11 Joint Evaluation

Final evaluation
Sector-Specific Action Plan for Health
2011-2013

Synthetic summary

FIIAPP
COOPERACIÓN ESPAÑOLA

cooperación española

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Report made by:
María Sarabia Barquero (Team Coordinator), Inma Gisbert Civera (Specialist in Public Health and Cooperation) and Carlos Rodríguez Ariza (Specialist in Evaluation).

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If you have any questions about this document, please contact:
Evaluation and Knowledge Management Division
General Secretariat of International Cooperation for Development
Ministry of Foreign Affairs and Cooperation
C/ Serrano Galvache, 26. Torres Ágora. Torre Norte
28071 Madrid
Ph:+34913948808
e-mail: evaluacion-sgcid@maec.es

Index

Abbreviations

AECID	The Spanish Agency for International Development Cooperation
CPF	Country Partnership Framework
EASP	Andalusian School of Public Health
FIIAPP	The International and Ibero-American Foundation for Administration and Public Policies
GFATM	Global Fund for AIDS, Tuberculosis & Malaria
HRBA	Human Rights Based Approach
IHP+	International Health Partnership
ISCIII	Institute of Health Carlos III
MDO	Multilateral Development Organisation
NGDO	Non-Governmental Development Organisation
OTC	AECID Technical Cooperation Office
PACRES	Network of Health Experts Action Plan
PAHO	Pan American Health Organization
PAS	Sector-specific Action Plan of the AECID
PAS-S	Sector-specific Action Plan for Health of the AECID
SGCID	Office of the Secretary-General for Development Cooperation
SM2015	Salud Mesoamerica 2015 Initiative
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund

Synthetic summary

1. Background and objective of the evaluation

The AECID Reform of 2007 changed the structure of the Agency from having two geographic directorates and one thematic, to developing its sectoral and instrumental side. This involved the creation of the Directorate of Sectoral and Multilateral Cooperation, along with other new units. This new directorate was assigned responsibilities in the definition of sectoral policies and the management of various aid instruments. Within it, the Department of Sectoral Cooperation was established, a unit responsible for developing the sectoral vision within the general functions of the Directorate of Sectoral and Multilateral Cooperation.

AECID had until then been an organization with a predominantly geographical structure, with a track record of sectoral specialization and work, particularly in the field, although the specialized sectoral vision was less developed in headquarters. With the Department of Sectoral Cooperation, the institution was equipped with a unit that would allow it to offer a sectoral approach to the issues of cooperation and thus become more closely aligned with the organizational model of other cooperation agencies of the Member States of the EU, which already had a body responsible for guidance in this area.

Along with the creation of the Department of Sectoral Cooperation, AECID also promoted sectoral dialogue with other actors through the Harmonization Boards, the sectoral Networks of Experts and the development of the Sector-specific Action Plans (the PASes). The sector-specific action plans are part of the commitments made by AECID in its First Management Contract and are designed as instruments of strategic planning to improve the quality and effectiveness of poverty reduction, and the coherence between the strategic plan of the Spanish Cooperation (Master Plan and Sectoral Strategies) and the operation of AECID (CPF and Operational Programming). The PASes sought to establish the priorities and core values in each of the sectors in order to facilitate decision making by identifying the most appropriate instruments and partners for these priorities, and to include the institutional strengthening actions necessary for this.

The Sector-specific Action Plan for Health (PAS-S) (2011-2013) had as an objective progress towards the right to health, aligning itself with the strategic objectives set out in the III PD (3rd Master Plan), to improve the effectiveness of health aid, and encompassing the strategic lines and action guidelines established in the Health Strategy of the Spanish Cooperation. With the PAS-S, AECID sought to incorporate into its actions the sector--wide approach in health, targeting institutional coherence in the sector as well as the improvement of its effectiveness by deepening in subsectoral concentration and in the reduction of health aid fragmentation.

The PAS-S has three strategic lines: (i) integral strengthening of quality and equitable health systems through the strengthening of national capacities in health systems, ensuring greater predictability, equality and sustainability; (ii) integration of priority programs in the health systems, emphasizing support of sexual and reproductive health and of infant health and nutrition, and; (iii) institutional strengthening of AECID aimed at actions within the institution as well as instruments and spaces for coordination and harmonization so as to generate synergies with other departments, sectors, instruments and modalities.

The Biennial Evaluation Plan 2013-2014 of the Evaluation Division for Development Policies and Knowledge Management of the SGCID included carrying out the final evaluation of the PAS-S of AECID (2011-2013) with the following objectives:

1. To assess the PAS as an instrument of strategic and budgetary prioritization planning of the health sector in AECID.
2. To analyze the degree of articulation, operationalization and delivery of the strategic lines and priority actions defined in the PAS-S in the period 2011-2013, identifying guidelines, limitations and achievements.
3. To analyze the role of the PAS-S in the coordination of AECID with other actors in the Spanish Cooperation, at international level, as well as the level of alignment with the procedures of partner countries.

The time scope of this evaluation was the period between 2010 and 2013. However, 2009 was also taken into account for specific aspects of analysis due to it being the year the design process of the PAS-S began with the prior development of a diagnostic.

The evaluation was an external summative type and involved an assessment of the achievements, strengths and challenges of the design and implementation of the PAS-S as a strategic-operational planning instrument with an educational purpose to try to generate inputs that support: (i) the improvement of the effectiveness of the PASes, as a generic planning instrument at the sectoral level; (ii) the updating of the design and the proposal for implementation and monitoring of the second PAS-S in the current context of the Spanish Cooperation, as set out in the Terms of Reference.

The evaluation process also had a use-oriented approach, eminently practical and adapted to the needs of the potential users in AECID and to the context within which the recommendations should be implemented. It also had a systemic approach with the aim of facilitating analysis and understanding of the stated issues.

2. Methodology

To meet the objectives, the evaluation was structured into three questions which organized the process of inquiry, analysis and interpretation of the results. The questions are also directly related to each other. These three questions are:

Q1. Has the PAS-S proven to be a useful instrument for the strategic-operational planning of health sector content in AECID? Strengths and limitations.

This question, directly linked to objective 1, meets the criteria of relevance, coherence and internal consistency with regards to the dimension of design, and the criterion of effectiveness of the dimension of results for the analysis of the PAS-S as a strategic planning instrument of the health sector of AECID. It likewise introduces analysis of the concentration and the instruments to assess the influence of the PAS-S in budgetary decisions and in the mechanisms of channelling aid.

Q2. Has the PAS-S proven to be a useful instrument for strengthening coordination processes in health with partner actors in development, including partner countries? Strengths and limitations of the instrument.

With the aim of responding to Objective 3, this question was used to analyze the degree of influence of the PAS-S on the internal coordination of the institution and of the institution's coordination with other sectoral actors. The criterion of mainstreaming of health is also incorporated here through the role that coordination plays in the horizontal incorporation of health in other non-health sectors and actors of AECID.

Q3. What have been the achievements and limitations of the implementation of the content of the PAS-S? Hindering and facilitating factors.

This question relates to objective 2 and the criterion of effectiveness. It also deals with the dimension of structure in its importance when properly assessing both the achievements and limitations of the implementation of the instrument, and the degree of sustainability of the achievements made.

With regard to methodology, a mixed-method approach was used, incorporating in the collection of information qualitative techniques such as semi-structured interviews, focus groups and workshops,

as well as quantitative ones, such as questionnaires. An extensive literature review was also carried out and the databases provided by AECID and the Statistics Unit of SGCID were drawn upon, as well as the quantitative information available through the infoAOD (Information of Official Development Aid) system of the Spanish Cooperation.

Specifically, the following techniques were used:

- A total of 35 semi-structured interviews were carried out with staff in headquarters, with expatriate staff via Skype, and with key informants in international institutions (the United Nations, European Commission and PAHO).
- Three focus groups were conducted, involving a total of 15 people, some of whom were also interviewed individually. These groups were: (i) one with integral members of Spanish Cooperation's Health Harmonization Board; (ii) one with Health Area staff of AECID, and; (iii) one with AECID Sector Unit heads.
- A workshop with the specific goal of exploring the program theory of the PAS-S was facilitated. A total of 7 people participated, including managerial and technical staff, who discussed the design and implementation of the instrument.
- Two online questionnaires were sent out, one to members of the network of experts in health and the other to OTC Coordinators from the countries which had participated in a strategic planning process and/or operational programming at country level. Twenty three of the 47 members of the network of experts in health to whom the questionnaire had been sent responded and, in the case of the OTC Coordinators, 10 of 26.

In order to contribute to the verification, correction and correlation of the information obtained from the diverse sources and to obtain a more complete picture of the contribution and influence of the PAS-S in the areas subject to assessment in this evaluation, appropriate triangulation of the collected data was carried out, wherever possible.

In the design phase some limitations of the evaluation process were identified and subsequently confirmed during fieldwork; in relation to the instrument, the PAS-S exhibited low evaluability mainly due to: (i) the limitation of the information available, both in terms of quantity and in terms of the formats, which did not correspond to the structure of the instrument: (ii) the lack of monitoring and information collection related to its proposal for action; and (iii) some incoherencies and discrepancies identified in the quantitative data provided by the different sources, mainly due to the heterogeneity of the processing of the data and to the personalized recording of information.

Regarding access to the key informants, evaluation fieldwork took place in an unfavourable context due to its coinciding with: (i) the absence of the PAS-S manager for most of the fieldwork, a key actor as a source of structured information and as a facilitator within the institution, both for dialogue with the various units of AECID, and also to enable guidance of the evaluation team with regard to the identification and collection of information pertinent to the objectives of the evaluation; (ii) the lack of engagement and unwillingness of some key informants of the evaluation to collaborate with the evaluation process; and (iii) the inability, after several attempts, to coordinate schedules among the people convened to the focus groups so as to ensure a representative participation in the application of this technique.

The Evaluation Team, in order to overcome as far as possible these limitations, increased the number of key informants originally planned as well as the documents to be reviewed so as to consider not only the PAS-S, but also the context in which it had been implemented. This was done to identify the elements that had influenced the implementation of the PAS-S, as well as everything that the PAS-S had been able to influence. These shortcomings nonetheless meant that analysis of the advances and achievements of the PAS-S was limited primarily to its contribution to achieving the core values, included in the PAS-S, which characterize the sector-wide approach of the Agency to health. Therefore, this evaluation offers an overview and rests on those strategic aspects identified as the most significant and amenable to being evaluated in time and with the resources available.

3. Main findings of the evaluation

Regarding the first objective, concerning the role played by **the PAS-S as an instrument for strategic-operational planning,** an analysis was carried

out of its importance in relation to: (i) whether it met the needs identified in the diagnostic prior to its implementation, (ii) the coherence of its design with the guiding framework that it aimed to operationalize, and (iii) its connection with the planning processes: Operational Programming of AECID and Country Partnership Frameworks (CPF) of the Spanish Cooperation.

The design of the PAS-S is aligned with the guiding framework of the Spanish Cooperation in health, encompassing the lines prioritized in both the 3rd Master Plan and the Health Sector Strategy as described in Table 1.

The introduction of the approaches of: (i) Global Health, (ii) Social Determinants of Health and (iii) Health in All Policies, has in turn ensured alignment with the international framework. This helps the PAS-S have a high degree of coherence with the 4th Master Plan, although some aspects are identified which should – according to this evaluation team – be updated in a future document or sectoral instrument.

The PAS-S provides an update and improvement of the existing guiding framework in the following aspects: (i) the operationalization of the guiding lines, reorganising them under the 4x4 model; (ii) the introduction both of an approach to health harmonized with the international agreements in Global Health and of the approach of the Social Determinants of Health; (iii) the reinforcement of the idea of intersectorality with the approach of Health in All Policies; (iv) the concretization of the proposals of effectiveness and quality of aid contained in the III PD (IHP+, increase of the aid program, guidelines for sectoral concentration and contribution to the global initiatives for the strengthening of health systems); and (v) the further alignment with the European Framework under the framework of the EU Global Health Policy.

The gender and human rights based approaches (HRBA) are accounted for in the design of the PAS-S, as well as a focus, understanding gender as a determinant of health, on specific content development. The priority programs of Strategic Line 2 include sexual and reproductive health. Also, actions defined as priorities in the Gender PAS are prioritized so as to advance the approach of health rights, including treatment of sexual violence, access to family planning and interventions aimed at reducing maternal mortality, such as basic emergency obstetric

Table 1: Adherence to the PAS-S to the guiding framework of the Spanish Cooperation

	Health Strategy (2007)	3rd Master Plan	PAS-S (advances made)	COHERENCE
Action Framework	Aid Effectiveness, MDGs and Strengthening of health systems	Aid Effectiveness, MDGs and Strengthening of health systems AECID Reform	Prioritization III PD (What, how, where and with whom)	✔
Health Focus	Health as a right and PHC Approach (Alma Ata)	Health as a right PHC Approach (Alma Ata)	SDH Global Health Health Equality and Universal Access	✔
Strategic Objective	Improving health	Improving health	Advancing towards the right to health	✔
Strategic Lines	9 Strategic Lines.	6 Strategic objectives 16 strategic lines	3 Strategic Lines 10 priority actions	✔
Mainstreaming Priorities	Poverty, human rights, gender, environment	Poverty, human rights, gender, environment	SDH (gender as an SDH) HiAP	✔
Intersectoriality	Basic social needs Determinants of Health Multisectoral	Development objectives	HiAP	✔
International Commitments	MDGs, Aid Effectiveness, Commitments to MDOs, GFATM IHP, CC-EU	MDGs, Aid Effectiveness, Commitments to MDOs, GFATM IHP, CC-EU	EU Global Health Policy Adelaide Statement on Health Resolution 62.12 of the WHA	✔

care. The PAS-S also incorporates the HRBA as a way of progressing towards the right to health, promoting the reinforcement of health systems as duty bearers so that they can ensure the right to health of the entire population, as well as the empowerment of the rights holders, encouraging their participation in health.

Regarding **internal coherence,** weaknesses are seen in the operational capacity of the PAS in terms of its implementation and to facilitate its monitoring. The Strategic Lines were broad and contained numerous actions without adequate prioritization between them, or sequencing of the implementation to focus institutional action. A causal logic chain where proposed activities are linked with expected results and these in turn to the final objectives to which the instrument responds was not identifiable. This hindered identification of a Program Theory of the instrument.

Furthermore, a wide diversity in relation to the different views of the PAS held by AECID staff at headquarters and in the field was detected. This also weakened its internal consistency, coherence and consensus in its implementation. These views include the following functions: (i) to act as a strategic planning instrument linked to the strategy of sectoral concentration ; (ii) to act as a definition framework that is sectoral and at the same time operative for action in the sector; (iii) to act as an action framework for the institutional strengthening of the sectoral approach.

In the **strategic and budgetary planning of AECID,** the presence of the health sector could not be ascribed to the PAS-S, although a contribution of the same was observed when it had already been decided to work in the health sector in relation to the alignment of the proposals with the lines of the PAS-S.

The PASes appear in the methodologies for the preparation of the Country Partnership Frameworks (CPF) as instruments which in each sector set down the practical lines of action of AECID. They are also recognized as a basis for policy dialogue. Their function is coherent with the place the sectoral structure has occupied in the Master Plans; in the 3rd Master Plan the PASes are linked to the mandate of sectoral concentration, and in the 4th Master Plan, based on development results, moving from the sectoral level to an instrumental one in order to serve development results.

In the Operational Programming of the AECID "the sectoral" is transformed into outputs[1], ie. into the actions that contribute to the desired outcomes agreed upon in the CPF. According to the methodology of the CPF, the sectoral problematic pertains, within the results chain, to the level of the specific objectives (Figure 1). At this level, and given that development problems are multisectoral and multidimensional, the PASes are oriented towards the best contribution of the Agency to development results and where enhanced dialogue is needed between sectors to advance towards them. It is at the level of outputs that the PAS-S would have a greater impact, because these are sectoral.

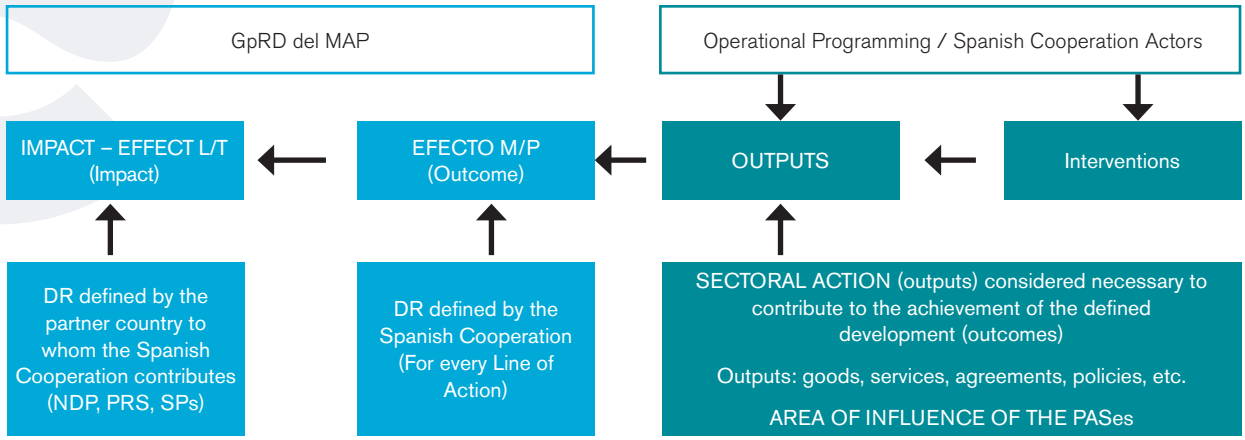
Since the PASes and the PAS-S in particular have occupied a marginal place in the distinct methodologies and in the planning processes, its influence on those processes in headquarters has been determined by the participation of the Sectoral Areas of the Department of Sectoral Cooperation in the spaces generated for it. This has been highly valued by the other units of the Agency.

In the field, the usefulness of the PAS-S is valued positively, less for the prioritization of the sector than for sectoral definition and policy dialogue with partners. The greatest identified potential of the use of the PAS-S is not as a strategic instrument that determines strategy in the sector, but as an **instrument guiding action,** a reference when strategic decisions have already been agreed to.

In addition to the role of the PAS-S in methodologies for geographical planning, the influence of the PAS-S on these processes has also been determined by institutional and contextual factors, such as:

1The outputs are the goods, services, agreements, policies, etc. considered necessary to help produce the defined outcomes, according to the logical sequence of the results chain. In general, it is necessary to define more than one output in order to achieve each of the expected outcomes. The outputs are obtained through the execution of interventions of cooperation.

Figure 1. Area of sectoral action influence on the chain of results



Source: Own elaboration based on Figure 6 of the CPF Manual 2013

- The asynchrony between the strategic and operational planning in which the Agency participates. Before the adoption of the PAS-S, 10 CPFs had been designed and 16 countries had carried out a Operational Programming of the AECID exercise and, in the years 2012 and 2013, the lifetime of the PAS, no Operational Programming of the AECID was carried out.
- The development and implementation of the first PASes (including the PAS-S) coincided with an initial period of institutional learning of new models and planning processes, which necessitated the institution becoming capable of handling their respective methodologies and establishing coordination mechanisms between the different units of the Agency (at headquarters and in the field) so as to plan jointly as an institution with a results oriented management approach to development.

Despite the influence of these factors, the analysis of the content of the CPFs developed to date shows an alignment with the sectoral content set out in the PAS-S. The health sector has significant representation in the field - in 61.5% of the CPFs (16 of 26) under any of the three formats identified in the literature review (prioritized, in association or as an intervention area). The presence of the health sector in distinct formats, not just as a priority sector, and the number of country programs where health actions would be carried out, indicates the relevance of an instrument that ensures, as far as possible, sectoral coherence of the diverse actions and the potential to undertake intersectoral actions.

From a geographic viewpoint, a greater bilateral presence of the sector can be seen in Latin America, with ten countries (in three as a priority sector), and, by income level, eleven Middle Income Countries have incorporated the health sector in one of the identified formats.

Regarding the influence of the PAS-S on budget allocation, significant concentration patterns were identified that affect the effectiveness and quality of aid to the sector and that correspond to the content of the PAS-S:

- A change in the health funding priority of the Agency was identified. In 2012, 57.14% of total aid to the sector was concentrated on Strategic Line 1, when historically its percentages had been below the aggregate of the CRS (Creditor Reporting System) codes that make up Strategic Line 2. 48.37% (€ 86,063,441) of the total ODA for health over the period 2010-2012 was concentrated on CSR 121 "general health".
- Over two-thirds of the ODA for health of the Agency was concentrated on three areas: sanitary policy and administrative management (35.6%); sanitary care (24.9%)[2] and medical research

2 This percentage is the total of the data of codes 12220-Basic Health Care (12.9%) and 13020-Reproductive health care (11.96%)

(7.7%). These areas are included among the priority actions contained in the PAS-S. They cover aspects considered building blocks of health systems and related to the 4x4[3] model that structures the PAS-S.

- An attempt to reduce the aid fragmentation associated with the reduction of the number of actors and the greater sectoral specialization of strategic partners of the health sector during the lifetime of the PAS-S was identified.
- At a geographic level, 60.1% of the total ODA for health disbursed by AECID in the period 2010-2012 was concentrated on the 16 countries that include the health sector in their CPFs. Eleven of these 16 countries were among the top 20 recipient countries of Agency aid to the sector.
- There is greater support for strategic partners specialized in the sector: Ten NGDOs qualified to work in health executed 60.6% of the health budget in the two Requests for Proposals and support from specialized agencies such as the WHO/PAHO (SL1 and SL2) and the UNFPA (Sexual and reproductive health) can be observed. The WHO has been the priority body in multilateral aid to the sector.
- A commitment was identified to ensure a more predictable and less earmarked aid for strategic partners in the sector through the use of mechanisms and approaches that provide greater predictability and budgetary ability for implementing impactful interventions in the sector like the IHP + and/or the NGDO Agreements.
- Factors of context and institutional structures were identified that have inhibited the influence of the PAS-S on budget allocation processes. These include: reduction of the ODA, budgetary inertia, unrealistic budget milestones, absence of coordination mechanisms, the novelty of the instrument and its short implementation period.
- Despite the factors inhibiting the influence of the PAS-S on budget allocation processes, patterns of alignment with the content of the instrument were identified. These could be explained by: (i) the institutional depth of the priority of strengthening health systems in the sector, (ii) the greater capacity for influence in the instrumental logic than in the geographic due to the existence of formal mechanisms for coordination with the Department of NGDOs and of spaces for fluid communication with the Department of Multilateral Cooperation and the Programme Support Unit, and (iii) the existence of "informal" mechanisms of impact and influence that mean the final outcome of decision-making can be affected.
- Formal mechanisms for joint work between the sectoral and the geographic such as with the Department of NGDOs have been identified, as well as spaces for fluid communication, such as the communication established between the Department of Sectoral Cooperation and the Department of Multilateral Cooperation and the Programmatic Support Unit.
- The existence of mechanisms of impact and influence as a result of informal coordination between the different units that meant the final outcome of decision-making could be affected.

With regard to objective 2 — Analyze the role of the PAS-S in the coordination of AECID with other actors of the Spanish Cooperation at international level as well as at the level of alignment with the procedures of partner countries —, the Diagnostic identified some significant weaknesses in institutional coordination and included among its recommendations the need to improve coordination at different levels. The PAS-S took on these recommendations and incorporated actions to strengthen internal management and coordination with other areas of sectoral cooperation and to promote technical and policy dialogue between the Agency and international bodies and national entities who are experts in health and cooperation.

Regarding **interdepartmental coordination,** a low appropriation of the PAS-S outside of the

3 The 4x4 model for health systems is that on which the theoretical approach of the EU to Global Health is based and includes the four basic principles of health (based on the WHA62.2 (Resolution 62.2 of the WHA (World Health Assembly)): Health in all policies , participatory leadership, patient-centred care and universal cover; the four building blocks (based on the "building blocks" of the WHO): Human Resources, access to medicines and medical supplies (including access to R&D&I in health) , infrastructure and logistics and resources and financial models of the health system; the four stages that make up the process of approximation to a health system (following the principles of IHP+): Analysis of the overall situation, definition of health strategies (including the provision of health services), development of a single budget for health and definition of a single system of monitoring and sanitary information, and the four health priorities: infant health, sexual and reproductive health, communicable diseases and non-communicable diseases.

Department of Sectoral Cooperation was identified. The PAS-S is not a reference point for actions in health. The Health Area is, however. The coordination mechanisms established are of an informal character and work with the Department of Sectoral Cooperation from other departments is carried out on demand and, in these cases, the Health Area is supported by the content of the PAS-S. The advice given by the Health Area to the other units is highly valued by other departments.

The Network of Sectoral Health Experts of the AECID, a proposal included in the PAS-S, has served as a horizontal space for knowledge management that has contributed to improving **coordination between headquarters and the field,** using the PAS-S as a framework and document of institutional sectoral positioning. The Network of Sectoral Health Experts of the AECID had an action plan (PACRES), aligned with the contents of the PAS-S and that formed part of the Work Plan of the Health Sector Unit, which was used to coordinate actions and create synergies between headquarters and the field within the health sector.

An improvement was also observed in the flow of information between headquarters and the field in relation to the international framework through the creation of spaces for two-way communication with the OTCs; to share information in international forums and, in turn, to bring to these forums field experience and information.

Regarding the **mainstreaming of health** proposed by the PAS-S, based on the approach of Health in All Policies (HiAP) of the Declaration of Adelaide, the mechanisms of joint work and coordination needed to be able to operationalize this approach were not provided, nor were the protocols and guidelines necessary to do so developed.

In the period of implementation of the PAS-S, the **interinstitutional coordination between AECID and the SGCID** was strengthened to set out a joint position with the Spanish Ministry of Foreign Affairs and Cooperation in spaces of coordination with other institutions such as the Ministry of Health, Social Services and Equality for participation in international forums. Despite this improvement, some informants pointed to a lack of clarity in terms of the roles and responsibilities in health of each of the institutions.

The active participation of AECID internationally is recognized and Spain was identified as one of the Member States of the European Union most active in Global Health in the last five years, proposing initiatives and working groups. Other spaces of recognition of the work done by AECID are the IHP+ and the contributions to the Global Initiatives in coordination between SGCID, AECID and the Permanent Representation of Spain to the United Nations (REPER) in Geneva.

In relation to international agreements, the PAS-S displayed the flexibility sufficient to progressively incorporate the agreements and working consensuses that the Spanish Cooperation has been acquiring through the IHP+ and in other international forums (such as the GFATM), providing a working framework which allows the Agency to coordinate in health with other actors on international strategies and global initiatives.

This flexibility stems primarily from the alignment of the design of the PAS-S with initiatives and work approaches that predominated in these years in the international doctrinal framework of the sector, and which have been promoted by the Agency over the lifetime of the PAS-S (IHP+ or Global Health).

A process of consultation and coordination between the different Spanish institutions of International Health (MHSSI, Spanish Ministry of Foreign Affairs and Cooperation, REPER Geneva and others depending on the specific topic, eg. ISCIII) has been consolidated prior to each Council and the World Health Assembly and the PAS-S has been a reference in the establishment of the position of AECID for these processes.

The Spanish Cooperation's Health Harmonization Board was formed before the implementation of the PAS-S under the Spanish Presidency of the EU, with the aim of developing the Commission communication on the EU Role in Global Health (COM(2010)0128). The Spanish Cooperation's Health Harmonization Board has been highly valued by its members as a space for establishing mechanisms of exchange and coordination with varying degrees of formality. Although the PAS-S didn't participate in its formation, it became involved and set the technical content of the working groups. The Spanish Cooperation's Health Harmonization

Board has allowed AECID maintain a technical dialogue from an institutional position with other sectoral actors.

With regard to objective 2, related to the **degree of articulation, operationalization and delivery of strategic and priority actions defined in the PAS-S identifying guidelines, limitations and achievements,** the lines of advance laid down in each of the Strategic Lines were used as a reference for its analysis and its contribution, according to the original design of the PAS-S, to the core values of the sector-wide approach to health of AECID.

The PAS-S has two areas of activity. On the one hand, Strategic Lines 1 and 2, from a complementary perspective, focused on strengthening health systems and local capacities as the cornerstone of the cooperation actions of AECID in the health sector. In the case of SL-1, the intention was to work from an integrated approach of support to national health plans as a whole. In the case of SL-2, the aim was an integrated approach of the specific health programs – infant health, sexual and reproductive health and communicable diseases – promoting a more holistic action and within the national health systems. These lines constituted the core of the proposal of the sector-wide approach to health put forward by the PAS-S.

On the other hand, in parallel with the specific interventions in the area of health, SL-3 focused on the challenges identified in the Diagnostic to improve the quality of health actions related to the strengthening of institutional capacities, so as to enhance the profile of AECID as an effective and quality partner in the health sector. These challenges, by dealing with institutional elements, affected not only the PAS-S, but also referred to the institutional space of possibility that the Agency enabled for the implementation of the PAS as a generic instrument, although in this respect there may be many nuances between the different sectors.

In relation to SL-1 and 2, some advances were identified, such as: (i) the prioritization of the integral strengthening of equitable and quality health systems, (ii) the reduction of support to the priority programs within the health systems, (iii) the increase of the weight of budget support in health, (iv) the greater geographical concentration on the destination of the ODA in health and reduction of the number of actors.

In SL-1 it is important to highlight that, in the interviews with the technical staff of the various units of AECID, it was notable how the integral strengthening of health systems and their institutional capacities feature in staff discourse when speaking about the priority of the health sector and in the type of actions that should be prioritized in the Agency ODA intended for the sector.

In this SL-1 constant support has been maintained, with a mean percentage greater than 48% of AECID ODA for health prioritizing the bilateral modality of support in the strengthening of the health systems. In 2012, a change was seen in the tendency of prioritization increasing up to 54.7% the ODA allocated to this first strategic line which, for the first time, surpassed the SL-2. This was one of the aims included in the PAS-S. Furthermore, budget support was promoted entailing 15.7% of AECID ODA for health and the work approach within the IHP+, thereby contributing to the reduction in support for programs with isolated components, to the fragmentation of aid to the sector and to the improvement of aid predictability.

In relation to the strengthening of capacities for the definition and implementation of health policies and strategies, the PAS-S is framed within the principles of the new EU health policy, including universal access to equitable and quality health services through approaches such as the IHP+ which puts the principles of efficiency and quality of aid into practice in the health sector. Spain signed the global IHP+ Compact in 2010 and in the years of implementation of the PAS-S, a commitment to work from this approach that promotes support harmonized to a single health plan was observed, the financing through the national budget and evaluation through a single monitoring process led by the partner country. Seven of the nine countries that have prioritized health in their CPF work in the IHP+ and, in four of these countries, AECID facilitated in the process of adherence to the Initiative. Furthermore, the framework of the IHP+ and the promotion of this approach to tackling health is the clearest institutional commitment to contributing to a predictable, equitable and sustainable financing of the health systems included in this SL.

Budget support was identified as the main instrument for the channeling of aid to the sector, a strategic aspect of the IHP+ approach. It was noted in the comments of the people interviewed that, while there is inconsistency in the annual percentages channeled through budget support, independently of the consulted source, and although it fell short of the milestone of reaching 60% of aid channeled through budget support that the PAS-S gleaned from the III PD, the tackling of cooperation in health should be developed within the program approach, favouring budget support to strengthen national health systems.

AECID had an important role in the coordination and supported the joint evaluation of the IHP+ in 2012 in Mozambique, Mali, Ethiopia and Niger, maintaining its systematic commitment to the accountability proposed by this Initiative. The OTCs of El Salvador, Ethiopia, Mali, Mauritania, Mozambique and Niger participated in the monitoring process of the fourth round of *IHP+ Results 2014,* a voluntary act that involves a strong coordination exercise of actors both in Spain and in partner countries in the collection of information and in the process of policy dialogue in the field that is necessary. Participation in the process demonstrates a commitment to transparency and accountability which means the results and the traceability of changes can be observed at global and national level. Action in the field is coordinated by the Health Area of AECID who, in coordination with the OTCs of the countries involved, compile the information before submitting it to the Ministry of Health, Social Services and Equality.

At the geographic level, it was noticeable how the instrumental approach of the health cooperation in Sub-Saharan Africa has prioritized harmonized approaches, and this has helped to ensure greater aid effectiveness to the sector. Going back to the data from AECID, in sub-Saharan Africa in the period 2010-2012, 59.31% (€ 37.5 million) of total health funding was channelled under a programmatic approach (budget support and basket funds). On the other hand, agreements with NGDOs have been another mechanism that has allowed health work with predictability. Through the calls of 2010 and 2014, almost 34% of the budget (€ 49,760,000) of the ODA in health was allocated to sub-Saharan Africa, where 43.2% (€ 21.5 million) was allocated to interventions with an emphasis on strengthening health systems.

Support for **Social Protection Systems** during the years of implementation of the PAS-S was developed mainly through support for the global network initiative for Social Health Protection *(Providing for Health*-P4H) within the WHO, optimizing resources and prioritizing initiatives of coordination and harmonization of approaches for the health work among donors. Despite this, there were no demands registered for technical cooperation of the countries nor offers of expert Spanish staff to respond to these demands under the framework of the P4H (WHO) initiative and of the SOCIEUX Service (EuroAid).

With regard to support in **knowledge and research management,** the CRS of Medical Research (12182) accounted for 7.78% (€ 13,837,714) of the net total of the ODA in health in AECID in the period 2010-2012, it being the component that shows a greater stability within the entire sector. Support for specific initiatives was identified, mostly public-private partnerships, that promote lines of research which are guided or which have an applied research component: (i) Salud Mesoamerica 2015 Initiative (SM2015); (ii) Drugs for Neglected Diseases Initiative (DNDi); (iii) West Africa Malaria Initiative (WAMI); (iv) Tropical Disease Research (TDR); (v) the Institute for Global Health (ISGLOBAL) through the Barcelona Centre for International Health Research (CRESIB). These elements point to a clear intention regarding the role of R&D, the practical orientation of the information and the know-how for the strengthening of health systems.

In relation to the **South-South Cooperation and Triangular Cooperation,** instruments proposed by the PAS-S in this SL, despite the fact that in the interviews conducted it was observed that these instruments are considered suitable for the strengthening of the health system and the systems of social protection, as well as for the exchange of experience between countries regarding these and other issues, no experiences have been registered during the years of implementation of the PAS-S.

In SL-2, a decrease in the percentage of health ODA channeled multilaterally was noted; in 2009, 17.68% of aid to the sector was channelled multilaterally and this percentage decreased to 9.92% during the period 2010-2012.

Significant efforts were also noted to redirect the interventions in SL-2 towards work approaches that are more inclusive and/or aligned with the strengthening of national health systems. Also, consultation mechanisms were set out so as to improve bilateral/multilateral articulation confirming an approximation to the content of the PAS-S of pre-existing initiatives co-financed with other actors. Some examples of this reorientation towards the lines of the PAS-S are:

Pre-existing interventions that only worked in one of the blocks of the health systems have been reoriented towards a more holistic approach so as to contribute to the strengthening of health systems, for example, the ESTHER Program of the Spanish Ministry of Health, Social Services and Equality.

Reorientation of strategic approaches in global initiatives (GFATM) and regional programs (Salud Mesoamerica 2015 Initiative (SM2015)) to achieve greater alignment with the sanitary policies of partner countries.

Revision of new initiatives adopted within the priority programs so as to improve alignment with national health policies and a more integral strengthening of the health systems of partner countries, for example, the work carried out through the NGDO Agreements and multilateral interventions.

These advances regarding the proposal of the SL-2 of the PAS coexist also with a greater specialization of the implementers of the aid allocated to the priority interventions, actors specialized in health that base their work on the same approaches as those upon which the PAS-S is based. The strategic partners in the health sector of AECID are: i) among the MDOs: the WHO, UNFPA and DNDi, which they support through voluntary contributions; and ii) among the NGDOs: Doctors of the World, Medicus Mundi, and Action Against Hunger, all of whom are specialized in the sector.

On the other hand, and as already mentioned when discussing coordination, the mechanisms of information exchange with the field through the Network of Sectoral Health Experts of the AECID have contributed to improved multilateral actions, from the work experience of sectoral experts in headquarters and in the field, as well as in the articulation of bilateral and multilateral action in health, an institutional challenge that came up in the Diagnostic and through the interviews carried out. Some noted examples are:

- The advocacy work in the SM2015 for changing or enhancing the work approach in initiatives implemented in the countries. Among the issues subject to advocacy work are maternal and child health care from an intercultural approach to the indigenous population, the weaknesses of using economic incentives to human rights to ensure staff stability and the sustainability of interventions in communities, the expansion of the focus of attention on adolescent pregnancy to include activities related to prevention, sex education and family planning methods and not only to cover pregnant adolescents.
- The promotion of the articulation of regional initiatives and programs with institutional mechanisms that had a regional mandate: (i) the WAMI Project *(West Africa Malaria Initiative),* in association with CRESIB and the Universities of Mali and Ghana, was technically defined with an integrated approach to health and to the strengthening of regional institutional mechanisms (ECOWAS); (ii) the SM2015 was launched with an integrated approach to health and the strengthening of regional institutional mechanisms (Council of Ministers of Health of Central-America - COMISCA).
- The participation in the monitoring rounds and evaluation exercises of the commitments of the IHP+ in which the OTCs were involved and participation involving all the actors of International Cooperation at country level in a sectoral policy dialogue with the governments of the signatory partner countries, and as part of an exercise in transparency and mutual accountability.
- The involvement of the OTCs in the monitoring of the Global Fund in order to contribute to improved effectiveness of this aid mechanism and to achieve greater complementarity, coordination and alignment between it and the country programs and national development plans. Spain currently participates in four coordination mechanisms at national level.

Strategic Line 3 has had few advances that have influenced the other two lines, failing to achieve a significant degree of strengthening of institutional capacities to integrate the sectoral approach to health in AECID. Strengthening of technical capabilities

and expertise of human resources has been uneven, as has the creation of protocols and mechanisms to improve coordination and articulation between the different units of AECID.

The proposed institutional strengthening of the Agency was based on three pillars: the reduction of aid fragmentation and equity in the allocation of resources (quality of aid), coherence and integrated knowledge management. In practice, these pillars were mainly centred on improving and formalizing interdepartmental and interagency coordination with sectoral partners, increasing the technical capacity and degree of expertise of human resources and contributing to generating synergies based on a proposal of knowledge management that allows the experience and capabilities of different actors be capitalized upon.

Regarding the **Quality of Aid,** mechanisms or instruments were not identified that facilitate the influence of the PAS-S in these planning and coordination processes. However, some significant trends of sectoral concentration were notable that affect the lines of progress earmarked by the PAS-S and the quality of the aid offered by AECID to the sector: (i) the prioritization in their actions of the strengthening of national health systems (SL-1), (ii) the increase in aid to the CRS 121 and in the use of instruments that offer greater predictability (agreements, contributions not earmarked for specialized MDOs and budget support); (iii) the countries that prioritized health within their CPFs feature on the list of priority countries for the health sector, a list that included the criteria of equity referred to in the Commission communication on the EU Role in Global Health; and (iv) a closer relationship with qualified health partners was advanced with the aim of contributing to a greater impact of Agency aid. This advance cannot be clearly linked to the influence of the PAS-S since in the process of making decisions regarding the prioritization of health in geographic planning, a network of different factors come into play that have their own weight when determining a possible prioritization.

The Guide for Policy Dialogue, a tool planned for in the PAS-S and that is currently being developed, is, in the opinion of Health Area staff and that of other sectoral actors, key to strengthening the sector-wide approach to health in the Agency through targeting the improved understanding and technical capacity of AECID staff, in headquarters and in the field, for sectoral policy dialogue with partner countries and other actors.

Finally, in the line of the quality of the aid, the big weakness of the PAS-S has been its lack of monitoring that conditioned the entire implementation cycle of the instrument. According to some informants, the lack of monitoring of the PAS-S was motivated by the significant changes made to the instrument prior to its adoption:

(i) indicators identified for monitoring were deleted, and (ii) it was not considered necessary that the implementation and performance of the PAS-S be subject to institutional accountability. Both these aspects meant that monitoring of the PAS-S was not considered a priority. The only information relating to monitoring that was identifiable was the sector note which, although it displays information relevant to the sector, does not go into each of the lines of action in depth nor, in the case of the health sector, has it been able to occur annually.

Regarding **Coherence,** the strategic collaboration frameworks with partner institutions proposed by the PAS-S were initiated during the early stages of implementation, such as is the case with ISGlobal and the FCSAI (Spanish Foundation for International Cooperation, Health and Social Policy). However, due to the budgetary context of the Agency, others were yet to be implemented (EASP and the ISCIII).

In relation to the protocols and interdepartmental coordination for the **mainstreaming of health,** three guides or manuals developed under the PAS-S could be identified; (i) the operational Guide for direct health disaster response, (ii) the Guide for the incorporation of health in the ICTs and (iii) the guidelines developed for the Water Fund. However, their use could not be verified, nor whether they had been properly used to promote a more mainstreaming work approach to health. Added to this is that which has already been mentioned in the section on coordination of the limitations in interdepartmental coordination and the lack of protocols and mechanisms.

In the line of **knowledge management,** the PAS-S was unable to mobilize the will necessary to provide greater institutionalization to the Spanish Cooperation's

Health Harmonization Board and the Network of Sectoral Health Experts of the AECID. These latter are spaces that, in the opinion of most of the informants, have enriched the Agency in issues of health and cooperation and offered the opportunity to capitalize on the knowledge of the actors as a resource to be optimized to improve its actions in health.

In general, sector leadership identifies the lack of budget associated with the PASes as the major weakness in order to enable further progress in this line. Prior to 2012, the Department of Sectoral Cooperation had a budget at its disposal that stemmed from various budgetary instruments that allowed it to hold meetings and hire technical assistance to support the strengthening of the sectoral approach (management commissions, nominative subsidy to the FIIAPP, etc.). This budget was allocated to actions for institutional strengthening included in the SL-3s of the different PASes. This budget has not been received from 2012 onwards, and this has hampered the ability to plan, with a strategic and procedural vision, the strengthening of the Agency in this respect.

The analysis undertaken found that sectoral milestones and objectives proposed in the PAS-S did not conform to the possibilities offered by the context or to the institutional structure which in turn projected change. The assumptions of context and structure underlying the proposal to strengthen the sector-wide approach to health were significantly altered during the period of its implementation, affecting the consolidation of the advances and posing additional challenges.

Some inhibiting elements of the implementation and current sustainability of the PAS-S were identified: (i) the change of contexts between the time of its design and that of its implementation; (ii) the absence of sustained economic resources for the execution of the content of the instrument; (iii) the institutional delegation of the implementation of the PAS-S in the Health Area; (iv) the limited degree of attention to the strengthening and creation of technical sectoral capacities in health; (v) the lack of regular and systematic monitoring linked to an institutional accountability regarding the execution of the instrument; (vi) the limited management of knowledge; (vii) the non-systematic efforts to improve coordination and coherence in the actions of the Agency within the sector.

Finally, the people interviewed identified some favourable elements of the implementation of the instrument related to the need of the Agency to meet the demands of the international scope. These related mainly to two aspects: (i) to increase sectoral concentration in order to improve the effectiveness and quality of the aid generated by the commitment of the Agency to incorporate the sectoral approach as a strategic element in its reform process; (ii) to enhance the technical dialogue of AECID in an international context that called for more quality participation in substantive discussions regarding the sector.

Another favourable element identified by the informants is the continuity of the work of the Health Area. This continuity predates the instrument itself, since in its design it incorporated processes, tools, relationships with other actors, etc. and dates back to the period of development of the Commission communication on the EU Role in Global Health and that would continue over the lifetime of the PAS-S. This work is recognized by other sectoral actors and valued by the institution as the factor most responsible for giving greater coherence to the actions of the Agency in health.

The PAS-S coincided with a period of adjustments of views between its initial design and its implementation, mainly within three parameters: (i) two different administrations – the first, responsible for the impetus of the sectoral approach and, the second, heir to the implementation of an instrument, of its philosophy and approach; (ii) two different budgetary contexts – the design phase within a context rich in resources and the implementation phase, within a context of economic crisis with a significant restriction of funding allocated to the cooperation for development in general, and the health sector in particular; (iii) different strategic emphases due to rotation of the leadership of the Department of Sectoral Cooperation (4 managers) during the years of the design and validity of the PAS-S. In this period of adjustment, gaps appeared between what was initially planned and what was actually possible, gaps that are also acknowledged by the sectoral leaders surveyed and that acknowledge that the changing context is an important explanatory factor in the evolution which the remaining PASes also had.

The positive assessment of the technical capacity of the Health Area, together with a lack of appropriation of the instrument in headquarters, have led

to the *de facto* creation of an institutional delegation of the implementation of the PAS-S in this area, with two significant consequences:

The content of the instrument was able to permeate processes and actions of the Agency because the Area has played a proactive role – and not only as a consultant – in the processes of defining decisions and positions on health. The international scope and influence on the instrumental logic are examples of this.

The sustainability of the progress of the PAS-S depends to a large degree on the active participation of the Area and its staff in the processes. This dependence is a significant debilitating factor in the sustainability of the progress and the proposal for action of the instrument.

The informants considered having a unit within the institutional organization that provides specialized treatment and ensures the quality of the actions of the Agency in health to be important to the effectiveness and quality of aid in the sector. However, the delegation of the execution of the PAS-S in the Area, when the sectoral approach in health is designed to crosscut the entire institution, represents a significant inhibiting factor in the implementation of the PAS-S in its original conception. This situation is common to the other PASes.

Many of those interviewed believe that the technical capabilities of AECID in the sector can clearly be improved and that they should be treated as a priority both in headquarters and in the field. They identify this shortcoming as a limiting factor in the implementation of the PASes and the sustainability of the progress made.

4. Conclusions

The main conclusions of the evaluation process are:

In relation to the question of **whether the PAS-S has proven to be a useful instrument for the strategic-operational planning of health sector content in AECID**:

C1. The coherence and significance of the design of the PAS-S did not ensure the usefulness and influence of the instrument in the strategic-operational planning in health. The limited operational capacity of its design and various inhibiting factors affected the deficiency of execution of SL-3, thereby weakening the potential of the instrument to influence planning.

C.2 Health has a significant presence in the geographical planning; however, it is not possible to attribute the prioritization or kind of presence that is identified in the CPFs and the Operational Programming of the AECID to the PAS-S because other factors carry a greater weight in this regard. The main usefulness of the PAS-S is related to its orientating nature to guide health actions of AECID once the pertinence of working in the sector has been agreed upon.

C.3. Significant progress was noted in the core values of the sector-wide approach to health related to the directing of the aid aligned with the content of the PAS-S. The influence of the instrument in these advances has been limited in the formal budget allocation processes, but active through informal mechanisms of consultation and advice introduced by the Health Area.

In relation to the question of **whether the PAS-S has proven to be a useful instrument for strengthening coordination processes in health with partner actors in development:**

C.4. The PAS-S alone has been insufficient to advance greater coordination in health in AECID, also affecting the ability to mainstream health in the actions of the Agency. Significant differences are noted in institutional coordination depending on the degree of health specialization of the actors.

C.5. The PAS-S has been an instrument facilitating coordination with other sectoral actors in that shared aims and work approaches existed previously.

Regarding what the **achievements and limitations of the implementation of the PAS-S have been**:

C.6. Progress is noted in Strategic Lines 1 and 2 related to the advancement of the sector-wide approach to health of the Agency and that have as a reference the core values contained in the design of the PAS-S. These advances would show that, to the extent that the contextual and institutional constraints allowed, the instrument has contributed to improving the efficiency and quality of aid to the sector during its lifetime.

C.7. The limited execution of SL-3 compromises the sustainability of the progress made by the PAS-S, as it has been seen to affect the instrumental line designed for the strengthening of the institutional conditions of the Agency, and to enable the development and consolidation of the sector-wide approach to health of AECID.

5. Lessons learned

L.1. Sectoral planning instruments require a parallel institutional effort aimed at broadening the understanding of the "sectoral" in its potential contribution to the efficiency and quality of aid, as well as development results not necessarily linked to a particular sector.

L.2. Planning instruments, in the absence of monitoring and an accountability exercise linked to it, put at risk: (i) the proper implementation of the instrument; (ii) the capacity for learning, adaptation and reorientation during execution and (iii) the quality of the instrument itself to contribute to its own execution.

L.3. The potential for headquarters-field articulation through sectoral networks could be optimized for other issues and processes of guided decision-making or in those in which the Agency participates. This articulation enhances the position of the Agency and the decision-making process through knowledge distinct from, but complementary to, that coming from headquarters.

6. Principal recommendations

Given the findings of the evaluation process and the conclusions that have been reached, the following recommendations are made:

R.1. The development of a guiding instrument for the action in health of the Agency based on a sectoral institutional position defined in consistency with the current guiding framework and encompassing inputs garnered from the field. The instrument would aim at strengthening the sector-wide approach to health of the Agency, adapting to the institutional conditions of AECID, with clear operational guidance and without trying to address different institutional purposes in the one document.

R.2. Addressing the institutional strengthening for the integration of the sector-wide approach to health (SL-3) within a proposal that is global, comprehensive, systematic and with a process vision for the promotion of the appropriate institutional conditions for the effective implementation of the sector-wide approach to health in the Agency.

R.3. The establishment of interdepartmental and interagency coordination protocols as well as stable mechanisms to capitalize on the sectoral knowledge and experience in the Network of Sectoral Health Experts of the AECID and the Spanish Cooperation's Health Harmonization Board.

R.4 The development of technical capability and the updating of staff to enhance their expertise and performance in the management of the sector-wide approach to health. This recommendation should be included in the design and implementation of an Institutional Strategy that addresses the development of sectoral institutional capacities in a more integral manner.

R.5. Monitoring the management and performance of the instrument updated under a methodology that conforms to the institutional monitoring system and allows support for the proposal of global monitoring proposed in the 4th Master Plan.

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