the supply side in terms of getting results on health coverage, insurance schemes. What’s the compact between the federal and the state level that will incentivise them on results?” This sees a results framework as needing to be tied to financing.

Unless you can tackle those blocks in the system there is going to be a disconnect between the centrally sponsored schemes and the local level. One development partner observed that, “you can have lots of money going into the centre, for example for the visceral leishmaniasis [black fever] programme, but if there is little ownership in the states, it will not get down to the affected districts effectively.” The point was made that state governments are not necessarily against donors going straight to the local level as they are also motivated by quick results and visible changes on the ground.

Nevertheless, interviewees felt the modality of targeting district levels needs to be thought about. One development partner asked “if donors go directly to the districts, who are these recipients then accountable to?” There is a danger that technical assistance measures turn into parallel programmes that do not improve the system as a whole. They went on to say that **“What is provided at district-level needs to go hand-in-hand with improved accountabilities, incentivisation and measuring performance-based results within the mainstream system.”** Work needs to be done with local governance bodies or within the health system on how to demand better public services.

Donors have also found that investing in “nice projects” at local level is not sustainable as the systems collapse when the funding stops. It seems therefore that the changes on the ground need to be promoted as part of an overall sustainable system. This will probably mean that results are slower, but when they are achieved they are likely to be more sustainable. Changing the approach of a government ministry and then waiting for these effects to trickle down to the ground is likely to be a slow process, but at least there is felt to be new generations of civil servants who are more open to such ideas.

PUBLIC V PRIVATE

A key issue for the development of effective health infrastructure is that government spending for public health is still very low. According to a parliamentarian, “only 3-4 countries in the world are below India in terms of ranking.” The MP goes on to remark that “health spending accounts for just 3.2% of the national budget” and at the state level – where there is more competence for health service delivery, “spending on health is still only 5-7% of states’ budgets.”

Many stakeholders felt that achieving the MDGs was threatened by the government transferring its responsibilities in the health sector to private companies. Since 1991, the service sector has been opened up to the private sector. According to one development partner interviewed, 80% of outpatient service provision and 50% of inpatient currently happens in the private sector. This reliance on the private sector has led to a massive divide in health service provision. Whilst underinvestment in health infrastructure has resulted in under-equipped, under-staffed state hospitals, world-class private facilities exist for the wealthy.

A parliamentarian observed that India is apparently the sixth country in the world in terms of the level of out-of-pocket spending for health – the top five being highly developed countries: “Private sector facilities have improved, but in real terms, the improvement of public healthcare services has not happened.” State-of-the-art technology does exist now in the health sector, but largely only in the private sector and not accessible to the poorest.

Since only around one-tenth of the population has any kind of health insurance, this means that, for many, healthcare is either unaffordable or a potential cause of serious indebtedness and poverty. The National Sample Survey Organisation (NSSO) found that 40% of the Indian population had to take loans if a family member got sick. In the case of 35% of Indian families, if any family members were admitted in hospitals, they fell below the poverty line.

According to an MP, the Parliamentary Committee on Health has stated that health spending should be at least 10% of the national budget. Furthermore, they argue that “India is an emerging economy. The people are poor, but not the country. What is needed is the political will for better use and distribution of existing domestic funding.”

The 11th FYP “explicitly envisaged an increase in public expenditure on health to at least 2 per cent of GDP”⁶² and the budget of the Ministry of Health was increased by 22% year on year for the fiscal year 2009-10.⁶³ However, it was not felt that this really changed the overall balance of payments in the health sector or the government focus on promoting the profitability of the private sector. For example, whilst the 2002 National Health Policy foresaw an overall increase in health spending to 6% of GDP by 2010⁶⁴, two-thirds of this was to come from private sector investment in hospitals and particularly modern healthcare technologies.

Stakeholders recognised that the government is turning to health insurance schemes to try to increase access to hospital services for some of the poorest. In April 2008, the Ministry of Labour launched a major new National Health Insurance Scheme. More than 20 million smart cards have now been distributed in what is one of the biggest health insurance programmes in the world.

Some stakeholders highlighted that too few people knew about or had access to the smart-card scheme. The government has started funding NGOs to raise awareness of this, but more needs to be done. Others rejected the very idea that such a scheme could provide a real solution for the millions of poor in Indian society. It was felt that health (like other social sectors) was being treated as a lucrative market, when in fact it is a human right under the Indian Constitution. As an MP put it, “it should be the responsibility of the state itself to ensure health of its people.”

However, as one development partner interviewee put it, there should not be an “oversimplification of the negative aspects of the private sector [...] A well-regulated private sector can help the public system by delivering services.” It was also felt by many that the government cannot achieve change in India without the private sector on board.

It is when the private sector is unregulated that it becomes dangerous. A donor gave an example of problems emerging from lax government control in maternity services: “The regulation of the private sector is bad. The quality is bad, even though people pay a lot of money out-of-pocket.” A development partner suggested the use of “tools such as subsidies, social franchising, social marketing, voucher schemes etc” to achieve

national aims in partnership with the private sector, although they recognised that scaling up is always the problem.

Overall, then, the government was seen to need to increase public spending on healthcare delivery to meet the needs of its population – particularly the poorest – and achieve the MDGs. At the same time, the government **needs to work more closely with the private sector to ensure overall oversight and quality control to fulfil its pledge to ensure the provision and availability of primary healthcare to all.**

Potential obstacles to higher government health spending in the future to deliver public health services were identified as being budget deficits at both national and state government levels and the high cost of land in urban areas and a growing shortage of nursing staff.

CROSS-SECTOR LINKS FOR BETTER HEALTH OUTCOMES

The importance of **addressing the social determinants of health**, such as water, sanitation, nutrition and education, was highlighted by several interviewees, claiming that it was not possible to look at health policy in isolation when working towards health outcomes in India: One development partner highlighted that “there are large amounts of money being given to each of these areas, but it is not always easy to get effective coordination between them”.

India is probably one of the countries where linking water, sanitation, health and nutrition appears most vital, given, as Indian National Health Policy highlights, that “common water-borne infections – Gastroenteritis, Cholera, and some forms of Hepatitis – continue to contribute to a high level of morbidity in the population”.⁶⁵ According to the WHO, diarrhoea is one of the most common causes of death in children under five in India. Acute diarrhoeal disease is one of the major consequences not only of water pollution but also of the failure of proper management of sewage in both cities and rural areas.⁶⁶

As highlighted by one development partner, recent studies showed that one important factor in reducing maternal mortality rates would be to sanitise the toilets in the maternity hospitals.

62 Planning Commission, Government of India, *Mid-term Appraisal of the 11th Five Year Plan* p.1 http://planningcommission.nic.in/plans/mta/11th_mta/chapterwise/chap7_health.pdf

63 Source: The Economist Intelligence Unit, *healthymagination Health of Nations* www.healthofnations.com/countries/profile/india#spending-overview

64 Ministry of Health and Family Welfare, Government of India, *National Health Policy 2002* p.24 http://mohfw.nic.in/NRHM/Documents/National_Health_policy_2002.pdf

65 Ministry of Health and Family Welfare, Government of India, *National Health Policy 2002* p.4 http://mohfw.nic.in/NRHM/Documents/National_Health_policy_2002.pdf

66 WHO Regional Office for South East Asia, *India country health system profile, Millennium Development Goals Annex 2* www.searo.who.int/en/Section313/Section1519_10857.htm

Hygiene and cleanliness are a real problem in clinics and hospitals in India, where water-borne diseases are a huge issue – people do not know enough about transmission routes. Solutions are not just about spending money to treat these diseases, but in educating people and improving facilities to prevent them in the first place.

The development partner went on to argue that, “if we are looking at reaching MDGs vertically, it is not going to happen – it should be taking place in a broader health platform. You are going to fail on one MDG if you do not link it to the others.” Current challenges include that there were not seen to be any coordinating mechanisms to tie activities together from different government departments. A supplementary view from another development partner was that this multi-sectoral coordination was easiest and most effective at local level. “We can spend our life trying to make departments work together. At village level, coordination is a lot better. If you stick to the lower level [you can] see positive examples there.” There are village health sanitation committees, but it is not clear how efficient these are yet.

KEY POLICY RESPONSES: NRHM AND RCH

Whilst the National Health Policy of India, which is currently in the process of being revised, recognises the interdependence between health, nutrition, water and sanitation, it does not propose any concrete actions on how to cooperate with other line ministries in order to ensure the effective interlinkages between the sectors. On the contrary, it clearly states that the health policy should strictly address health sector issues, in its narrow sense. This document also reflects the still persisting rivalries between the line ministries and the battle for competencies **at national level**.

However, interviewees expressed hope that the new FYP, to be finalised in 2011, will adopt a more integrated approach. Donors, as well as CSOs involved, are pushing for that.

Moreover, a more integrated approach to healthcare has already been initiated **at district level**, through the implementation of the NRHM 2005-2012. The NRHM mission document states the aim to “Carry out necessary architectural correction in the basic healthcare delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water”.⁶⁷ It targets 18 out of 28 states in India, with a budget of ca. EUR 1 billion and includes a concrete timeline and indicators integrated into the programme document.

It aims at effective integration of health concerns with determinants of health such as sanitation and hygiene, nutrition, and safe drinking water through the preparation and Implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation and hygiene, and nutrition.

To ensure effective implementation of such plans, the NRHM includes a training component on linking health, water, sanitation and nutrition for ASHAs who would be able to deliver key health interventions at the very local level, reaching even the rural areas which have been most isolated from health services. The national mission aims to provide one ASHA per village or roughly one for every 1,000 population. The ASHA is given a drug kit and basic training and expected to carry out home visits.

Front entry to the Ministry of Health in New Delhi: Linking health, water and sanitation is key.

Photograph: DSW



67 www.mohfw.nic.in/NRHM/Documents/Mission_Document.pdf

The **RCH II programme** aims to improve access to the necessary facilities, whilst decentralised, participatory planning is a key principle, aiming to refocus services to the needs of communities and individuals. As part of this, and to specifically improve outreach, NGOs and voluntary organisations are to be involved in a much larger way.

According to WHO, “Major causes of infant mortality continue to be pre-maturity birth and low birth weight, poor intra-partum and newborn care, diarrhoeal diseases, acute respiratory infections and other infections.”⁶⁸ According to the National Institute of Health and Family Welfare, the available evidence suggests that a priority should be impacting on neonatal mortality rates which have remained rather stagnant. Intensive and urgent efforts are required to adopt home-based newborn care based on validated models, such as the Gadchiroli model as recommended by the 11th FYP.

The role of the ASHAs at community level can therefore be crucial in integrating interventions to improve child health and reduce infant, under-five and maternal mortality, thus contributing to achieving MDGs 4 and 5. Through home visits, they can provide essential antenatal and post-natal care, reviewing progress, identifying problems, referring ill newborns and reinforcing important care messages, such as on the importance of breastfeeding. They can refer and manage risks and unwanted pregnancies, support immunisation delivery, and detect and manage problems from anaemia in mothers to nutrition deficiencies and respiratory infections in infants.

One experienced donor commented that “NRHM has made a huge difference. When it came in, I was very cynical. I thought it was going to be another white elephant. But it has done a huge amount in getting resources right down to block primary health centre level. We see that when we go to field visits, medicines and instruments are in stock, which they never used to be.”

Interestingly, states targeted by NRHM have shown marginally better than average improvement. For example, the state of Tamil Nadu has seen a decline in the infant mortality rate of as much as 6 points in two years, compared to an overall national decline of just 4 points in three years.

However, there are still massive implementation challenges, particularly around the availability of health workers. The use of ASHAs as community health workers was considered a good idea and it

was right that it was being incentivised. However, it was felt that the workers are becoming overloaded with many different interventions and tasks and, as one development partner expressed it, “they get to a stage where they cannot cope”. Efforts to increase capacity need to be thought through effectively and realistically to promote more sustainable service delivery.

Given that over half of all births are conducted in the home, there is still a need to increase the availability of skilled and equipped birth attendants to support safe deliveries in areas without comprehensive obstetric care and to increase access to emergency care within two hours’ distance.

THE ROLE OF DONORS IN MANAGING FOR RESULTS

The majority of interviewees did not want to see the total disappearance of donors from the country. One NGO representative said, “my take is that if we have poor MDG performance and government spending of only 4.5 per cent of GDP on health and infrastructure/economic development, [then] we need external funds.” There was still felt to be a role for international donors to play in supporting health spending, capacity and management in India.

Furthermore, there was a strong feeling that **donors had a clear role to play in pushing for achievement of the MDGs**. They can target their finance to results in terms of MDG targets and apply pressure to the Indian government where appropriate to work towards these objectives. This is not incompatible with the principle of ownership, since the MDGs are an agreed target that the government has already committed to working towards.

One participant expressed the view that **financing for results** was useful for providing a system of incentivisation for progress towards the achievement of key health objectives and the MDGs. However, they saw this as much more a question for the Ministry of Finance than the Ministry of Health. Additionally, it was commented that the amount of money from donors is not enough to incentivise the government to do this work unless it wants to.

Paying only for results also has problems in that it requires enough money in the first place to carry out the programme to reach whatever the milestone is. Furthermore, as one development partner put it, “we need to be modest on what we

68 WHO Regional Office for South East Asia, *India country health system profile, Millennium Development Goals Annex 2* www.searo.who.int/en/Section313/Section1519_10857.htm

can achieve in a short timeframe in a country like India. Three years is not enough to change things.” Judging policies on results needs to take this into account.

The interviews provided evidence of the World Bank linking its funding to results. DFID has been working with three state governments on new state Programme Implementation Plans (PIPs). These focus a lot less on inputs, “but rather a mix of inputs, outputs and outcomes.” Health indicators used by DFID are available on the DFID website and are disaggregated by gender and income.

The RCH II programme was felt to have a clear results focus on some of the key MDG indicators. On the other hand, one interviewee explained that NRHM uses parameters, not results indicators, but something more like process indicators.

Monitoring results was a key area where stakeholder involvement and the role of CSOs was seen to be important. Donors could play a role in supporting the watchdog role of CSOs, which can ensure that health policy and delivery is achieving positive health outcomes. For example, there has already been some success in monitoring and low-level interventions in the field of education through village education committees which monitor aspects such as teacher absenteeism. Another interesting technique highlighted by a donor was that “community procurement has been experimented with and that’s been remarkably successful.” These solutions can be sustainable and make a difference to monitoring and achieving results.

DONOR POLICY COHERENCE

A major finding of the fact-finding visit to India was around how different donor policies can impact on health outcomes in a developing country such as India. For example, many Western governments are giving aid to health priorities in India, whilst at the same time encouraging a brain drain of trained health personnel from the country into their own health systems. It was felt that donor governments could make a big contribution just by stopping this poaching of human resources.

Similarly, Western approaches to intellectual property were strongly challenged as undermining India’s development. One CSO interviewee felt passionately that discussions over the future Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) “are trying to hit our patent system all the time [...] We ask the government not to succumb to the ‘big daddy’ and not to accept the IP provisions.” Even a government representative opined that negotiations such as the one around the free trade agreement (FTA) with the EU are “a way for the EU to get access to Indian market because the EU market is saturated. Indian exports on the other hand are subject to very strict environmental rules – non-tariff barriers.”

The WHO representative highlighted that European countries are asking for a clause on data exclusivity, which if introduced would have “serious implications for the development of new medical products such as vaccines and increases in prices”. As an Indian CSO stakeholder put it “we are not fighting only for us in this free-trade issue, but for life-saving drugs for many in the whole world.”



Strong stands against the FTA taken by a CBO outside of New Delhi.

Photographs: DSW

Furthermore, any increases in prices are likely to hit the poorest most in a country such as India, where out-of-pocket payments account for nearly 80% of the country's health expenditures. Most of these costs are already related to the prices of medicines and over 30% of the population are already estimated to be driven below the poverty line when they need health treatment. Therefore, there is an acute risk that the EU's FTA with the Indian Government will worsen the current situation and directly negatively impact on any progress towards achievement of the health MDGs.

Different stakeholders also felt that the policy of the Indian government to support generic medicine production to provide affordable medicines to the Indian population had been a failure. Many generic producers in India are in fact supplying Africa rather than the Indian population. Furthermore, there is a real risk of multinational pharmaceutical companies buying up Indian generic manufacturers and cutting the cheap supply even more. Unless India is allowed to protect its cheap generic manufacturers, there is a danger that vital medicines will remain beyond the means of a majority of India's population, undermining health advances elsewhere.



Indian CSOs preparing for a demonstration against the FTA.

Photograph: DSW

CONCLUSIONS AND RECOMMENDATIONS

OWNERSHIP

- Although specific policies should not be determined by **donors**, the latter do have a role to play in promoting good practice in terms of **governance, participatory democracy, transparency and respect for human rights**. They should also promote and support country progress towards achievement of the **MDGs**.
- In order to ensure true country – as opposed to government – ownership, both the national government in India and the donor community need to actively promote **genuine participatory democracy** by involving a representative diversity of stakeholders in policy processes.
- Donors should also support local and community-based organisations to take on the role of holding health authorities and the private sector to account, particularly where reliance of government funding can restrict the ability of organisations to take on this critical role. CSOs should be supported to do more than just fire-fighting health problems in communities.
- The Global Fund Country Coordinating Mechanism (CCM) is an interesting example of good practice in engaging all the stakeholders around certain health issues (HIV/AIDS, malaria and TB). Although the real influence that, for example, CSOs can have is limited, the CCM co-chair selection procedure has a lot of potential and could be applied to the broader health and other sectors.
- Donors can add value to the Indian situation by bringing specific expertise and experience to Indian stakeholders, particularly at district planning level.
- The parliament and civil society both have much to gain from improving their mutual understanding, sharing information and cooperating. MPs can get a better understanding of the realities on the ground and CSOs can get issues raised with government ministries.

DONOR COORDINATION

- There seems to be a clear **link in India between the strength of the national approach to a policy issue and the ability of donors to coordinate** around that agenda. The HIV/AIDS agenda is one where coordination is high thanks to the Global Fund CCM and the Indian National AIDS Control Programme. Lessons learnt should be replicated in other areas.
- Whilst **coordination** between donors – especially between multilaterals and bilateral – remains an important task, it also needs to be enhanced **between vertical and horizontal levels of Indian government and service planning and delivery mechanisms**. Donors then need to coordinate with the most appropriate level of activity.
- **Harmonising reporting mechanisms** for Indian stakeholders is a relatively easy way for donors to reduce transaction costs for development assistance without increasing their own costs. In order to ensure that the process is effective and sustainable at country level, harmonisation needs to be supported by donor headquarters.
- Donors need to coordinate not just to provide funding for specific programmes, but **to increase the capacity of the system** to deal with the extra funding. However, technical assistance should focus on clearly agreed deliverables requiring specific expertise at state and district levels, instead of overcrowding national ministries with foreign staff.

MDGs AND MANAGING FOR RESULTS

- The national government needs to **increase spending on public health** to ensure access to primary healthcare for the large number of poor in India. Levels of public spending on healthcare in India are amongst the lowest in the world.
- **The private sector** has an important role to play in the delivery of health services in India, however it is essential that **there is effective monitoring of these by government and not a simple passing of responsibility**. It is not acceptable that 35% of Indian families fall below the poverty line if a family member has to go to hospital.
- **Health insurance schemes** can be a part of the solution of increasing access to hospital services for some of the poorest, but more needs to be done to help the most vulnerable access these schemes and access to primary healthcare needs to be guaranteed even to those who cannot benefit from these systems. Especially **European donors** can and should play a crucial role through know-how transfer, by building on their countries' long-standing experience with social security and health insurance schemes to enable the Indian government to choose the best option for the country.
- Systems are needed in India that can deliver positive health outcomes whilst respecting state and district specificities. The national government and donors have roles to play in facilitating and encouraging positive change at district level without dictating exact policies from above. Considering the size and complexities of a country such as India, **interventions by donors at district level would also ensure a greater impact and higher visibility of health aid**. However, such efforts need to be accompanied by measures improving accountabilities, incentivisation and results-based management at district level.
- **Programmes such as NRHM and RCH II** have been successful at promoting effective change at local levels. Such programmes point the way forward in India, but donors and the government have to avoid creating parallel programmes that do not improve the system as a whole or throwing money at local systems that do not have the capacity to absorb it. Efforts are needed to ensure sustainable improvement in service delivery.
- A key priority in India is **supporting and facilitating community groups** and local governance bodies within or outside the health system who can demand better public services and hold the authorities to account in delivering positive health outcomes.
- To achieve the MDGs in India will require coherent and integrated approaches that address not only pure health systems, but also strategically related sectors such as sanitation, hygiene, education and water. These **integrated approaches** might be more easily and most successfully developed at local levels, and hence the need for donor and government support to such efforts at the local levels.
- **Donors have a responsibility not to undermine any development results of external assistance with their policies in other sectors**. India is a showcase example for the need of policy coherence in development: In particular, Western governments' practice of recruiting trained health professionals from India and using trade negotiations to prevent India producing and distributing generic medication **can be major obstacles to achieving health outcomes in the country**. Trade negotiations such as the EU's Free Trade Agreement in India need to be scrutinised by independent experts with regard to their impact on the partner country's social situation, before being signed. In the light of a global responsibility for achieving the right to health for all, the international community needs to monitor trade agreements of this nature and prohibit clauses with potentially adverse effects for universal access to medicines both in India and the developing world in general.
- It can be acceptable for donors to provide results-based financing to promote achievement of the MDGs, however expected results need to be realistic as positive change can take time in a country such as India. Process indicators can also be useful as a proxy.

BIBLIOGRAPHY

A Thomson Reuters Foundation Service, *AlertNet*: www.trust.org/alertnet/country-profiles/india

Avert (international AIDS charity) www.avert.org/aidsindia.htm

Countdown to 2015, *Official Progress Report (2010)*

www.countdown2015mnch.org/documents/2010report/CountdownReportAndProfiles.pdf

DSW, *Euromapping - Mapping European Development Aid & Population Assistance*, 2009.

www.euroresources.org

European Commission, *Country Strategy Paper for India 2007-13*

Ministry of Statistics and Programme Implementation, Government of India, Central Statistical Organisation,

India MDG country report 2005 www.unicef.org/india/ssd04_2005_final.pdf

Ministry of Statistics and Programme Implementation, Government of India, Central Statistical Organisation,

India MDG country report 2009 www.indiasanitationportal.org.in/sites/default/files/ssd04_2009_final.pdf

Ministry of Health and Family Welfare, Government of India, *National Rural Health Mission - Mission Document*

www.mohfw.nic.in/NRHM/Documents/Mission_Document.pdf

Ministry of Health and Family Welfare, Government of India, *National Health Policy 2002*

http://mohfw.nic.in/NRHM/Documents/National_Health_policy_2002.pdf

OECD, *data*: www.oecd.org/dataoecd/62/30/1877912.gif and www.oecd.org/dac/stats/idsonline

Planning Commission, Government of India, *11th Five Year Plan 2007-12, Social Sector*

http://planningcommission.nic.in/plans/planrel/fiveyr/11th/11_v2/11th_vol2.pdf

Planning Commission, Government of India, *Mid-term Appraisal of the 11th Five Year Plan*

http://planningcommission.nic.in/plans/mta/11th_mta/chapterwise/chap7_health.pdf

The Economist Intelligence Unit, *healthymagination Health of Nations*

www.healthofnations.com/countries/profile/india#spending-overview

UN Development Programme, *MDGmonitor.org* www.mdgmonitor.org/map.cfm?goal=&indicator=&cd=356

WHO regional Office for South East Asia, *India country health system profile*:

www.searo.who.int/en/Section313/Section1519_10852.htm

WHO Regional Office for South East Asia, *India country health system profile, Millennium Development Goals*

Annex 2 www.searo.who.int/en/Section313/Section1519_10857.htm

WHO, *World Health Report 2000* www.who.int/whr/2000/en/whr00_en.pdf

WHO, UNICEF, UNFPA and The World Bank, *Maternal Mortality in 2005* www.who.int/whosis/mme_2005.pdf

LIST OF ACRONYMS

AfGH	Action for Global Health European NGO Network	NFHS II	Second Indian National Family Health Survey
ARVs	Antiretroviral drugs	NGO	Non-Governmental Organisation
ASHA	Accredited Social Health Activist	NRHM	Indian National Rural Health Mission
CBO	Community-based Organisation	NSSO	Indian National Sample Survey Organisation
CCM	Global Fund Country Coordinating Mechanism	OECD	Organisation for Economic Co-operation and Development
CHC	Community Health Centre	ODA	Official Development Assistance
CIDA	Canadian International Development Agency	PHC	Primary Health Centre
CSO	Civil Society Organisation	PIPS	Programme Implementation Plans
CSP	Country Strategy Paper (of the European Commission)	PMTCT	Prevention of Mother-to-Child Transmission
DFID	UK Department For International Development	RCH	Reproductive and Child Health programme
DSW	Deutsche Stiftung Weltbevoelkerung (German Foundation for World Population)	SIDA	Swedish International Development Cooperation Agency
E7	China, India, Brazil, Mexico, Russia, Indonesia, Turkey.	SRHR	Sexual and Reproductive Health
EC	European Commission	SRS	Sample Registration System (official Indian data)
EU	European Union	SWAp	Sector-wide Approach
EUR	Euros	TB	Tuberculosis
FYP	Indian Five-Year Plan for Development	TFR	Total Fertility Rate
G8	The Group of Eight major developed economies (France, Germany, Italy, Japan, UK, USA, Canada and Russia, with the EU also represented)	TRIPS	Trade Related Aspects of Intellectual Property Rights
GAVI	The Global Alliance for Vaccines and Immunisation	UNAIDS	Joint United Nations Programme on HIV and AIDS
GDP	Gross Domestic Product	UNFPA	United Nations Population Fund
IDA	International Development Association of the World Bank	UNICEF	United Nations Children's Fund
IHP+	International Health Partnership	USAID	United States Agency for International Development
IMR	Infant Mortality Rate	USD	United States Dollars
INGO	International Non-Governmental Organisation	WB	World Bank
JANS	Joint Assessment of National Strategies	WHO	World Health Organisation
MDGs	Millennium Development Goals		
MIC	Middle Income Country		
MMR	Maternal Mortality Rate		
MP	Member of Parliament		
NACO	Indian National AIDS Control Organisation (division of Ministry of Health & Family Welfare)		
NACP	Indian National AIDS Control Programme		

Action for Global Health (AfGH) is a network of European health and development organisations advocating for the European Union and its Member States to play a stronger role to improve health in development countries. AfGH takes an integrated approach to health and advocates for the fulfilment of the right to health for all. One billion people around the world do not have access to any kind of healthcare and we passionately believe that Europe can do more to help change this. Europe is the world leader in terms of overall foreign aid spending, but it lags behind in the proportion that goes to health.

Our member organisations are a mix of development and health organisations, including experts on HIV/AIDS, TB or sexual and reproductive health and rights, but together our work is organised around a broad approach to health. AfGH works to recognise the interlinkages of global health issues and targets with a focus on three specific needs: getting more money for health, making healthcare accessible to those that need it most and strengthening health systems to make them better equipped to cope with challenges and respond to peoples' needs.

In advance of the upcoming Fourth High Level Forum on Aid Effectiveness in South Korea in November 2011, AfGH commissioned DSW Brussels to undertake six combined fact-finding and advocacy visits to developing countries in order to assess the impact of current aid structures and aid effectiveness principles on health-spending in those countries. The overall objective of these fact-finding visits is to bring evidence and experience from developing countries to support European advocacy for global health, by producing country-specific policy briefings and disseminating them to key decision makers and organisations in Europe and in developing countries.

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