WORLD HEALTH ASSEMBLY IHP+RESULTS UPDATE (May 2010)

ihp+ results

Strengthening accountability to achieve the health MDGs

CONTENTS

STATEMENT FROM THE IHP+RESULTS INDEPENDENT ADVISORY GROUP

The Advisory Group to IHP+Results was established to provide independent advice to IHP+ Results on its work to monitor and evaluate the IHP+. As members of the Advisory Group[a], we welcome this important report. While providing advice at the outset of the progress report we have not been involved in shaping its content. Our comments are thus about what the report says, what it does not say, and what it could or should say.

The International Health Partnership and Related Initiatives (IHP+) was established to: improve co-ordination and harmonization of international support to national health plans in line with the Paris Declaration on Aid Effectiveness; strengthen health systems; and ensure access to health care is scaled up and health outcomes improved. In our view, the IHP+ provides a framework for consolidating a number of pre-existing commitments already made by its signatories[b]. Moreover, it affords an opportunity for signatory countries to create greater health coherence in their overall foreign, economic, trade and development policies and not simply those related to the health sector.

Importantly, IHP+ includes a promise by signatory countries to account for actions on these commitments. It is disappointing that we are not at this time commenting on the first comprehensive annual progress report of the IHP+, but on a very partial account. In this regard the report should be viewed as an opportunity for all IHP+ stakeholders to reflect on both the challenges and obstacles faced in delivering on the commitments of the IHP+, and on why the progress report itself has proven to be a difficult exercise.

The process of this report's creation has revealed major shortcomings in the translation of signatories'[c] political statements into concrete and practical actions and outputs against which they can be monitored. It raises questions about the varying degrees of 'buy-in' to the IHP+ principles by different signatories, and that many signatories are unwilling or feel unable to participate in the accountability process, despite having committed to do so. The United States did not sign up to the IHP+ and is excluded from this evaluation altogether; given its prominence in shaping global aid policies its inclusion in the IHP+ is something that should be actively pursued.

The progress report's accountability framework is not without its problems. Difficulties with the reporting mechanism may have accounted for some of the reluctance by many of the signatories to supply the data required for a proper assessment of IHP+ outcomes, but this reluctance is still regrettable in light of signatory commitments to public accountability.

A purpose of the IHP+ was to bring greater coherence and coordination to the fragmented and bewildering state of development assistance for health. It is therefore very disappointing to see the lack of a common framework for all signatories, despite the diversity of interests that have created challenges for developing such a framework. However, we welcome the establishment of the IHP+ Working Group on Mutual Accountability to oversee the development of a set of Standard Performance Measures, drafts of which

a Membership of the Advisory Group is on an individual basis – members are not representing the organisations for which they work

b The IHP+ Global Compact makes clear that the IHP+ builds on work and commitments made in other processes and events including the Paris Declaration on aid effectiveness, the High Level Forum on Health MDGs and the G8.

c IHP+ signatories include national governments of IHP+ partner countries, and their development partners (bilateral development agencies, multilateral agencies,and other international organisations). For a full list of signatories, see http://www.internationalhealthpartnership.net/en/partners

are reflected in this report. This is an important opportunity to arrive at a more coherent set of criteria by which to monitor and evaluate all signatories, and thereby to ensure a methodology that is robust, meaningful and capable of strengthening the mutual and public accountability of the IHP+ signatories.

In moving forward and building on what has been learnt thus far, it is clear that the reporting process will require greater commitment and cooperation at the highest level from all IHP+ signatories.

Looking forward to the next progress report due at the end of 2010, we would like to see the following actions from the IHP+ signatories:

1. Agreement on the Standard Performance Measures against which signatories should report to measure behaviour change in line with the IHP+ commitments. Analysis of these indicators should be conducted for each recipient country as well as for the overall performance of individual signatories.
2. Officially commit to incorporating the Standard Performance Measures as part of the joint annual review of the health sector in every IHP+ country, as well as in the Common IHP+ Monitoring & Evaluation Framework. This should reduce the high transaction costs of multiple evaluations and ensure that necessary and appropriate data are being systematically produced each year.
3. The production of a narrative report by IHP+ signatories on how well they are increasing coherence across a range of other sectoral policies known to affect health outcomes and the capacities of countries to develop and sustain equitable and effective health systems. Key sectoral policy areas would include: trade, intellectual property, foreign investment, macroeconomic or other conditions associated with aid and debt relief and may extend to policies related to migration and human rights.
4. In moving forward it will also be important to guard against any erosion of IHP+ Results' independence from the Scaling-up Reference Group (SuRG) to which it reports.

There is still confusion about the meaning and role of the IHP+ and what additional value it brings. We are however less concerned with the label of 'IHP+' than with the clear need for a more effective, coordinated, coherent and efficient system of international and global development assistance for health.

We wish to emphasize that meaningful accountability for the IHP+ is not a punitive device but a means to improving collective efforts towards achieving the shared goal of improved health. In that spirit, we urge the IHP+ signatories, stakeholders and the IHP+Results team to be more demanding of the next rounds of progress reporting.

Advisory Group Members: Ronald Labonté, Gill Walt, David McCoy, Gita Sen, Devi Sridhar, David Sanders, Rene Loewenson, Ravi M. Ram, Adrienne Germain, Anna Marriott, Lola Dare.

Reviewing the Results of the IHP+

This 2010 **World Health Assembly Update produced independently by IHP+Results summarises progress** that International Organisations, Bilateral Donors, 'Other Funders', Country Governments and Civil Society are making to improve aid delivery for the health sector to strengthen health systems and achieve health results[1].

As the founding manifesto of the partnership, the **2007 IHP+ Global Compact forms the basis for this report.**

Statements of commitment that heads of agencies and government leaders have signed are *quoted verbatim throughout this report in highlighted text,* to remind us of the pledges that have been made to address those health MDGs which are off track.

Although the Global Compact mostly re-states past commitments, such as to the 'Paris Principles for Aid Effectiveness' and 'Accra Agenda for Action', the IHP+ acknowledges the **urgent need for a more effective, coordinated, coherent and efficient system of international and global health development assistance.**

As a partnership for results, the IHP+ brings the expectation that signatories will be held individually and mutually accountable for aid effectiveness and for responsible governance in the health sector.

This **focus on mutual accountability** is arguably the most important value that the IHP+ adds over other initiatives in the health sector. It should provide enduring contributions that improve how business is done – for institutions and the individuals within them to be more transparent about the actions they choose to, or not and to take more responsibility for the impacts these are having.

IHP+Results has been contracted by the IHP+ as a 'North-South Consortium' of researchers and civil society to independently monitor and report on this progress over 3 years from 2009 to 2011. We have been working with the OECD DAC *Task Team on Health as a Tracer Sector* (TTHATS) to **contribute lessons from the IHP+ to the next high-level forum on Aid Effectiveness in 2011 and to not duplicate existing generic aid effectiveness** monitoring processes (see box on page 28).

Through IHP+Results, we hope to contribute towards strengthening mutual accountability for results in the health sector more broadly by **building on the work that others are doing and on existing processes – especially within countries.**

This report provides a **brief description of the tools and approach** that IHP+Results has developed, in collaboration with the IHP+ Partners, for each signatory to account for their progress and to hold each other mutually accountable. We share some of the **lessons learnt in the first year (2009)** of establishing this paradigm-shifting monitoring & accountability mechanism for the Partnership.

IHP+Results will publish the first **Independent IHP+ Performance Report at the end of 2010.** More details on progress being made, together with further information about IHP+Results, can be found online in the North-South Observatory for IHP+Results (www.ihpresults.net).

This Update summarises key points of **progress to the end of 2009** in implementing each commitment and presents the **Standard Performance Measures** that are being proposed by IHP+Results to monitor and report on this progress. (These proposed measures are subject to change through further consultation with IHP+ signatories in the IHP+ Working Group on Mutual Accountability and on the advice of the IHP+Results Independent Advisory Group).[2]

The Update also briefly outlines the **tools and process that IHP+Results is implementing** in 2010, together with suggestions for **collaboratively building mechanisms at the international and country levels that will improve Mutual Accountability** for results in the Health Sector.

1. This Update presents a selection of the preliminary findings from the first year of implementing IHP+Results in 2009. These are mostly based on data from an Interim Report on Progress in Implementing IHP+Results, submitted to the IHP+ SuRG in February 2010. Further information from this report is available in electronic format on the North-South Observatory for IHP+ Results (www.ihpresults.net).

2. The Mutual Accountability Working Group of the IHP+ SuRG was established on a time-limited basis to jointly review and improve the IHP+Results approach for 2010, in response to a recommendation in the IHP+Results Interim Progress Report (February 2010).

The IHP+ Global 'Compact' for achieving the Health Millennium Development Goals

In 2000, the international community agreed to support development targets that became enshrined in the Millennium Development Goals (MDGs)[3]. In 2007, recognising that the health-related goals are particularly off-track, 26 developed and developing countries and international agencies signed the International Health Partnership (IHP) Global Compact[4].

The IHP+ Global Compact calls *for the international system to provide adequate resources, as well as effective, efficient, well coordinated collective efforts, focused on delivering accessible sustainable health systems and backing comprehensive country owned and developed health plans which produce tangible and measurable results. The Compact also calls for the creation of sustainable and fair structures for health systems financing, as this is particularly important for building strong national health systems.*

The IHP+ commits Signatories to **work effectively together with renewed urgency to build sustainable health systems and to improve health outcomes** in low and middle-income countries through:

- Providing support to strong and comprehensive country and government-led national health plans in well coordinated ways;
- Strengthening and using existing systems for coordination;
- Coordinating support to implement sector plans; and
- Shared accountability for achieving results.

The IHP+ is meant to ensure that the global commitments from a range of 'related initiatives' get implemented through **strengthened country partnerships** that:

- Reflect the unique situation in each country;
- Channel support into country owned health plans; and
- Secure fair and sustainable financing of national health systems.

Defining country-level commitments

IHP+ signatories in each country are expected to define for themselves how to take these commitments forward, agree measurable targets (drawing from current in-country processes) and to reflect these in a Memorandum Of Understanding (MoU), Code of Conduct or a Compact at the country level, to which partners would be held to account.

Progress to the end of 2009

- IHP+ Compacts had been signed in 4 countries (Ethiopia, Mali, Mozambique and Nepal). Burundi & Zambia were close to signing their Country Compact. In Kenya, partners feel that the well-established 'Code of Conduct' signed by all stakeholders in August 2007 contains most of the elements of a Compact and this will be used to reflect the IHP+ commitments in this country. Nigeria is in the process of developing a Compact at the federal level, and Cambodia does not see the need for a Compact, as the country with its development partners had just concluded the health sector planning process for the Health Sector Support Programme 2 (HSSP 2) on joining the IHP+ and the 'Joint Partnership Arrangement' was signed in December 2008.
- The quality of these country-level documented mutual commitments is variable. In some cases these lack specificity (for instance, on how these commitments will be implemented and tracked) or measures to promote compliance and mutual accountability.
- It is not yet evident what added value IHP+ Compacts have over existing agreements, such as SWAps, MoUs and Codes of Conduct. If these continue to be implemented without effective accountability mechanisms in place, their value is likely to remain questionable.

Proposed Standard Performance Measure to assess whether country-level commitments are documented and mutually agreed

For development partners:

- *Proportion of IHP+ countries where the signatory has documented support for or commitment to an IHP+ Country Compact or equivalent.*

For IHP+ country governments:

- *IHP+ Compact or equivalent mutual agreement in place*

3. http://www.un.org/millenniumgoals/
4. Subsequently this has become referred to as the International Health Partnership and related initiatives (IHP+). For more information see http://www.internationalhealthpartnership.net/en/home

Expanding participation in the IHP+

Initial signatories to the Global Compact committed to ***expand the Partnership***. Those present at the 2008 Ministerial Review of the IHP+ further agreed that all development partners should be encouraged to join the initiative and to *actively seek the engagement of additional EU member states, the USA and Japan in 2009*[5].

Progress to the end of 2009

- 26 governments and agencies signed the IHP+ Global Compact in September 2007[6].
- There are now 46 IHP+ Signatories - a 77% increase in just over two years. (For the latest listing of Signatories, see the IHP+ Website).
- Although the U.S. Government (USG) has not formally joined the IHP+ as a signatory, it has communicated support for the principles of the IHP+. The proposed USG Global Health Initiative (GHI+) reflects many of these underlying principles and proposes to reform how the USG contributes to the health aid architecture, as well as to improve integration across its agencies, budgets, and program areas.
- The European Union has been reconsidering its role in Global Health, with specific reference to the IHP+ principles and process, and is expected to place explicit expectations on aid effectiveness in the health sector, with concrete targets.

Ensuring Civil Society participation

The Global Compact commits signatories to invite Civil Society *to participate in the design, implementation and review of the Partnership at global and country levels.* This recognizes that *Civil society and other stakeholders have an important role in both the design and implementation of national plans.* Civil society is expected to *play a key role in holding all partners to account on performance and progress of the Partnership.*

At the 2009 IHP+ Ministerial Review, Signatory and Civil Society Representatives re-committed to ensuring that there is meaningful Civil Society engagement at all levels *by proactively supporting and adequately resourcing activities to improve coordination and strengthen capacity, especially of national Civil Society organisations.* They acknowledged that *Civil Society participation is critical in Country Compact development, implementing and monitoring, as well as in assessing needs, setting priorities, developing, implementing and monitoring of national health and HIV/AIDS plans and strategies to ensure accountability.*

Progress to the end of 2009

- At the international level, the IHP+ has taken a number of steps to ensure the participation of northern and southern civil society groups. Both of these constituencies have formal representation on IHP+ governance structures[7].
- A Civil Society Consultative Group was in the process of being established to facilitate the greater inclusion, communication, and coordination of a wider range of health-focused civil society constituencies in IHP+ bodies and oversight processes[8].
- The Civil Society Health Policy Action Fund (CSHPAF)[9] was established in 2009 to support southern civil society organisations (CSOs), networks and coalitions to become more effectively engaged in national health policy processes. To date, 106 proposals were submitted by CSOs from 19 IHP+ countries, in response to the CSHPAF first funding round, demonstrating the need for such support.

5. IHP+ Ministerial Communiqué, 5th February 2009, Geneva.
6. http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_external_review_2008_EN.pdf (p2)
7. http://www.internationalhealthpartnership.net/CMS_files/userfiles/ORG(1).pdf
8. For the latest information on progress see http://www.internationalhealthpartnership.net/CMS_files/documents/executive_meeting_minutes_25_mar_EN.pdf
9. http://www.healthpolicyactionfund.org/

- In most IHP+ countries, Civil Society in some form has been provided with renewed opportunities to get involved in national processes, often building on historical involvement in country coordination mechanisms; Health Sector Working Groups; Annual Reviews; and in teams drafting National Health and HIV Plans. With some exceptions, this has tended to be limited to participation by one international Civil Society Organisation and one country-level umbrella Non-Governmental Organisation (NGO).
- There are outstanding questions about how effective Civil Society engagement is in planning & decision-making processes at the country level; whether these processes are transparent & inclusive enough to allow for effective engagement; who gets to represent the public interest & whether representatives have a legitimate mandate; how representatives get selected; and whose interests are being served.
- Civil Society is considered to be a partner in the IHP+ but the organisations representing Civil Society are not expected (or able) to sign up to the IHP+ commitments and to be held accountable, like other partners. These are all important issues for the Civil Society Consultative Group to start addressing in 2010.

Proposed Standard Performance Measure of Civil Society involvement in Accountability Mechanisms

- *At the time of writing, an appropriate measure for Civil Society involvement was still being discussed through the IHP+ Working Group on Mutual Accountability.*

10 2008 External Review of the IHP+ was undertaken by Responsible Action, in collaboration with the London School of Hygiene & Tropical Medicine. This report is available online at http://tinyurl.com/2u7f5bq

11. Based on interviews with the IHP+ Core Team and review of the Team's progress reports to the IHP+ SuRG

12. IHP+Results is delivered through a consortium of civil society and academic organisations, led by Responsible Action in collaboration with the London School of Hygiene and Tropical Medicine (LSHTM) and Oxfam GB, with national representatives in 9 IHP+ countries.

    Oxfam's role is to promote links between IHP+ Results and civil society. Oxfam has not been directly involved in producing this report.

Monitoring and evaluating the IHP+

The IHP+ Global Compact calls for *an independent evidence-based assessment of results at country level and of the performance of each of each of us individually as well as collectively.*

Progress to the end of 2009

- In 2008 (within the first year of signing the IHP+ Global Compact) the first External Review of the IHP+ was commissioned by the IHP+ SuRG[10], which published a formal management response to the recommendations. Most of these recommendations have subsequently been implemented[11].
- IHP+Results[12] was commissioned by the IHP+ Scaling-up Reference Group (SuRG) to undertake an independent, evidence-based assessment of results, to strengthen individual and mutual accountability within the IHP+ from 2009 to 2011.
- This provides an independent, voluntary mechanism for signatories to transparently and publicly demonstrate what actions they are taking to implement their IHP+ commitments.
- During 2009, IHP+Results was asked to focus on the 9 initial countries that signed the IHP+ Global Compact (Burundi, Cambodia, Ethiopia, Kenya, Mali, Mozambique, Nepal, Nigeria, Zambia). From 2010, this will be extended to up to 15 countries.
- The first IHP+Results Interim Progress Report was presented to the IHP+ Scaling-up Reference Group (SuRG) in February 2010. This described lessons learned during the first year of implementing IHP+Results and raised important questions about how Signatories, together with Civil Society, could take more responsibility for their Individual, Mutual and Public Accountability to the commitments made in the IHP+ Global Compact and in country-level agreements. (Summarized in the box on Page 11).
- From 2010, IHP+Results will offer a mechanism to independently rate the performance of IHP+ signatories against a standard set of measures and to report their progress in public IHP+Results Partner Scorecards (See Page 14).
- More information about IHP+Results is available through the online North-South Observatory for IHP+Results (www.ihpresults.net)

Annual reviews of progress against the IHP+ commitments

The Global Compact requires partners to meet each year to review their progress against the commitments they have signed up to.

Progress to the end of 2009

- A high-level **Ministerial Review of the IHP+** by Signatories and Civil Society representatives took place in February 2009. This considered the findings of the first External Review of the IHP+[13] conducted by *Responsible Action* in 2008. The Ministerial Communiqué from this meeting set out a number of key actions that were required *through an acceleration of progress in 2009, so that tangible change could be achieved at all levels in support of countries*[14].
- Signatories have not met their Global Compact pledge to *meet each year to review progress against these commitments.* The next Ministerial Review is not scheduled until early 2011, at least 2 years since the first meeting. These reviews by senior government representatives, agency leaders and Civil Society are **a key element of mutual accountability within the IHP+ that should be maintained on an annual basis,** if possible.
- IHP+Results will publish **periodic Performance Reports** on the global progress in implementing the IHP+ commitments. The next report is due in December 2010, for Ministerial Review in early 2011.

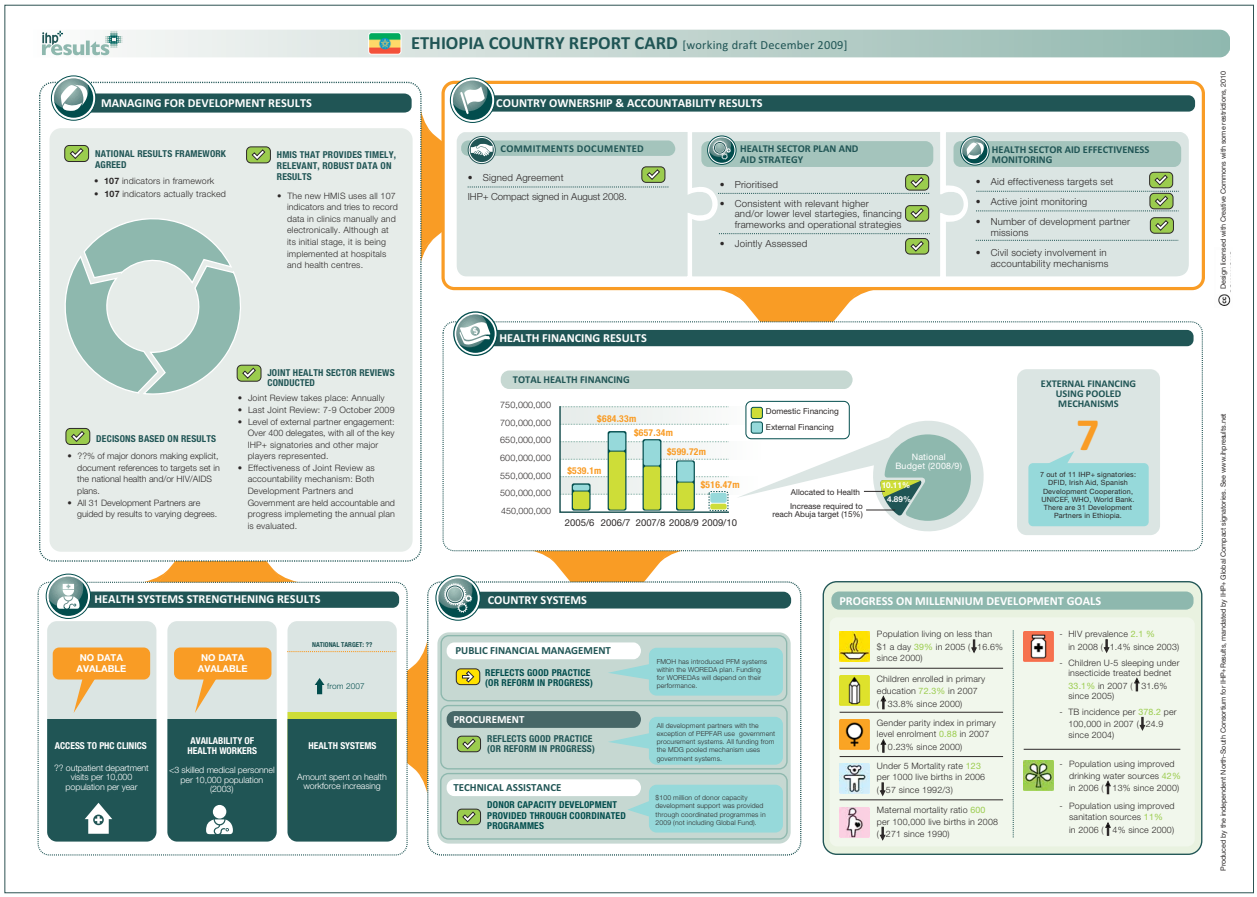

Figure 1: Draft IHP+Results Country Report card (specimen)

13 http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_external_review_2008_EN.pdf
14 http://www.internationalhealthpartnership.net/CMS_files/documents/ministerial_review_meeting_commu_EN.pdf

Lessons and recommendations from the first year of implementing IHP+Results in 2009

Efforts to strengthen transparency and accountability will take time to become established practice

- Few signatory agencies are currently set up to collate and report information on the actions that they are taking to meet their IHP+ commitments.
- Accountability has yet to become embedded in the ways that most agencies work; although there has been progress, a lot more needs to be done at both the international and country level to improve mutual accountability for progress and for results.
- The IHP+Results process is perceived to be making a positive contribution to improving accountability, but must evolve to become a more effective part of accountability mechanisms that are collaboratively built and used by all stakeholders.
- Concerted efforts are needed within countries to strengthen routine aid effectiveness monitoring in the health sector. This could be done through existing Joint Annual Reviews (JARs).
- Making information publicly available will enable external stakeholders to become more engaged, strengthen accountability and improve management for results. However, there is little current information available in the public domain about how well IHP+ Signatories are performing or to provide evidence of contributions the IHP+ is making within countries. At the time of writing, no signatory agency had fulfilled their Global Compact commitment to annually report on their progress.

IHP+Results will be more effective through providing a simpler and lighter approach to data collection and reporting

- To avoid duplication, IHP+Results should use existing data sources and data collection processes as far as possible, particularly within countries. However, efforts by IHP+Results to draw from M&E and accountability processes within countries (especially through JARs) had limited success. Timing of these reviews is unpredictable in some countries and in most cases aid effectiveness data are not collected and jointly reviewed through this process.
- If IHP+ signatories meet the Global Compact commitment to routinely make available transparent and unbiased information on their progress for the purpose of external review, the process of data collection could be simplified.
- Our attempt to use standard measures based on Paris Indicators (for the health sector) did not succeed – mainly because the tools and data collection approach did not make it clear to agencies how and where this information could be obtained.
- A revised approach should be developed with partners for 2010 that uses existing Paris Declaration indicators, datasets and monitoring processes, as far as possible. IHP+Results must continue to collaborate with the OECD/DAC and with Paris Survey country focal points.

Mutual accountability needs to be fostered by all IHP+ signatories

1. All IHP+ signatories should be offered the opportunity to voluntarily participate in the IHP+Results independent performance review mechanism. Those that participate should be explicit, specific, and transparent about the actions they are taking or that still need to be addressed.
2. Transparent, good-quality information will enable IHP+Results to independently review progress in implementing the IHP+ and the findings should be made public through updated IHP+Results Partner Scorecards.
3. At the country level, Joint Annual Reviews of the health sector could explicitly review aid effectiveness and be strengthened as a forum for mutual accountability by applying mutually agreed standard measures of aid effectiveness in the health sector.
4. The SuRG should consider the recommendations of a Mutual Accountability Working Group on how to build the platform for mutual accountability and on a set of standardized performance monitoring measures.
5. The SuRG needs to ensure that a High-Level Ministerial Review of the IHP+ is convened within 12 months, to review progress at this critical point in time.

PROGRESS ON THE COLLECTIVE IHP+ GLOBAL COMPACT COMMITMENTS

All IHP+ signatories have committed to ***work together in more efficient ways to improve health care and health outcomes*** *in low and middle-income countries.*

Collectively Strengthening & Using Country Systems

All signatories committed to **build on and use the existing systems at country level for planning; coordination; delivery; and management of the health sector**, within the overall national development framework to achieve MDG related outcomes.

Progress to the end of 2009

- Ethiopia, Burundi, Zambia, Mali and Cambodia could provide evidence that their national procurement systems either reflect good practice, or that reform processes are underway. Kenya and Nigeria are still challenged by having weak procurement systems, although in Nigeria a 'Public Procurement Act' has been passed to begin addressing these deficiencies[15].
- Burundi, Cambodia, Mali and Nepal are reported to have Public Financial Management (PFM) systems that reflect good practice[16].
- The Global Fund to fight Aids Tuberculosis and Malaria (the Global Fund) introduced a new policy in 2009 promoting improved use of national procurement systems. The Fund reported that by 2009 approximately 87% of its funding to government recipients flowed through national procurement systems (up from 56% in 2006)[17].
- AusAID has agreed to use national procurement systems in Nepal, having joined the pooled funding mechanism in 2009 & is supporting national procurement planning – including for using country distribution systems. (No external funding currently uses national procurement systems in **Cambodia**)[18].
- UN agencies are still more likely to use their own procurement systems, although typically this is intended to be an interim measure to support countries in transition. UNICEF claims to be working to harmonise its inputs with other UN agencies. In Cambodia there is evidence that UNFPA is working with donors to strengthen government procurement systems[19].
- The World Bank reported it was using country systems 'where possible' (with evidence for this in Kenya, but other countries still need to be validated).

Proposed Standard Performance Measures of strengthening and using country Public Financial Management and procurement systems

For development partners:

- *Proportion of external health sector aid that uses public financial management systems in partner countries, which either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.*
- *Proportion of health sector aid that uses government partner country procurement systems which either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.*

For IHP+ country governments:

- *Country procurement and public financial management systems [for the health sector] either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.*

Collectively strengthening Health Systems and tackling critical gaps in Human Resources for Health

Country governments, acting with their respective civil society, committed *to tackle the challenges facing country health systems – particularly* ***having enough trained health workers, in the right places and with the motivation, skills, equipment, commodities and medicines to do their work.***

15 These findings are based on data collected by IHP+Results country representatives through interviews with IHP+ Signatory representatives
16 These findings are based on data collected by IHP+Results country representatives through interviews with IHP+ Signatory representatives.
17 Taken from the GFATM narrative scorecard, available at http://network.human-scale.net/docs/DOC-2601
18 Taken from the AusAID narrative scorecard, available at http://network.human-scale.net/docs/DOC-2601
19 Taken from narrative scorecards available at http://network.human-scale.net/docs/DOC-2601

Progress to the end of 2009

- WHO has reported that 47 of 57 (82%) 'Crisis Countries' with critical shortages in their health workforce, now have a multi-year HRH plan in place.
- Collective ongoing support for addressing Human Resources for Health (HRH) deficiencies has been provided through Global Health Initiatives related to the IHP+:
  - The Global Health Workforce Alliance (GHWA) hosted the first Global Forum on HRH in 2008 that produced the 'Kampala Declaration and Agenda for Global Action' (subsequently endorsed by G8). HRH Country Profiles are being updated. A 'tracking survey' has been initiated to assess the extent to which there has been mutual accountability & progress on the Kampala commitments. This should produce evidence & an accountability framework that can be linked to IHP+Results.
  - The Partnership for Maternal, Newborn and Child Health (PMNCH) has initiated a work stream to strengthen country capacity for HRH planning.
- WHO is providing ongoing technical support to improve the production, distribution, skill mix and retention of the health workforce, and has developed Global Policy Recommendations, including for 'Increasing Access to health workers in remote and rural locations' (due to be released).
- The Global Fund has introduced a Key Performance Indicator & explicit targets for the total amount and proportion of its funding that is provided to support health systems strengthening. The 2010 target is $750 million.

Proposed Standard Performance Measures of investments in strengthening health systems

For development partners:

- *Proportion of IHP+ countries where there is documented support for a national HRH plan that is integrated with the health plan.*

For IHP+ country governments:

- *The country is implementing (or developing) a national HRH plan that is integrated with the health plan.*

Note: This HRH measure has been selected as a proxy measure of progress in strengthening country health systems

Collectively Ensuring Accountability

All IHP+ Signatories committed ***to be held accountable in implementing the Global Compact.*** At the 2008 Ministerial Review of the IHP+ they agreed to **establish a robust framework for mutual accountability.** This included making use of one common results framework with a single set of indicators & to jointly provide resources to collect the necessary data in each country.

All IHP+ partners committed to fully participate in and provide support for country-level accountability mechanisms. Recognizing the importance of mutual accountability at the global level, they mandated the annual independent monitoring and evaluation review of the IHP+ being undertaken by IHP+Results.

Signatories agreed to explore mechanisms for providing ongoing in-country feedback to development partners to accelerate the achievement of commitments. They envisaged that this would include reviews of performance against Country Compact commitments and the commitments made in the Ministerial Communiqué.

The importance of Civil Society engagement in global- and country-level accountability mechanisms was re-emphasised.

Progress to the end of 2009

- At the international level, steps have been taken to ensure accountability through independent monitoring & evaluation and annual reviews of the IHP+, as described in the previous section (Pages 9 - 10). The first independent IHP+Results 'Interim Progress Report' to IHP+ Signatories in February 2010 was critical of Partners for losing momentum on their Mutual Accountability commitments & recommended they take full responsibility for their individual, mutual and public accountability.
- On the recommendation of IHP+Results, the IHP+ SuRG has convened a time-limited Mutual Accountability Working Group to collaboratively improve IHP+Results as a mechanism for accountability and to propose how the SuRG and IHP+ Signatories should work to build the mechanisms for Mutual Accountability in the health

sector during 2010 and beyond.

- Mutual Accountability at the country level tends take the form of Joint Reviews between development partners, national governments, and (not in all cases) civil society. Of the 9 countries reviewed by IHP+Results, all except Nigeria have a joint annual health sector review mechanism. Kenya, Ethiopia & Nepal had reviewed or planned to review the IHP+ or aid effectiveness commitments in the health sector. A further 2 countries (Burundi & Zambia) were considering introducing such measures. IHP+Results has worked with some countries to incorporate aid effectiveness reporting into these reviews.
- There is an important opportunity for the IHP+ commitments to be mutually reviewed in more systematic ways through these country-driven mechanisms. The IHP+ can add value to this process by ensuring that the performance concerns raised through country reviews are reflected back at the international level to the attention of the heads of agencies; management boards of international organisations; political leaders; and people who care within the general public.

Proposed Standard Performance Measures of whether Mutual Accountability is being demonstrated

For development partners:

- *Proportion of IHP+ countries where mutual assessments have been made of progress implementing health sector commitments on aid effectiveness.*

For IHP+ country governments:

- *Joint Annual Health Sector Review (or equivalent mutual assessment) held to assess progress implementing health sector commitments on aid effectiveness.*

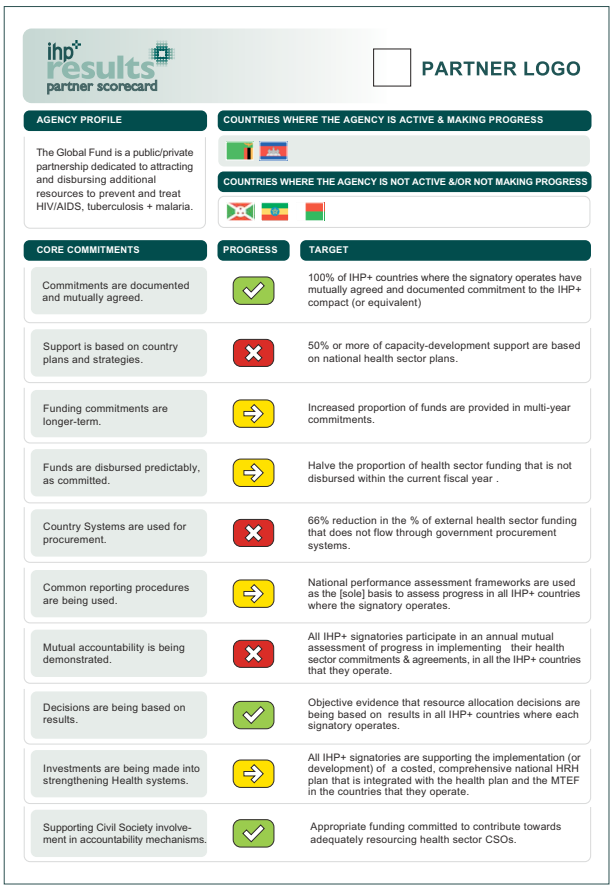

Figure 2: Draft IHP+Results Partner Scorecard (specimen)

Mali as a Case Study example of IHP+ implementation

In April 2009 the Mali IHP+ Country Compact was signed by 12 partners and the National Government. The Government of Spain has subsequently joined the partnership.

The Mali Compact provides a common framework to implement the government's comprehensive strategy document *Programme de Développement Sanitaire et Social (PRODESS II*). Partners characterized this as a mechanism that would help remove bottlenecks to funding and implementation.

The Mali Government views the IHP+ as "a flexible framework for all partners to move forward towards more effective aid". Partners agree that the negotiation of the Compact allowed the Ministry of Health to show leadership in improving health effectiveness; drafting the Compact also produced agreement on a limited number of national indicators to track results. The Compact has been used as a tool for planning because this includes all donor commitments and is shared by all stakeholders. Alongside the Compact, a number of new strategies have been developed, including for human resources.

National stakeholders consider that the IHP+ has led to more effective government-partner working relationships and has started to reinforce existing processes. The IHP+ is often referred to as a set of principles. These will be tested through renegotiation of the PRODESS and its financial arrangements (2010-11). NGOs are broadly supportive of the IHP+ approach, provided they are included in plans and continue to receive resources for the services they provide.

In recent years Canada, Netherlands, Spain and Sweden have provided sector budget support, enhancing national government ownership and alignment around national priorities. However, further expansion of budget support has been constrained by some donor policies not permitting the use of this funding modality, as some agencies prefer to spread risk by engaging in alternative forms of support. Some financing remains unpredictable, mainly because agencies cannot clearly forecast their medium-term commitments.
Key health indicators that trigger donor disbursement have been further harmonised. The Ministries of Health and Finance are addressing some development partners' concerns about government disbursement capacity.

Agency participation in annual national planning helps align them with national priorities. However, significant earmarking remains and still steers overall financial support towards vertical programmes. There tends to be more alignment in procurement and supply. Monitoring and evaluation in the health sector is beginning to improve, as there is a single results framework and joint sector review process (co-chaired by a civil society representative). Coordination of technical assistance remains limited and some duplication of activities is reported. Health systems strengthening is central to Mali's national strategy, and health outcomes have progressed over the years, although major constraints in building capacity are compounded by insufficient investment.

What to look out for in the coming months:

- Have more partners joined the budget pooling mechanisms?
- Have Government and funding agency planning and budgeting schedules been harmonized?
- Is budget support disbursement faster and more reliable?
- Are the IHP+ principles being fully applied as the new National Health Strategy is being developed?
- Are partners investing more (long-term) resources to support health systems strengthening?

Tools and Mechanisms for Accountability

IHP+Results has developed a Partner Scorecard tool for agencies and national governments to publicly report the progress they are making to implement their IHP+ Global Compact commitments.

- A simplified **Partner Scorecard** will be implemented from 2010 (the design of this tool evolved to improve a prototype tested in 2009). See Figure 2.

This uses a limited set of **standard performance measures**

- These measures have been **developed through consultation** with the IHP+ Scaling-up Reference Group and with the OECD DAC (to track those IHP+ commitments that are about improving aid effectiveness in the health sector).
- They will be used to **track progress over time, to compare agencies, and to show how each is performing across the IHP+ countries** in which they operate.
- Each agency will be required to take **responsibility for voluntarily and openly disclosing the data needed as evidence** of progress against these measures. Voluntary and transparent disclosure of information for performance monitoring is considered a cornerstone of mutual accountability for aid effectiveness. Future IHP+Results reports will reflect the extent and quality of the information that signatories provide.
- IHP+Results will **validate the ratings of Standard Performance Measures for each agency against objective criteria**, using the data provided. The IHP+Results Advisory Group will subject any disputed ratings to independent adjudication.
- In later years, **agencies could choose to present their own Scorecard** (that should still be independently validated). IHP+Results would like to see this established as standard practice.

IHP+Results will transparently report the actions that each Signatory is taking to progress their commitments.

- This will **make visible to other partners and the public what each Signatory is actually doing**, to enable peer review and responses to these actions. This is essential for building cooperation within the partnership, regardless of whether each partner trusts the other to 'do the right thing'.
- The findings of **peer reviews amongst partners and public commentary will be reported to provide qualitative reflections** on whether signatories are meeting expectations, ensuring that standard measures will not set performance expectations to the 'lowest common denominator'. Over-emphasis on performance measurements that expect defined results can also lead to mutual risk-averse behaviour[20], so we hope that the qualitative reflections will recognise behaviours that drive progress, such as: 'preparedness to take calculated risks'; 'embracing and learning from failure' and 'willingness to change entrenched ways of working'.

IHP+Results will independently publish Performance Reports (that include the most up-to-date Partner Scorecards) to indicate how well IHP+ Signatories are performing.

- The first of these reports will be published at the end of 2010.
- Interim results and ongoing commentary on progress and challenges in implementing the IHP+ commitments will be updated as these become available in the online North-South Observatory for IHP+Results.

Participation in the IHP+Results mechanism is voluntary. However, we will publicly review the extent to which each IHP+ Signatory is transparently reporting on their progress against the IHP+ commitments, by whatever means they choose to do this.

Building mutual accountability mechanisms at both the international and country levels will take time and is likely to progress through stages, with some agencies taking the lead (See Figure 3, page 27). Partners in the IHP+ are not yet collaborating effectively to build the mutually reinforcing system through which to be held accountable for their performance. Only a few signatories had started to take the lead to demonstrate their accountability by participating in IHP+Results in 2009. However, with the SuRG having committed in February to ensuring that Mutual Accountability is taken seriously, we expect in 2010 to see the accelerated progress that has been promised since the IHP+ was launched.

20 Perrin (2002)

PROGRESS BY INTERNATIONAL ORGANISATIONS & BILATERAL DONORS

Aligning external support with National Health Plans & Strategies

International Organisations & Bilateral Donors (Development Partners) committed to ***accept national health policies and plans as the basis for providing funding*** *and to avoid introducing new plans or projects that are inconsistent with national health plans and priorities.*

They agreed to implement a shared approach to reviewing national health plans and sector management arrangements, to minimise requirements for further assessments.

Progress to the end of 2009

- Preliminary findings suggest that Development Partners (DPs) are making greater efforts to support and align their activities with these national plans. For instance, in Cambodia, DPs reported that all external funding to the health sector is aligned with the Royal Government of Cambodia (RGoC) Annual Operational Plan (AoP) and Health Sector Plans.
- All 9 countries in our review reported having prioritised national health sector plans and strategies in place. However, these plans still tend to accommodate competing priorities that reflect the availability of donor funding or donor priorities.
- In 2009 the IHP+ SuRG agreed on a standardised process to review the quality of national health sector plans & strategies through 'Joint Assessments of National Plans & Strategies' (JANS), so they could be used as the basis for coordinated funding support[21].
- An IHP+ inter-agency working group had finalised a draft tool and guidelines by the end of 2009. Scoping missions to assess the feasibility of conducting the JANS process had been carried out (or were planned to take place) in Ethiopia, Rwanda, Vietnam, Nepal and Uganda. Zambia has planned to use the JANS tool to structure discussions with stakeholders in the country on the new health sector strategy in early 2010.
- The Global Fund (GFATM) introduced National Strategy Applications (NSA) mechanism in 2008 for funding requests to be based on country strategies, to replace the existing requirements for detailed proposals[22]. Recommendations for the first 'learning wave' pilot NSA countries were presented to the Fund's Board in November 2009 and although the mechanism is still considered to be 'untested', this demonstrates a positive move by the Fund aligned with the IHP+ principles. At the end of 2009, the board also approved a streamlined new grant architecture that has the potential to support national programme approaches that are better aligned with national cycles and systems.

Proposed Standard Performance Measures of whether support is based on National Plans and Strategies

For development partners:

- *Proportion of current capacity-development support provided through coordinated programmes consistent with national plans/ strategies for the health sector.*
- *Proportion of aid flows to the health sector that is reported on national budgets.*

For IHP+ country governments:

- *National Health Sector Plans/Strategy in place with current targets and budgets that have been jointly assessed*

21 For more information please see: http://www.internationalhealthpartnership.net/en/about/j_1253621551

22 NSAs are an approach that enables funding requests to the Global Fund in the form of a national strategy – which has been independently "validated" using broadly-agreed, international standards – and some minimal additional information. It will create an incentive for country stakeholders to develop robust national strategies, eliminate parallel planning efforts and contribute to improving harmonization among donors. The national strategy could be a disease-specific strategy or a health strategy.

Providing fair & responsible funding support to national Health Sector Budgets

Development Partners committed to ***agree with each national government*** *on the sources and amounts of funding for the health plan.*

At the first High-level Ministerial Review of the IHP+ in 2008, they furthermore agreed to secure more effective and predictable financing, as well as **additional resources to achieve the health MDGs.**

Partners reaffirmed their commitment to maintaining levels of development aid and domestic health budgets. They also committed to deliver predictable financing and to ensure that all domestic and external resources are used effectively - recognizing that this is critical to achieving results and to attracting additional resources.

Progress to the end of 2009

- Seven of 9 countries in our review had undertaken financing gap assessments against their national budgets. The other two countries were busy with this. In Mozambique the funding gap appears to be decreasing (from $213.16 million in 2009 to $188.64 million committed in 2010). In contrast, Burundi has a widening gap.
- Ethiopia was the first country to establish an IHP+ Compact in 2008, to develop ambitious health sector budgets based on MDG scenarios, and to establish the MDG Performance Fund to pool donor contributions. Under the least ambitious scenario, funding to the health sector would need to be doubled from 2007 levels in order to achieve an annual per capita spend of $14.3. Contributions to this fund were initially slow, but have since increased significantly to enable implementation of key elements of the health sector plan – such as undertaking Woreda-based Planning & employing 30,000 Health Extension Workers. The government's own per capita expenditure on health has also increased from ETB 16 in 2007/8 to ETB 26.60 in 2008/9[23].
- Accurate recent data on development funding for health are extremely challenging to obtain for most countries, although the available information seems to indicate a trend towards increased funding overall[24]. But these increases have been extremely varied across countries and are still far from meeting global commitments or country expectations to implement more ambitious health plans that will adequately address the MDG priorities[25].
- The impacts of the global financial crisis on development funding for health was not yet apparent in funding reports, due to time latency. However, the weakness of OECD country public finances and the global economy are likely to have impacts over an extended period that will require sustained international solidarity and innovation to maintain and increase investment in the health MDGs for longer-term global prosperity.
- Overall, Development Partners reported a greater awareness of and commitment to being more transparent about how their funding is provided, in line with the 2008 Accra Agenda for Action[25]. A significant number of IHP+ Signatories have also signed up to the International Aid Transparency Initiative that will begin monitoring their transparency from 2010, following a process of scoping, research, technical analysis and user consultations.
- A 'High Level Taskforce (HLTF) on Innovative International Financing for Health Systems' was convened in 2008[26]. The Taskforce reported that there is an estimated $10 billion global funding gap per annum for the health MDGs to be met. A number of potential innovative financing mechanisms were identified to complement traditional aid and bridge this gap.
- At the 2009 UN General Assembly a group of IHP+ funding agencies responded to the Taskforce recommendations by pledging to raise $5.3 billion from innovative sources of funding. A number of specific initiatives have been announced on what could be done to achieve this, but details are still needed on how the full commitment would be delivered and by when.

23 For further information please see http://network.human-scale.net/docs/DOC-2407

24 Based on analysis of the OECD Donor Reporting Database and few reports from countries obtained by IHP+Results.

25 For more information please see www.oecd.org/document/3/0,3343,en_2649_3236398_41297219_1_1_1_1,00.html

26 Launched in September 2008 to help strengthen health systems in the 49 poorest countries in the world. Chaired by UK Prime Minister Gordon Brown and World Bank President Robert Zoellick, the Taskforce released its Recommendations in May 2009, identifying a menu of innovative financing mechanisms to complement traditional aid and bridge the financing gaps which compromise attainment of the health-related Millennium Development Goals (MDGs). For more information see: http://www.internationalhealthpartnership.net/en/taskforce

- Government leaders from Nepal, Malawi, Ghana, Liberia and Sierra Leone responded by announcing plans to expand access to free health services. Specific commitments from development partners to support the national budgets of these countries to achieve this still need to be figured out and this provides a key opportunity for partners to apply the IHP+ principles. IHP+Results will monitor progress on this for IHP+ countries in 2010.

At the time of writing, an appropriate measure for funding support to national health sector budgets was still being discussed through the IHP+ Working Group on Mutual Accountability.

For IHP+ country governments the following Standard Performance Measure is under consideration:

- *Proportion of national budget allocated to health.*

Using shared mechanisms to manage and account for external funding

Development Partners agreed to increasingly use *shared mechanisms for managing and accounting for funds, reporting on progress and reviewing performance.* This is necessary to reduce the transaction costs on countries; to rationalise planning & budgeting procedures; and to better align external funding contributions with national plans and budgets.

Progress to the end of 2009

- The High-Level Task Force on Innovative International Financing for Health Systems recommended the establishment of a Health Systems Funding Platform for the Global Fund, GAVI Alliance, the World Bank and others to coordinate, mobilize, streamline & channel the flow of existing & new international resources to support national health strategies. Progress has been made by these three agencies, facilitated by WHO, that includes an agreed workplan for 2010 with a target to improve harmonisation and alignment of funding in at least 4 low-income countries[27]. There are still outstanding questions about how this mechanism will be implemented; about the roles of the partners; how this will affect existing relationships with other donor agencies; how resources will be managed; how the mechanism will work in practice; as well as how civil society will be engaged in the governance arrangements.
- Whether more harmonized and better-aligned donor funding sources will yield results within countries probably depends on the capacity of national systems to effectively programme this funding over an extended time period. There are IHP+ countries in which development partners are investing in & using public financial management systems that have not been reliable in the past, such as:
  - In Cambodia, where selected donors (including DFID and the World Bank) are providing both technical and financial assistance to strengthen public financial management systems.
  - AusAID increasing its alignment with public financial management systems in Cambodia and Nepal through using pooled funding mechanisms and SWAps[28].
- Most donors report that they use national performance assessment frameworks to fulfil their reporting requirements (although this still needs to be verified through objective measures). This could be reducing duplicative monitoring requirements & transaction costs to countries. It is more feasible to coordinate funding if development partners use the same results to make their funding decisions.
  - In 2009 82% of Global Fund grants were reported as being aligned to national M&E systems. The 2010 Global Fund target is 90%.

Proposed Standard Performance Measures of the use of shared mechanisms to manage and account for external funding

For development partners:

- *Proportion of external health sector aid that uses public financial management systems in partner countries, which either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.*

For IHP+ country governments:

- *Proportion of [IHP+] countries in which transparent and monitorable performance assessment frameworks are used to assess progress against (a) the national development strategies and (b) health sector programmes.*

27 For more information see http://tinyurl.com/3a7prny
28 From the AusAID narrative scorecard. For more information please see http://network.human-scale.net/docs/DOC-2601

Keeping support flexible & responsive to country needs

Development Partners committed to *contribute funding to national health plans that address the whole health system – including public and non-state sectors.*

Support could be provided for specific aspects of the plans, but where possible (in accordance with their respective funding policies and guidelines) provided in flexible ways. This includes flexibility to fund non-government services (either directly or via government) and to address critical funding gaps.

They also committed to *work to ensure that disease and population specific approaches and those to achieve broad health system strengthening are mutually reinforcing. Recognizing that this may include revising existing health and disease specific programmes to make better use of the support.*

Progress to the end of 2009

- The Global Fund and GAVI Alliance have signalled their intention to begin jointly programming their resources towards health systems and are working with the World Bank and WHO to establish a 'Health Systems Funding Platform'. This could potentially provide more flexible results-based funding that is not tied to disease-specific priorities.
- Pooled funding mechanisms to support national health sector budgets are a practical means of providing relatively flexible (un-earmarked) funding support to countries. There appears to be more development funding for health being channelled through these mechanisms in IHP+ countries, although this needs to be assessed for all countries using objective measures. Examples include:
  - The Ethiopia MDG Performance Fund established in 2008 to fill gaps in underfunded child and maternity health services attracted $54 million in 2008/9 & this pooled funding was projected to increase to $100 million in 2009/10.
  - Budget support in Nepal has increased. A pooled fund increased by 74% from $36.6 million in 2008/9 to $63.8 million in 2009/10, which is equivalent to 58.6% of total DP financing (totalling $109 million)[29].
  - In Cambodia partners are increasing pooled funding through the Joint Partnership Arrangement Development Partner Interface Group (JPIG)[30].

Proposed Standard Performance Measures of the use of flexible funding aligned to what the country needs

For development partners:

- *Proportion of aid flows to the health sector that is reported on national budgets.*

Making more predictable, longer-term funding commitments

Development Partners committed to r*eview [their] policies and procedures at global level to enable better-coordinated and longer term support at country level.*

Progress to the end of 2009.

- Most donor agencies report that they provide indicative multi-year commitments of at least 3 years[31]. UNFPA, UNICEF and DFID have moved to providing 5-year indications wherever possible. As yet, there is little consistency across countries in how this is being applied.
- No specific evidence could be found in any of the IHP+ countries surveyed that longer-term donor commitments have improved health sector budgets – for instance, through the country's medium-term expenditure frameworks being adjusted.
- Most agencies report having a mechanism to agree on timing and amounts of disbursements. For GAVI and the Global Fund, these are part of grant proposals. AusAID provides rolling funding estimates to governments on an annual basis. In some countries, DFID indicates the anticipated annual funding to governments over a number of years. Exceptionally, UNICEF in Nepal reported that

29 In 2009 AusAID joined the World Bank and DFID in contributing to the pooled fund for health. For more details see http://network.human-scale.net/docs/DOC-2399

30 IHP+ relevant activities, principles and policies are being implemented by JPIG partners. They report disbursed funds against the Royal Government of Cambodia's (RGoC) Annual Operational Plan (AoP) and Health Sector Plan (NHSSP II). Indicating anticipated annual funding approximately 10 months before the start of the financial year.

31 Multi-year is used to mean 'long-term' in the Paris declaration on aid effectiveness.

no disbursement shcedules had been agreed with government due to the unpredictability of UNICEF's own funding.

- Signatories reported that they perform well against their disbursement schedules, although we have not independently verified this. In 2008, GAVI reported disbursing 60% of funds within 90 days. Their target was 70%, but a November 2009 Board decision was made to delay some disbursements. UNICEF reported 100% on-time disbursement in Zambia and Mozambique, exceeding their commitments. The Global Fund reported that actual disbursements were 95% of the expected amounts.

Proposed Standard Performance Measures of more predictable, longer-term funding

For development partners:

- *Proportion of health sector aid disbursements released according to agreed schedules in annual or multi-year frameworks.*
- *Proportion of funding to the health sector that is provided through multi-year commitments*

Linking support to achieving results

Development Partners committed to *test and evaluate ways to link [their] support to achieving results at country level, including success in strengthening health systems.*

Other Funders signing the Global Compact agreed to *continue to invest in learning and evaluation to ensure the best possible linkages between [their] support and achieving results at the country level.*

Progress to the end of 2009

- The Global Fund and GAVI have continued to demonstrate that continuation of funding is dependent on results being demonstrated.
  - GAVI performance-based Immunisation Services Support (ISS) funds are only disbursed (beyond an initial investment phase) on demonstrating results that have already been achieved.
- The Global Fund rewards strong-performing grants with a higher percentage of expected funding being disbursed than poor-performing grants. The Fund will operate a 2010 target difference in disbursements of 30% between higher and poor performing grants, compared to 19% in 2009[32].
- Concerns have been raised by civil society that basing funding decisions on results has the potential to penalise poor performance or reward positive results. This continues to be perceived by some as a controversial approach.

Proposed Standard Performance Measures of whether decisions are based on results

- *At the time of writing, an appropriate measure for whether decisions are being based on results was still being discussed through the IHP+ Working Group on Mutual Accountability.*

Changing development partner behaviours

The Global Compact commits Development Partners to *ensure [their] staff make [the IHP+] a priority, have incentives and are empowered to work in a coordinated way at country level.*

Progress to the end of 2009

- In response to the 2008 'External Review of the IHP+' that found no agency had begun to institute internal processes to bring about these changes, partners represented at the IHP+ Ministerial Review in 2009 agreed to *make significant changes in [their] corporate policies and procedures to effect the transformations in country-level behaviour that the IHP+ envisages. In particular to strengthen the delegated decision-making authority of development partner representatives at the country-level. Donors agreed to ensure consistency of their policy positions within the governance structures of all multilateral agencies. Multilateral agencies and bilateral donors committed to make concrete changes to their business policies and procedures in accordance with the Accra Agenda for Action,* including to transparency and that all funds mobilized should appear in national budgets.
- Most Development Partner representatives surveyed by IHP+Results felt that they are cooperating through country health sector teams on a regular basis. However, it was still evident in country reviews that the quality of this cooperation remains highly dependent on the personal

32 For further details see GFATM Key Performance Indicators - http://www.theglobalfund.org/en/performance/kpi/?lang=en

motivation of individual champions; more still needs to be done to put in place formal incentive structures and to formally delegate authority to agency representatives that have the competence & institutional support to implement 'new ways of doing business'[33].

- Commitment to and understanding of the benefits of greater transparency still need to become part of the culture and modus of operation for most agencies (perhaps with the exception of Global Fund and GAVI). IHP+Results has been significantly restrained from publicly reporting findings or the information that has been reported by agencies under the condition that this still needs to be 'signed off' at the senior level.

Proposed Standard Performance Measures of development partner behaviour changes

- *Qualitative measure based on Peer perceptions of whether each Partner is undertaking behaviours that drive progress, such as: 'preparedness to take calculated risks'; 'embracing and learning from failure' and 'willingness to change entrenched ways of working*

Reporting annually on performance

Development Partners promised to *be accountable for delivering the funding and technical support that [they] have committed for health, and to report annually on [their] performance at country and global levels.*

Progress to the end of 2009

- Since 2007 no agency had publicly reported on their performance in implementing their IHP+ commitments at either the country or global level.
- In 2009 IHP+Results started to provide a voluntary mechanism for agencies to report their progress. Although the initial uptake was generally slow, a number of agencies have worked hard to produce an account of the actions they have been taking.
- Implementing this mechanism revealed that agencies are not set up to easily provide information on their performance when requested, or even to record what specific, accountable actions they have been taking to implement their IHP+ commitments. This demonstrates that most agencies had not yet incorporated the IHP+ expectations into their internal performance targets and measures.
- The IHP+ Common Evaluation Framework was developed through a consensus-building process in 2008. This aims to coordinate efforts in countries to monitor performance in the health sector and to evaluate the results of joint efforts to strengthen health systems. Based on a Plan of Action agreed in late 2008, greater efforts are being made by Partners to improve the availability, quality and use of the data for country health sector reviews and planning. The Country Health Systems Surveillance (CHeSS) approach has been developed to facilitate consensus around indicators and measurement strategies for health systems monitoring; enhance support to capacity-building for data synthesis and analysis, including filling critical data gaps; and to improve access to and use of data for health planning and decision-making. Initial preparatory work for this has been undertaken in Ethiopia and Zambia (and in several non-IHP+ countries).
- The IHP+Results tools & procedures are being simplified. Transparent, voluntary reporting needs to be promoted as a keystone of mutual accountability. The IHP+ has the potential to make development partners more responsible for reporting on and being accountable for their own performance in providing funding and technical support that they have committed for health.

The following IHP+ Signatories have reported on the accountable actions they are taking to implement their IHP+ commitments:

- AusAID
- DFID
- GAVI Alliance
- Global Fund
- UNAIDS
- UNFPA
- UNICEF
- WHO
- WB

A narrative description of each agency's reported actions is available electronically[34] as a supplement to this Update.

33 These findings are based on data collected by IHP+Results country representatives in interviews with agency representatives.
34 http://network.human-scale.net/docs/DOC-2601

Overview of Actions

During 2009, DPs reported on a range of actions they were taking across the 5 Results Areas, within the mandate of their organisation. Reporting was done on a voluntary basis. Listed below are example Results Areas, that we feel best illustrate how IHP+ commitments can be translated into SMART[35] actions[36]. For the full range of actions that DPs have reported to be taking, see Annex 1.

Ownership and Accountability

- Provide $30 million for civil society capacity building and increased coordination 2007-2010. (GAVI)
- Provide technical assistance on procurement to Cambodian MoH with the aim of ultimate transition to government systems. (AusAID)
- Increase participation in nationally-led programme-based approaches to ensure harmonization and alignment of aid. (UNFPA)

Health Financing

- Disburse £450 million over three years to 2011 to support health strategies of 8 identified IHP+ countries. (DFID)
- Ensure at least 85% of DFID ODA for health and AIDS in JANS countries will be reported on partner government budgets. (DFID)
- Support 15 governments to produce evidence based plans and budgets for their next national health planning cycles beyond 2010. (UNICEF)
- In 2009-10 financial year, provide AU$5.2 million pooled funding for the National Health Plan in Nepal and AU$10.5million in Cambodia in 2009 calendar year. (AusAID)
- Fund over 4-5 year cycles aligned with national planning cycles. (UNFPA)

Country Systems

- Establish joint HSS funding platform with the Global Fund and World Bank by the end of 2009. (GAVI)
- Reduce the number of health-related Project Implementation Units (PIUs) we use in IHP+ countries. (DFID)

Health Systems Strengthening

- Maintain financial support for health system strengthening to meet end 2010 target of $750 million. (GFATM)
- Address health inequalities with the aim of 80% of health districts in GAVI eligible countries to have more than 80% immunisation coverage (GIVS goal) by 2010. (GAVI)
- Strengthen health systems at country level with the aim of 80% of eligible countries to have applied for GAVI HSS support. (GAVI)

Managing for Development Results

- Work with partners to simplify GAVI reporting through joint programming on HSS, using single results-based framework. (GAVI)
- Commit £100 million in funding to World Bank Health Results Innovation Trust Fund. (DFID)

35 Specific, Measureable, Accountable, Realistic, Timely.
36 These examples are illustrative and no attempt has been made to provide an example for each IHP+ signatory.

PROGRESS BY IHP+ COUNTRY GOVERNMENTS

Developing and using prioritised national health plans

Country governments agreed to *use [their] national health plans, embedded in [their] overall development frameworks, to guide development of the health system and how resources are used in the sector.*

These plans would *incorporate priority programmes such as immunisation, tuberculosis, malaria, reproductive health and the health components of multisectoral HIV/AIDS plans.*

They agreed to *work with national stakeholders and international agencies, when updating their health plans, to develop a common vision for the health sector, and identify targets and budgets that reflect this vision.*

Progress to the end of 2009[37]

- Most national plans still tend to accommodate competing priorities that reflect the availability of donor funding or preferences.
- In Mozambique, the MoH felt health sector planning needed to be better harmonized. Lack of information sharing by development partners apparently still presents a challenge. The IHP+ is supporting improvements in the planning process; a study on evidence of equity in health; releasing national health accounts; training more personnel; improving the dialogue on M&E; and long term planning using and applying the MTEF.
- Implementation of the Joint Assessment of National Strategies (JANS) process should provide us with a better measure of whether health sector plans reflect a common vision and include associated targets and budgets.

Proposed Standard Performance Measures of health sector development based on prioritised national health plans

For IHP+ country governments:

- *National Health Sector Plans/Strategy in place with current targets & budgets that have been jointly assessed*

Engaging Citizens & Civil Society

Country governments signing the *Global Compact agree to engage and involve [their] citizens and civil society so they know what to expect and can give feedback on performance.*

Progress to the end of 2009

- Initial findings suggest that civil society has some degree of meaningful involvement in planning, decision-making and joint reviews in most of the IHP+ countries reviewed (Cambodia, Ethiopia, Kenya, & Nepal).
- Mali and Zambia plan to ensure greater future involvement of civil society.

Further information on Civil Society engagement can be found on Page 8.

Improving governance in the Health Sector

Country Governments commit to *implement [their] health plans efficiently, through stronger health and financial management systems, tackling misuse of resources, and working with non-government organisations.*

Progress to the end of 2009

- Most countries have been working to strengthen their public sector procurement and Public Financial Management (PFM) systems.
  - Burundi, Cambodia, Mali and Nepal reported that their PFM systems reflect good practice.

37 The findings in this section only reflect formal returns from the Government of Mozambique. IHP+Results were unable to routinely gather information from IHP+ country governments. Perspectives on IHP+ responses in other countries were gathered through interviews with IHP+ signatories' country representatives.

- In Kenya and Nigeria, efforts are underway to develop a reform programme for the PFM system.
- The MoH in Mozambique report that disbursements are always made through the agreed mechanisms, predominantly through the PROSAUDE common fund[38]. All PROSAUDE partners use country procurement systems, but sometimes these do not meet the standards for international tenders.

- The Government of Zambia in 2009 uncovered corruption in the health sector & has taken strong steps to address the issue[39].

Proposed Standard Performance Measure of improved governance

- *Country procurement and public financial management systems for the health sector either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.*

Equitable access to health services by the poor and vulnerable

County governments committed to *work to ensure increased public funding for health care and to develop improved health financing mechanisms including risk pooling based on universal coverage in order to increase access for the poor and most vulnerable and protect people from excessive health expenditure, within [their] national budget and macroeconomic constraints.*

Progress to the end of 2009

- Domestic contributions to the health sector have increased in Cambodia, Ethiopia, Mali & Zambia. However, government health expenditures in the African IHP+ countries reviewed are not on a trajectory that will reach anywhere near the 15% Abuja target[40]. In Kenya and Nepal domestic spending on health has fallen during the last decade, most likely due to political instability[41].

Proposed Standard Performance Measure equitable access to health services by the poor and vulnerable

- *At the time of writing, an appropriate measure for equitable access to health services by the poor and vulnerable was was still being discussed through the IHP+ Working Group on Mutual Accountability.*

38 PROSAUDE is the joint fund for financing the health care sector by foreign and international donors in Mozambique.
39 http://network.human-scale.net/groups/zambia/blog/2009/11/09/the-bumpy-ride-bites-25-from-zambia-s-2010-health-budget
40 http://www.un.org/ecosocdev/geninfo/afrec/vol15no1/151aids5.htm
41 http://network.human-scale.net/community/ihp/blog/2009/07/09/nepal-political-developments-consequences-for-the-ihp-process

Nepal as a Case Study for IHP+ implementation

The Nepal IHP+ Compact was signed in February 2009[42] and articulates a set of commitments of the Ministry of Health and Population (MOHP) and External Development Partners (EDPs) to improve alignment between donor and government health programmes. There is general optimism that the Compact will lead to improved coordination, improved aid effectiveness, increased dialogue between CSOs and government, as well as an increased role for CSOs in monitoring government programmes. Stakeholders interviewed could not agree as to whether the IHP+ had boosted the 2004 health SWAp or whether improvements in aid effectiveness predated the IHP+. It was also widely acknowledged that few concrete actions have followed commitments made in the Compact, and there appears to be limited understanding of the nature and purpose of the IHP+.

There are discernible increases in government and donor financing for health programmes and DFID, the World Bank and AusAID now contribute most of their health funding via a pooling mechanism that increased by 74% between 2008/9 and 2009/10. Despite this, healthcare financing is regarded as seriously inadequate, short of the MOHP request for 10% of government funding. Some informants were optimistic that the IHP+ would generate substantial increases in external health funding, but mentioned a need to manage the government's expectations; they considered it more realistic to expect better predictability than increased funding.

There is some evidence that EDPs use and attempt to strengthen country health systems. The Compact is aligned with the NHSP-IP and the *Three Year Interim Health Plan* and the IHP+ builds on existing country coordination processes such as the SWAp and the Joint Annual Review (JAR) meetings. Donors adopting pooled funding by definition adopt government systems: other EDPs do not use these country systems but there are examples of EDPs funding capacity building activities with the aim of strengthening government systems.

Harmonization and alignment remain weak. Poor harmonization *within* some EDPs is also a problem, notably between country office and HQ levels. Moreover, sharing of information remains inadequate and some EDPs still practice direct implementation without informing the Ministries of Finance and MOHP. Donor processes and timings, not those of the government, frequently drive health missions. Some partners believed that the number of missions had increased.

EDP activities tend to be consistent with Nepal health plans, suggesting there is some country ownership of EDP-funded programmes. However, political instability in Nepal over recent times has had important implications for country ownership, making it difficult for EDPs to build lasting relationships within the MOHP. Currently there is no IHP+ focal point within the government. Some stakeholders suggested that the Compact consultation process had encouraged communication between government and CSOs, engendering buy-in from many CSOs, But others suggested that CSO influence was not substantial and that their roles and contributions towards implementing the Compact have not been properly defined.

JAR meetings were widely regarded as an important accountability mechanism. Improved flows of information and broad engagement with health meetings have enhanced the mutual accountability of EDPs and government. However, while many considered the JAR mechanism effective, no one agency takes overall responsibility for monitoring Compact commitments and there has been no specific process in place to do this. Other challenges have included lack of government accountability and transparency, weak national monitoring and evaluation systems and weak systems for gathering health data.

42 IHP+ signatories are the Ministry of Health and Population; AusAID; DFID; KfW/GTZ; UNAIDS; UNFPA; UNICEF; World Bank; WHO

MUTUAL ACCOUNTABILITY IN THE HEALTH SECTOR

Putting mutual accountability into practice requires development partners to:

- **Demonstrate solidarity** ("working together" to make aid work better and to deliver results in the health sector).
- **Allow a diversity of views** on how to tackle unbounded problems.
- **Broaden the circle of accountability** to include national governments and civil society (and the organisations that claim to speak for them).
- **Mutually assess process outcomes**, such as their own and other partner's willingness to cooperate, or to be transparent in making performance information available.
- **Support 'double-loop', adaptive learning**, based on honest appraisal in their organisation and in the partnership of why things are working or not.
- **Strengthen the communication and interaction with other partners** (especially between national governments and international development partners) to build reciprocal cooperation.

These practices could **become more systematic by partners collaborating to create and use mechanisms for accountability.** The IHP+ Scaling-up Reference Group (SuRG) that represents the partners and is supported by the IHP+ Core Team should take responsibility to actively promote mutual accountability and to ensure the effectiveness of mechanisms such as:

- **Regular forums for partners to work together** (this includes: IHP+ Inter-Agency Country Health Sector Teams: the Annual Inter-Agency Country Health Sector Teams Meeting; IHP+ SuRG; and IHP+ High-Level Ministerial Reviews).
- **Issue-focused Technical Working Groups** that are time-limited and accommodate a diversity of views on how to tackle problems that cannot be solved by any single agency.
- **Advocacy to broaden the circle of accountability** and to include civil society in processes and institutions that make decisions that affect the public.
- **Joint Annual Reviews in the Health Sector** hosted by national governments to include mutual assessments of process outcomes towards improving aid effectiveness and governance in the health sector at the country level.
- **Regular, independent assessments of progress,** including well-researched Case Studies and internal reviews that support 'double-loop', adaptive learning.
- **Transparent, real-time reporting** of the actions being taken and progress being made, to strengthen communication and interaction with other partners and to build reciprocal cooperation.

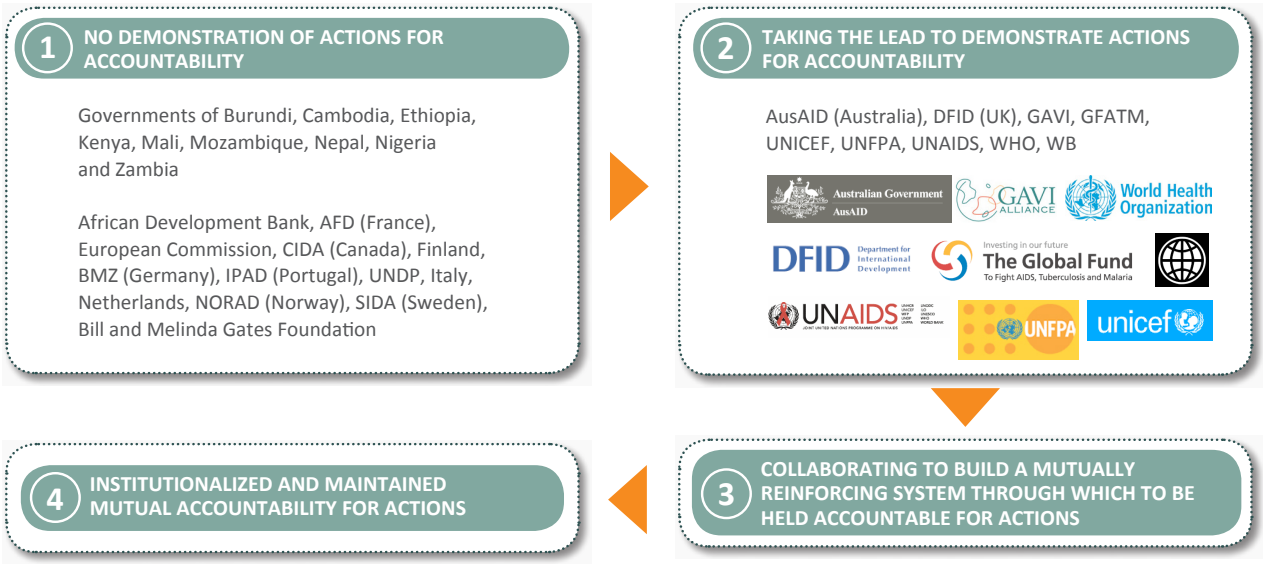

Figure 3: Process of IHP+ signatories towards full Mutual Accountability

Aid effectiveness measures for the health sector

The IHP+ Global Compact explicitly states that ***the IHP+ is a key step in putting the Paris Declaration on aid effectiveness into practice in the health sector.***

The IHP+ Commitments are grounded in the Paris Framework and Accra Agenda for Action, applied to the Health Sector.

IHP+Results proposes applying Paris Declaration Aid Effectiveness Indicators as the basis for a small set of Standardised Performance Monitoring Measures for the IHP+, selected in consultation with the OECD/DAC & IHP+ Signatories. This will be the first real effort to apply the Paris Framework at the sector level for monitoring and evaluation[43]. It will ground the IHP+ monitoring in existing reporting and coordination processes that have already broadly gained credibility.

These will be supplemented by a small number of additional (mostly qualitative) indicators. Adapting the Paris Declaration framework to the needs of the health sector is true to the spirit of the Declaration, which called for both quantitative and qualitative monitoring of Aid Effectiveness to know what is working and whether effectiveness measures are really producing development impacts.

The Paris Framework is currently under review and this needs to be informed by the experiences of applying the Paris Principles. By contributing to the OECD/DAC Technical Task Team for Health As a Tracer Sector (TTHATS), IHP+Results can contribute this review from the health sector perspective, in the lead-up to the Fourth High-Level Forum on Aid Effectiveness in 2011[44]. Monitoring within Results Areas for IHP+Results is thematically aligned with the clusters of the OECD/DAC Working Party on Aid Effectiveness (WP EFF).

The challenges of collecting and interpreting these data for the diverse range of IHP+ Signatory agencies and IHP+ country settings has to be acknowledged (and the Paris Framework is not without its flaws). However the advantages of tracking a very limited set of standard measures to compare progress over time, across agencies and countries makes this a rational approach. For a number of agencies, substantially basing IHP+ performance monitoring on the Paris framework will demand more focused and frequent (annual) reporting. However, this should be considered an appropriate and necessary investment for intensifying progress through the IHP+.

There are still outstanding questions about: the targets to be used for the Paris Indicators that are selected as IHP+ Performance Measures; what baseline should be used to track progress; whether to assess the performance of each agency on data only for the selection of IHP+ countries, or more broadly; whether reporting on these measures will be feasible in all cases; and who should collect the data.

IHP+Results is committed to not duplicating existing efforts and to using data that are routinely collected, as far as possible. The SuRG Working Group on Mutual Accountability is expected to address these questions that are relevant to all IHP+ Signatories by the end of May 2010, so that IHP+Results can prepare the Partner Scorecards that will be based on these measures, for the 2010 IHP+ Performance Report at the end of the year.

43 Apart from the attempt of the Education for All Fast-track Initiative attempt to disaggregate data from the 2008 Paris Declaration Survey for the education sector.

44 IHP+Results has been an active member of OECD/DAC Task Team on Health as a Tracer Sector (TT HATS) since 2009 and will continue to contribute toward information sharing and the Health Sector focus for the Fourth High-Level Forum in 2011.

PROGRESS TOWARDS ACHIEVING RESULTS WITHIN COUNTRIES

Funders agreed to *hold organisations receiving support – and [themselves] – accountable for measuring impact and directing funding toward demonstrated success and to continue to invest in learning and evaluation to ensure the best possible linkages between [their] support and achieving results at the country level.*

- It is fundamentally important for all partners to know whether they are doing enough of the right things within countries to build sustainable health systems that improve health outcomes. At the global level, we need to assess whether all the efforts & investments put into the IHP+ are achieving results within countries, to show progress on the MDGs.
- This requires all Partners to systematically review and learn from the results that are available within countries. Comparing these results against the expectations for progress & the commitments that have been made can lead to better understanding of why there are differences, so that corrective or scaled up actions can be taken.
- Much more investment into learning and evaluation is required. Since 2007 signing of the IHP+ Global Compact, too little has been done by Partners to transparently measure & review their individual or collective actions to implement the IHP+ commitments at the country level.
- IHP+Results is undertaking longitudinal case studies in 2 countries to try understand why results are being achieved (or not) over time and how the IHP+ is contributing to change. The boxes on pages 15 & 26 provide a synopsis of baseline Case Study findings from the first year of reviewing results with partners in Mali & Nepal.
- Most countries do not yet demonstrate how the resources available are used to achieve health results (with the exception of vertical programmes that monitor and report on outputs, such as the 'Number of adults receiving antiretroviral treatment'). Partners do not share information or lessons learnt frequently enough. In many cases, this information is criticised as being weak and unreliable. However, we emphasise the importance of using what information is available to learn from what is being achieved in the health sector.
- IHP+Results has started tracking a very limited set of indicative results from each country (mostly from existing data sources), to produce **IHP+Results Country Report Cards** that graphically summarise this progress. Working drafts of these scorecards from 2009 are available electronically, as these are currently being modified to provide a simpler design.
- The first independent **IHP+Results Performance Report** at the end of 2010 will publish **IHP+Partner Scorecards** for those IHP+ Signatories that agree to participate in this mechanism and **IHP+Results Country Report Cards** for (up to 15) IHP+ countries that consent to being reviewed in this way. This should provide a clear indication of progress 3 years into the IHP+ and of what still needs to be done.

We expect the leaders of IHP+ Global Compact signatories to sit with Civil Society representatives in early 2011 to honestly appraise their contributions to global health and to hold each other to account for translating their IHP+ commitments into actions that produce results.

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