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# M&E Proposal

**Annual Monitoring and Evaluation of the IHP+**

*Technical Proposal*

Prepared for: IHP+ Scaling-up Reference Group

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## List of Acronyms

ACOSHED	African Council for Sustainable Health Development
ACT	Artemisinin-based combination therapy
AMREF	African Medical & Research Foundation
ART	Antiretroviral Therapy
CDPRG	Communicable Disease Policy Research Group
CGD	Centre for Global Development
CI	Catalytic Initiative to Save a Million Lives
CREHS	Consortium for Research on Equitable Health Systems
CSO	Civil Society Organisations
DAC	Development Assistance Committee
DFID	Department for International Development
EC	European Commission
GAVI	Global Alliance for Vaccines Initiative
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHIN	Global HIV/AIDS Initiatives Network Global HIV/AIDS Initiatives Network
GHWA	Global Health Workforce Alliance
HEFP	Health Economics and Financing Programme
HHA	Harmonisation for Health in Africa
HMN	Health Metrics Network
HSS	Health Systems Strengthening
IHP	International Health Partnership
IPT	Intermittent preventive treatment
IRBF	Innovative Results Based Financing
KAP	Knowledge, Attitude, and Practices
LHSTM	London School of Hygiene & Tropical Medicine
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MHRC	Miz-Hasab Research Centre
MoF	Ministry of Finance
MoH	Ministry of Health
NGO	Non-Governmental Organisation
ODI	Overseas Development Institute
P4H	Providing for Health
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother to Child Transmission
RA	Responsible Action
SuRG	Scaling-up Reference Group
SWAp	Sector Wide Approach
TARSC	Training and Research Support Centre
TOR	Terms of Reference
UN	United Nations
UNFPA	United Nations Population Fund
USA	United States of America
WHO	World Health Organisation

## I. INTRODUCTION

The proposed monitoring and evaluation activity will represent the first major evaluation of the International Health Partnership against its goals and principles after the first few years of its initial launch. The team proposed to support the IHP+ evaluation involves a Consortium comprising two Southern organisations Responsible Action (South Africa) and the Miz-Hasab Research Centre (Ethiopia), a major academic institution the London School of Hygiene & Tropical Medicine (LSHTM), and a global NGO Oxfam both of which have a wide network of collaborators and affiliates in Southern countries. The Consortium commits to developing a tailored methodology to monitor and evaluate the IHP+ initiative, conduct a yearly monitoring of the implementation of all 10 IHP+ countries, and carry out in-depth evaluation in a sub-set of 3 countries with a view of making specific recommendations to individual countries and agencies.

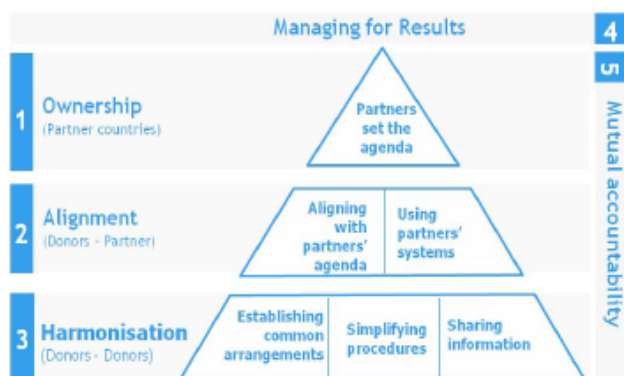
The evaluation effort will build on the IHP+ own selected evaluation measures: inputs, process, outputs, outcomes and impact, with a particular focus on countries accountability towards IHP commitment. The team will maintain a client focus in order to capitalize on the team's unique contribution of having an institutional presence and reputation in multiple recipient countries, including partnerships and collaborators that can provide both access and knowledge of the health sector. Additionally the Consortium will bring expertise in global aid architecture, health systems, organisational management, public health, epidemiology, and operations research, as well as a strong evaluation experience, including the **short term external review of the IHP+** in 2008.

## II. BACKGROUND

### Context

The International Health Partnership (IHP) launched in September 2007 was a politically historical event that brought together 26 signatories including 7 countries, 18 bilateral and multilateral partners, and the Bill and Melinda Gates Foundation to sign a Global Compact<sup>1</sup> aimed at supporting the achievement of the Health Millennium Development Goals. The IHP builds upon a number of initiatives that have aimed to improve the effectiveness of development aid. These include country SWAp (Sector Wide Approach), budget support and tools to increase donors coordination such the UNAIDS 'Three Ones' initiative. In 2005, donors endorsed the Paris Declaration on Aid Effectiveness aimed at improving the effectiveness of aid and its impact on development.<sup>1</sup> See Figure 1. Its five main principles include increased country ownership, better alignment of donors funding with countries systems and procedures, harmonisation of donor programmes, managing for results and mutual accountability. It sets out practical measures with specific targets to be met by 2010 and regular reviews. The IHP is seen as the translation into practice of the Paris Declaration, with a specific focus on the health sector.

**Figure 1. Framework for the Paris Declaration on Aid Effectiveness**



The IHP was conceived in a context of unprecedented growth in international funds dedicated to improving health, of which a substantial proportion is targeted at ‘vertical’ programmes such as prevention and treatment programmes for HIV/AIDS (through the GFATM and PEPFAR and other) and immunization programmes (notably through GAVI). The sharp growth in resources available, as well as the dramatic increase in the number of funders and stakeholders means that the IHP’s principles are more relevant than ever to recipient countries, which tend to be overwhelmed by donors’ multiple requirements<sup>2</sup>.

The IHP+ aimed therefore at addressing a number of problems resulting from how global health development institutions operates:

- Long-standing fragmentation and unpredictability in official development aid for health;
- Inefficiencies and duplication caused by the overlapping mandates of agencies;
- Increasingly complex aid architecture, including a proliferation of global health initiatives, that need to be managed, monitored and reported to at country level;
- The specific administrative procedures created within development agencies over many years make it difficult to harmonise systems across different agencies;
- Poor levels of coordination among global agencies, and between global agencies and recipient country governments.
- Limited alignment of development assistance with country priorities or needs;
- Disproportionate levels of HIV/AIDS financing, at the expense of other health priorities;
- Inadequate volumes and quality of aid financing, much of which continues to be allocated on the basis of hard-earmarking and conditionality, and tends to be focused on short-term priorities;
- Weak health systems in recipient countries, with chronic underinvestment in the health workforce and poor public administration.

### **Rationale and Early Experience of the International Health Partnership**

The rationale for the establishment of the IHP was that countries can only achieve the health-related Millenium Development Goals by the scaling up of access to, and quality of, health services. As demonstrated earlier because of the vertical nature of many health programmes, further investments and development of health systems in countries will need to be supported by long term national strategic planning and resources.

The objectives of the IHP are to promote greater country ownership, donor alignment with national strategies, better aid effectiveness, enhanced coordination and mobilisation of all actors, including non-state actors and place more focus on strategy and health systems performance<sup>1</sup>.

The IHP+ initiative encompasses a number of specific activities including<sup>1</sup>:

- Develop ‘country compacts’ that commit development partners to sustained and predictable funding and increase harmonization and alignment in support of one results-orientated and costed national health plan and strategy that tackle health systems constraints;
- Generate and disseminate knowledge, guidance, and tools in specific technical areas related to strengthening health systems and services;
- Enhance coordination and efficiency and leverage predictable and sustained aid delivery for health;
- Accountability and monitoring performance.

Eight countries signed up to the IHP in September 2007 and thus demonstrated their commitment to enhance aid effectiveness and to strengthen health systems. In 2008 a further two countries joined as fully inaugurated countries, plus four adjunct countries (Figure 2).

**Figure 2. IHP+ countries**

Ten fully inaugurated countries		Adjunct countries
Burundi	Mozambique	Benin
Cambodia	Nepal	Burkina Faso
Ethiopia	Nigeria	Ghana
Kenya	Mali	Niger
Madagascar	Zambia	

The IHP was extended to include a number of ‘related’ initiatives and became known as the IHP+. The related initiatives are:

- Harmonisation for Health in Africa (HHA)
- Innovative Results Based Financing (IRBF)
- Catalytic Initiative to Save a Million Lives (CI)
- Providing for Health (P4H)
- Deliver now for Women and Children
- GAVI Health Systems Strengthening (HSS)
- Health Metrics Network (HMN)
- Global Fund National Strategy Applications
- Global Health Workforce Alliance (GHWA)
- UN Secretary General’s MDG Africa Initiative

The IHP+ is led by an inter-agency steering group, the **Scaling-up Reference Group (SuRG)** that is providing oversight to the IHP+ process. The SuRG is jointly chaired by the WHO and the World Bank and includes representatives of the 8 main multilateral agencies. A **Core Team** based in Geneva, Washington DC and Brazzaville and is responsible for day-to-day coordination and interface with all partners and addressing bottlenecks to progress<sup>3</sup>. Temporary **Interagency Thematic Working Groups** involving the participation of the civil society have been established around specific areas of technical work, and **Country Health Sector Teams** led by the national government and consisting of development partners, bilateral agencies, civil society and the private sector are key structures for taking the work forward within the IHP+ countries.

## II. AIMS AND OBJECTIVES OF THE CONSORTIUM

### Aims

1. To review progress at country level in implementing the agreed national strategic plan (based on Country Compacts) with a focus on results achieved;
2. To monitor adherence of development agencies and governments in regard to their commitments to the IHP principles;
3. To contribute to building sustainable capacity and momentum at national level for monitoring and evaluation of global and national health initiatives (including IHP), and
4. To make specific recommendations to countries and SuRG with a view to strengthen implementation of the IHP+ principles and contributing to inform the policy debate.

### Objectives

1. To assess country status and progress vis-à-vis the national strategic plan by reviewing inputs, processes, outputs, outcomes and impact achieved over the duration of the project;
2. To assess development agencies harmonisation of actions and alignment with recipient countries plans, systems and procedures;
3. To track whether committed resources by development agencies are allocated in the framework of IHP and whether they are disbursed to recipient governments;
4. To track recipient governments allocation of domestic and development aid funds to health and whether they reach the level of facilities (in selected countries);
5. To explore the accountability channels at global, national and sub-national levels in relation to IHP; and their appropriateness and effectiveness to country settings;
6. To identify overall national level channels to promote broader stakeholder participation in the policy process and enhancing accountability and transparency, including the civil society, the private or informal sector, non-medical practitioners (where relevant).

### Principles of the Consortium

1. The Consortium will build on structures developed as part of the **IHP+ Short Term Review** (a collaborative platform – see below), and will harness the experience and knowledge of conducting the Short Term Review (conducted by Shaun Conway, Andrew Harmer and Neil Spicer who are part of this proposal team).
2. A key principle of the monitoring and evaluation exercise will be to make **specific, concrete recommendations** to individual countries, agencies and the IHP+ SuRG based on the review findings
3. A **participatory approach** will be used and in particular we will involve civil society in the monitoring of both governments and donors commitments to the IHP
4. An extensive existing network of collaborators in countries will be involved, notably Oxfam's country offices and affiliated organisations as well as three networks based at the London School of Hygiene and Tropical Medicine: the **Global HIV/AIDS Initiatives Network** (GHIN), the **Health Economics and Financing Programme** (HEFP) and the **Consortium for Research on Equitable Health Systems** (CREHS).
5. We will promote **transparency** by extending and building on what was developed as part of the IHP+ Short Term External Review: the **collaborative knowledge platform** based on Clearspace technology. This is an innovative approach that is easily accessible and usable by all stakeholders that will enable stakeholders to engage through blogs and online discussion forums.
6. We will strive to build in **sustainability** in the M&E process and **build capacity of civil society** in target countries to independently monitor their governments' achievements towards the IHP+ principles.

7. Our expertise will be broadened by forming an **Advisory Panel** consisting of northern and southern partners to ensure good governance practice and effective communication.
8. We will promote **south-south** and south-north **learning**.

### III. SCOPE OF WORK

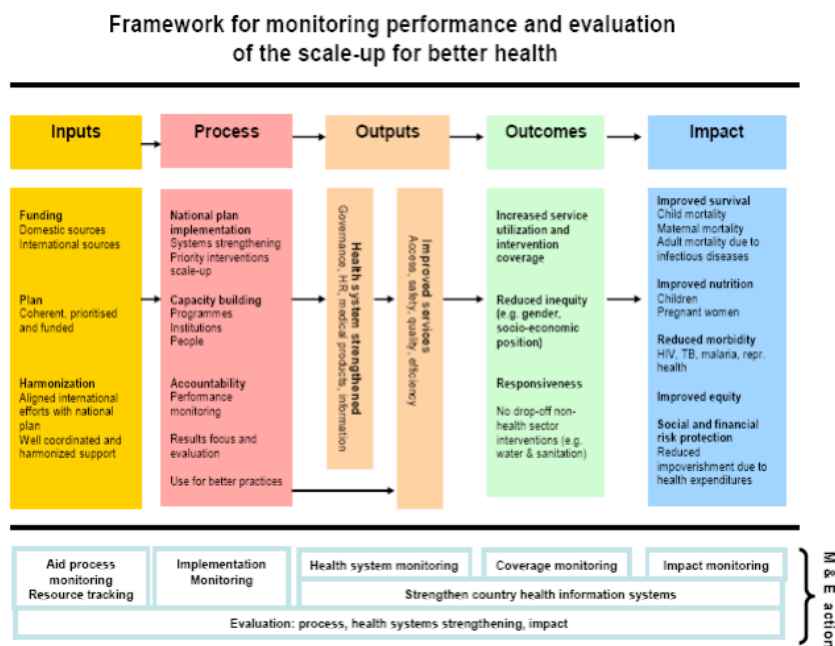
The scope of this review will involve the following components:

- A. Annual monitoring of progress across the 10 IHP+ signatory countries.
- B. In-depth evaluation studies in three case study countries.
- C. Capacity building in monitoring and evaluation to civil society groups
- D. Knowledge management, communications and advocacy strategy

For components A and B listed above, the methodology will be based on the following parameters and frameworks:

- Framework for monitoring of performance and evaluation of the scale-up for better health provided in the TOR (Figure 3);
- DAC criteria for data collection/analysis (relevance, effectiveness, efficiency, impacts and externalities, sustainability)<sup>4</sup>;
- We will also draw on the WHO conceptual framework on governance and its dimensions as applied to the aims and objectives of this evaluation<sup>10 11</sup>; see Figure 4.

**Figure 3. Framework for monitoring performance and evaluation of the scale up for better health**



**Figure 4. Leadership and governance: elements (WHO)<sup>5</sup>**

- Policy guidance:
  - Formulating sector strategies and technical policies. Vision.
  - Identifying the roles of public, private and voluntary sectors
- Intelligence and oversight:
  - Generation, analysis and use of data on health systems goals and outcomes, especially for vulnerable groups
  - Monitoring the effects of policies and reforms; policy options
- Collaboration and coalition building:
  - Across sectors in government and with external actors.
- Regulation and incentives – ‘fairly enforced’.
- System design.
  - Ensuring a fit between strategy and structure and reducing duplication and fragmentation.
- Accountability to the public. Transparency.

## A. Annual monitoring of progress in IHP+ countries

We propose to conduct annual monitoring of the IHP implementation at the global and national levels. At the global level we intend to track whether the commitments of the main international development agencies engaged in the IHP+ as well as the SuRG have been adhered to on an annual basis as a means of ensuring these agencies are accountable. Depending on data availability we will also track commitments of non-signatory development partner agencies. At the national level we will review progress to date in all ten IHP+ fully inaugurated signatory countries and track progress over the following 3-year period, with results reported annually.

The review process will also highlight **early lessons learned from the implementation** of the country compact and shed light on problems and make recommendations on how to solve these with the aim of strengthening subsequent development of national compacts. The recommendations will be made to development partners, recipient governments and key stakeholders – mainly civil society organisations.

**Key themes to be explored through the monitoring process** will be drawn upon and adapted (but not exclusively) from the Paris Declaration on Aid Effectiveness, in order to strengthen harmonisation between initiatives and also to build on existing methodology. This would cover the following areas:

- Country ownership and **commitment** to the IHP+
- Timely development of the compact
- **Completeness** of the compact (cost, result oriented)
- Involvement of a wide range of stakeholders in the development of the compact, including civil society
- **Alignment** of donors strategy with compact; of aid allocations with compact; and of M&E with national M&E system
- Use by countries of various **harmonization instruments** such as SWAp, budget support, 3X1
- Capacity to manage by results
- Percentage of aid flows channelled through programme based approaches
- Transactional costs associated with the implementation of the IHP+
- Focus on **health systems strengthening** (strategy, allocation)
- **Transparency** of information and process for accountability of implementation is clearly established, notably in direction of civil society
- Behaviour changes
- Assessment of the SuRG as a governance mechanism
- Assessment of the Inter-agency Core Team

The focus of the monitoring process at country level will be on a set of qualitative and quantitative indicators including **inputs, processes, and outputs**. Once agreed, the core indicators to be monitored will be the same in all countries. The **data collection process** will

take place through a **phased approach**. In the first year, we will focus on inputs and behaviour change relating to development partners' reform processes and adoption of the country compact for recipient countries. The process of implementing the country compact as regards the national plan, capacity building, accountability, focus on results and use of better practices will be explored in year two. The last year will concentrate on reviewing progress towards health services improvement and health systems strengthening. (Figure 5).

A matrix based on Figure 5 will be developed in the inception phase that will consider the key themes/questions, objectives, activities, source of evidence (surveys, interviews, literature, etc.) and indicators for analysis. In addition, the initial list of indicators described in Figure 5 will be built as much as possible through a 'bottom-up' approach as to reflect country specific dimensions.

**Figure 5. Initial list of indicators for monitoring of IHP+**

<b>Inputs: funding, plan, harmonisation</b>	<b>Process: national plan implementation, capacity building, accountability</b>	<b>Outputs: improved services, health systems strengthened</b>
Mechanisms available for improved coordination among agencies	Aid effectiveness measures for health in FWC compared to other countries	Indicators & reviews of plan implementation – activities carried out, targets reached, expenditure levels met, services expanded, financing reforms developed
Changes introduced by H8 agencies to streamline procedures and operations, harmonise, align	Appraisal of health plan – does it build systems? Does it have good M&E plan?	Engagement of civil society and Parliament in planning and progress reviews
GFATM funds country health plans	Is the costing and budget realistic?	Availability of data for M&E, quality of data
Increasing efficiency of aid use; shown by more flexible funding for health systems and more predictable funding	Proportion of donor funds that are on budget and support the health plan; proportion that use national procurement systems	Use of M&E findings in revising plans, strategies and budgets.
Strong mutual accountability process that holds agencies to account for their in-country behaviour and funding (incl. whether have kept to compacts in FWC)	Government spending on health Monitoring country progress in implementing national health plans that scale up services	
Volumes of aid disbursed - for TA, AIDS, other		

Source: Adapted from “annex A – possible indicators to focus for evaluation of IHP+”.

Through the network of institutions working in collaboration with Consortium members and Oxfam's country offices and affiliated organisations we will identify local researchers who will act as focal points in each of the ten countries. These researchers will have primary responsibility to conduct the key informant interviews and gather documentary evidence, observe key meetings, and will be supported by Consortium members.

The monitoring process will rely predominantly **on the review of secondary data available**. This will be complemented with some key informant interviews and observation of meetings to clarify gaps and gain insights into the policy process. We will strive to collate, validate and triangulate existing data and monitoring and evaluation efforts at country level.

At the **global level**, the following **methods/data sources** will be drawn upon:

1. Analysis of **documentary evidence** including assessment of existing independent monitoring and evaluation exercises:
  - Development partners financial reports of aid disbursements (for budget tracking purposes) to IHP signatory countries
  - 5 Year Evaluation of the GFATM
  - Global HIV/AIDS Initiatives Network assessments of the effects of global HIV/AIDS Initiatives on country health systems
  - World Bank evaluations
  - Parliamentary inquests
  - Donors' evaluations
  - OECD/DAC peer review evaluations (eg UK and USA in 2006, EC in 2007, France 2008)
  - Individual consultancy reports
2. **Selected key informant interviews with global development partners** in order to assess whether they are living up to their commitments globally and as part of Country Compacts. These will mainly be carried out on the phone or by taking advantage of participation in global meetings.
3. **Develop and validate a 'development partner scorecard'** (based on the business sector Global Reporting Initiative concept). In order to construct the scorecard, we will select a set of key indicators that reflect development partners' political and financial commitment to the IHP principles. The chief aim of the scorecard is to promote voluntary compliance and self-reporting by development partners that can be implemented in the first three years of the review as a standard tool. It is also expected that the scorecard will contribute to create a more sustainable accountability monitoring & reporting mechanism as it becomes routinely adopted by all development partners.

**The country level** monitoring will use the following **methods/data sources**:

1. Analysis of **documentary evidence at country level** including:
  - national level aggregations/reports using routine data,
  - previous studies,
  - M&E conducted by academic institutions, civil society organisations or donors.
1. **Selected key informant interviews** with major stakeholders in the health sector of each country.  
The number of interviews is not pre-determined but is likely to be up to ten persons per country and encompass the following type of stakeholders:
  - Government officials (MoF, MoH)
  - Representatives of multilateral and bilateral development partner agencies in countries (including WHO, the World Bank, UNAIDS, UNFPA, DFID and others)
  - Country civil society/ user groups representatives
  - Multi-actor coalitions, national coordination bodies
2. **Participant observation** of selected policy forums, sectoral review meetings as appropriate.
3. An **external assessment of completeness and timeliness of the national compact** by the Consortium researchers. The Consortium has a strong experience in carrying out such assessments.<sup>6-8</sup> The external assessment of the compact will use a standard analytical grid to evaluate how complete and holistic the document is but also whether and how key stakeholders have been associated with its design and implementation and the mechanisms that have been drawn to ensure its implementation.

## B. In-depth evaluation case studies in three countries

In a sub-set of three countries we propose to conduct an in-depth evaluation process building on the yearly monitoring activity described above. This evaluation will be based on **selected case studies** as previous research has shown that this approach yields useful evidence<sup>9</sup>.

The case studies will be selected in a transparent manner in consultation with the SuRG and the Advisory Panel. Possible criteria for selecting the case study countries include: potential for generalising the results; representing markedly different scenarios; existing interest to monitor and evaluate outcomes by local institutions; good access to policy makers, availability of data; progress towards implementing the Compact; and existing linkages with Consortium institutions.

### Examples of key themes for the evaluation

- What trends are emerging in the early implementation of the IHP+?
- What are the progress to date, both in countries and donor to implement the IHP+?
- What are the **constraints/limitations** to implement the IHP+, including possible transactional costs in changing systems?
- What incentives are developed for strengthening adherence to the IHP+?
- How IHP+ addresses **scale up** in relation to sustainability?
- What are the effects of the IHP+ on health systems strengthening?
- What are the **early outcomes and impacts of the IHP+ programme** (focus on existing reported indicators such as child and maternal health, immunization, infectious diseases prevalence)?

The case studies will embrace all five components of the analytical framework (Figure 4): **inputs, process, outputs, outcomes, impacts**. In addition to the list of initial indicators provided, the evaluation studies will consider the following:

**Figure 6. Initial list of indicators for evaluation of IHP+**

Outcomes	Impact
- Service access and availability indicators (e.g. facilities equipped, staffed & with supplies to deliver ART)	- Child and maternal mortality rates
- Coverage of maternal and child health, AIDS, TB and malaria interventions including skilled birth attendance; PMTCT uptake; numbers on ART; immunisation rates; TB cure rates; IPT and ACT use etc	- HIV, TB, malaria prevalence
- Coverage rates analysed by socio-economic groups and vulnerable groups	- Change in numbers of families pushed into poverty by health spending

Source: Adapted from “annex A – possible indicators to focus for evaluation of IHP+”.

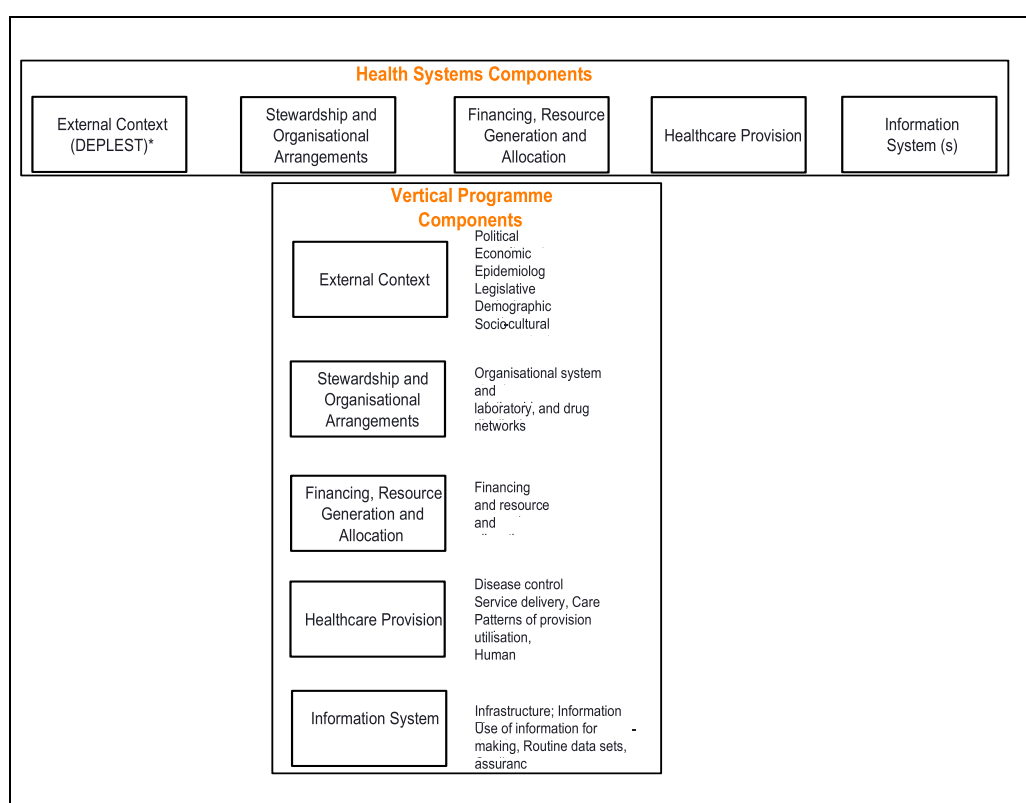
The implementation process outlined above for the monitoring exercise will be adopted for the evaluation process. This includes further development of the design and methodology during the inception phase in line with country priorities; working with local partner institutions for the data collection/analysis/dissemination; reliance on secondary data. A phased approach will also be adopted. Given that a limited amount of primary data will be collected, the first step will be to map existing routine data sources and available studies.

Our data mapping will focus on health systems indicators, a limited number of easily retrievable outcomes measures and resources tracking showing how funds are channelled to

health programmes and evaluate how resources are aligned to national plans. If available, the new WHO/WB indicators for health systems will be used.

The evaluation will use common protocols and standardized indicators and measurement tools, with appropriate country adaptations. It will draw on the analytical framework of the IHP+ evaluation that is highlighted in Figure 5 and on the Toolkit for rapid assessment of health systems and communicable diseases that was specifically designed to evaluate health programmes within health systems and developed by the LSHTM and Imperial College<sup>10 11</sup>, see Figure 7. The Toolkit will be modified for the purpose of this particular evaluation.

**Figure 7. Toolkit for rapid assessment of health systems and communicable diseases**



**Methods and data sources** planned for the evaluation include:

1. The case studies will involve **semi-structured interviews** with key stakeholders including policy makers, practitioners, managers in the health sector at national, district and local level, civil society representative etc. (with a wider range of actors than in the rest of the countries). These will be recorded, transcribed and translated to ensure quality of data and facilitate analysis. Interviewing process will adhere to ethical principles including informed consent, confidentiality, permission to quote and record and obtain government permission where relevant.
2. **Participant observation** of a broader set (than for the monitoring) of policy forums and sectoral review meetings will be conducted.
3. **Resource tracking**, of IHP+ funds within case study countries. In the evaluation studies we will focus on tracking resources received by the case countries and how they are disbursed within countries. We will rely on secondary data sources, for example public expenditure reviews and national health accounts. We will endeavour to track government funds and assess a possible fall in government resources following increased external assistance.

4. **Outcome / impact tracing.** We will trace changes in two or three specific outcomes (e.g. number of trained midwives attending deliveries; HIV/TB cases treated continually) and impacts (e.g. under-5 mortality). These will be selected in line with country priorities as specified in the national plans and funded under IHP+ and collected through existing surveys (e.g. DHS) and possibly routine data.
5. To complement the analysis we will conduct **focus group discussions at the community level** with users and non-users to gain information on inputs (e.g. availability of drugs, health workers), access issues (e.g. distance, costs), etc.

The 3 years evaluation intends not to provide a definitive assessment of IHP effectiveness, as attribution remains challenging, but will aim to focus both on quantitative and qualitative analysis of the IHP implementation. The evaluation intends to provide **lessons learned for IHP countries to improve and strengthen the implementation process**, while serving as a **communication platform towards non-participating countries**. It will also assess countries progress to adhere to IHP principles and scrutinize selected outcomes and impact. The evaluation will specifically explore countries leadership and commitment to deliver the IHP, the progress to date and changes in the incentive structures that are developed to ensure that implementation occurs.

Our proposal is built on a number of **key assumptions** that are highlighted below

- Engagement and close collaboration of national governments and international agencies in the M&E exercise
- Availability of routine data and secondary data sources for the purpose of conducting monitoring and evaluation assessments, notably for the case studies
- Availability of secondary data, at donors and country levels for the tracking of financial flows

### **C. Capacity building in monitoring and evaluation to civil society groups**

One key part of our proposal is to use the monitoring and evaluation process to provide selected capacity building to civil society in ten countries on how to effectively take their government accountable to the commitment to the IHP+ principles. This would be consistent with the Paris declaration on aid effectiveness evaluation which stressed the key role to be played by civil society in achieving progress with better harmonization of donors aid.<sup>12</sup> This could also enable countries to develop “champions” that would advocate further progress.

The second aim of the project (building capacity to monitor) will be lead by Miz-Hasab (Ethiopia) as a centre for cross-national training in research and advocacy and as a way to foster **South-South collaboration, mutual support and development of expertise in policy-to-practice** that can go beyond this project. We will provide 2 training sessions for participating members of civil society and these will be delivered by our Ethiopian partner in cooperation with all partners, thus promoting South-South collaboration.

### **D. Knowledge management, communications and advocacy strategy**

The Consortium is committed to the idea that it should contribute to **policy change**. In support of an effective advocacy and dissemination strategy, we will identify the most appropriate ‘leverage points’ for catalysing policy change. This involves **engaging with appropriate stakeholders**, organisations and decision-making bodies, including government and civil society organisations, and delivering findings at appropriate points in policymaking cycles. It is important to target the specific policies it is expected the M&E evaluation can influence, rather than unrealistically aiming for wholesale policy or legislative change across the health sector. It will therefore be essential to be familiar with policy contexts, and decision-making structures<sup>14</sup> and processes within countries, and to **tailor communication and advocacy strategies** accordingly.

**Transparency in communication** of progress and results will be another key feature of the evaluation process. Our communication platform will serve as a means to share good practice between countries. But it will also serve to advocate with signatory countries, non signatory countries and donors the achievements and benefits of the IHP+.

## **Knowledge management and communication**

The **Annual Monitoring and Evaluation of the IHP+ Consortium** will build on systems developed as part of the **Short Term Review of the IHP+**:

1. All information and documents relating to the review will be collated in a wiki-style<sup>1</sup> **information management system** in which the associations between this information and linkages with external references can be rapidly developed. This will provide a fully searchable online **knowledge-base** for uploading and storing all document files relating to the review. This will allow us to collaboratively review, add to and comment on content in an efficient way. It will also produce a knowledge base as a by-product of the review that can become a useful resource to the IHP+ and to the proposed M&E consortium network, with the option to continuing building on after the review.

2. The review will use a Web 2.0 **collaboration technology** approach for enabling open communication between Stakeholders, Respondents, the Core Support Group and Advisory Panel. This is based on the **Clearspace** collaboration platform application, hosted by the Human-Scale Network<sup>2</sup>. The Clearspace collaboration platform is a simple to use Internet-based application. This will provide tools for:

- Managing participation in the review process by a network of ‘internal’ and ‘external’ partners;
- Managing collaboration, review and feedback on content;
- Managing the complexity of information flows and maintaining a record of all non-confidential communications;
- Managing documents and attachments, making these accessible to everyone;
- Posing open questions to the network for discussion;
- Updating the network on progress and news;
- Tracking and documenting discussions and feedback;
- Managing project tasks and updating the status of review activities.

Participants using Clearspace will have the advantage of being able to perform the following actions among others:

- Post a question or a discussion point to the broader network or Core Support Group, view online discussions and respond to questions or contribute comments to the online conversations that are taking place
- View and add comments to a Core Support Group Blog
- View or post announcements.
- View, search, upload and comment on document pages or attachments
- Manage personal tasks relating to their role in the review

## **Dissemination and communication of findings**

Monitoring and evaluation findings will address the **needs of different stakeholders** at global and country level and be relevant to current policy directions. Messages need to be presented to and discussed with national governments and subsequently delivered using a range of formats that are accessible to different stakeholder groups and appropriate to their needs. The Monitoring and Evaluation will provide policy-relevant messages and make concrete and

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<sup>1</sup> A wiki is software that allows registered users or anyone to collaboratively create, edit, link, and organize the content of a website, usually for reference material. Wikis are often used to create collaborative websites and to power community websites. These wiki websites are often also referred to as wikis; for example, Wikipedia is one of the best known wikis. Wikis are used in businesses to provide affordable and effective intranets and for Knowledge Management.

<sup>2</sup> Note that participants not choosing to or who are not able to access this application over the Internet will not be excluded from participation, as they will receive updates and information by email.

achievable recommendations that decision-makers and advocacy stakeholders are able to act on.

The Monitoring and Evaluation will provide stakeholders with understandings of a complex, multifaceted policy context. It is important when disseminating findings to clarify complex issues and to synthesise findings so that packages of information are accessible and useable. Monitoring and Evaluation findings will be presented in a range of appropriate formats. These will be finalised during the inception phase, but are likely to include among others:

**Annual Monitoring and Evaluation reports** which will be supported by **policy briefing sheets** as an effective way of communicating key messages to civil society stakeholders, development partners and policy-makers at all levels.

**Country stakeholder workshops and meetings** will be important means of sharing findings with and getting feedback from development partners, policymakers and other stakeholders at appropriate intervals..

Finally working closely with, and communicating findings to **existing country bodies** such as the National AIDS Councils over the course of the Monitoring and Evaluation should be an effective means of promoting country buy-in and ownership for country studies, engaging a range of organisations and enhancing the prospects that the findings are acted upon.

### **Advocacy**

The IHP is a politically established partnership and makes commitments that inherently challenge vested interests and power relations at global and national level. This is why engagement of stakeholders and transparency in communication will be a key feature of the Consortium's endeavour. The advocacy activities in the monitoring and evaluation process aim to **engage civil society** and to support increased influence of voices that are marginalised from policy and budget decisions, at both national and global levels.

Advocacy activities are constrained by budget limitations of the monitoring and evaluation programme, but Consortium Members as well as Advisory Panel members will be able to add value by linking the existing civil society activities in IHP countries to this programme.

For the purposes of the programme, therefore, the advocacy plan will deliver:

- Annual national events in IHP countries at which representatives from Civil Society, Government and Donors together give input to the first draft country reports. This will be facilitated by Responsible Action with support from Oxfam GB regional management teams.
- Through existing CSO positions in global partnerships such as GFATM and IHP Steering Group, access to relevant evidence for input to the M&E programme.
- Through Advisory Panel and Consortium Member alliances, communication of data and information to CSO networks and organisations in IHP countries. Managed by Responsible Action through in-country research institutions.
- An uncensored, but negotiated, foreword commentary by the Advisory Panel (see below) on the official monitoring and evaluation reports (following the precedent of the WHO 3by5 reports).
- Invitation for civil society representatives to the Research Institute Capacity Building sessions with Miz Hasab.

### **Advisory Panel**

The Advisory Panel of 12 eminent health researchers and health rights advocates will advise the monitoring and evaluation programme to ensure rigorous design, good governance and ethical practice and effective communication of findings.

Specifically, the Advisory Panel will advise on the design strategy at inception stage; will advise on the annual monitoring reports and the evaluation report before submission to the IHP+

Steering Group; will provide an uncensored, but negotiated, foreword commentary to the official (i.e. approved by the Steering Group) versions of the reports (a precedent set by the WHO 3by5 monitoring reports); will facilitate links to existing and developing work by research and advocacy alliances in IHP countries; and will participate in communication and presentation of findings..

The Advisory Panel consists of 12 member selected on the following criteria:

- A balance between northern and southern members, particularly in IHP countries.
- A gender balance.
- A balance between health and/or evaluation research experience on the one hand, and health rights advocacy experience on the other.
- Nominations from the consortium members and their partners are still being received. A number of those nominated have accepted in principle to act as members of the Advisory Panel as shown in the long list below. Final selection will be according to the criteria mentioned and then to the discretion of the consortium members:

Name	Affiliation	Accepted?
Dr Ruairi Brugha	Royal College of Surgeons, Ireland	Y
Dr Lola Dare	ACOSHED Nigeria/ University of Ibadan Nigeria	Y
Dr Adrienne Germain	International Women's Health Coalition USA	Y
Thomas Kibua	African Medical & Research Foundation Kenya	
Prof Ron Labonte	University of Ottawa/ Canada People's Health Movement	Y
Max Lawson	Oxfam UK	Y
Dr Rene Loewenson	TARSC Zimbabwe	Y
Dr David McCoy	University College London/ UK People's Health Movement	Y
Prof Anne Mills or Prof Gill Walt	London School of Hygiene & Tropical Medicine UK	Y
Prof David Sanders	University of Western Cape/ RSA Equinet	

The Advisory Panel will meet physically at the Inception Planning meeting in Addis Ababa and will develop its own strategy for fulfilling the roles outlined above.

Advisory Panel members retain the right to nominate individuals in their stead to attend meetings or to perform the functions agreed at the Inception Planning meeting.

## IV. IHP+ MONITORING AND EVALUATION TIMELINE

	Year one				Year two				Year three			
	First quarter	Second quarter	Third quarter	Fourth quarter	First quarter	Second quarter	Third quarter	Fourth quarter	First quarter	Second quarter	Third quarter	Fourth quarter
<p><b>INCEPTION PERIOD</b></p> <ul style="list-style-type: none"> <li>Organisation of management processes and structures</li> <li>Inception workshop (Ethiopia)</li> <li>Appointment of Advisory Group</li> <li>Finalise design and tools for monitoring and evaluation processes</li> </ul> <p><b>MONITORING</b></p> <ul style="list-style-type: none"> <li><b>1. Global level yearly monitoring of Development</b></li> <li>Partners behaviour</li> <li>Analysis of documentary evidence (including aid disbursements tracking)</li> <li>Selected key informant interviews (mainly phone)</li> <li>Production and validation of score card</li> <li><b>2. National level yearly monitoring of inputs, processes, outputs</b></li> <li>Analysis of documentary evidence at country level</li> <li>Selected key informant interviews</li> <li>Participant observation of strategic in-country meetings</li> <li>External assessment of compact</li> </ul> <p><b>EVALUATION</b></p> <ul style="list-style-type: none"> <li><b>National level evaluations</b> in 3 countries on inputs, processes, outputs, outcomes, impact</li> <li>Data mapping (routine data sources and available studies)</li> <li>Semi-structured interviews</li> <li>Participant observation of strategic in-country meetings</li> <li>Analysis of secondary data (resource tracking and outcome/impact tracing)</li> <li>Focus group discussions with community members</li> <li>Data analysis</li> <li>Writing up of results</li> </ul> <p><b>CAPACITY BUILDING</b></p> <ul style="list-style-type: none"> <li>Training workshops on monitoring, evaluation and advocacy</li> </ul> <p><b>ADVOCACY AND DISSEMINATION</b></p> <ul style="list-style-type: none"> <li>Liaison with national CSO coalitions</li> <li>Annual event for CSO input and engagement on the monitoring reports at country level</li> <li>Final project workshop</li> </ul> <p><b>COMMUNICATIONS</b></p> <ul style="list-style-type: none"> <li>Production of yearly monitoring reports</li> <li>Production of evaluation reports</li> <li>Production of briefing notes</li> <li>Multi-country communication platform (information management system and clearspace)</li> </ul> <p><b>ADVISORY PANEL</b></p> <ul style="list-style-type: none"> <li>Advisory Panel meetings</li> <li>Discussions and feedback</li> </ul> <p><b>PROJECT MANAGEMENT</b></p> <ul style="list-style-type: none"> <li>Programme administration and management</li> </ul>												

## V. DELIVERABLES and MILESTONES

Milestone #	Milestone name	Lead Partner	Delivery date
M1	Presentation to and agreement with the SuRG of Inception Report, including the communication strategy and M&E design	RA	Month 6
M2	Agreement with the SuRG on a communication strategy	RA	Month 6
M3	Appointment of the Advisory Panel	OXFAM	Month 6
M4	First monitoring report	Consortium	Month 13
M5	Second monitoring report	Consortium	Month 24
M6	Third monitoring report	Consortium	Month 35
M7	Evaluation report	Consortium	Month 34
M8	Final project workshop	Consortium	Month 36

## VI. CONSORTIUM AND MANAGEMENT

The Consortium has been brought together to provide a unique combination of academic experience, hands on evaluation skills and profound knowledge of health systems in the developing world. It involves two partners that are situated in the South and intends to further develop a sustainable South-South capacity building facility in order to promote enhanced ownership by “Southern” countries, consistently with the IHP philosophy. The team has been designed to provide a wide range of expertise and experience in order to meet the monitoring and evaluation component of the study, as well as build capacity in IHP countries and carry out advocacy activities.

Our Consortium has a strong experience in monitoring and evaluation of health programmes and health systems. All its experts have conducted high profile evaluations of health programmes in lower or middle-income countries. The team that is proposed to conduct the work is multi-disciplinary and has a strong focus on both M&E, health systems and development assistance. Members of the Consortium were involved in the short term evaluation of the IHP+ in 2008 and have a unique understanding of its objectives and its challenges.

The Consortium includes Miz-Hasab, a partner that has direct experience of the implementation of the IHP+, and as Ethiopia is the first country to have completed the “Compact”. This will be particularly relevant in setting up capacity building based activities for other IHP countries.

The Consortium will be led by Responsible Action; Dr Shaun Conway will be the Consortium Lead, and Dr Andrew Harmer will be the Consortium Coordinator. Responsible Action will take responsibility for the management of the project, contracting the other partners, and will monitor the budget. All the partners will contribute at least one person to be on the management committee and will be fully participatory in all Consortium decision making. The Consortium will organise an inception workshop to bring all the partners and representatives from the IHP countries together, and thereafter will hold regular management teleconference meetings to ensure the smooth running of the project.

The Consortium will adhere to the ethical requirements of their own institutions, as well as those of the countries in which the work will be carried out. It is committed to providing open access to data assembled under the auspices of the IHP+ Monitoring and Evaluation Programme, and use this data in member publications and advocacy activities.

A summary of main responsibilities follows:

Organisation	Main responsibilities	Personnel
Responsible Action (South Africa)	<ul style="list-style-type: none"> <li>• Project coordination</li> <li>• Collaborative platform and observatory</li> <li>• Knowledge management</li> <li>• Annual monitoring of progress across the 10 IHP+ signatory countries</li> </ul>	Dr Shaun Conway Dr Andrew Harmer
London School of Hygiene and Tropical Medicine (UK)	<ul style="list-style-type: none"> <li>• Design of the methodology</li> <li>• Annual monitoring of progress across the 10 IHP+ signatory countries</li> <li>• In-depth monitoring studies in three case study countries</li> <li>• Contribution to capacity building</li> </ul>	Dr Dina Balabanova Ms Sandra Mournier-Jack Dr Valeria Oliveira Cruz Dr Neil Spicer
Miz-Hasab (Ethiopia)	<ul style="list-style-type: none"> <li>• South-to-south capacity building</li> <li>• Country reviews</li> </ul>	Dr Hailom Banteyerga Amaha
Oxfam (UK)	<ul style="list-style-type: none"> <li>• Advocacy meetings and training/mentoring</li> <li>• Public communications</li> </ul>	Mr Tom Noel

The Consortium will heavily draw on the existing network of partners as detailed in the table below, including Oxfam country offices and affiliates.

## Consortium's collaborative networks and synergy with IHP+

IHP countries (full signatories)	GHIN countries (LSHTM)	HEFP/CREHS countries (LSHTM)	CDPRG countries (LSHTM)	OXFAM GB	MHRC
Burundi Mozambique Cambodia Nepal Ethiopia Nigeria Kenya Mali Madagascar Zambia	Mozambique  Ethiopia  Zambia	Cambodia Nepal  Nigeria Kenya  Madagascar Zambia	Cambodia	Burundi Mozambique Cambodia Nepal Ethiopia Nigeria Kenya Mali Zambia	Ethiopia
IHP countries (Adjunct)					
Benin Burkina Faso Ghana Niger	Benin	Benin Burkina Faso Ghana		Benin Burkina Faso Ghana Niger	

All partners have a long standing experience in carrying out consultancy work in developing countries, notably in Africa and Asia.

In addition the core team of experts who will conduct the work speak and write in fluent English, French and Portuguese, which will facilitate communication with stakeholders other study actors.

Details of the partners of the Consortium and the key personnel involved follow.

### 1. Responsible Action, South Africa

Responsible Action ([www.re-action.co.za](http://www.re-action.co.za)), is a South African Health and Sustainability consultancy, part of the Human|Scale Development Group ([www.humanscalegroup.com](http://www.humanscalegroup.com)) with offices in South Africa, the UK and Tanzania.

The company employs a multi-disciplinary team of implementation and technical specialists and works with an extended network of technical associates.

Responsible Action believes in the power of partnerships and of building purpose networks through which to scale up work in health and sustainability in two key areas: Health and Sustainability programs and Delivering Technical Assistance in the Development Sector.

Responsible Action oversees a portfolio of projects valued at more than \$8 million annually. These include programs delivering health service strengthening support through Public-Private Mix initiatives funded through donor co-investment; running health service and community-based outreach programs; implementing large-scale workplace health interventions for HIV and TB, and undertaking short-term technical and management consultancy projects.

In 2008 Responsible Action undertook the External Short-term Review of the International Health Partnership and Related Initiatives (IHP+), in collaboration with the London School of Hygiene and Tropical Medicine.

Shaun Conway, MBChB, is an International Public Health practitioner and researcher and policy advisor, primarily focussing on HIV and TB, Health Systems, and Human-scale development. He is experienced in evaluation of Development Assistance and Global Initiatives, Public-Private Partnerships and Public Private Mix in HIV Care Delivery, Corporate Sustainability and Workplace HIV Care programmes. He was the team leader of the External

Short-term Review of the International Health Partnership and Related Initiatives which was undertaken in 2008. In 2005/6 he undertook a complex multi-country evaluation of the WHO 3 by 5 Initiative within a 5-person Independent Evaluation Team, and has also acted as Consultant Health Advisor to the Global AIDS Policy Team and the AIDS & Reproductive Health Team, of the UK Department for International Development (Policy and Research Division).

Andrew Harmer, MSc, PhD is currently a Policy Advisor for Responsible Action. He is a global health policy analyst with a background in Politics and International Relations, and has a specialist interest in global health partnerships and initiatives; global health governance; health systems strengthening. He was part of the team that carried out the External International Health Partnership and Related Initiatives which was undertaken in 2008. He worked with the London School of Hygiene and Tropical Medicine to develop a research proposal on the global governance of blood safety.

## **2. The London School of Hygiene and Tropical Medicine (LSHTM), UK**

The London School of Hygiene and Tropical Medicine ([www.lshtm.ac.uk](http://www.lshtm.ac.uk)) is the UK's leading institution in postgraduate teaching and research in public health and tropical medicine. The School is a national and international focus of collaboration in teaching and research, where clinical, population, laboratory and social sciences are integrated to address the broad issues of health.. The School obtained top ratings (5) in the 2001 Research Assessment Exercise carried out by the Higher Education Funding Council for England. It is currently undertaking collaborative research and consultancy work in over 100 countries worldwide.

Based in the Department of Public Health and Policy, the Health Economics and Financing Programme (HEFP), the Global HIV/AIDS Initiatives Network (GHIN) and the Communicable Disease Policy Research Group (CDPRG) are three research programmes that undertake work on monitoring and evaluation of health systems.

The Health Economics and Financing Programme (HEFP) ([www.hefp.lshtm.ac.uk](http://www.hefp.lshtm.ac.uk)) has been in existence since 1990 and aims to produce and disseminate knowledge to improve the performance of developing country health systems at both macro and micro levels. Its staff have internationally recognised expertise in health economics and policy analysis, and a strong track record producing high quality, policy- relevant research in areas crucial to strengthening health systems. HEFP has long-term links with Southern research partners, built up over many years of collaborative research. Staff are experienced in working with policy-makers at both national and international levels, and are active in international initiatives and networks including the Alliance for Health Policy and Systems Research, the Disease Control Priorities Project, Equinet and Roll Back Malaria. Recently HEFP has been involved in the tracking the level of external investment to maternal, newborn and child health by donors as part of Countdown to 2015.

Since 2005, the HEFP has managed a DFID funded Research Programme Consortium: the Consortium for Research on Equitable Health Systems (CREHS) ([www.crehs.lshtm.ac.uk](http://www.crehs.lshtm.ac.uk)). CREHS combines the analytical frameworks of economics and policy analysis to generate new knowledge on how to strengthen health system policies and interventions which preferentially benefit the poorest. The Consortium is made up of eight research institutions based in Kenya, India, Nigeria, South Africa, Tanzania, Thailand and the UK. Partners undertake collaborative research at national and international levels on health sector reform, financial risk performance, human resources for health and scaling up coverage of key interventions. Through the management of this Consortium, the HEFP has gained valuable experience in successfully coordinating work across several regions; working with a variety of stakeholders including policymakers, academic groups, multilateral and civil society organisations; and effectively communicating our research outputs to different audiences.

The Global HIV/AIDS Initiatives Network (GHIN) ([www.ghinet.org](http://www.ghinet.org)) is a network of researchers in 22 21 countries (including Ethiopia, Mozambique and Zambia) that explores the effects of three major Global Health Initiatives on existing health systems. These are the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank's MAP programme and the U.S. President's

Emergency Plan for AIDS Relief. Key research themes are sub-national scale-up, health systems capacity and equitable access.

The Network focuses on collecting evidence from regions, facilities and services, and communities, in order to inform policy development at national and international levels. Working in a network has enabled members to share expertise and to generate multi-country comparisons in addition to context specific policy lessons.

The Communicable Disease Policy Research Group (CDPRG) provides a focus of expertise on the diverse public health problems associated with communicable disease control internationally. The Group focuses on multidisciplinary research in support for, and of, policy reform and comprises a team of specialists in clinical medicine, epidemiology, public policy and public health, all of whom have substantial portfolios of research on the diverse health problems facing the countries in Europe, Asia and Africa. The team has an established wide range of collaborative partnerships with institutions and individuals both domestically in the UK and internationally including multilateral agencies, bilateral agencies and industry. In addition the group also draws on the considerable expertise across the Health Policy Unit, the Department of Public Health and Policy, and the wide range of disciplines found within the London School of Hygiene & Tropical Medicine. Notable areas of research which have received considerable attention have included health systems analysis, analysis of strategic planning, law as a tool to support communicable disease control, policy analysis, development and ranking of indicators to assess performance.

Dina Balabanova MSc, PhD (HEFP) is a Lecturer in Health Policy/Systems at the London School of Hygiene and Tropical Medicine. Her PhD examined health financing reform in Bulgaria in relation to population illness behaviour, values and willingness to pay. She has worked in various capacities in the LSHTM, and in 1999-2001, as a Regional Policy Adviser for Oxfam (former Soviet Union and Yemen), advising on programme development, health strategies and advocacy-oriented research. In 2001-06, she led work on health systems in the former Soviet Union within the Health Systems Development Programme. Her research interests include access to care and its determinants, health system reform in transitional and low-resource settings, informal payment and community financing. She conducted research on health systems evaluation and system responses to chronic disease requiring complex inputs (diabetes, hypertension, tuberculosis, cervical cancer). She has an extensive publication record, and is involved in a range of collaborations and consultancies.

Sandra Mounier-Jack MSc, MBA (CDPRG) is a Lecturer in Health Policy at the Department of Public Health and Policy, whose current research projects include evaluations of health policy on the control of communicable diseases including pandemic flu, HIV and tuberculosis. She has a Master in Public Health and a Master of Business Administration, and has been involved in the health sector for many years. She has published analyses of health policy evaluation in high profile journals including the Lancet and the WHO bulletin, and presented her findings to a range of international bodies. She is currently an advisor to the UK House of Lords for a committee on the work of intergovernmental organizations in the control of infectious diseases and has advised the UK government's Cabinet Office. From 2001-2004, she was project officer in charge of the technical assistance health programme of the EU in Russia, where she managed a portfolio of €20 million in projects and designed and evaluated many health projects. She has ample field experience of donors coordination and challenges faced by national governments in managing aid. She was among founding members of the Russian CCM. She is a Non Executive Director of the Primary Care Trust of Kensington and Chelsea. She is a French national.

Valeria Oliveira Cruz MSc, PhD, (HEFP) has over 10 years of experience as an analyst in health systems and international development assistance for health in low and middle income countries. She currently holds an appointment as a Lecturer in the Health Policy Unit, LSHTM. She has been interested in further understanding the effects of different health financing and delivery strategies, in particular donor funding on the health systems of recipient countries. Her research has focused on the nature of the relationships between recipient Governments and Development Partners in the health sector and how it is affected by different modes of assistance (project support, sector wide approach, budget support). Prior to her current appointment, she worked as a part of the operational team of Working Group 5 of the

Commission on Macroeconomics and Health. During that period, she contributed to the analytical work on health systems constraints to scaling up priority health interventions in developing countries. In Brazil, while working on a joint project between UNODC and the Ministry of Health, she acquired extensive experience in policy formulation and implementation of HIV/AIDS prevention and treatment programmes (among intravenous drug users) at national and local levels, in the context of international financial and technical cooperation.

Neil Spicer MSc, PhD (GHIN) is a Lecturer in Health Policy and Global Health Initiatives based at the Health Policy Unit, LSHTM. His current projects include the Global HIV/AIDS Initiatives Network and the Short Term Review of the IHP+. Neil areas of expertise include global HIV/AIDS initiatives, global health policy and architecture, health services research and community participation. His previous work includes evaluations of major health and social policy initiatives including the UK Children's Fund and Lambeth Southwark and Lewisham Health Action Zone. Neil has a PhD in Geography from Glasgow University.

### **3. Miz-Hasab Research Centre (MHRC), Ethiopia**

The Miz-Hasab Research Centre ([www.miz-hasab.com](http://www.miz-hasab.com)) specializes in health research. It was established in October 1996 as a private research centre in Addis Ababa, Ethiopia. The Centre conducts a wide range of research works in both development and health. (see <http://www.Miz-Hasab.com>). It has fourteen researchers working on a permanent basis with a the director of the Centre who coordinates all research and business activities. In addition other researchers a from Addis Ababa university get contracted to work in their areas of specializations from the public health and social sciences.

#### **Description of previous works in evaluation of health programmes**

- Formative evaluation of the Millennium Village project, (2008) a study conducted in four African countries with focus in health and agriculture by ODI and OSI. The Centre was in charge of evaluating the health sector of the project in Ethiopia. Dr. Kent Buse was project coordinator.
- A Rapid Appraisal of the Health Extension Program (2008) in collaboration with John Snow International. The health extension program is linked to the national strategy in primary health care delivery service.
- The Centre was the leading investigator for the 'AID effectiveness study of the three funds for HIV/AIDS: MAP, GF and PEPFAR.'(2007) The study was originally initiated by the Centre for Global Development but at present Miz-Hasab Centre is managing it independently.
- Evaluation of Maristops reproductive Health Programs in Ethiopia (2007); Maristops Addis Ababa.
- Evaluation of Health and urban development programs supported by the Government of Netherlands. (e.g. sewage support, fuel wood project and the Catholic Sisters' health program in Kechene, AA.). (2007)
- The System-Wide Effects of the Global Fund in Ethiopia: Follow up Study Report (2006) final. Hailom Banteyerga<sup>1</sup>, Aklilu Kidanu<sup>1</sup>, and Kate Stillman<sup>2</sup> Miz-Hasab, Addis Ababa Ethiopia, and <sup>2</sup> Partners for Health Reformplus, Bethesda, USA
- The System-Wide Effects of the Global Fund in Ethiopia: Baseline Study Report (2005). Hailom Banteyerga<sup>1</sup>, Aklilu Kidanu<sup>1</sup>, Sara Bennett<sup>2</sup> and Kate Stillman<sup>2</sup> Miz-Hasab, Addis Ababa Ethiopia, and <sup>2</sup>Partners for Health Reformplus, Bethesda, USA
- Cross generational sex: causes and effects (2005) ( a study on two major cities in Ethiopia - Addis Ababa and Nazereth) sponsored by PSI.

#### **Specific experience related to IHP+**

The SWEF study, the MVP evaluation and the AID effectiveness in health study was conducted with the CGD. The Centre's Senior Researcher and PI, Hailom Banteyerga Amaha (PhD) is currently a member of the advisory panel of IHP+ short-term evaluation study. (Aklilu Kidanu is the owner and the managing director of the centre)

**Hailom Banteyerga Amaha PhD** is a lead researcher and senior consultant for health research at Miz-Hasab Research Center, a private research company working in health, education and development in Ethiopia and Sub Saharan African countries. His research works cover KAP studies in HIV/AIDS, stigma and discrimination, health policy and systems. Currently he is the principal investigator of the SWEF study in Ethiopia, (Health 20/20), the national health extension program, and the MVP Ethiopia health sector study with ODI. Hailom Banteyerga is also a faculty staff at Addis Ababa University and lectures in health communication, supervises PhD research and chairs the PhD program in Applied linguistics in development and communication, with an academic rank of Associate Professor.

#### 4. Oxfam GB

Oxfam ([www.oxfam.org.uk](http://www.oxfam.org.uk)) works with others to overcome poverty and suffering. It is an independent organisation, registered as a charity, affiliated to Oxfam International, with partners, volunteers, supporters and staff of many nationalities – part of a global movement to build a just and safer world. We are a catalyst for overcoming poverty. To achieve the greatest impact, we work on three inter-linking fronts: saving lives by responding swiftly to provide aid, support and protection during emergencies; developing programmes and solutions that empower people to work their way out of poverty; campaigning to achieve lasting change. All our work is based on the belief that everyone has the right to: life and security; a sustainable livelihood; basic social services; be heard; and equity.

We work at all levels from global to local, including international governments, global institutions as well as with local communities and individuals, to ensure that everyone's rights are fulfilled and protected. We work closely with others to implement the most appropriate, effective solution in any particular situation. The size of our network, combined with our knowledge, experience, resources and collaborative approach, enable us to have both an immediate impact and lasting change to be realised.

We believe that: all human lives are of equal value. Everyone has fundamental rights – these must be recognised and upheld at all times; poverty makes people more vulnerable to conflict and natural disasters. Much of this suffering is unnecessary and must be relieved; people's vulnerability to poverty and suffering is increased by unequal power relations based on, for example, gender, race, class, caste and disability; women, who make up the majority of the world's poor people, are especially disadvantaged; unequal power relations must be addressed wherever they occur; in a world rich in resources, poverty is a morally indefensible injustice which must and can be overcome. Poverty, vulnerability and suffering are not pre-ordained events. All too often, poverty is the result of decisions taken, intentionally or unintentionally by those in power. Unjust policies and practices, nationally and internationally must be challenged and removed; with the right resources, support, and training, people living in poverty can solve their own problems. We all have a personal responsibility to work together to overcome poverty and suffering.

Oxfam's global work in health development and development financing covers a number of areas and themes:

- Influencing national and global policy and practice by working in collaboration with communities, health authorities, professional associations, research institutes, civil society, governments and donors to develop equitable health financing and provision models at district and national level.
- Supporting civil society partners in developing countries and in the North to organise, advocate and campaign around health and development finance issues that impact directly on the lives of marginalised people.
- Collaborative research with affiliates and partners to deliver rights-based policy evidence to influence terms of debate nationally and globally. Oxfam International's current policy framework for Essential Services, including health services, was published in 2006 and is available on the Oxfam website: [http://publications.oxfam.org.uk/oxfam/add\\_info\\_038.asp?TAG=&CID=](http://publications.oxfam.org.uk/oxfam/add_info_038.asp?TAG=&CID=)

Oxfam campaigned in 2006 and 2007 for the establishment of the International Health Partnership to encourage collaboration between donors, governments and civil society towards achievement of the Millennium Development Goals through building strong, universal and equitable health systems, supported by appropriate strategic financing plans. Oxfam is allied to the IHP CSO Forum globally, and is supporting CSO coalitions in Zambia, Nepal and Mozambique directly through financial, technical and alliance support.

Oxfam provides financial and technical support to alliances of NGOs and CSOs that monitor and evaluate development finance, and advocate for rights-based policy and practice in development financing. This includes budget tracking and consumer perception surveys at national level.

Oxfam provides financial and technical support to global and national coalitions of campaigners and activists to raise the voice of marginalised people in policies and practices that affect their lives. Oxfam is a founding member of the Global Call to Action on Poverty and the Global Campaign for Education. Oxfam facilitated civil society representation to the recent World Bank Health, Nutrition and Population strategy drafting process in 2007.

Oxfam staff represent Civil Society alliances in an individual capacity on the Board of the GFATM and the Board of Unitaid.

Tom Noel MSc, MA, is the Oxfam GB Global Programme Adviser for Basic Social Services, which involves supporting Oxfam offices worldwide to develop effective programmes that deliver the health rights of marginalised people; advocating in global forums for rights-based health policy and practice; and developing Oxfam strategy and operational frameworks on the right to essential services. He holds an MSc in Health Policy, Planning and Financing from the London School of Hygiene and Tropical Medicine (2004) and a MA from the University of Cambridge in Modern Languages (1992). He worked for 7 years for the African Medical & Research Foundation (AMREF) in the fields of organisational development, programme support, communications and resource mobilisation. Prior to that he established a foundation for palliative care in the Czech Republic in partnership with the Sue Ryder Foundation UK, the Municipality of Prague and the Czech Ministry of Health and Social Affairs, which is now locally run and resourced.

## VII. BUDGET

*Available on request from the IHP+ Core Team*

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Responsible  
Action 



**Miz-Hasab**  
**Research Centre**

# M&E Proposal

**Annual Monitoring and Evaluation of the IHP+**

*Supplementary Submission*

Prepared for: IHP+ Scaling-up Reference Group

Prepared by: Responsible Action; LSHTM; Miz Hasab Research Centre; Oxfam GB

24 September 2008

Proposal Reference: IHP02+ (Supplementary)

## Purpose

This Supplementary Submission responds to the request of IHP+ SuRG for additional clarifications to our Proposal:

1. Data collection (quantitative): Please provide further detail on the process for annual quantitative data collection and analyses, including:
  - o Initial list of indicators and sources, please be specific as possible, e.g. Total Health Expenditure rather than 'national indicators for healthcare financing'
  - o Possible data gaps and how these would be addressed
  - o Brief description on the collection process and how this would be linked to existing country processes/timetables
  - o Further detail of how data would be monitored and evaluated over time
2. Data collection (qualitative): Please provide further detail on the process for annual qualitative data collection, including:
  - o Initial list of e.g. 5 potential questions
  - o Brief description on the collection process and how this would be linked to existing country forums/meetings
  - o Detail of how data will be monitored and analysed over time
3. CSO Involvement: Please concretely explain how and when CSOs will be involved in your proposed monitoring and evaluation process, as well as the value-add of your proposed process, focusing on obtaining an independent picture of what changes are occurring in country
4. Budget: [Revised submission format using the provided Template].

## Data collection

### A. Monitoring and Evaluation Approaches

1. Monitoring and evaluation activities will be undertaken within **thematic focus areas** that reflect the **IHP+ core commitments**. These will be reviewed and finalised at the Inception Workshop and include:
  - Execution of Country Compacts
  - Financing for National Health Plans
  - Implementation of National Health Plans (and Government role)
  - Mutual Accountability and changing donor behaviours
  - Functioning of in-country cooperation mechanisms
  - Managing for Results (including strengthening national HMIS)
  - Civil Society Engagement
  - Private (non-state) Sector
  - Health Systems Strengthening and use of country systems
  - IHP+ institutional arrangements
  - Research relevant to the IHP+
2. Each **Thematic Focus** will have a **technical lead** within our Team, who will be responsible for moderating content in the Online Observatory, as well as for overseeing the collection and primary synthesis of related data. They will provide commentary on emerging trends and facilitate online discussions about the validity and inferences of new data as this becomes available.
3. Both qualitative and quantitative data will be collected within each thematic area to assess the **performance of the IHP+ against the DAC Criteria** indicated in **Table A**.
4. **Quantitative data** will be monitored and evaluated against indicators that are specific to each area, for which examples are provided in **Table B**. Almost all of these are likely to be existing, validated indicators<sup>1</sup> that we will finalize in the Inception Phase, using the following criteria:
  - Feasibility to operationalise
  - Already validated by Development Partners, Health Metrics Network or previous research
  - Routinely collected within countries
  - Consistent or comparable across countries

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<sup>1</sup> LSHTM recently reviewed all indicators that are regularly collected by WHO, UNAIDS and others. This identified approximately 25 key indicators that are produced on a routine basis as part of on-going reporting (for GFATM, WHO, UNAIDS, WB) in the countries and that were assessed by a sub-group of technical experts to be the most relevant to the focus area (in this case the HIV/AIDS policy response). This was followed by a review session (based on a modified DELPHI process) where a number of experts from the WB, WHO, UNAIDS at global and national level validated this list. We would plan to take a similar approach in the Inception Phase and also to align with the current WHO work on health systems strengthening indicators.

5. The process of finalising this indicator set will include:
- Mapping the existing and proposed indicators in IHP+ focus countries
  - Identifying a set of core indicators through the Inception Phase.
  - Agreeing on the criteria for measuring donor performance during the Inception Workshop
  - Referring the proposed Core Indicators to the Health Metrics Network working group and to other stakeholders for their comments.

**Table A: Sample Evaluation Questions for DAC Performance Criteria**

DAC Criteria	Evaluation Questions
<b>Relevance</b>	<ul style="list-style-type: none"> <li>• Are the IHP+ objectives relevant to the needs, priorities and policies of the participating agencies and countries?</li> <li>• Is the IHP+ designed to meet its objectives in ways that are relevant to partners and countries</li> <li>• Do the IHP+ principles and processes have a potential for replication in additional countries?</li> <li>• What other processes underway is the IHP+ likely to affect or to be affected by?</li> </ul>
<b>Effectiveness</b>	<ul style="list-style-type: none"> <li>• To what extent have the IHP+ objectives been achieved?</li> <li>• Are the successfully achieved activities sufficient to deliver the agreed outputs?</li> <li>• To what extent are the identified outcomes the result of IHP+ intervention, rather than external factors?</li> <li>• What are the reasons for the achievement or non-achievement of outputs or outcomes?</li> <li>• What could be done to make the IHP+ more effective?</li> <li>• How effective is the health plan in strengthening the overall health systems beyond specific short-term targets?</li> </ul>
<b>Efficiency</b>	<ul style="list-style-type: none"> <li>• Have measures been taken during the planning and implementation phase to ensure that resources will be efficiently used?</li> <li>• To what extent has the Work Plan been delivered as agreed?</li> <li>• What are the impacts of the additional resources that have been made available as a result of the IHP+ on the health sector?</li> <li>• To what extent have there been changes in the level of government health care expenditure and the level of disbursed aid?</li> <li>• What proportion of donor funds are on budget and support the health plan? What proportion of inputs is disbursed through the national procurement systems?</li> <li>• Could the IHP+ activities have been carried out in better, more cost-effective or quicker ways?</li> <li>• What have been the barriers or enablers to making these changes in a timely and effective fashion? From what your own country has done? From what the development partners have done?</li> <li>• Are there alternatives to the IHP+ processes that could achieve the same objectives more efficiently?</li> </ul>

DAC Criteria	Evaluation Questions
Impacts & externalities	<ul style="list-style-type: none"> <li>• Does the country have an effective M&amp;E plan to Manage for Results?</li> <li>• What has happened so far as a result of the IHP+?</li> <li>• What would have happened without the IHP+?</li> <li>• What positive and negative effects is the IHP+ having?</li> <li>• What real differences has the IHP+ made to how development partners are working together and to how aid is being delivered?</li> <li>• Is the IHP+ starting to contribute towards capacity development and institutional strengthening (especially at the country level?)</li> </ul>
Sustainability	<ul style="list-style-type: none"> <li>• How has the predictability of the funding for the health sector changed since the IHP+ was implemented?</li> <li>• To what extent does the IHP+ warrant ongoing investments to be made?</li> <li>• Are IHP+ partners and stakeholders supportive of the ongoing role of the IHP+?</li> <li>• To what extent has the country-level IHP+ process achieved buy-in and resulted in clear roadmaps that are adequately supported</li> <li>• Are the planned IHP+ governance and accountability mechanisms in place and will these be adequate?</li> <li>• How effective have the mechanisms for improved coordination among agencies involved in IHP and health systems strengthening been?</li> <li>• Are systems being developed for ensuring that partner agencies fulfil their commitments within country compacts, and if yes, how effective are these? Are their actions made public? What are the implications for particular agencies in terms of their ability to commit to country compacts?</li> <li>• What is the role of in-country civil society organisations (CSOs) in monitoring donor actions and through what channels?</li> <li>• What examples are there of specific policy or practice changes that has resulted in CSO involvement in implementing country compacts.</li> <li>• What is the level and forms of involvement are CSOs and governments involved in planning, budgeting, progress reviews.</li> </ul>

6. We will use existing data sources to measure these quantitative indicators, after undertaking an initial **data mapping exercise** in each country to establish the sources and quality of available data. Examples of appropriate data sources include:
- Country's own monitoring of Country Compact Implementation (e.g. data collected using the Ethiopia Compact Data Collection Instrument)
  - National Health Sector Performance Monitoring Reports
  - Joint Health Sector Review / SWap Reports
  - National Health Accounts
  - Focused evaluation studies by others
  - OECD/DAC peer review evaluations

7. **Qualitative data** will be monitored and evaluated against a set of generic performance questions across the thematic areas, as well as some specific-point questions that are relevant to individual focus themes.
8. **Generic Performance Questions** include:
  - What was expected to happen?
  - How has what actually happened different from what was expected?
  - Why did these differences occur and what can we learn from this?
  - Do the expectations need to be changed, or does something need to be done differently?
  - What further specific questions does this raise?
  - How can the sources of information about this be improved?
  - Who needs to know about this?
9. **Specific-point questions** will be identified through an iterative process, starting with those that the IHP+ Short-Term External Review raised and identifying further questions in the inception phase consultation. We would also encourage partners, stakeholders and other public participants to identify emergent questions through the Online Observatory, which has a specific functionality that allows for this. This will open up the M&E questions to a broader audience so that we can hear a range of responses. A sample of specific questions of immediate interest can be found in *Table A*.

## **B. Potential data gaps and how these would be addressed**

10. We will place **strong emphasis on local researchers** in our networks supporting country-level M&E activities to identify additional sources of data, including from unpublished sources, and to obtain this by legitimate means. Our network on the ground will alert the group to new information that can be expected.
11. Through the Online Observatory, we will promote **collaborative review of the available data** to get feedback on the validity, identify gaps and receive suggestions for how these gaps can be addressed through supplementary sources.
12. Where data gaps remain, these will be **highlighted in our reports** together with analysis of what implications this has for drawing conclusions and to make recommendations for how to address these gaps.
13. We will **review the adequacy of national Health Management Information Systems and Routine M&E** in each country, under the relevant focus theme, to highlight major gaps to make recommendations for further strengthening these.
14. A **registry of research** that is relevant to the IHP+ will be established under the relevant thematic area in the Observatory (although this will not formally function as a clearing-house, this could potentially become an established resource to researchers).

### C. Data collection procedures

15. The processes for data collection will **use existing in-country processes and timetables**, as far as possible. For example, to coincide with Joint Sector Reviews.
16. **Mapping the existing monitoring and evaluation processes** in each country will be an important activity of the Inception Phase, so that we can establish an annual timetable for the IHP+ Monitoring visits.
17. **Monitoring will be a continuous process**, with the results for countries being collated and reviewed throughout the year, as these become available. These will be synthesised at the end of the annual cycle to produce the Annual Monitoring and Evaluation Reports.
18. We will identify **opportunities to participate as observers in routine country reviews** and utilise these as opportunities to meet with other stakeholders. This could include conducting 'exit interviews' with reviewers, where this is possible. Our country-level researchers will help to facilitate this.
19. Routine monitoring will be **supplemented with a limited number of key informant interviews** that will be conducted at critical points of progress. This is particularly relevant to International Partners and stakeholders and we will build on the consultation processes established through the Short-Term Review.
20. We will establish an Online Observatory (built on the Clearspace Collaboration Platform) as an important mechanism for ad-hoc and participant-driven data collection. This **collaboration and knowledge management** tool has recently undergone a significant technological upgrade that enables rich collaboration possibilities – including through traditional email communication. We will use the database of respondents from the Short-Term Review as the starting point to grow a purpose network of individuals subscribed to the Observatory.
21. An **in-depth evaluation** will be conducted in three countries, where we will be undertaking semi-structured/qualitative interviews with global and national stakeholders at the country level, including MoH officials, CSOs, development partners and others. This will be done through close collaboration with country-level researchers and Civil Society.

## Involving Civil Society in Monitoring & Evaluation

### A. Civil Society Involvement in the Inception Phase

22. The Advisory Panel (Reference Group) has prominent southern and northern CSO representatives who will **co-convene the Inception Workshop** with the Consortium members to advise on the M&E design, advocacy strategy and choice of countries for evaluation.
23. In each IHP country, Consortium members will identify a **national CSO partner** with research capacity and/or national CSO with networking/representation capacity. Key to CSO partner selection will be the depth, history and accountability of its engagement with smaller groups and individuals within the country; and the breadth of issues with which it is concerned (to avoid single issue domination).
24. CSO partners in IHP countries will be engaged in the **inception phase design**, including in the selection of monitoring indicators and parameters. We will encourage collaborative participation in this process through the Online Observatory (training for this will be provided through the M&E Capacity Building activities).

### B. Civil Society involvement in the annual monitoring process

25. There is already a good deal of **existing CSO engagement** on health systems policy and practice in all IHP+ countries. The annual monitoring exercise intends to link with established activities as far as possible, rather than to build new CSO platforms. We will engage the networks of our Consortium Partners and Advisory panel members, to participate in a civil society collaboration and communication forum in the Online Observatory that we will establish.
26. CSO partners from the IHP+ countries will be included in the Miz Hasab **M&E Capacity training** to orientate them to the process, establish a cross-country network and strengthen the specific skills required to contribute towards M&E.
27. At first draft stage of drafting annual monitoring reports, **public meetings** will be held with national CSO groups (including parliamentarians, health service user groups, media and registered NGOs), government and donor agencies to give CSOs a political platform through which to express their interests in and any concerns about the findings, and to negotiate how their perspectives can be represented more strongly, if necessary.
28. The **Advisory Panel will provide a foreword to the annual monitoring report** before it is presented to the IHP+ Steering Group. This foreword will be negotiated with the IHP+ Steering Group before publication, but will represent the independent views of the panel.
29. The Consortium Partners will provide an **Open Access documentation space in the Online Observatory** for CSOs and any other interested individuals to access and use data for their research or advocacy purposes. The collaboration platform also has a function for users to rate and make comments on any content, which could lead to collaborative use of this information (for example, between Northern and Southern collaborators). This potential to build new links between people and organisations with a common interest is an exciting development.

### C. Civil Society involvement in focus country Evaluation Studies

30. The **CSO Partners in the Evaluation study countries will receive technical and financial support** from Consortium members to participate in the evaluation activities, including for establishing collaborative networks with wider CSO groups, particularly those representing health service users, in order to influence evaluation design; access training on evaluation; collate relevant community-level data; and establish collaborative relationships with research institutions.
31. The **Advisory Panel will provide a foreword to the Evaluation reports** before these are presented to the IHP+ Steering Group. This foreword will be negotiated with the IHP+ Steering Group before publication, but will represent the independent view of the Panel.
32. The **Online Observatory** will (as already mentioned above) be a valuable resource for the Evaluation process.

### D. Capacity-building Training for Civil Society M&E

33. Building local Civil Society **capacity to meaningfully participate in the country-level IHP+ Monitoring and Evaluation activities is a necessary investment**. Extensive experience of working with local researchers through the LSHTM-affiliated research networks and with groups such as TASC has provided us with insights into the competencies that typically need to be developed before local researchers can contribute to valid and high quality monitoring and evaluation activities.
34. This process is also essential to **orientate local researchers to the IHP+ and the M&E process**. It will also build a cross-country network of M&E trained CSO representatives.
35. **Capacity-building training will be highly applied and relevant to the IHP+ M&E**, although this will also contribute to local skills development for ongoing M&E research beyond the IHP+ 3-year monitoring and evaluation. We would like this to be a sustainable contribution to participating IHP+ countries.
36. The training will develop Civil Society technical competencies, such as:
  - How to use the Online Observatory
  - How to identify, collect, analyse and report relevant data
  - Relevant research methods
  - Reporting on developments within countries
  - Stakeholder analysis
  - Networking methods
37. Behavioural competencies that will be developed include:
  - Appreciation for what the IHP+ is trying to achieve and why this is important
  - Understanding the policy process and what evidence is important for IHP+ advocacy
  - Understanding research ethics (such as confidentiality) and good research practices
  - Appreciating the importance of data quality and integrity, as well as accurate reporting of findings

38. These activities will also provide the opportunity to establish competent M&E systems for CSO representatives to use within countries, such as:

- Reporting tools
- Computer connectivity
- Quality assurance procedures
- Researcher performance agreements

### **E. The value-add of Civil Society Participation in the M&E process**

39. Civil Society Organisations are important and legitimate stakeholders in the IHP+ M&E as partners, service providers and the representatives for people who are affected by the IHP+.

40. Civil Society has been identified as crucial to influencing Development Partners and National Governments to become mutually accountable. Their participation in the M&E process will bring the perspective of what is important to people and a broader range of stakeholder perspectives.

41. This will also increase the transparency of the M&E process.

42. As contributors to the M&E activities, Civil Society is often much better informed and has a more contextualised understanding of what is 'happening on the ground' than many academic researchers or senior government staff.

43. Through their networks, Civil Society can access and disseminate information in ways that formal institutions cannot.

44. Civil Society involvement will also add value to the independence of the monitoring and evaluation reports by:

- Contributing to the design of the M&E strategy;
- Contributing to the choice of indicators;
- Discussing and negotiating the first draft of the reports;
- Contributing a foreword to the reports that carries the weight of an independent panel of internationally respected researchers and civil society representatives.

45. Benefits to the Civil Society participants will include:

- Gaining open and transparent access to research findings for their own advocacy use;
- Working in collaboration with academic researchers to promote action research;
- Gaining opportunities to participate in the accountability forums on national health plans;
- Improved capacity for research and dissemination of M&E findings;
- Gaining access to personal relationships with ministry and donor officials.

**Table B: Sample Quantitative Indicators and Data Sources by Thematic Focus**

Thematic Focus	Sample Indicators	Sources (examples)
Execution of Country Compacts	<ul style="list-style-type: none"> <li>Proportion of DPs participating in the annual planning process (See <i>Table C for others</i>)</li> </ul>	<ul style="list-style-type: none"> <li>National Compact Monitoring Reports</li> </ul>
Financing for National Health Plans	<ul style="list-style-type: none"> <li>Total Health Sector Expenditure per Capita</li> <li>Percentage increase in baseline External Funding to the Health Sector actually delivered</li> </ul>	<ul style="list-style-type: none"> <li>National Health Accounts</li> <li>Donor Reports / DAC</li> </ul>
Implementation of National Health Plans	<ul style="list-style-type: none"> <li>Service delivery targets (e.g. ITNs distributed)</li> <li>Health Results (e.g. Infant Mortality Rate)</li> </ul>	<ul style="list-style-type: none"> <li>Joint Health Sector Review Reports</li> <li>MDG monitoring reports</li> </ul>
Mutual Accountability and changing donor behaviours	<ul style="list-style-type: none"> <li>Proportion of DPs reporting their country activities on time</li> </ul>	<ul style="list-style-type: none"> <li>Donor Report Card</li> </ul>
Functioning of in-country cooperation mechanisms	<ul style="list-style-type: none"> <li>Proportion of agreed Cooperating Partner Actions carried out on time over a 6-month period</li> </ul>	<ul style="list-style-type: none"> <li>CHST meeting reports</li> </ul>
Managing for Results (including strengthening national HMIS)	<ul style="list-style-type: none"> <li>Proportion of National Health plan Indicators (sub-set) with Valid Data</li> </ul>	<ul style="list-style-type: none"> <li>National Health Sector Performance Monitoring Reports</li> </ul>
Civil Society Engagement	<ul style="list-style-type: none"> <li>Number of health districts with local CSO participation in planning</li> </ul>	<ul style="list-style-type: none"> <li>Key Stakeholder Interviews</li> </ul>
Private (non-state) Sector	<ul style="list-style-type: none"> <li>Number of registered non-state providers</li> </ul>	<ul style="list-style-type: none"> <li>Research by other institutions</li> </ul>
Health Systems Strengthening and use of country systems	<ul style="list-style-type: none"> <li>Ratio of trained Nurses to Population (in Public Sector)</li> </ul>	<ul style="list-style-type: none"> <li>National Health Workforce Surveys</li> </ul>
IHP+ institutional arrangements	<ul style="list-style-type: none"> <li>Proportion of work-plan outputs delivered on time</li> </ul>	<ul style="list-style-type: none"> <li>SuRG Management Reports</li> <li>Issue Management System Reports</li> </ul>

**Table C: Sample Indicators for Annual Monitoring of the IHP+ Country Compact Implementation<sup>2</sup>**

Indicator	Ethiopia Target 2010	Baseline	Year 1	Year 2	Year 3	Comments
<b>One Plan</b>						
Proportion of development partners that have integrated their plan with the Government plan at national and sub national levels						
Proportion of development partners not requesting the Government for separate planning documents	95%		Example 85%	Example 94%	Example 98%	
Proportion of development partners participating in the annual planning process						
Proportion of development partners participating in the development / review of the HSDP						
Main health sector development strategies, HMIS and HRD, finalized and implemented according to plans						
<b>One Budget</b>						
Proportion of development partners who provided funding commitments for a period of at least 3years						
Proportion of development partners who confirmed their annual commitment by programme and geographic area by February each year	95%		Example 75%	Example 95%	Example 100%	
Percentage of funds channelled through the Government preferred modalities						
Based on the MDG Fund appraisal, progress on implementation of improvement plan for financial management system						
Percentage of funds from development partners disbursed as per the schedule provided in the annual plan	100%		Example 70%	Example 88%	Example 100%	
Percentage of funds from Government disbursed as per the schedule provided in the annual plan						
Proportion of financial reports submitted on time						
Proportion of development partners using Government preferred modalities for procurement	80%		Example 79%	Example 81%	Example 79%	
Based on the MDG Fund appraisal, progress on implementation of improvement plan for procurement system.						
Proportion of TAs hired based on the request of the Government						
Yearly increase of domestic financial allocation to the Health Sector						
Development Partners submit financial reports to the Government as per agreed schedule (Yes/No)						
Government submit financial reports to the CJSC as per agreed schedule (Yes/No)						

<sup>2</sup> Adapted from Ethiopia Country Compact Indicators for Monitoring the Progress of Harmonization and Alignment (August 2008)

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Indicator	Ethiopia Target 2010	Baseline	Year 1	Year 2	Year 3	Comments
<b>One M &amp; E Reporting System</b>						
Proportion of development partners requesting separate reports						
Proportion of review missions conducted jointly by Government and development partners						
Proportion of coordination meetings held as planned between FMOH, MOFED and Partners						
Implementation and reporting on a single results based framework for all funding streams (Yes/No)						
<b>Overall Harmonization and Alignment Process</b>						
Number of parallel project management units						
Proportion of development partners that have signed the compact						
Proportion of Development Partners providing untied aid						

