



»» Budget Support Consequences for Sexual and Reproductive Health

Introduction

Budget support (BS) has become increasingly important as a European aid instrument: The European Commission (EC), the United Kingdom, the Netherlands, Sweden, Ireland, Denmark and Germany are raising the proportion of aid spent through General BS.¹ More specifically, the German Ministry for Economic Cooperation and Development is planning to spend half of its Official Development Assistance in Sub-Saharan Africa in this way and the EC has set the objective to grant 50% of its development aid through this form of assistance by 2010.²

According to the EC, the overall objective of BS is to help partner countries to become independent from international aid. With BS donors fund governments directly and measure performance outcomes, rather than monitoring how the government allocates funds and implements programmes. BS can be divided in two major types: General Budget Support (GBS) and Sector Budget Support (SBS). GBS replaces funding streams for

specific projects and programmes, eg, reproductive health, with general support to partner governments, to allocate as they see fit. SBS represents a transfer to the national treasury in support of a sector programme policy and strategy.³

BS has the potential to enhance political dialogue and public finance management, while supporting “partner” government “ownership” over ODA and encouraging long-term investment strategies. Providing money that developing country partner governments can allocate through their national budget cycles could build more efficient and accountable governance, strengthen national competence and national systems.

However, BS also can be used as a particularly flexible and non-transparent lever to exert political or ideological influence over partner governments. Moreover, BS makes it difficult to verify where the money goes and often impossible to evaluate whether specific areas within a given sector receive aid – such as Sexual and Reproductive Health (SRH) within the health sector.

Some facts and figures about BS

According to the latest figures, 44% of programmable money (€13.5 billion) in the 10th European Development Fund (EDF) is scheduled to be channelled through BS, compared with 25% in the 9th EDF⁴. This includes a modest increase in GBS and a significant increase in SBS, from 2% of total resources in the 9th EDF, compared to 16.1% in the 10th.

Donors do not provide BS to all partner countries. The EC requires that the following be in place in order to provide BS⁵: (1) a well-defined national or sector policy and strategy; (2) a stability-oriented macroeconomic framework; and (3) a credible and relevant programme to improve Public Financial Management (PFM)⁶.

Country Strategy Papers

EC Budget support includes fixed and variable payments (“tranches”):

a) The fixed tranche is strongly linked to IMF programmes⁷; progress in implementing public financial management reforms; submission of the auditor general’s report and budget performance reviews and dialogue with the EC delegation.

b) The amount of the variable tranche is tied to specific performance indicators. Sometimes some of the indicators address health issues, such as the following in Uganda:

- Outpatient department use per capita per year, in public and private facilities.
- % of children < 1 years old receiving DPT immunization
- % of births taking place in public and/or private facilities
- % of established health posts held by qualified staff.



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Implementation of BS is mostly negotiated in budget support donor groups, meetings between BS donors and the partner country's government to harmonise and align aid. Harmonising aid can bring benefits, such as reduced transactions costs for partners and increased transparency, but also can magnify the unpredictability and volatility of financial flows⁸ because if donors together make a decision (e.g. to decrease the amount of a variable tranche) the impact of this is much larger than a decision of a single donor.

Advantages of BS: Ownership, Fewer Conditionalities and Reduced Transaction Costs?

Ownership

One advantage of BS is that, in principle, it gives the opportunity for local stakeholders to focus on national systems and procedures rather than on the donors' multiple procedures. It can, in theory, create greater aid "ownership" in the partner government. However, a well-documented lack of consultation and even exclusion of national parliaments and civil society organizations (CSOs) from the negotiation of BS and its allocation, actually limited civic ownership⁹.

In addition, even when there is "country-ownership", it is often limited to the Minister of Finance. "Negotiation" or even "consultation" often does not include social ministries, such as the Ministry of Health, which are needed to achieve poverty alleviation. This is partly because many ministries lack the capacity and knowledge to be meaningfully involved in those processes. When subject matter experts are excluded, it is very likely that certain issues, eg, SRH, will be left aside in the allocation of donor funds. The success of BS requires participation of all relevant parts of the government, the national parliaments and CSOs to plan, execute and account for public spending¹⁰.

Conditionalities

The Joint Evaluation of General Budget Support 1994–2004¹¹ reported that BS implementation increased conditionality. Different from other aid modalities, during the negotiations leading to the implementation of BS, the governments agree their demands at a single table. Given the number of actors involved and the multiplicity of interests, the negotiations can result in a significant increase in the final number of conditions¹².

Transaction costs

Another issue that should be questioned, often presumed as an advantage of BS, is the notion that use of existing systems/institutions can avoid parallel structures and reduce transaction costs. However, an EC¹³ study could not prove that BS reduces transaction costs.

Concerns related to health outcomes

Does general BS increase partner governments' funding of education and health? The evidence so far is unclear.¹⁴ In the case of the EC's BS, despite the Commission's stated commitment to the promotion of gender equality and SRH, two recent studies show that measurement of performance on these issues is almost entirely absent from the EC's BS¹⁵. It is therefore essential that mechanisms and monitoring tools are in place to ensure that funds going to the general budget directly support efforts to meet the MDGs.

Certain issues will surely lose funding in some countries if BS is the exclusive aid modality. In addition, BS can over-centralise procurement, eg, of critically needed health supplies, leading to reduced disbursements, shortages and surpluses, inappropriate supply based on central assumptions rather than local realities, and waste. For example, problems with centralised procurement have been shown to result in reduced immunisation, reduced availability of vaccines where and when needed, and lack of medical instruments and equipment¹⁶.



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Budget Support Consequences for Sexual and Reproductive Health

MDG contracting

The EC would like to provide more long-term and predictable GBS “whenever deemed possible” during the implementation of the 10th EDF. This enhanced form of GBS will take the form of an “MDG contract” to highlight the contractual nature of its long term financial commitments and its focus on MDG-related results, notably in health and education.

The MDG-contract has the following key features:

- Six year commitment of funds;
- At least 70% fixed tranche, not contingent on performance;
- Up to 30% variable tranche, with two elements: (a): at least 15 % of the total commitment will reward performance against MDG-related outcome indicators and public sector financial management reforms based on progress reports. (b) If there are major concerns about performance with respect to implementation of the PRSP (or equivalent), performance monitoring (and notably data availability), progress with PFM improvements, and macroeconomic stabilization, up to 15% of the annual allocation could be withheld.
- Countries are eligible for MDG Contracting if they have a successful track record in implementing BS, commitment to monitoring MDGs and improve domestic accountability for budgetary resources, active donor coordination and mechanisms to support performance review and dialogue.

The primary difference between MDG contracting and GBS is that performance review can only lead to changes in the allocation after the first three years. This increases aid predictability and can deepen the EC’s dialogue with its partner countries on poverty reduction outcomes.

The EC has begun developing ‘MDG contracts’ in a limited number of countries¹⁷. 10 countries¹⁸, all in the ACP region, have been preselected to get such a contract. The contracts will in most cases be included in the country Annual Action Programmes to be submitted to the EDF Committee towards the end of 2008. The EC plans to extend MDG contracts to other countries, including Asian countries, at a later point.

Case Study

MDG contracting Burkina Faso

Burkina Faso’s six-year MDG contract is scheduled to be signed at the end of 2008 by the EC and should start in January 2009. From the total amount of BS for Burkina Faso for the period 2008-2013 (€ 529 Million), about 60% (€ 320 Million) will be allocated to the MDG Contract. In addition to the 70% fixed / 30% variable ratio described above¹⁹, the contract might include the possibility of final bonus (after 6 years) when the overall results are very good²⁰. It is however unclear where that money should come from. There is no final decision on the indicators yet, but it seems that for the fixed tranche, indicators will be related to good governance, macro-economy, ownership, and tax-income. For the performance tranche there will only be 1 indicator (which, according to the EC²¹, should be chosen carefully so it does not freeze allocation to the tranche too easily²²).

Concerns and questions:

- There was no consultation with CSO²³ or the national parliament²⁴ on the MDG contract, and it is not clear whether the process to establish indicators has been truly “country-owned” (led by the government).
- It is unclear how independent monitoring of the MDG results is ensured. Who will monitor progress and who is responsible for the final decision on the performance trench linked to this review?
- There is no benchmark for CSO funding to monitor progress or implement actions to increase results towards the MDGs.
- Mid-term contract review will take place in 2010, probably together with the review of the CSP. However, it is unclear what kind of changes (indicators or only budgetary allocations etc.) can take place in that review.
- Although the EC, in its latest documents²⁵ on the MDGs, mentions that 15% of the variable performance component could only be adjusted after three years (“in the second half of the programme”), the specificities of the Burkina Faso case seem to show that the whole performance tranche (up to 30% of the total) can be adjusted on a yearly basis. That diminishes the predictability of aid.



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MDG contracting has received mixed reactions. On the one hand, some EU member states (MS) have the same fears as with GBS: that in cases of crisis, as recently seen in Kenya, long-term committed BS can easily get used for purposes other than poverty alleviation. Other stakeholders say that the MDG contracts as they are currently proposed do not go far enough. Since a substantial part of the money is only released annually, the contracts do not help governments assess the exact envelope of resources that they will finally receive²⁶. The World Bank has shown some interest in MDG contracting in certain countries but no clear decision has been made public about the Bank's actual involvement. MDG contracting looks like a promising way of modifying BS.

Recommendations

BS, and MDG contracting in particular, has significant potential for reducing poverty. To increase the likelihood of success:

- Donors should ensure that their numerous policy commitments to SRHR are reflected in those financial agreements by monitoring performance indicators related to it. All performance indicators included in the financing agreements must measure the impact of the BS on eradicating poverty, which is its main objective of (European²⁷) Development policy.
- In order to increase the effectiveness of health spending through BS, capacity-building of social ministries, including the Ministry of Health, should be part of the donors' plans to achieve the MDGs.
- The European Commission and other donors should be transparent about the analysis of the assessment which forms the basis for the decision whether or not to use BS as an aid modality in a specific country.
- To ensure a strong and clear link between BS aid and the achievement of the MDGs, national parliaments and civil society must be given direct, explicit, transparent and detailed involvement in budgetary monitoring²⁸. Parliaments should scrutinize the BS financing agreements and CSOs in partner countries should be supported²⁹ to monitor national budget implementation, to increase the accountability of aid to citizens both in European and partner countries.
- BS is too often only considered a domain for technical specialists. More information on the functioning of BS should be provided to all stakeholders including CSO, all EC delegation staff and national parliamentarians.

FOOTNOTES

- 1: Glenys Kinnock, Report on the Millennium Development Goals – the midway point. See <http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML+REPORT+A6-2007-0220+0+DOC+WORD+V0/EN&language=EN>
- 2: Working towards more, better and faster aid: the EC presents its results for 2006, see: <http://europa.eu/rapid/pressReleasesAction.do?reference=IP/07/351&format=HTML&aged=1&language=EN&guiLanguage=fr>
- 3: Whither EC Aid's briefing not on BS. See <http://weca.files.wordpress.com/2008/05/budget-support-12may1.pdf>
- 4: EC representative at roundtable discussion, 27 March 2008, organized by Action Aid and ECDPM. See <http://weca-ecaid.eu/2008/03/25/workshop-on-budget-support-with-ec-and-eu-csos-brussels-27-march/>
- 5: Working towards more, better and faster aid: the EC presents its results for 2006, see: <http://europa.eu/rapid/pressReleasesAction.do?reference=IP/07/351&format=HTML&aged=1&language=EN&guiLanguage=fr>
- 6: PFM is meant to strengthen institutional capacities of the country (support to financial administrations and to national institutions controlling the budget like the court of auditors, etc.), and support national systems performance (tax collection and customs systems, budget preparation, budget performance, internal controls mechanisms, etc.).
- 7: In relation to a stability-oriented macroeconomic framework, the criteria identified in the guidelines for the European Commission to judge are: • The quality of the framework, using as a starting point 'information from the IMF'; • The relationship between the partner country and the IMF. The guidelines state that 'satisfactory implementation of a financial or non-financial programme with the IMF will be sufficient assurance of a stability-oriented macroeconomic policy.' European Commission (2007) Guidelines on the Programming, Design&Management of General Budget Support, p. 17.
- 8: Survey of BS donor groups, EC. Not yet publically available.
- 9: Eurostep, 'We decide you own', See http://www.eurostep.org/wcm/index.php?option=com_content&task=category§ionid=8&id=112&Itemid=1.
- 10: Foster, Mick, (2004), 'Accounting for Donor Contributions to Education for All: How should finance be provided? How should it be monitored?'. See <http://www.mickfoster.com/docs/TrackingFinancialFlowstoEFADraftNov04.pdf>

- 11: The Joint Evaluation of General Budget Support 1994–2004, IDD and associates may 2006 See <http://www.oecd.org/dataoecd/42/38/36685401.pdf>
- 12: Ibid.
- 13: EC representative at roundtable discussion, 27 March 2008, organized by Action Aid and ECDPM. See <http://weca-ecaid.eu/2008/03/25/workshop-on-budget-support-with-ec-and-eu-csos-brussels-27-march/>
- 14: See The Joint Evaluation of General Budget Support, p.53
- 15: EIPA, (2007), Briefing Paper 8: Gender and Sexual and Reproductive Health Indicators in the EU Development Aid, p. 8.
- 16: Foster, Mick, Regmi, 'Raghav Review of Nepal Health Sector Programme: A Background Document For The Joint Annual Review. See <http://www.mickfoster.com/docs/FINAL%20SUBMITTED%2013NOV%20%20draft.doc>
- 17: See European Community Treaty
- 18: In principle Ghana, Mozambique, Madagascar, Uganda, Benin, Mali, Zambia and Rwanda plus Tanzania and Burkina Faso have been
- 19: There is no publicly available comprehensive list yet. Countries where eligibility has been confirmed: Burkina Faso, Tanzania and Mozambique. Most probably, Uganda will most probably also get one. Kenya will not be eligible.
- 20: On average €40 million is fixed and €10-15 variable. In 2009: €38 will be fixed and €12.2 variable (which makes a total of €50.2) after that every year €37.8 Million will be fixed and €16.2 Million variable.
- 21: Discussion with EC desk Officer of Burkina Faso, 24 June 2008.
- 22: Idem.
- 23: Idem.
- 24: However, according to the EC, CSO has been consulted for the CSP but there is no information publicly available on that consultation.
- 25: The EC desk officer for Burkina Faso mentioned that the capacity of African Parliaments are sometime overestimated. They often lack resources to be meaningfully involved.
- 26: The "MDG contract", an approach for longer term and more predictable General Budget Support, June 2008. there is no final version publicly available but please find an earlier version at <http://doku.cac.at/eudiscussionpaper070619.pdf>
- 27: See European Community Treaty.
- 28: Kinnock, point 71.
- 29: Kinnock.



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