ihp+ results

Strengthening accountability to achieve the health MDGs

ANNUAL PERFORMANCE REPORT 2010

CONTENTS

Re-Action™ Responsible Action for Health & Sustainability

Oxfam

ACRONYMS AND ABBREVIATIONS

CPIA	Country Policy and Institutional Assessment
CSO	Civil Society Organisation
DFID	UK Department for International Development
DP	Development Partners
DRC	Democratic Republic of Congo
EC	European Commission
GAVI	The Global Alliance for Vaccines and Immunization
GBS	General Budget Support
GFATM	The Global Fund to Fight AIDS, TB and Malaria
HLF4	High Level Forum on aid effectiveness
HMIS	Health Management Information System
HMN	Health Metrics Network
HRH	Human Resources for Health
IHP+	International Health Partnership and related initiatives
JANS	Joint Assessments of National Strategies
MDGs	Millennium Development Goals
MoH	Ministry of Health
OECD	Organisation for Economic Co-operation and Development
OECD/DAC	The Development Assistance Committee
PAF	Performance Assessment Framework
PBAs	Programme Based Approaches
PFM	Public Finance Management
PIUs	Project Implementation Units
SBS	Sector Budget Support
SPMs	Standard Performance Measures
SuRG	IHP+ Scaling Up Reference Group
TT HATS	The Task Team on Health as a Tracer Sector
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	The United Nations Children's Fund
WB	World Bank
WHO	World Health Organisation
WHS	World Health Statistics

INDEPENDENT ADVISORY GROUP FOREWORD

As members of the Independent Advisory Group to IHP+Results, we have reviewed the second annual performance report to provide this commentary on the methodology, scope and relevance of the information it contains.

We begin by affirming the importance of accountability in improving aid effectiveness, both in general and specifically within the health sector. To that end, this report makes a significant and important contribution (and one which could be an exemplar for tracking Aid Effectiveness in other sectors). This report now includes standardized indicators for IHP+ partners to describe and explain their commitments and actions to promote greater health aid effectiveness. Self-reporting on these indicators is improving the accountability of IHP+ signatories to their commitments. However, it will be important to improve the degree of independent verification of the information provided by signatories in the next accountability round.

The methodology and quality of data provided in this report also shows considerable improvement from the first report. Some methodological challenges remain, and these will need to be resolved in future assessment rounds. For example, some indicators (in important areas such as civil society engagement and capacity building) remain open to interpretation, and require more careful measurement and qualitative texture. Such refinement, the need for which is acknowledged in the report, will further increase the rigour and usefulness of the data in the next accountability exercise. These methodological issues do not undermine the present report's reasonable assessment of IHP+ signatories' performance regarding their commitments under the IHP+.

The empirical information provided in the scorecards is particularly valuable and makes international health assistance processes more transparent and accountable. The scorecards should be made widely available, and rendered accessible in terms of presentation and language, to a wide range of interested stakeholders. They represent useful instruments for promoting discussion at country and global levels about how procedures and processes could be improved.

We are aware that not all Development Partners view all of the measures as applicable to their work. Nonetheless, as IHP+ signatories, they have committed themselves to being accountable for improving health Aid Effectiveness and harmonization. We thus encourage them to specify how their practices are consistent with the measures and to report on this accordingly. Additionally, to better ensure accountability of both Development Partners and governments with agreed commitments, it is crucial that indigenous organizations and institutions are allocated resources and assistance to develop their capacity to engage in this monitoring process.

It is notable that only half of all IHP+ signatories have participated in this accountability round. The long-term robustness and utility of the accountability exercise rests on participation by a larger proportion of reporting signatories and we encourage all signatories to participate in the next accountability round. We believe that this accountability exercise provides important opportunities for all signatories to improve their compliance with the spirit of both the IHP+, and the Paris Declaration on Aid Effectiveness. Some donors (notably the USA) have not signed up to IHP+. We encourage the SURG and IHP+ Executive Team to

share this report, its methodology and processes with these donors, and to explore points of convergence and joint learning with these donors with respect to their own accountability processes for improving aid effectiveness.

As we noted in the foreword to the 2010 World Health Assembly Update[1], we believe that donor assistance in health should not be viewed in isolation from other aspects of foreign policy covering areas such as trade, investment, security and climate protection. These policies have profound effects on health outcomes and the challenges faced by health systems in developing countries. We regard the accountability of IHP+ as but one dimension of improving foreign policy coherence, in which improving health Aid Effectiveness and health system strengthening is one of many important means of achieving better health outcomes.

We commend reported IHP+ progress in some areas, such as the increased use of national planning and review processes by countries and improved alignment of external Development Partners to those processes and plans. However, this report also gives reasons for concern. There appears to be low use of country systems, notably country led procurement, by external development partners; and only one of the African country signatories participating in this accountability round has come close to achieving the Abuja target of committing 15% of its national budget to the health sector. Five countries appear to have reduced their public health expenditures relative to their overall budget. Moreover, there is no credible way at present to measure whether country reports of national health expenditures includes, or excludes, transfers of health development assistance. This makes it difficult to determine the level of national commitment to health sector development by aid-recipient IHP+ partners. These are issues that need closer attention in the next round of the accountability exercise in 2011.

To conclude:

The progress that has been made in establishing this accountability process, and the tools that have been developed for it, provide a unique contribution to the debate on Aid Effectiveness in health. They are also of substantial value for the Aid Effectiveness debate beyond the health sector. We encourage the IHP+ Executive Team, SURG and signatories to:

- communicate this development to other sectoral aid groups
- explore how the important findings in this report can be made more accessible to the increasing number of stakeholders in global health and
- ensure that this work continues into the future in response to country and global demands for more accountable support to the health sector.

More generally, we encourage the SURG to begin to consider how the momentum for Aid Effectiveness in health can be sustained and increased beyond the current IHP+ work plan, which comes to an end in 2011.

Advisory Group Members: *Prof Ronald Labonte; Prof Gill Walt; Dr David McCoy; Prof David Sanders; Dr Ravi Ram; Prof Adrienne Germain; Dr Lola Dare; Mr Tobias Luppe.*

[1] IHP+Results World Health Assembly Update, 2010

EXECUTIVE SUMMARY

The International Health Partnership and Related Initiatives (IHP+) was launched in 2007 with a commitment by developing country governments and Development Partners (DPs) to "work effectively together with *renewed urgency* to build sustainable health systems and improve health outcomes in low and middle-income countries." To achieve this, IHP+ signatories specifically committed to delivering and using all available health sector resources to implement "…strong and comprehensive country and government-led national health plans in a *well coordinated way*".

Signatories to the IHP+ Global Compact mandated IHP+Results to annually undertake "*…an independent, evidence-based assessment of results at country level and of the performance of each [signatory] individually as well as collectively*"[3] to report on whether these commitments and expectations of the IHP+ are being achieved. This Performance Report reflects the IHP+Results findings for the second annual cycle of monitoring, undertaken in 2010. It builds on the findings of previous reviews, and will inform the third annual performance review in 2011[4].

Evidence for this report was collected from a sub-set of 25 IHP+ signatories[5] that opted to participate. Each agency provided data for a set of Standard Performance Measures (12 for DPs and 10 for country governments, see page 38 for a list). These measures closely reflect the OECD/DAC Aid Effectiveness indicators, which have been applied to the health sector for this purpose.

From these self-reported data, IHP+Results has produced a credible Development Partner or Country Scorecard for each participating IHP+ signatory. Their performance has been rated using transparent and objective criteria[5], against the agreed target for each measure. The data collection and rating procedures were implemented in accordance with a review methodology approved by the IHP+ governing body[7]. This methodology had been updated through an IHP+ Mutual Accountability Working Group process to address the recommendations and lessons from the first round of IHP+Results performance monitoring[8].

Results:

This independent review has found that the participating country governments and Development Partners made some progress in improving how effectively they were delivering and using health aid by 2009. These findings are broadly consistent with those from the OECD 2008 Paris Declaration monitoring survey, which is conducted at the national level (i.e. does not capture sectoral performance), and covers a larger number of countries and Development Partners.

Ethiopia, Mali and Mozambique have seen the most improvements in Development Partners actions to meet their IHP+ targets. Burundi, Djibouti, DRC, Niger and Nigeria have benefitted less. However, these results might be expected given the length of time since each country joined the IHP+ (Djibouti only signed up to the IHP+ Global Compact in July 2009, Niger and DRC in May 2009) and the relative strength of these countries systems and processes.

[2] IHP+Results is an independent consortium of research and advocacy organizations, led by Re-Action, working in partnership with the London School of Hygiene and Tropical Medicine, and Oxfam GB.

[3] http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_global_compact_EN.pdf accessed 19/01/2011

[4] IHP+Results 2011 monitoring will reflect on how this report, and the tools and findings presented here, have been used to take steps towards real mutual accountability.

[5] 10 IHP+ country governments: Burkina Faso, Burundi, Djibouti, DRC, Ethiopia, Mali, Mozambique, Nepal, Niger and Nigeria. 15 Development Partners: AusAID, Belgium, EC, GAVI, the Global Fund, Netherlands, Norway, Spain, Sweden, UK, UNAIDS, UNFPA, UNICEF, WHO and World Bank.

[6] More information about criteria for rating can be seen at: www.ihpresults.net/how/methodology/rating

[7] The IHP+ Scaling Up Reference Group: http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_surg__terms_of_reference_EN.pdf

[8] The details of this were reported in the IHP+Results World Health Assembly Update, 2010

Partners generally did well to agree on the high-level frameworks and plans for delivering and using resources in the health sector, based on each country's own priorities [9]. However, performance in strengthening and using country systems to manage these resources is mixed. For instance, Burkina Faso, Burundi and Mozambique had strengthened their public financial management systems and in five countries with strong country financial management systems [10] DPs overall met the target of a 33% reduction in the proportion of funds not using these systems. However, the use of country procurement systems by DPs appeared to have declined overall.

Civil society appears, overall, to have become more engaged in national health policy processes in the participating countries. All DPs reported providing some support to civil society engagement (although this requires further investigation and discussion with southern civil society organisations).

There has been mixed progress in securing responsible and predictable financing for the health sector: overall the proportion of DP funding through multi-year commitments fell between the baseline and 2009 period, but 9 of 15 DPs were providing 90% or more of their health aid through multi-year commitments. Five governments (Burkina Faso, Burundi, Djibouti, Nepal and Niger) increased the proportion of their national budget allocated to health. However these increases were widely variable and none of the African governments reviewed had yet met the 15% Abuja target of national budget allocated to the health sector [11]. The performance of these governments in disbursing the available health sector budgets on time also showed a mixed picture. Countries allocated a lower proportion of funding to Human Resources for Health (HRH), compared to historical levels. This was despite a number of countries having developed more ambitious HRH plans and beginning to integrate these into national health plans and budgets, as promoted by the IHP+. HRH funding is the best proxy measure that IHP+Results has to assess whether the IHP+ is strengthening health systems, so this raises a concern that the purpose of the IHP+ is not yet being achieved.

Conclusions and recommendations:
The findings in this report can be credibly used to inform ongoing conversations about Aid Effectiveness in the health sector. These need to be taken up and discussed by IHP+ signatories and other stakeholders (including civil society) in all relevant forums. These findings should also contribute to the 4th High-Level Review of Aid Effectiveness during 2011, where health is being reported on as a tracer sector [12].

Whilst participants in IHP+Results 2010 survey represent approximately half of all IHP+ signatories and some major DPs are not included, it is possible to draw some conclusions that may be useful for other country governments and DPs, whether they are IHP+ signatories or not.

For the subset of IHP+ signatories participating in this review, there seems to have been an overall improvement in the effectiveness of how aid is being delivered and used in the health sector. But it is too early to state whether these improvements are contributing to stronger health systems or better health outcomes. Overall, by 2009, progress by signatories fell short of implementing their IHP+ Global Compact commitments to work with *renewed urgency* to build sustainable health systems and to improve health outcomes.

This report and scorecards should prove invaluable for IHP+ stakeholders to use during 2011 to hold themselves and others to account for their commitments, and to strengthen mutual accountability.

[9] National strategy, compact, results framework and mutual monitoring process. See IHP+ Compact Guidance note http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_compact_guidance_note_EN.pdf.

[10] Burkina Faso, Ethiopia, Mali, Mozambique and Niger. For more information see Section 3.3 below.

[11] Although Burkina Faso was closest to the target, having reached 14.6% in 2009.

[12] IHP+Results and the IHP+ are members of the OECD DAC Technical Task Team on Health as a Tracer Sector (TTHATS) that is preparing for the High-level Forum on Aid Effectiveness.

There are inherent limitations to the approach that IHP+Results has used to produce this report: the potential bias of self-reporting; the findings cannot be generalised to all IHP+ signatories; and there is a time lag – results reflect signatories' performance in 2009. However, these limitations can be used to the advantage of the IHP+ if further steps are taken towards towards embedding mutual accountability into the ways IHP+ signatories work.

Scorecards can be used as tools to promote dialogue, as the basis for stronger accountability. They can inform internal reviews within individual agencies, joint reviews between partners, and public review processes. This would increase accountability to the IHP+ commitments, both within countries and at the international level.

IHP+ Partners are therefore encouraged to review the ratings on their own scorecard (together with their disaggregated ratings that are reported online [13] by IHP+Results), to question and plan how to improve their performance and the quality of their reporting. Partners are encouraged to use these scorecards and performance measures within joint reviews and other mutual accountability forums to understand the factors behind each other's ratings, and to question whether their current performance has changed since 2009. Civil Society and other stakeholders should use these scorecards to demand public accountability for the IHP+ signatories to keep their commitments. However, this needs to be done with care, considering how important the context is when comparing across countries – even within the same agency. More needs to be done to improve the accessibility of this work to country-based civil society organisations. Future monitoring should aim to increase participation rates, improve the completeness of data reported, and ensure that the measures are interpreted more consistently.

The IHP+ provides credible instruments and mechanisms to promote accountability. For this to contribute more towards ensuring that health sector results are being delivered, IHP+ signatories and stakeholders need to build on their current efforts to strengthen their individual institutional, mutual and public accountability for these results.

[13] See www.ihpresults.net/results/data/

Overview of Development Partner performance

INDICATOR	STANDARD PERFORMANCE MEASURE	AusAID	Belgium	EC	GAVI	GFATM	Netherlands	Norway	Spain	Sweden	UK	UNAIDS	UNFPA	UNICEF	WHO	World Bank
1DP	Partner has signed commitment to (or documented support for) the IHP+ country compact, or equivalent agreement, where they exist.	✓	✓	✓	→	→	✓	✓	→	→	✓	→	✓	✓	✓	✓
2DPa	Percent of aid flows to the health sector that is reported on national health sector budgets.	!	!	→	?	✓	!	!	✓	✓	→	→	!	✓	→	✓
2DPb	Percent of current capacity-development support provided through coordinated programmes consistent with national plans/ strategies for the health sector.	?	✓	✓	–	–	✓	✓	✓	–	✓	✓	✓	✓	✓	✓
2DPc	Percent of health sector aid provided as programme based approaches.	✓	✓	✓	✓	✓	✓	!	→	✓	→	✓	!	✓	✓	✓
3DP	Percent of health sector aid provided through multi-year commitments.	→	✓	✓	✓	!	✓	✓	!	✓	✓	–	✓	!	!	✓
4DP	Percent of health sector aid disbursements released according to agreed schedules in annual or multi-year frameworks.	→	?	✓	✓	✓	✓	✓	!	✓	✓	✓	✓	✓	✓	✓
5DPa	Percent of health sector aid that uses country procurement systems.	✓	✓	!	–	✓	✓	!	✓	✓	→	?	→	→	!	!
5DPb	Percent of health sector aid that uses public financial management systems.	✓	✓	✓	?	✓	✓	!	✓	✓	✓	?	→	→	!	✓
5DPc	Number of parallel project implementation units (pius) per country.	✓	!	→	–	✓	✓	!	✓	✓	→	–	✓	✓	✓	!
6DP	Partner uses the single national performance assessment framework, where they exist, as the primary basis to assess progress (of support to health sector).	✓	→	→	!	✓	✓	✓	→	→	✓	✓	→	→	✓	✓
7DP	Partner has participated in mutual assessment of progress implementing commitments in the health sector, including on aid effectiveness, if a mutual assessment process exists.	✓	→	✓	!	–	✓	–	→	✓	✓	✓	→	✓	→	✓
8DP	Evidence of support for civil society to be actively represented in health sector policy processes - including health sector planning, coordination & review mechanisms.	✓	→	→	→	→	✓	✓	→	→	→	✓	→	→	→	→

A detailed breakdown by Country, for each Development Partner, is available on the IHP+Results website ***www.ihpresults.net***

Overview of Country Goverment's performance

INDICATOR	STANDARD PERFORMANCE MEASURE	Burkina Faso	Burundi	DRC	Djibouti	Ethiopia	Mali	Mozambique	Nepal	Niger	Nigeria
1G	IHP+ Compact or equivalent mutual agreement in place.	→	✓	!	→	✓	✓	✓	✓	✓	→
2Ga1	National Health Sector Plans/ Strategy in place with current targets & budgets.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2Ga	National Health Sector Plans/ Strategy in place with current targets & budgets that have been jointly assessed.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3G	Proportion of public funding allocated to health.	→	→	?	→	!	!	!	→	→	!
4G	Proportion of health sector funding disbursed against the approved annual budget.	→	!	?	✓	?	!	→	✓	!	✓
5Ga	Public Financial Management systems for the health sector either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	✓	✓	!	!	✓	✓	✓	!	✓	!
5Gb	Country Procurement systems for the health sector either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	?	?	?	?	?	?	?	?	?	?
6G	An agreed transparent and monitorable performance assessment framework is being used to assess progress in the health sector.	✓	✓	!	!	✓	✓	✓	✓	✓	!
7G	Mutual Assessments, such as Joint Annual Health Sector Reviews, have been made of progress implementing commitments in the health sector, including on aid effectiveness.	→	✓	✓	!	✓	✓	✓	✓	✓	→
8G	Evidence that Civil Society is actively represented in health sector policy processes - including Health Sector planning, coordination & review mechanisms.	→	✓	✓	?	✓	✓	?	✓	✓	?

A detailed breakdown by Development Partner, for each Country, is available on the IHP+Results website ***www.ihpresults.net***

1. INTRODUCTION

The International Health Partnership and related Initiatives (IHP+) was launched in 2007 with the objective of accelerating progress towards achieving the health-related MDGs. The IHP+ responds to fragmented efforts to address health system constraints and the unpredictable nature of international aid at a time when there are insufficient global and domestic investments in health. The inefficient ways in which some support is offered to countries, with duplication and fragmentation of activities carried out by multiple agencies through an array of vertical initiatives, have together produced an overly complicated and inefficient international aid architecture that still fails to show the impacts one would expect relative to the amount of money that is spent on improving health.

Since 2007, 25 Development Partners (DPs) and 24 developing country governments[14] have signed up to the IHP+ Global Compact, which builds on a number of pre-existing processes to promote aid effectiveness, based on the Paris Declaration and Accra Agenda for Action. The IHP+ commits DPs to deliver more effective development assistance to the health sector of these countries. It also commits participating country governments to use available domestic and external resources effectively and for all partners to *"...build sustainable health systems and improve health outcomes..."*

The IHP+ Global Compact calls signatories to report annually on the progress they are making in implementing their IHP+ commitments. It also calls for *"...an independent, evidence-based assessment of results at country level and of the performance of each [signatory] individually as well as collectively"*.[15] This explicit expectation for partners to be both individually and mutually accountable for the process and results of the IHP+ is a unique feature of this initiative.

IHP+Results is mandated to undertake this annual independent review of the IHP+. This report presents findings from the 2010 IHP+Results Survey and builds on previous reviews carried out in 2009-10.[16]

In response to the findings of these previous reviews and the experiences of implementing the first cycle of the IHP+Results process (in 2009), the IHP+ Scaling up Reference Group (SuRG)[17] in July 2010 adopted a set of Standard Performance Measures (SPMs) on which to base this Annual Review and to track progress on the commitments that have been made through the IHP+ Global Compact.[18] These performance measures include 10 indicators and targets for IHP+ country governments, as well as 12 indicators and targets for DPs. A full list of Standard Performance Measures is available on p42 below, and on the IHP+Results website[19]. These measures and targets draw directly on the Paris Declaration indicators and targets, applied to the health sector.[20]

[14] http://www.internationalhealthpartnership.net/en/partners accessed 19/01/2011.

[15] http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_global_compact_EN.pdf accessed 19/01/2011

[16] 2008 External Review of the IHP+, available at http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_external_review_2008_1_EN.pdf; and World Health Assembly IHP+Results Update (May 2010), available at http://www.internationalhealthpartnership.net/CMS_files/documents/world_health_assembly_ihpresults_EN.pdf.

[17] IHP+ inter-agency Scaling-up Reference Group will be responsible for setting overall strategic direction and information sharing for the IHP+. The SuRG includes representatives of all IHP+ signatories.

[18] Developed by a multi-stakeholder IHP+ Working Group, as detailed in the detailed methodology annex, available at www.ihpresults.net/how/methodology. A full list of the Standard Performance Measures is available at page 39.

[19] www.ihpresults.net/how/methodology/spm/

[20] http://www.oecd.org/dataoecd/57/60/36080258.pdf accessed 19/01/2011

During September and October 2010, IHP+ signatories reported on these measures – providing data for their baseline year (using whatever data were available for that point in time[21]) and for the 2009 period. Information was collected using a standard set of reporting tools and procedures developed by IHP+Results. Participation in this process was voluntary and participants included 10 developing country governments (Burkina Faso, Burundi, Djibouti, DRC, Ethiopia, Mali, Mozambique, Nepal, Niger and Nigeria) and 15 of the 25 IHP+ Development Partners (AusAID, Belgium, EC, GAVI, the Global Fund, Netherlands, Norway, Spain, Sweden, UK, UNAIDS, UNFPA, UNICEF, WHO and World Bank). [22]

The data collected have been analysed and presented in IHP+Results Partner and Country Scorecards. These provide a simple one-page graphical presentation of the progress of each participating IHP+ signatory. Progress is reported through a rating symbol (target achieved; progress made towards achieving the target; no progress, or regression) for each of the agreed Standard Performance Measures. The Scorecards provide an overview of data that can be explored in more detail online (www.ihpresults.net) and in the annexes to this report. Partner and Country Scorecards are available on the IHP+Results website[23].

This report synthesises the key scorecard findings for DPs and Country Governments to provide an overall review of progress within five Results Areas: (1) Ownership, mutual accountability and engaging civil society; (2) Transparent and responsible health financing; (3) Strengthening and using country systems; (4) Managing for development results; and (5) Strengthening health systems. These areas align with the OECD/DAC process for monitoring Aid Effectiveness and specifically link to the work of the Task Team on Health as a Tracer Sector (TT HATS). Ensuring alignment between IHP+Results and the TT HATS process should ensure that the experience of implementing the IHP+ contributes to the 2011 OECD High Level Forum review of Aid Effectiveness.

Conclusions have been drawn from this evidence and recommendations are provided to IHP+ signatories on ways in which they could accelerate their progress in implementing the IHP+ commitments. Although these are based on performance data from a sub-set of DPs and countries, and for only two data points in time, the key messages are likely to be relevant to all IHP+ signatories.

IHP+Results is an independent consortium of research and advocacy organizations, led by Re-Action! (Responsible Action for Health & Sustainability), working in partnership with the London School of Hygiene and Tropical Medicine, and Oxfam GB. IHP+Results is informed by an Independent Advisory Group (IAG), which was established to provide independent advice to IHP+Results on its work to monitor and evaluate the IHP+. The IAG members are international experts from civil society and academia[24].

21 See methodology section and Annex for more detail on baselines: www.ihpresults.net/how/methodology/

22 Germany and ILO expressed interest and hope to participate in future annual surveys.

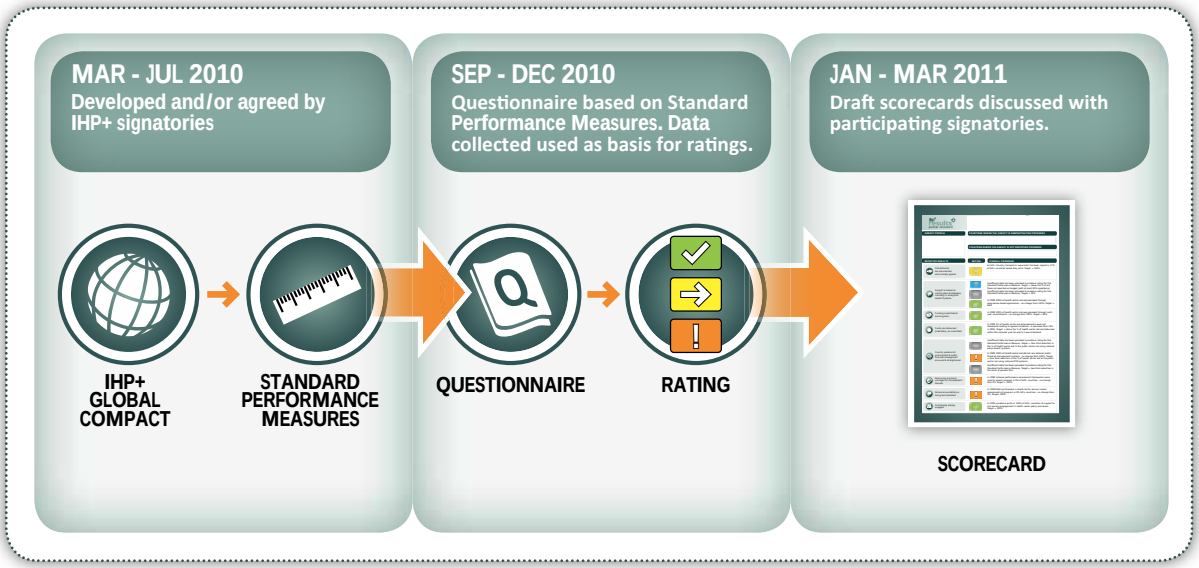
23 www.ihpresults.net/results/scorecards/

24 For more information about the Advisory Group membership, see www.ihpresults.net/about/consortium/

2. HOW THIS PERFORMANCE REVIEW WAS CONDUCTED

IHP+Results managed the 2010 survey through a process that started with IHP+ Signatories adopting the revised Standard Performance Measures in July (a full list is available at page 39). A structured survey tool [25] was completed by the representatives of country governments and Development Partners over the period September to October. These submissions were analysed by IHP+Results, with gaps and queries clarified with the reporting agencies. The Performance Measures were rated using transparent criteria [26] and Scorecards produced in the first quarter of 2011, to deliver this synthesis Annual Performance Report. Additional details, including disaggregated ratings, have been made available online with the release of this report.

Figure 2.1: Process flow for IHP+Results 2010 monitoring



Country government surveys were completed by IHP+ focal points in the Ministry of Health [27]. DP surveys were completed by representatives at the agency headquarters level who collated country office data where relevant [28]. IHP+Results supported data collection through providing detailed guidance [29], country-based support where requested, and regular international level support.

Critical assumptions and qualifiers

There are inherent limitations to the approach that IHP+Results has used to produce this Performance Report and its accompanying Scorecards. These include:

- **Availability of baseline data and the period that was used.** DPs and countries could select baseline in keeping with IHP+ 'light touch' principle. Baseline data were therefore provided for different years over the period 2005-8 across respondents, depending on what they had available. This report includes data from 2005-2007 as 'baseline'.
- **Possibility of double counting.** IHP+Results guidance [30] set out that funds should be reported by the agency that completes the final disbursement.
- **General Budget Support (GBS)** data has been incorporated for those DPs that reported using this mechanism by imputing a percentage for health, to reflect the % of government budget for health.

[25] The structured survey tool was available in French and English. An example can be found at www.ihpresults.net/how/data_collection/

[26] Criteria for rating can be found at www.ihpresults.net/how/methodology/rating/

[27] Following discussion with MOH officials, IHP+Results appointed a country researcher in 4 countries (Burkina Faso, Burundi, Mozambique, Nigeria) to support the data collection process.

[28] IHP+Results collected data directly from AusAID Nepal, following agreement with AusAID HQ.

[29] Available at www.ihpresults.net/how/data_collection/

[30] Available at www.ihpresults.net/how/methodology/limitations/ – see definition of disbursement (eg on pp16).

- **Data were not reported by some DPs.** The online methodology annex shows where data were not available [?] or the question is considered not applicable [–] by the respondent.
- **Some aid concepts and terminology can be complex and open to interpretation,** which might reduce the accuracy of this data[31]. For example many respondents stated that they have mutual accountability processes but gave very different examples of what that process involved.
- **Self-selection by IHP+ signatories to participate in the survey** means that these findings cannot be generalised to all IHP+ signatories. DPs also indicated in which countries they considered their agency to be "active" in supporting health sector development.

These points reflect lessons from IHP+Results experience in implementing this updated methodology for the first time. The approach has been proven feasible, not least by the significant amount of data submitted from a broad sub-set of IHP+ signatories. However, the data should be interpreted with care – in particular bearing in mind how each country context differs from others. The data provide a picture of how the IHP+ is being implemented and a sense of progress over time, which should prove an invaluable basis for discussions on how to improve performance and accountability. The IHP+Results process provides a set of tools that can support these discussions, and IHP+ stakeholders are encouraged to see this process in this light. An annex with further detailed explanations of the methodology and how the limitations have been addressed can be downloaded from the IHP+Results website[32].

3. PROGRESS TOWARDS ACHIEVING THE EXPECTED RESULTS OF THE IHP+

An evidence-based rating of the progress that each partner had made up to 2009 towards achieving the expected results of the IHP+ can be found in the IHP+Results Scorecards that are available with this report[33]. One Scorecard has been produced for each Country Government and Development Partner that has participated in the 2010 IHP+Results Survey. The ratings in these Scorecards have been made using the data reported by each partner for the set of standard performance measures and targets of the IHP+, based on transparent criteria.

This section of the report provides an analysis of the combined progress across all country governments and all Development Partners, within the five thematic Results Areas.[34]

3.1 Promoting Country Ownership, Mutual Accountability and Meaningful Civil Society Participation

Are countries taking the lead establish out national health sector plans, strategies and budgets?

All of the 10 IHP+ country governments reviewed met the target (2Ga) of having a national health plan in place. This is the basis for DPs aligning their external support to a country's health sector priorities. In most cases, national governments reported that their plans included performance indicators, as well as a budget that had been approved.

[31] This was a particular concern raised by Development Partners in Burundi, who decided to sit and establish a common understanding of the key terms and to resubmit data. We have not been able to incorporate that revised data in this report, but an analysis of the differences between the two sets of data is provided at www.ihpresults.net/how/lessons_learnt/

[32] www.ihpresults.net/how/methodology/

[33] Also available online at www.ihpresults.net/results/scorecards/

[34] Refer to the individual IHP+Results Scorecards to see how each agency or government is progressing overall. Note that DP performance is based only on data from the IHP+ countries in which they were active during 2009 and that participated in the 2010 IHP+Results survey.

The IHP+ Global Compact suggests that each country should establish a national compact or similar agreement as the basis for strengthening partnerships and mutual accountability for results at this level. A compact should be explicit about the commitments that are being made by DPs, the country government and domestic civil society to strengthen the country's health system and to achieve the health targets (as set out in the national health plan). Ethiopia, Mali, Mozambique and Nepal had Country Compacts in place by 2009 and a further two countries (Burundi and Niger) had 'equivalent country agreements'. The remaining countries expressed their intention to achieve this in the future.[35] These results might be expected given the length of time since each country joined the IHP+ (Djibouti only signed up to the IHP+ Global Compact in July 2009, Niger and DRC in May 2009).

Analysis of the quality of these compacts was not an objective of this review, but Compacts should be evaluated in order to understand whether the global intentions of the IHP+ and its level of ambition are being translated into country-level commitments.

More than 70% of Development Partners surveyed reported that they had signed the available compacts in Ethiopia, Mali, Mozambique and Nepal.[36] In Burkina Faso there appeared to be confusion about whether there was a compact, as the government reported that no compact was in place, but some Development Partners reported that they signed one.

The quality of national plans and budgets is an important consideration in order for DPs to feel confident to align their assistance with these national frameworks. However the IHP+Results standard performance measures do not give an indication of this. The new *Joint Assessment of National Plans and Strategies* (JANS) tool developed through the IHP+ might be able to provide additional information on the quality of plans for future reviews[37]. The JANS was piloted in 2010 in Nepal, Ethiopia, Uganda, Ghana and Vietnam.

- ***Country governments participating in the IHP+ have national health plans. Some have agreed compacts with Development Partners about how their health aid will flow, and others intend to reach similar agreements.***
- ***This could be a positive indication that the IHP+ process is changing the way that national governments are engaging with their Development Partners in some countries.***

Are Development Partner actions promoting country ownership?

DPs can promote country ownership through a range of the actions that they take. The measures used by IHP+Results to indicate whether DPs are taking these actions include: informing governments in advance what external resources they will provide, so this can be recorded on the national budget (2DPa); providing support for capacity building that is in line with national priorities (2DPb); and, providing aid for health through programme based approaches (2DPc).

[35] Nigeria signed a compact in 2010, which is not captured in our 2009 survey. For more details see: http://www.internationalhealthpartnership.net/CMS_files/userfiles/Nigerian%20Government%20and%20Partners%20sign%20Country%20Compact.pdf

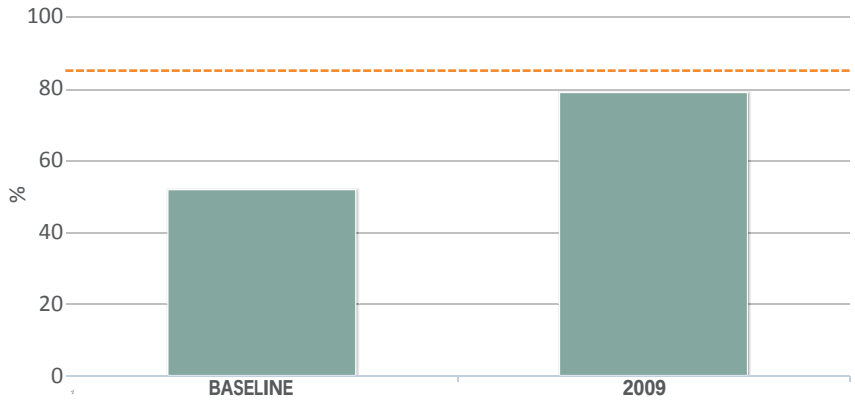
[36] GAVI and GFATM do not sign but send letters of support.

[37] Although this might not be possible as the JANS is a diagnostic tool to provide the government with an independent (conducted by internal and external specialists) assessment of the national health plan, and is not designed for the purposes of comparison or global reviews.

Reporting of external resources on the national health budget

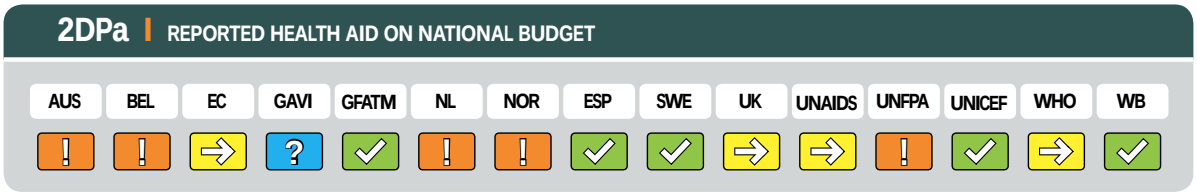
The proportion of health aid reported on the recipient country national health budget increased to 79% from a baseline of 52%. The most significant progress on this measure was seen in Ethiopia and Mozambique, where more than 50% of DPs surveyed and active in the health sector in the country met the target.

Figure 3.1: Aggregate proportion of partner support reported on national budgets. (2DPa)



The target to increase the proportion of health aid reported 'on budget' requires action both by DPs to provide this information and by the country government to record this in the national budget. Netherlands in Burkina Faso and UK and EC in Burundi reported that they provided the data but that it did not appear in the country budget.

Table 3.1: Development Partner aggregate performance in reporting health aid on national budgets



The extent to which external support for capacity development is becoming better coordinated and aligned with national priorities

Capacity building refers to the training and related activities supported by donors to improve the skills of individuals and institutions in the health system.

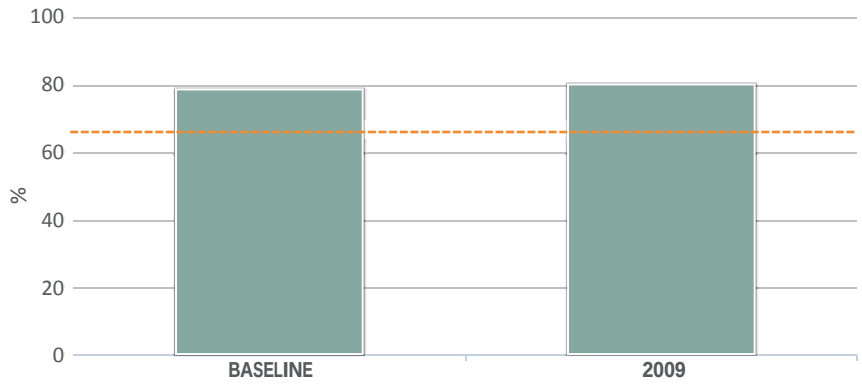
All DPs that provided data on this measure reported that they had already met the target of 50% of capacity building support coordinated and aligned with national priorities (others did not report as they do not directly provide capacity development support).

Progress towards Development Partners using Programme-Based Approaches

The OECD/DAC defines programme based approaches (PBA) as "a way of engaging in development co-operation based on the principles of co-ordinated support for a locally owned programme of development, such as a national development strategy, a sector programme, a thematic programme or a programme of a

specific organisation." [38] Eleven of the 15 DPs surveyed reported that they had already met the target of 66% of health aid delivered through Programme-Based Approaches. The collective volume of health aid provided through these approaches exceeded the target in baseline year and in 2009. Burkina Faso is the only country where all DPs surveyed reported maintaining or improving their use of these approaches.

Figure 3.2: Aggregate proportion of partner support provided as programme based approaches (2DPc)



- ***DPs have overall become more supportive towards national priorities by increasing the proportion of their health aid that is reported on national budget, delivered through programme-based approaches, or through coordinated capacity building support mechanisms.***

Are national governments and Development Partners being more mutually accountable for results in the health sector?

Mutual accountability is at the heart of the IHP+ and is key to a productive and respectful relationship between a country government and its DPs. The IHP+ has recognised that it is necessary to have a mechanism in place [39] for governments to hold DPs accountable for their commitments to provide health aid in a certain way, as well as for DPs to hold government accountable for fulfilling commitments to improve their health system and health outcomes. Mutual accountability also means working jointly together to address obstacles that might be encountered in trying to achieve these shared objectives.

Seven countries (Burundi, DRC, Ethiopia, Mali, Mozambique, Nepal and Niger) reported that they conducted a mutual assessment of health sector commitments in 2009 [40]. DPs reported that there was a high level of participation in Ethiopia, Mozambique, Mali and Nepal. Some DPs reported that they had participated in mutual accountability processes, even when the governments reported that these were not taking place (for instance in Burkina Faso, Djibouti and Nigeria). It seems that interpretation of what constitutes a mutual accountability process can vary. Better guidance is needed on how joint review processes should include a mutual review by National Governments, DPs and Civil Society Organisations, of how effectively aid

[38] Programme based approaches share the following features: (i) Leadership by the host country or organisation; (ii) A single comprehensive programme and budget framework; (iii) A formalised process for donor co-ordination and harmonisation of donor procedures for reporting, budgeting, financial management and procurement; (iv) Efforts to increase the use of local systems for programme design and implementation, financial management, monitoring and evaluation. http://www.oecd.org/dataoecd/10/46/44479916.pdf accessed 20 February 2010

[39] This process could be part of a joint annual review, a regular meeting, or production of an annual report.

[40] Djibouti reported that a mutual assessment(s) had been made in 2005 but not in 2009; and Burkina Faso and Nigeria reported that a mutual assessment(s) had been conducted in 2010.

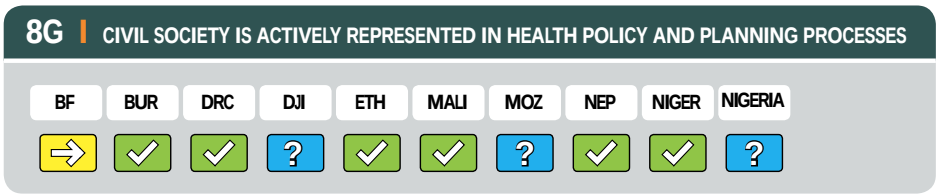
is being delivered and used to achieve results in the health sector at the country level. This should build on conventional joint annual review processes that tend to review progress in the health sector from the perspective of health service implementation. The Standard Performance Measures (SPMs) and targets that the IHP+ has adopted through the IHP+Results process can be used by country health teams to review how effectively DPs are providing support to the health sector and how effectively governments are managing all the resources available to the health sector. This should promote accountability on both sides – recognising that it is the responsibility of all to achieve health results. Further qualitative research is necessary to review how mutual accountability processes are working in practice, as this has not yet been a focus area of IHP+ activity.

- ***Most countries have joint health sector review processes, but there is considerable variation in how these are conducted. These reviews hold the potential for partners at the country level to hold each other mutually to account for their commitments to contribute towards achieving health results. This can be done using the objective criteria and standard measures now available.***

Is civil society's participation in health policy processes becoming more meaningful?

Civil society is expected to play a role in bringing the perspectives of communities and vulnerable groups into health policy processes. Civil Society advocacy groups can also serve as a watchdog in accountability mechanisms. As an indication of the extent to which this is happening, IHP+Results reviewed whether civil society has a seat at the health sector coordination mechanisms within each country (8G)[41] and whether DPs are providing support for civil society to engage with these country mechanisms (8DP)[42].

Table 3.2: Country government performance in supporting civil society engagement in policy processes



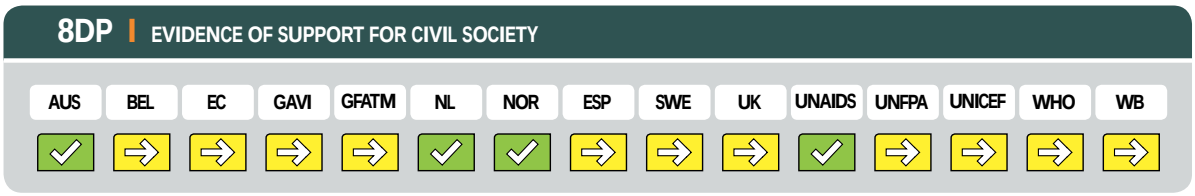
Governments reported that civil society is represented in the health coordination mechanism in seven of the ten countries (all except Djibouti, Mozambique, Nigeria). Civil society representation appeared to be increasing and had reached at least 10% of participants in six of these countries' coordination mechanisms (Burundi, DRC, Ethiopia, Mali, Nepal and Niger). In Ethiopia civil society constituted 25% of the membership of the country's health sector coordination mechanism; this figure was 30% in Mali. In some countries, the process begins with Civil Society representatives becoming more engaged in national health sector planning processes, before they become formally represented in the country's health sector coordination mechanism. All DPs reported that they provide support for civil society to participate in health policy processes (see table below)[43]. Other DPs provide support to civil society directly or indirectly. Further work is needed to tighten the definition of DP 'support' to civil society. DP reports do not include global level support provided, for example the Civil Society Health Policy Action Fund, supported by IHP+ with donor funding and implemented by Oxfam.

[41] The health coordination mechanism is usually a government led body comprising domestic and international stakeholders in the health sector. It is not the Global Fund Country Coordination Mechanism, but in some countries it overlaps with this mechanism.

[42] IHP+Results 2011 monitoring should provide a smarter indicator of the quality of civil society engagement in health policy processes.

[43] GAVI (in Ethiopia), Norway (in DRC and Nepal), UK (in Nigeria), Sweden (in Burkina Faso), UNAIDS (in Djibouti and Nigeria), UNFPA (in Burundi).

Table 3.3: Development Partner aggregate performance in supporting civil society engagement in policy processes



IHP+Results surveyed a range of Civil Society Organisations that could be identified as being connected in some way to the IHP+, to get an understanding of civil society views of the quality of their engagement in health policy processes. Most of these Civil Society representatives reported that they were already participating in developing national health plans and mutual accountability mechanisms. They also reported making a contribution to and, to varying extents, influencing the outcomes of national Joint Annual Health Sector Reviews.[44] A list of interviewed agencies is available on the IHP+Results website[45].

- ***Civil society representatives reported that they were engaging more in the surveyed IHP+ countries in processes to develop national health plans.***
- ***There is scope in most countries for further government engagement of their civil society, and for more DP support for civil society, to become more meaningfully involved in broader health policy processes.***

3.2 Transparent and responsible Health Financing

The IHP+ encourages governments to make ambitious prioritised plans based on need and evidence and to identify the financing gap that external resources should fill.[46] Transparent and responsible financing is crucial because a government needs to know how much money it will have for its health system in order to responsibly manage its health workforce, and budget for salaries, medicines, equipment and other expenses. It is therefore essential for a government to have reliability around DPs aid disbursements within the time frame promised.

Are governments allocating more funding for health?

A country's own financial resources are the most important contribution to operating effective health systems and improving health outcomes. African heads of state committed to allocating at least 15% of their annual government budgets to the health sector (3G).[47]

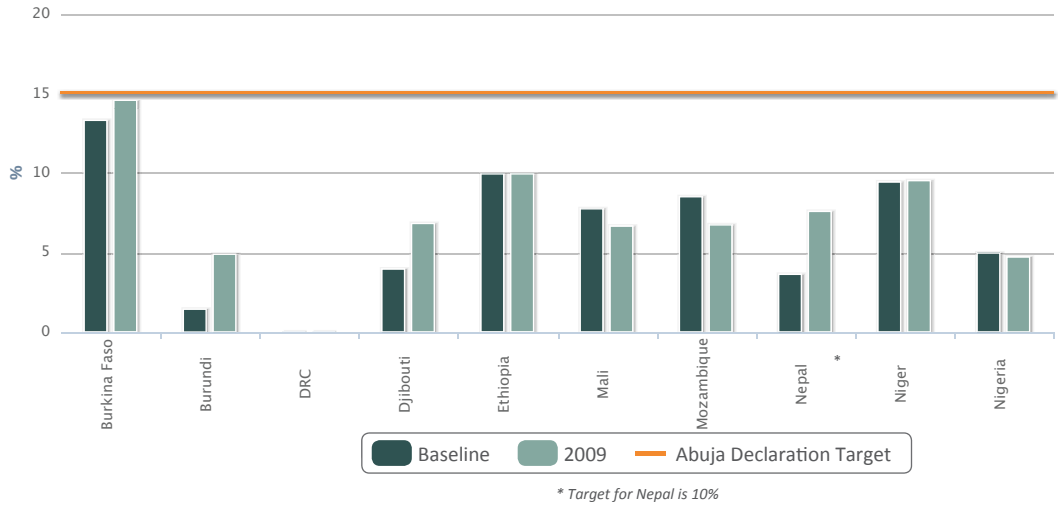
[44] Ethiopia and Nigeria, UNICEF (in Ethiopia) and WHO (in Mozambique, Burkina Faso, Burundi, DRC and Mali).

[45] www.ihpresults.net/how/methodology/

[46] See section on developing national plans in http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_compact_guidance_note_EN.pdf accessed 3 February 2011.

[47] Abuja Declaration, 2001. Nepal committed to allocate 10% of its annual government budget to the health sector.

Figure 3.3: Proportion of national budget allocated to health (IHP+ Results data)

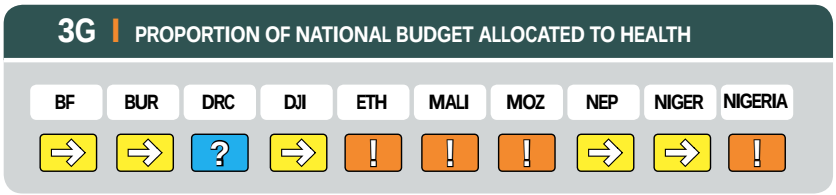


** Target for Nepal is 10%*

Figure 3.3 above tracks the changes in national health sector expenditure for each surveyed country. However, this should not be used to compare countries because of how external sources of funding have been reported by survey participants [48] [49].

Burkina Faso, Burundi, Djibouti, Nepal and Niger made progress towards allocating 15% (10% for Nepal) of national budget to health. No countries had achieved this target and five maintained or decreased their allocation. Burkina Faso was closest to the target, having reached 14.6% in 2009.

Table 3.4: Country government performance in allocating a proportion of the national budget to health



- ***African governments have not yet met their target of allocating 15% of national budget to the health sector (10% target for Nepal)***
- ***Trends are difficult to interpret because national health budgets were not being reported in standardised ways (to exclude external financial assistance)***
- ***Five countries improved, but three had a decrease in the proportion of the national budget allocated to health.***

[48] Burkina Faso and Mozambique excluded external assistance in their calculations; Djibouti and Niger included external assistance. Burundi, Ethiopia, Mali, Nepal and Nigeria did not provide information on whether they included or excluded external funding in their reported figures.

[49] In view of the variations in reporting on domestic allocations to health, IHP+Results looked for but was unable to find alternative credible sources of data, such as from initiatives tracking the implementation of the Abuja Declaration. A Centre for Health Sciences Training, Research and Development (CHESTRAD) survey on stewardship for financial management showed that no country has a health care financing process or system other than the annual budgeting cycle based on ceilings established by the Ministry of Finance. Ministries of health have no mechanism for tracking and delinking external resources in any credible way to ensure additionality and reduce both substitution and duplication. A copy of this survey will be available in May, entitled "Aligning ODA to budgeting cycles and appropriation processes in Africa: A case study in Nigeria".

Are Development Partners making long-term funding commitments to the health sector?

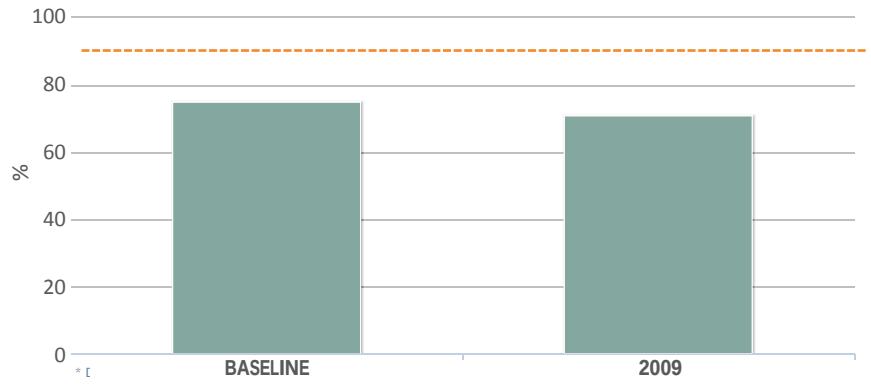
The measure of long-term predictability of external resources is the proportion of funding made through multi-year commitments. A multi-year commitment is one where the donor outlines to the government its financial commitment for at least the next three years for the health sector (3DP).

Table 3.5: Development Partner aggregate performance in providing multi-year (min. 3 years) funding commitments

3DP | PROPORTION OF HEALTH SECTOR AID PROVIDED THROUGH MULTI-YEAR COMMITMENTS													
AUS	BEL	EC	GAVI	GFATM	NL	NOR	ESP	SWE	UK	UNAIDS	UNFPA	UNICEF	WHO	WB
→	✓	✓	✓	!	✓	✓	!	✓	✓	–	✓	!	!	✓

Collectively, DPs are not meeting the target of 90% of their health aid provided through multi-year commitments - overall the proportion of multi-year commitments fell from 75% to 70% between baseline and 2009. But nine of the 15 Development Partners surveyed met the target of 90% of their health aid provided through multi-year comments in 2009 (Table 3.5). [50]

Figure 3.4: Aggregate proportion partner support provided through multi-year commitments (3DP)



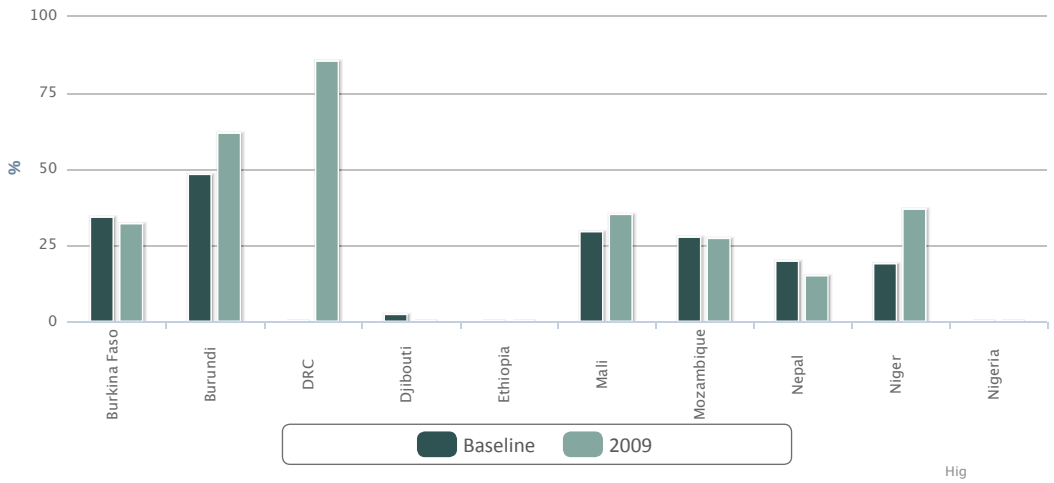
- ***Ten of the 15 Development Partners surveyed have improved the predictability of their aid by increasing multi-year commitments, and nine have met the target of 90% of funding being provided through multi-year commitments***
- ***However, overall the proportion of Development Partner aid provided through multi-year commitments fell between baseline and 2009***

[50] WHO, UNAIDS and GFATM cannot make 3 year multi-year commitments because of their budgeting cycles (WHO, UNAIDS) and grant making rules (GFATM).

Do country governments spend the total annual budget that they allocate to health?

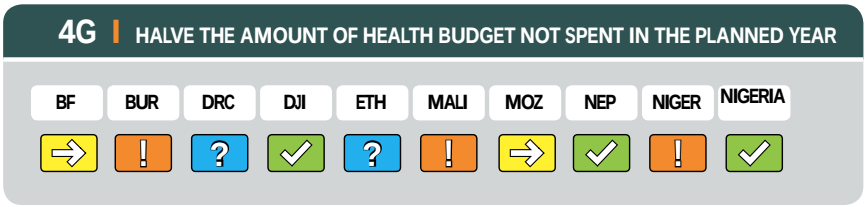
Country governments are ultimately responsible for allocating sufficient resources for health in their annual budgets, but they also have a responsibility to spend (disburse) those financial resources in the course of the planned year. The target for this is a reduction by 50% of funds that are not disbursed in the intended year, over previous levels.

Figure 3.5: Actual disbursement of government health budgets (Target: Reduced by 50%)



Five of the ten countries surveyed increased the disbursement of their health budget and three actually decreased the disbursement of their health budget. It is not clear why these changes have occurred.

Table 3.6: Country government performance in disbursing health sector budgets



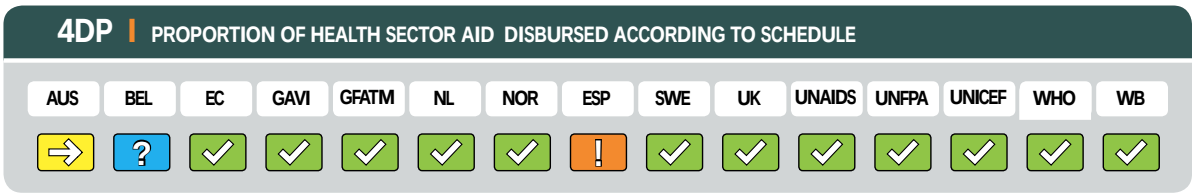
- ***Only four countries disbursed a greater proportion of the funds available within their annual health budgets, compared to their baselines.***

Do Development Partners transfer funds to countries on time?

This is an important measure because country governments can only disburse the funds that they receive within any budgeted period if these are delivered on time, as committed by their development partners. This was measured by IHP+Results using the proportion of actual disbursements in a year that were planned for that year (this identifies disbursements that were carried over from a previous year or brought forward from the next year). The measure differs from OECD/DAC indicator for aid predictability, which uses the proportion of disbursements planned for a given year that were actually made in that year. Both of these approaches provide interesting, but slightly different, pictures of the predictability of external funding for health. [51]

[51] IHP+Results will collect data for both questions in 2011 to ensure consistency with OECD/DAC.

Table 3.7: Development partner aggregate performance in the proportion of actual disbursements in a year that were planned for that year



IHP+Results found that 12 of 15 DPs surveyed reported that more than 90% of their health spending in 2009 was actually planned to take place 2009. Although there are no data from this measure to indicate the percentage of DP planned expenditure that was actually disbursed, this will be included in the next round of monitoring.

- ***The majority of funding provided by Development Partners was being disbursed during the year for which this had been committed to the country.***

3.3 Using and strengthening Country Systems

The IHP+ expects that health service delivery will be sustained over the longer-term through countries investing in stronger health systems. To make these investments, countries need to have sound financial management systems that can reliably spend the available health resources. When DPs use parallel systems and fragmented projects to provide resources to the health sector, this can undermine the country's own systems. This also loses opportunities to help countries build systems that are more effective, efficient, and equitable in meeting the needs of their citizens. On the other hand, DPs require national governments to have procurement and public financial management systems that are reliable enough before confidently committing financial resources to be managed through these systems. This can result in a 'stalemate' unless DPs take approaches that build this capacity with the expectation to incrementally transition to using the country's systems.

Are countries improving how they manage their health finances?

Governments have committed to improve their country systems for procurement (5Ga) and for public financial management (5Gb). [52] A health system requires a reliable supply of high quality equipment, medicines and diagnostics at an affordable price. This requires a strong procurement system that obtains value for money and does not waste resources. A health system also requires strong financial management to ensure that money is spent on the right activities, and that expenditure is accurately recorded and accounted for.

It is challenging to measure the strength of a procurement or public financial management system and IHP+Results has used the same measures as the Paris Declaration Survey to get an indication of whether these systems are improving. There was insufficient information to assess whether the ten surveyed countries had strengthened their country procurement systems using the OCED/DAC four-point scale. Niger was the only country to have completed this type of procurement systems assessment. Niger scored 'B' (on a scale from A to D, where A indicates the best rating). It was not possible to assess whether Niger's rating was an improvement, as there was no baseline figure.

[52] See also the indicators in the Paris Declaration http://www.oecd.org/dataoecd/57/60/36080258.pdf accessed on 23 January 2011.

The strength of Public Financial Management Systems was measured using the World Bank Country Policy and Institutional Assessment (CPIA)/PFM ratings. This is a broad cross-government assessment that is not health sector specific. National systems are scored on a scale of 1 (lowest score) to 6 (highest score). [53]

Table 3.8: CPIA/PFM scores showing assessments of strength of national Public Financial Management systems for the 10 participating IHP+ countries

Country	2005	2009	Change
Burkina Faso	4	4.5	0.5
Burundi	2.5	3	0.5
DRC	2.5	2.5	0
Djibouti	3	3	0
Ethiopia	3.5	3.5	0
Mali	4	3.5	-0.5
Mozambique	3.5	4	0.5
Nepal	3.5	3	-0.5
Niger	3.5	3.5	0
Nigeria	3	3	0

Three countries (Burkina Faso, Burundi and Mozambique) registered an increase in their CPIA/PFM scores between 2005 and 2009. Mali and Nepal registered a decrease and the remaining 5 countries (DRC, Djibouti, Ethiopia, Niger and Nigeria) showed no change from their baselines.

- ***There is insufficient evidence to state whether country procurement systems are improving.***
- ***Qualitative research or country studies would be required to assess if country procurement systems have improved in recent years. Existing evidence is inconclusive.***
- ***Three country governments (Burkina Faso, Burundi and Mozambique) had improved their public financial management systems. In Mali and Nepal these systems were assessed as having become weaker.***

Are Development Partners channelling funds through country procurement systems?

Only 53% of the total amount of development partner funding for procurement reported in this survey used country procurement systems in 2009. [54] This was a decrease from baseline of 60%. Six of the 14 DPs surveyed (for whom procurement is applicable) had met the target proportion of funding that used country procurement systems [55]. This measure is not applicable for the GAVI Alliance whose funds for procurement flow through a global pooled procurement mechanism that is managed by UNICEF. This is a technically difficult measure for some DPs to report on, so it is possible that the results for procurement are underestimated and that in practice a higher proportion of funds were flowing through country procurement systems. For instance, some DPs (including the UK, EC, Netherlands, Norway and Sweden) provide General Budget or Sector Budget Support that is not easy to disaggregate to determine what proportion is used for procurement [56]. A higher

[53] CPIA ratings are produced annually by the World Bank. For more information see http://www.oecd.org/dataoecd/45/46/35230756.pdf (accessed 24 January 2011) and http://siteresources.worldbank.org/IDA/Resources/CPIA2004questionnaire.pdf (accessed 24 January 2011).

[54] This is a different denominator to the Paris indicator – which shows procurement spend over total spend.

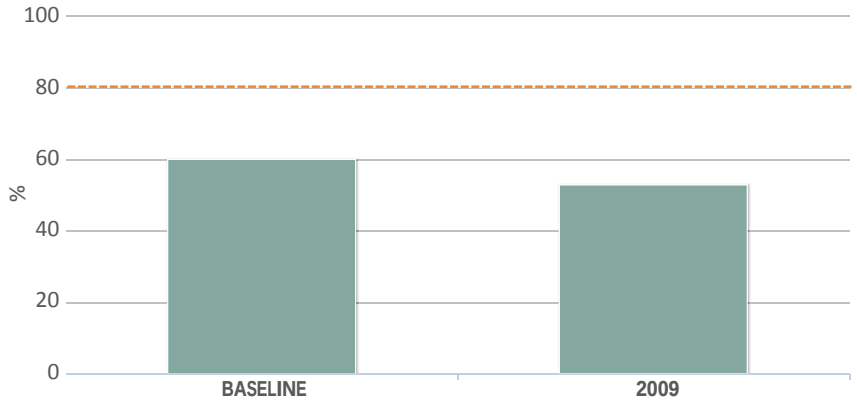
[55] The target for this measure is: 66% reduction in the proportion of funding not going through country procurement systems (with at least 80% using country procurement systems).

proportion of DPs provide aid through country systems to Ethiopia and Mali than to other countries, but it is not clear to what extent DP performance on this measure is influenced by assessments of the strength of country procurement systems (because data is not routinely available for indicator 5Ga, see above).

Table 3.9: Development Partner aggregate performance on using national procurement systems.

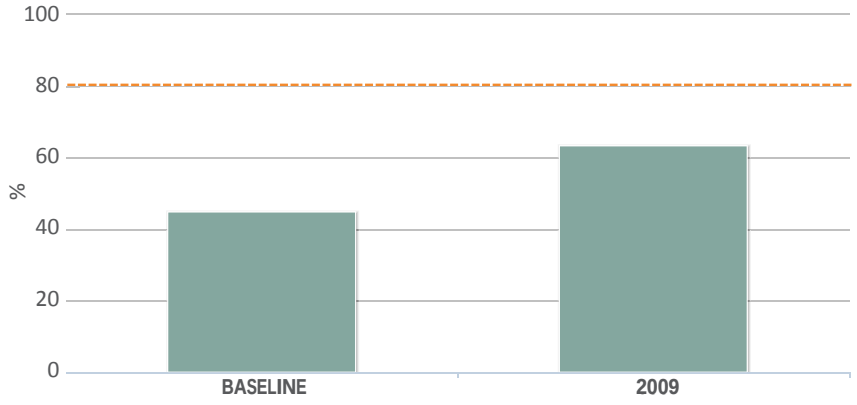
5DPa | PROPORTION OF HEALTH SECTOR AID USING COUNTRY PROCUREMENT SYSTEMS													
AUS	BEL	EC	GAVI	GFATM	NL	NOR	ESP	SWE	UK	UNAIDS	UNFPA	UNICEF	WHO	WB
✓	✓	!	–	✓	✓	!	✓	✓	→	?	→	→	!	!

Figure 3.6: Aggregate partner use of country procurement systems. (5DPa)



Are Development Partners channelling funds through country public financial management systems?

Figure 3.7: Aggregate partner use of country public financial management systems (5DPb)



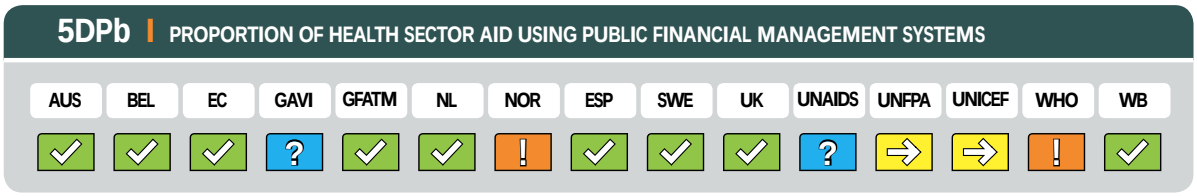
Of the total amount of Development Partner funding for health that was reported in this survey (in the five countries whose country financial management systems (PFM) were considered to adhere to broadly accepted good practices [57]), 63% used country financial management (PFM) systems in 2009. This was an increase of 18% over the baseline years (see fig. 3.7 above), and represents a collective achievement of the target [58] by DPs in the five countries with sufficiently strong systems. Eight of the 15 DPs surveyed achieved

[56] A description of the approach used to count procurement funding through SBS is provided in the methodology annex.

[57] PFM systems in Burkina Faso, Ethiopia, Mali, Mozambique and Niger were scored with 3.5 or above on the CPIA/PFM rating - 3.5 is the point at which DPs are expected to start using country PFM systems.

the target for using country PFM systems in the five countries with sufficiently strong systems. A higher proportion of DPs provided aid through the country systems of Ethiopia and Mali, followed by Mozambique, Nepal and Burkina Faso, in comparison with the remaining countries. Burundi, Djibouti, Nigeria, DRC and Niger had seen little improvement in the use of their country systems for both procurement and public financial management, over the baseline. Table 3.10 below shows the variable progress that Development Partners were making in using country public financial management systems.

Table 3.10: Development Partner aggregate performance on use of national Public Financial Management systems

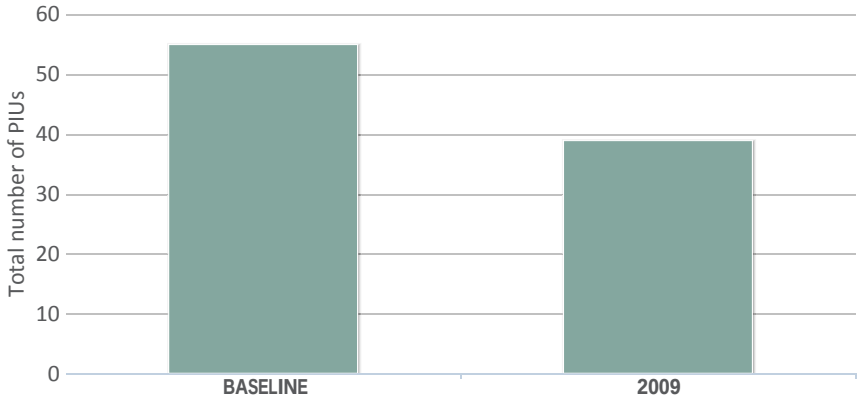


Are countries with robust systems more likely to receive Development Partner assistance?

Burkina Faso, Ethiopia, Mali, Mozambique and Niger had PFM systems with scores of 3.5 or above in 2009 (3.5 is the point at which DPs are expected to start using country PFM systems). [60] These countries appeared to have a higher proportion of DPs providing health aid through their country systems. However, Niger and Burkina Faso (two countries with the strongest PFM systems) did not appear to have received more financial support through their country systems in comparison with Ethiopia, Mali and Mozambique.

Have Development Partners reduced the number of standalone project implementation units?

Figure 3.8: Aggregate number of parallel Project Implementation Units (PIUs)



There had been a 29% reduction in the number of standalone project implementation units (PIUs) supported by DPs in the ten countries and this represents progress towards achieving the target of a two-thirds reduction (although it has to be acknowledged that country governments still request some DPs to establish or maintain PIUs for strategic or operational reasons). UNFPA reported the greatest reduction in the numbers of PIUs that it was involved with in the surveyed countries. Most other DPs reported that their agency strategy is to continue reducing their use of PIUs to deliver support to the health sector.

[58] The target for this measure is: 33% reduction in the proportion of health aid not using country PFM systems (with at least 80% using country PFM systems)

[60] This benchmark is set in the Paris Declaration targets: http://www.oecd.org/dataoecd/57/60/36080258.pdf

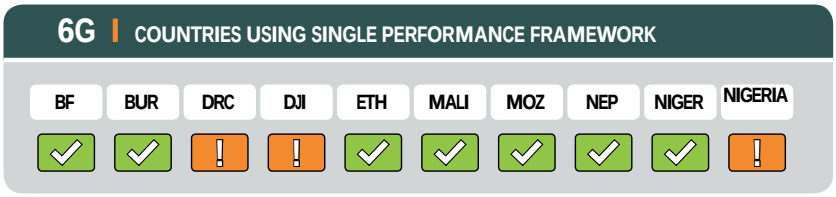
[61] Not applicable because DRC does not have a performance framework yet. This also applies to Nigeria.

- ***In five countries with strong country financial management systems, Development Partners overall met the target of a 33% reduction in the proportion of funds not using these systems.***
- ***The total amount of development partner funding using country procurement systems in 2009 appears to have declined since the baseline.***
- ***The number of PIUs was declining, but not enough to meet the targets that have been agreed.***
- ***There is insufficient information to conclude why relatively little progress was being made in Results Area, though it is worth noting that this is an area in which progress by Development Partner is contingent on governments making progress to strengthen their country systems.***
- ***It is encouraging that, on the whole, countries with stronger systems are receiving more support through those systems.***

3.4 Managing for Development Results

A single performance assessment framework is central to a government's efforts to measure health outcomes, monitor progress and identify areas of under-performance. Fragmented performance frameworks, information systems, and project based monitoring can hinder a government's efforts to have a comprehensive overview of progress in their country. Managing multiple performance monitoring and reporting requirements to meet the demands of different Development Partners also incurs high transaction costs to the government. Each IHP+ country government has committed to develop a transparent and monitorable performance assessment framework (PAF) that includes a comprehensive set of health and health systems indicators that all partners can use (6G). DPs have committed to using these frameworks as the *primary basis to assess progress* of their health aid (6DP).

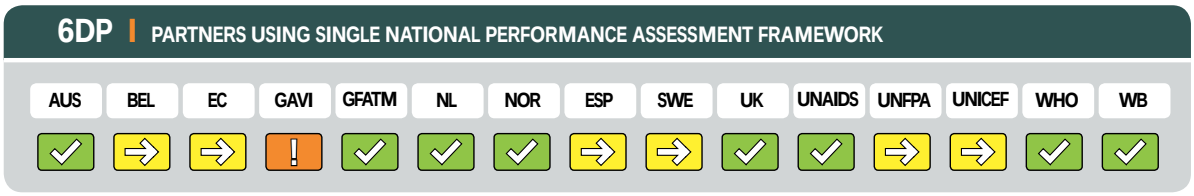
Table 3.11: Country government performance in establishing single Performance Assessment Frameworks



Seven of ten countries surveyed reported that they had a single performance framework in place (see table 3.11 above). [62] More than 60% of the DPs that were active in these countries claimed to use the national framework as the primary basis to assess the performance of their health aid, although this varies across countries (see table 3.11 above). It is not evident whether DPs use the national framework as the primary basis to assess the performance of *their* health aid to the country. DPs indicated that they required reporting on additional indicators (beyond the national performance assessment framework) in four countries (DRC, Ethiopia, Mali and Niger). It is not clear whether these additional indicators are required to meet the needs of DPs participating in this survey, or the needs of other DPs providing health sector support to the country. Nevertheless the outcome is the same: the existence of a single performance framework does not completely reduce the requests for countries to report on additional indicators.

[62] DRC reports not having a performance framework, but a number of DPs reported that there is one that they use as their primary basis of assessing progress.

Table 3.12: Development Partner aggregate performance in using national Performance Assessment Frameworks as the primary basis to assess progress



IHP+Results did not collect evidence of the quality of these country performance frameworks. These also depend on each country having a good Health Management Information System (HMIS) in place to collect and summarise reliable, timely data so that all partners can use these as indications of performance. Recent assessments suggest that Burkina Faso and Mali have an 'adequate' HMIS in place and that Ethiopia, Mozambique and Burundi each have a functioning, but inadequate HMIS. [63] Other countries have not yet had recent HMIS assessments. Ethiopia is an example amongst these countries of having made considerable investments into strengthening the HMIS since the IHP+ was launched.

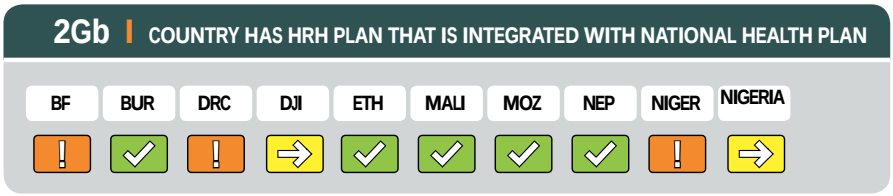
- ***Countries are overall better placed to monitor the performance of their health sector, since the start of the IHP+. More Countries have implemented national performance assessment frameworks and the majority of Development Partners are making greater use of these, where they exist.***
- ***It is not clear how much this reduces transaction costs, as some DPs still require additional reporting, using indicators that are not part of the national framework.***

3.5 Strengthening Health Systems

The main intention of the IHP+ was to invest, with countries, in strengthening health systems so that health aid could produce more effective health results. It is too early to expect IHP+ to have had a significant impact on strengthening health systems, and attributing any improvements to the existence of the IHP+ would in any case be difficult. IHP+Results is tracking a few key health systems indicators to provide a starting point for future monitoring of health systems strengthening. The extent to which national governments are prioritising Human Resources for Health (HRH) and developing more ambitious national HRH plans (2Gb) provides an initial proxy measure of this. This has been supplemented with data on the number of health workers per population and resources allocated to HRH to get a view of whether each country government is allocating resources according to its HRH plan. Countries' ability to implement these plans is linked to progress on more efficient aid to the health sector (as reviewed in the previous sections of this report). Responsible and predictable external assistance places Ministries of Health in a better position to plan, train, recruit and retain health workers.

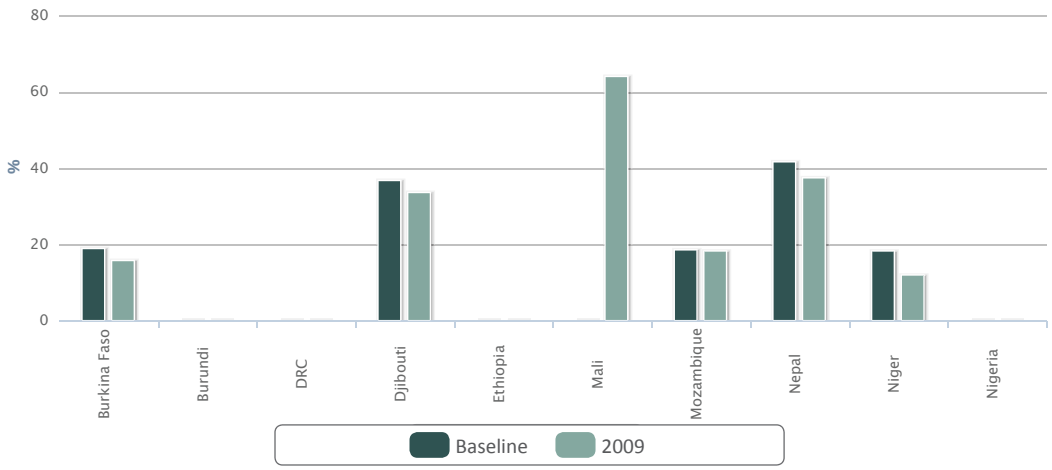
[63] The Health Metrics Network has provided assistance to some IHP+ countries to assess the quality of the HMIS and develop plans to improve them. Country assessments available at http://www.who.int/healthmetrics/support/en/ accessed 20 February 2011.

Table 3.13: Country government performance in putting in place Human Resources for Health (HRH) plans that are integrated with the national health plan.



Seven of the ten surveyed countries had an HRH plan in place, but only Burundi, Mali and Mozambique had fully integrated this with the national health plan (see table 3.13 above).[64] However, there appears to be a mixed picture of how this affects the resources allocated to HRH: 3 countries showed an increase in the absolute volume of funding for HRH, but all countries showed a decrease in the proportion of funding allocated to HRH (see figure 3.9 below). The Global Health Workforce Alliance (GHWA) has recently published a progress report on the Kampala Declaration, which found that 86% of high priority countries had an HRH plan, but that not all were costed.[65] Future GHWA progress reports should provide useful information to supplement the findings of the IHP+Results surveys.

Figure 3.9: Proportion of the health sector budget spent on Human Resources for Health (HRH)



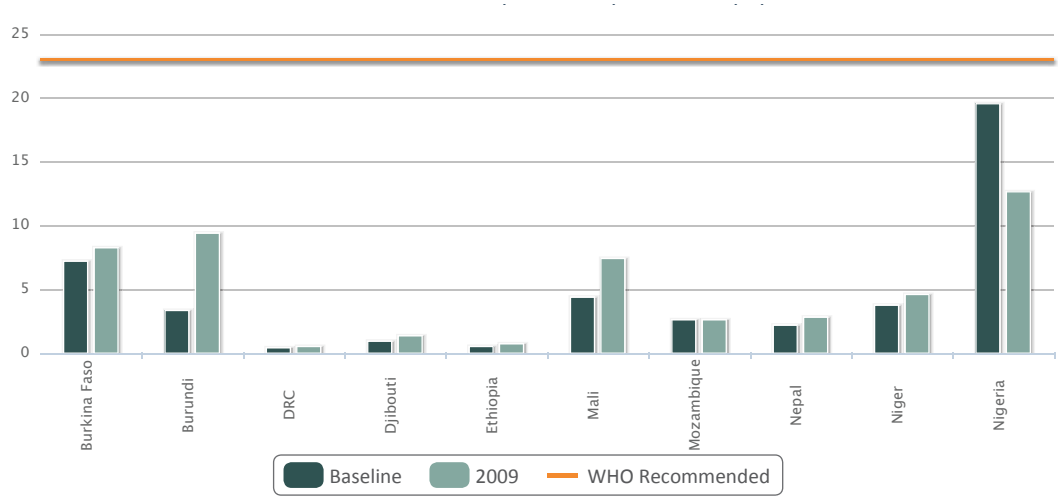
A more positive finding was that eight of the ten countries surveyed had increased the proportion of skilled health workers per 10,000 population (see figure 3.9 above), although all countries still fell short of the recommended critical threshold of 23 skilled health workers per 10,000 populations [66].

[64] DRC reported that it plans to develop an HRH plan.

[65] http://www.who.int/workforcealliance/knowledge/resources/kdagaprogressreport/en/index.html accessed 3 February 2011.

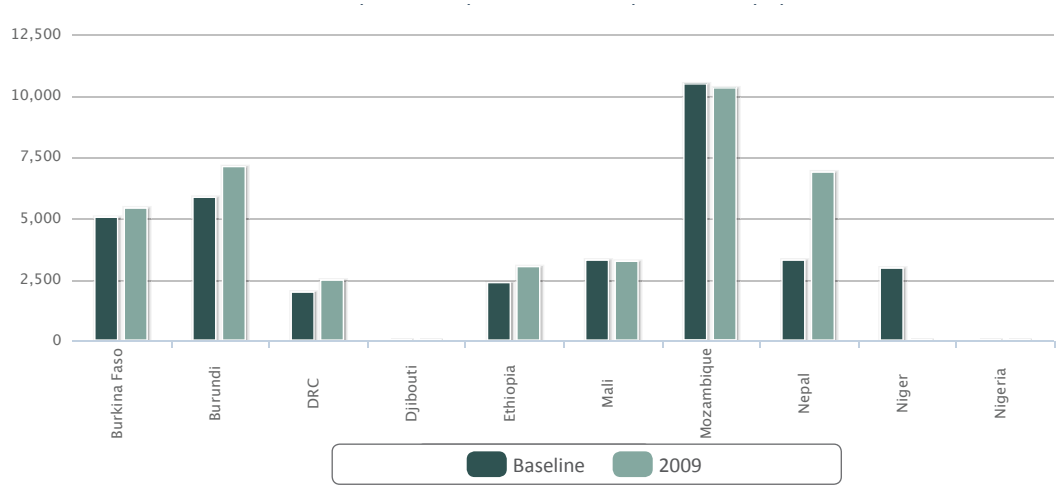
[66] 2006, World Health Report, threshold at 2.28 /1,000 population – http://www.who.int/whr/2006/en/index.html accessed 4 February 2011

Figure 3.10: Number of skilled medical personnel per 10,000 population



Future IHP+Results annual performance monitoring will attempt to collect evidence of health services changes and the extent to which the IHP+ has contributed to these changes. Four of the ten countries in the survey reported increasing numbers of outpatient visits per 10,000 of the population, which could provide an indication of increasing access to health services in these countries (although the proportion of births attended by skilled health personnel might be considered a more sensitive measure and could be included in subsequent performance reviews).

Figure 3.11: Number of Outpatient Department Visits per 10,000 population



- ***Some governments have developed more ambitious plans to invest in Human Resources for Health, but there is little evidence that more resources were becoming available to fund these.***
- ***Future IHP+Results performance reviews should provide stronger evidence of whether health systems are improving to deliver health results in the IHP+ countries.***

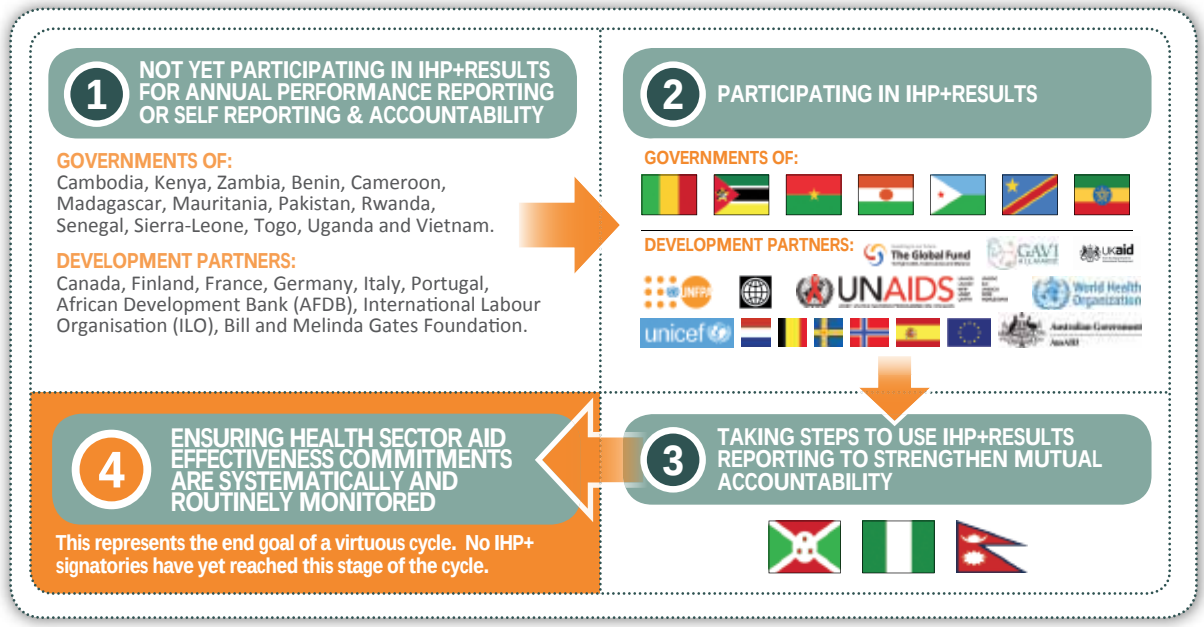
4. DISCUSSION

Credible Agency-specific Performance Scorecards are now available

This third IHP+ independent review presents the first complete set of standardised reports by country governments and their Development Partners on how they are delivering and using resources in the health sector. **Credible agency-specific performance scorecards are now available for fifteen Development Partners and ten developing country governments.** These scorecards provide visual summaries of how well each agency and country government is performing overall [67] against their IHP+ commitments, and demonstrate how effectively they are delivering and using health aid. Disaggregated results by country are also available online for each participating country. Together with the performance measures and targets, IHP+Results provides a set of tools that can be used by all parties within countries, as part of joint annual reviews, to monitor progress in improving the effectiveness of support to the health sector. Although the ratings in these scorecards are based on self-reported progress in 2009, these can be used as a starting point to discuss whether progress is viewed in the same way by all partners and to reflect on what has changed since 2009. This would form an important next step towards achieving real mutual accountability in country-level reviews. These discussions were started in early 2011 in Burundi and Nepal. IHP+Results provided data for discussion by country health sector teams in these countries and the potential for these tools to enhance ongoing discussions on mutual accountability was acknowledged [68]. IHP+Results will work with country teams and others who express an interest, to support the adaptation and use of these tools in ongoing country-level discussions and review processes.

Agencies and governments that have volunteered to participate in the IHP+Results process during 2010 have demonstrated their leadership and willingness to become more transparent and accountable (see figure 4.1 below). This should encourage remaining IHP+ signatories to participate in future monitoring, in line with the IHP+ Global Compact commitment to *"…an independent, evidence-based assessment of results at country level and of the performance of each [signatory] individually as well as collectively"* [69].

Figure 4.1: Participation in IHP+Results for Annual Performance Reporting & Accountability



[67] In the 10 survey countries where they are active.

[68] Although in Burundi, DPs raised concerns about the consistency of interpretation of key terms used in the survey, and so reconvened as partners and establish a common understanding and to resubmit data. We have not been able to incorporate that revised data in this report, but an analysis of the differences between the two sets of data is provided at www.ihpresults.net/how/lessons_learnt/

[69] http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_global_compact_EN.pdf accessed 19/01/2011

A number of participants have seen the IHP+Results 2010 monitoring process as a constructive exercise. Some Development Partners (such as Spain and UNFPA) have reflected on how it has been useful to strengthen their own internal performance monitoring. The IHP+ has helped to refine and apply these 'Paris Indicators' to the health sector in a way that should contribute useful lessons to the high-level review of Aid Effectiveness towards the end of 2011.

Conducting this exercise does raise some questions about the validity of measuring Aid Effectiveness in the health sector using the types of performance measures that the IHP+ has adopted. The concepts and terminology involved are complex and open to multiple interpretations. It is a challenging exercise to collect valid data for the more conceptual measures (such as 'use of country systems'). Each country context is uniquely challenging, so Development Partners and governments cannot deliver and use health sector resources in an idealised way but have to respond to the different and changing risk environments in which they operate operate, so comparisons between DP country office results should be made with caution. DP country office scorecards present a simplified view of the world and therefore need to be interpreted with an understanding of the context of each agency and country, especially when comparing performance across agencies and countries. For instance the scorecards for AusAID (providing health aid to Nepal) and the Global Fund (providing health aid to all ten survey countries) are not directly comparable.

IHP+Results is committed to learning and implementing lessons from each monitoring round. The challenge of measuring Aid Effectiveness should not be a barrier to attempting to measure and learn. As next steps in this evolving, incremental process further debate is needed [70] on what these performance monitoring results demonstrate and how they can be practically used to promote more effective, responsible resourcing of the health sector.

There is a growing movement towards greater transparency and accountability for international development assistance. This is exemplified by initiatives such as the UN Commission on Information and Accountability for Women's and Children's Health, the International Aid Transparency Initiative, Publish What You Fund and others. The IHP+Results process contributes to this by making data available in the public domain on the implementation of IHP+ commitments to health sector aid effectiveness.

It is now evident how health aid is being used and where it is being delivered more effectively.

There is also evidence of where there are specific gaps. This survey does not include all IHP+ signatories, or all health aid, but it does reflect how the major health donors are operating in 10 countries. This can infrom agency and country-based agendas for further discussion and action. In the face of this information ongoing failure to address these gaps cannot be excused and could expose IHP+ signatories to questions on their commitment. Inaction will present an obstacle to accelerating progress towards achieving the health-related MDGs.

Our findings suggest that progress has been made in key areas:

- The majority of governments and Development Partners have put in place the four policy pillars outlined in the IHP+ Compact Guidance note [71] (national strategy, a compact, a results framework and a mutual monitoring process).

[70] Through the IHP+Results website (www.ihpresults.net) and in follow-up consultations.

[71] IHP+ Compact Guidance note http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_compact_guidance_note_EN.pdf accessed 2 February 2011.

- DPs have made progress in aligning their health aid (financial aid and capacity building) with national priorities.
- Five governments (Burkina Faso, Burundi, Djibouti, Nepal and Niger) have increased the proportion of their national budget allocated to health.
- Three governments (Burkina Faso, Burundi and Mozambique) have strengthened their public financial management systems.
- DPs are increasing their use of public financial management systems for their health aid, and in five countries with strong country financial management systems [72] DPs overall met the target of a 33% reduction in the proportion of funds not using these systems.
- Civil society is seen to be engaging more in national health policy processes; governments appear to be involving them more (although the extent to which this engagement is considered to be meaningful needs to be further discussed with the organisations involved).

Less progress has been reported on targets for responsible health financing and for strengthening and using country systems. The IHP+Results survey has shown:

- No African government had met the 15% Abuja target (although Burkina Faso had reached 14.6%).
- DP performance in providing predictable financing for the health sector has been mixed: overall the proportion funding through multi-year commitments fell; but 9 out of 15 DPs are providing 90% of their health aid through multi-year commitments.
- Government performance in disbursing their health budgets was mixed.
- DP use of country procurement systems appeared to have declined.
- Civil society engagement in health sector policy processes could increase much further, and could be supported much more.
- Countries allocated a lower proportion of funding to human resources for health, despite developing HRH plans and beginning to integrate them into national health plans.

Overall, the IHP+Results findings are broadly consistent with the OECD 2008 Survey on Monitoring the Paris Declaration [73]. It is not clear that this mixed picture of progress will translate into stronger health systems and ultimately to better health outcomes and impacts. IHP+Results has collected and presented some data on health systems indicators, but it is too soon to expect to see positive trends in most of these measures that can be linked to the IHP+ or to recent changes in Aid Effectiveness behaviour by IHP+ signatories.

How to build on the gains that have been made and promote progress where this has been slow?

The findings of this survey suggest a number of enablers for building on progress where this has been made and to promote further change where this is needed:

Establishing national policy frameworks seems to be critically important. Burkina Faso, Ethiopia, Mali, Mozambique and Nepal have all invested in strengthening these frameworks since joining the IHP+ and have benefited from receiving a greater proportion of their health aid in ways that align with Aid Effectiveness

[72] Burkina Faso, Ethiopia, Mali, Mozambique and Niger. For more information, see section 3.3 above.

[73] http://www.oecd.org/document/0/0,3746,en_21571361_39494699_41203264_1_1_1_1,00.html accessed 2 February 2011. OECD survey includes a much larger set of countries and development partners, and was last conducted in 2008.

commitments. All (with the exception of Burkina Faso) have put in place the four key pillars of a national plan, compact, performance assessment framework and mutual accountability process. This suggests a tentative correlation between the existence of key policy frameworks and better aid. These four pillars are a critical starting point for leadership and ownership by national governments over how resources are allocated in the health sector. **More emphasis should be placed on putting the four pillars of the policy framework in place in the other IHP+ countries.**

The policy framework needs to be robust enough to attract support from DPs, so that it can be used as the basis for coordinated support and reduce the transaction costs of aid for governments. [74] IHP+ signatories (with the IHP+ Core Team) have developed tools and frameworks to help countries put in place these four pillars and to support country compact development. The Joint Assessment of National Strategies (JANS) tool can provide countries with an independent assessment of their emerging national health plans. [75] The IHP+ Working Group on Monitoring and Evaluation has developed guidance for comprehensive performance frameworks. [76] It can be argued that many of the policy improvements uncovered by the IHP+Results survey would have happened anyway, without the IHP+, but there is no counter-factual. Important progress has been made in other areas since 2009 that is not captured by this survey, such as the rollout of JANS in 6 countries and the signing of Nigeria's compact in December 2010. The results of this should be apparent in the next annual Performance Report. **Further application of these global level tools at the country level should be supported and encouraged by the IHP+ Core team and IHP+ working groups.**

Supporting sustainable implementation of national health plans requires **renewed and additional focus by the IHP+ signatories collectively and individually in the following three areas:**

1. *More predictable and responsible health financing.* Governments need to increase domestic allocations to health, in order to meet agreed targets (15% Abuja target for African governments). DPs need to increase the predictability of their health financing and continue to act on High Level Task Force recommendations to increase the volume of health financing.

2. *Governments and DPs need to make joint investments into improving country systems*, and to increase their use of country public financial management and procurement systems. Progress on this is complex to measure (for both IHP+Results and through the OECD Paris Declaration Survey process), as the measurement is of general country systems, and in some countries the actions required lie outside the health sector. Identifying joint actions to strengthen country systems should be a priority for country health teams and the IHP+ core team. IHP+ signatories and the core team should bring these issue to the forthcoming High Level Forum on Aid Effectiveness in Busan in November 2011

3. *The IHP+ needs to evaluate in more depth the factors that have contributed to the targets met and targets missed to inform future planning*, in order to learn from this initiative. The third year of IHP+Results monitoring in 2011 should provide opportunity for this.

Without sustained effort to address these three critical areas, faster progress on achieving the goals of the IHP+ seems a long way off.

[74] An exception is Burundi which reports having the four pillars in place but development partners do not recognise all of them.

[75] http://www.internationalhealthpartnership.net/en/about/j_1253621551 accessed 27 January 2011.

[76] http://www.internationalhealthpartnership.net/en/working_groups/monitoring_and_evaluation accessed 27 January 2011.

IHP+ signatories now have the tools and information to hold each other mutually accountable for improving the performance of public investments into health

Implicit in the IHP+ Global Compact's commitment to greater accountability is the promise of a shift in power to so that the accountability for results is shared between Development Partners and country governments. Although there are some signs of this happening in a few countries, the IHP+ is still a long way off from achieving mutual accountability at the country-level, where there is most potential for this to make the difference. It seems that the IHP+ is contributing to change in this direction, but this survey suggests that country level mutual accountability processes are not performing to their full potential.

At the global level a forum or space for a high-level mutual accountability review process needs to be found, as the High-level Ministerial Review of the IHP+ was last held in February 2009 was originally intended to be an annual event.

This report, together with its Performance Scorecards and online evidence are an invaluable resource for mutual accountability in the IHP+. Interpreted with care, IHP+ signatories can use these to hold each other mutually accountable for improving the performance of public investments into health, to achieve health results and value for the scarce resources available. Individual agencies can use these results and the framework that has been established, to internally review their own performance - looking critically at where the IHP+Results scorecards indicate there are gaps to be addressed.

Mutual accountability can drive improvement when reviews of the effectiveness of health aid are incorporated into country level joint annual reviews (JAR) of the health sector. If compacts and performance assessment frameworks are in place the JAR can annually take stock of progress, identify issues arising from this and undertake better planning for the year ahead. The IHP+ Core Team should develop guidance and good practice for country level mutual accountability processes as a resource to help countries share lessons in this pioneering area. The context of each country is critical to appreciate, so opportunities to locate this review process at the country level and for this to be led by country-level partners and the national government should be actively explored in 2011. This report will contribute to improving Aid Effectiveness if it is used by country health teams to identify problems and develop solutions. Even greater value will come if countries take ownership and leadership of the survey, adapting it to their annual timelines and needs, and using the tools developed by IHP+Results in their context. This would provide timely data owned by the country but with global comparability.

5. CONCLUSIONS

How credible are the findings?

The IHP+Results 2010 survey demonstrates that it is possible to measure Aid Effectiveness in the health sector. The findings in this report can be credibly used to understand the current state of play with regards to this. They are broadly consistent with the OECD 2008 Survey monitoring implementation of the Paris Declaration. There are limits to the generalisability of the findings because the IHP+Results Survey participants were a subset of approximately half of all IHP+ signatories, and that in turn is a subset of all country governments and development partners. Other major development partners, most notably the US Government, are not included. It is possible to draw some conclusions about this subset of IHP+ signatories that may be useful for other country governments and development partners, whether IHP+ signatories or not. Some methodological challenges to collecting and analysing data have been identified for a number of the Aid Effectiveness measures from which the IHP+Results measures are derived. These could be, in some cases, addressed in future surveys, whilst others require broader discussion as part of the High-Level review of Aid Effectiveness. Some of these can affect the comparability of ratings, so Scorecards and online disaggregated annexes should be interpreted with care.

To what extent has the IHP+ improved Aid Effectiveness within countries?

The findings suggest that for the subset of IHP+ signatories participating in this review, there has been an overall improvement in the effectiveness of aid delivery in the health sector. In these IHP+ countries, governments and Development Partners are putting in place the foundations (compacts, performance frameworks, results frameworks) for increasing progress, which has been supported in most cases by the IHP+. A few countries have strengthened their public financial management systems. Some, but not all, governments and Development Partners have increased health financing and made it more predictable.

Ethiopia, Mali, and Mozambique saw greatest progress in effectiveness of the health aid they received, followed by Nepal and Burkina Faso. All these countries, except Burkina Faso, have compacts with their development partners. Evidence is inconclusive on whether compacts result in improved health aid effectiveness, but there is a possible correlation. There has been less progress on effectiveness of health aid to Burundi, Djibouti, DRC, Niger and Nigeria. However, these results might be expected given the length of time since each country joined the IHP+ (Djibouti only signed up to the IHP+ Global Compact in July 2009, Niger and DRC in May 2009) and the relative strength of these countries systems and processes. All Development Partners have improved health Aid Effectiveness but most could do more. Civil Society is engaging more in country health processes. There is scope for more government engagement with civil society, and more development partner support for civil society.

It is too early to state whether Aid Effectiveness and the IHP+ is contributing to stronger health systems or improved health outcomes.

How can IHP+ stakeholders use the findings?

The report and scorecards provide an invaluable source of data for IHP+ signatories to hold themselves and others to account for their commitments. The scorecards for each country and agency provide an aggregate rating for each of the measures that give a high level view of performance. The online annexes provide disaggregated data that enable a more nuanced view of a development partner performance across different countries and contexts. Mutual accountability and monitoring IHP+ commitments and Aid Effectiveness must take place at the country level, led by countries. Global monitoring should bring together the results of country-based monitoring, to provide a global synthesis and to compare progress across countries and between partners. The IHP+Results team is ready to work with any IHP+ country government and development partner that would like to take ownership and leadership in applying these tools to support the monitoring process in their country or organisation. As an important next step towards real mutual accountability in this evolving, incremental process – IHP+ signatories and civil society organisations are encouraged to use the data and findings here as the basis for discussion in order to move towards a shared analysis of performance and agreement on priority actions to improve performance.

6. RECOMMENDATIONS

Each development partner and country government signing up to the International Health Partnership Global Compact agrees to participate in "an independent evidence-based assessment of results at country level and of the performance of each of us individually as well as collectively." Accountability is at the heart of the IHP+, in the spirit of solidarity and partnership between country governments, Development Partners and civil society. With the support of IHP+Results, the IHP+ provides both the instruments and mechanisms to promote this individual, mutual and public accountability. However, for the IHP+ to become really effective, we recommend that its signatories and stakeholders should build on current efforts to strengthen this accountability, in both the spirit and letter of the IHP+ Global Compact, using this report as an input to conversations about how to achieve this.

1. Strengthening individual accountability of development agencies and national governments

I. IHP+ Development Partners should use this report and scorecard to review the Aid Effectiveness of their health aid. They should develop a prioritised set of actions to improve their aid effectiveness, and they should review and report on their own progress regularly. To this end they could adapt and incorporate the IHP+Results survey tool in their own internal monitoring and accountability.

II. The same IHP+ signatories (as participated in 2010 review) should participate in IHP+Results 2011 monitoring. All other IHP+ signatories should be encouraged to participate in the IHP+Results 2011 performance review process.

2. Strengthening mutual accountability between IHP+ signatories

At the country level:

I. IHP+ country governments, Development Partners and civil society should use this report and scorecards to jointly review their collective progress towards improving how external aid and national resources are effectively delivered and used to deliver results in the health sector. This review should result in an agreed set of individual and collective actions to improve how all available resources are used in the health sector. Progress on these actions should be reviewed regularly and within Joint Annual Reviews.

II. Standard performance measures, such as the ones reported in the IHP+Results Scorecards, should be incorporated into annual health sector reviews. These should become routinely reported on by all partners and the national government.

At the global level:

III. IHP+ SuRG and Executive team should take responsibility for ensuring that the leaders of national governments, donors and international agencies together with civil society review what progress has been made in delivering on their IHP+ commitments. The IHP+ Global Compact stated that "the signatories to this compact will meet each year to review progress against the commitments."

IV. This IHP+Results report and scorecards should be used in this global review of progress and it should result in an agreed set of prioritised actions to improve the Aid Effectiveness of health aid.

V. Progress on these actions should be reviewed regularly.

VI. The IHP+ Core Team should facilitate the production of technical guidance and standards for country-

level mutual accountability processes. This can be achieved through reconvening the IHP+ working group on mutual accountability. Experiences can be shared on how to incorporate the standard performance measures into county health sector review processes and for using these reviews to promote mutual accountability for health sector results. WHO country offices should facilitate in-country consultation to ensure that the standards are relevant and implemented at country level.

VII. The IHP+ working group on mutual accountability should review the experience of the 2010 IHP+Results process, gain feedback from participants, and make recommendations for improving the process. This should particularly focus on how to ensure that these processes can become more sustainable and country-driven.

3. Strengthening public accountability

I. The IHP+ SuRG and Executive Team should make this report and scorecards widely available, including at existing meetings such as the World Health Assembly. Versions of the report should be made available that are more accessible to a wider audience in countries, amongst civil society and for researchers.

II. IHP+ signatories should ensure that the findings of this report and its scorecards are used to inform preparation for and discussion at the 2011 High Level Forum on Aid Effectiveness in Busan. This should reflect the positive lessons learned about the feasibility of monitoring Aid Effectiveness at the sector level; and how progress can be made through establishing mechanisms for mutual accountability and transparency in aid delivery and use.

III. IHP+Results will provide online public access to the detailed findings that have been used to develop this report and scorecards, by agency and by country.

We encourage civil society, researchers and others interested in Aid Effectiveness and health aid to use the findings in this report to hold governments and Development Partners to account for improving the effectiveness of their health aid.

GLOSSARY OF KEY TERMS

AID EFFECTIVENESS	Aid effectiveness is the effectiveness of development aid in achieving economic or human development (or development targets).
APPROVED ANNUAL BUDGET FOR THE HEALTH SECTOR	Is the annual budget as it was originally approved by the legislature. In order to support discipline and credibility of the budget preparation process, subsequent revisions to the original annual budget — even when approved by the legislature — should NOT be recorded here. This is because it is the credibility of the original, approved budget that is important to measure and because revisions to the annual budget in many cases are retroactive.
CAPACITY DEVELOPMENT	The process whereby people, organisations and society as a whole unleash, strengthen, create, adapt and maintain capacity over time.
COUNTRY POLICY AND INSTITUTIONAL ASSESSMENT (CPIA)	The Country Policy and Institutional Assessment (CPIA) assess the quality of a country's present policy and institutional framework. "Quality" refers to how conducive that framework is to fostering poverty reduction, sustainable growth, and the effective use of development assistance. (World Bank)
COUNTRY PROCUREMENT SYSTEMS	Donors use national procurement procedures when the funds they provide for the implementation of projects and programmes are managed according to the national procurement procedures as they were established in the general legislation and implemented by government. The use of national procurement procedures means that donors do not make additional, or special, requirements on governments for the procurement of works, goods and services.
DEVELOPMENT PARTNER	Includes bilateral and multilateral donors, e.g. country aid agencies, and international organisations.
4-POINT SCALE USED TO ASSESS PERFORMANCE IN THE PROCUREMENT SECTOR	The OCED has outlined a procedure to produce an indicative picture of the quality of procurement systems, based on a 4-point scale. Detailed information can be found on the OECD website.
GENERAL BUDGET SUPPORT	General budget support is a sub-category of direct budget support. In the case of general budget support, the dialogue between donors and partner governments focuses on overall policy and budget priorities (OECD 2006).
HEALTH AID REPORTED ON NATIONAL HEALTH SECTOR BUDGET	This should include all health sector aid recorded in the annual budget as grants, revenue or loans.
HUMAN RESOURCES FOR HEALTH (HRH) PLAN	Human Resources for Health (HRH) plans should address the key constraints that need to be addressed to achieve agreed objectives on HRH. A HRH plan includes three main elements: it is costed, evidence-based and comprehensive.
HEALTH SECTOR COORDINATION MECHANISM	Multi-stakeholder body that meets regularly (usually monthly or quarterly) to provide the main forum for dialogue on health sector policy and planning.
HEALTH SECTOR AID	ODA contributed to the health sector. ODA includes all transactions defined in OECD/DAC statistical directives paragraph 35, including official transactions that are administered with the promotion of economic development and welfare of developing countries as its main objective; and are concessional in character and convey a grant element of at least 25%.
IHP+	A global partnership that puts the Paris and Accra principles on Aid Effectiveness into practice, with the aim of improving health services and health outcomes, particularly for the poor and vulnerable.
IHP+ COUNTRY COMPACT	The IHP+ is open to all countries and partners willing to sign up to the commitments of the Global Compact. IHP+ Global Compact defines commitments following Paris principles on national ownership, alignment with national systems, harmonization between agencies, managing for results and mutual accountability.
JOINT ASSESSMENTS OF NATIONAL STRATEGIES (JANS)	Joint assessment is a shared approach to assessing the strengths and weaknesses of a national strategy. IHP+ partners have developed a process for the Joint Assessment of National Strategies (JANS) with the intention that a JANS assessment is accepted by multiple stakeholders, and can be used as the basis for technical and financial support. In this definition, a plan has been jointly assessed if the JANS process, or a similar joint assessment, has been completed (please provide details in the "Answers and additional information column of the survey tool).

MUTUAL ACCOUNTABILITY	Two or more parties have shared development goals, in which each has legitimate claims the other is responsible for fulfilling and where each may be required to explain how they have discharged their responsibilities, and be sanctioned if they fail to deliver. (DFID)
NATIONAL PERFORMANCE ASSESSMENT FRAMEWORKS	The basis of a government's policy to make information about the quality and performance of health care services available to the public and partners. National Performance Assessment Frameworks should be comprehensive (i.e. cover all areas of health sector performance).
ODA	Grants and concessional loans for development and welfare purposes from the government sector of a donor country to a developing country or multilateral agency active in development. ODA includes the costs to the donor of project or programme aid, technical cooperation, debt forgiveness, food and emergency aid, and associated administration costs. (OECD/DAC)
PARALLEL PROJECT IMPLEMENTATION UNIT (PIU)	When providing development assistance in a country, some donors establish Project Implementation Units (They are also commonly referred to as project management units, project management consultants, project management offices, project co-ordination offices etc.). These are designed to support the implementation and administration of projects or programmes.
PARIS DECLARATION	The Paris Declaration, endorsed on 2 March 2005, is an international agreement to which over one hundred Ministers, Heads of Agencies and other Senior Officials adhered and committed their countries and organisations to continue to increase efforts in harmonisation, alignment and managing aid for results with a set of monitorable actions and indicators. (OECD)
PERFORMANCE ASSESSMENT FRAMEWORK	The basis of a government's policy to make information about the quality and performance of health care services available to the public and partners. National Performance Assessment Frameworks should be comprehensive (i.e. cover all areas of health sector performance).
POOLED FUNDING MECHANISM	A funding mechanism which receives contributions from more than one donor which are then pooled and disbursed upon instructions from the Fund's decision-making structure by an Administrative Agent (or Fund Manager) to a number of recipients. Sometimes known as a Multi Donor Trust Fund. Taken from http://www.undg.org/index.cfm?P=152
PROGRAMME BASED APPROACHES (PBAS)	PBAs are a way of engaging in development co-operation based on the principles of coordinated support for a locally owned programme of development, such as a national development strategy, a sector programme, a thematic programme or a programme of a specific organisation.
PUBLIC FINANCIAL MANAGEMENT SYSTEMS (PFM)	Legislative frameworks normally provide for specific types of financial reports to be produced as well as periodicity of such reporting. The use of national financial reporting means that donors do not impose additional requirements on governments for financial reporting.
RESULTS AREAS	IHP+Results uses the following five thematic areas that IHP+Results to track IHP+ performance. These areas are chosen to align with the OECD/DAC process for monitoring Aid Effectiveness: Ownership & Accountability; Transparent & responsible health financing; Using & strengthening country systems; Strengthening health systems; Managing for Development Results.
SECTOR BUDGET SUPPORT	Sector budget support is a sub-category of direct budget support. Sector budget support means that dialogue between donors and partner governments focuses on sector-specific concerns rather than on overall policy and budget priorities (OECD 2006).
STANDARD PERFORMANCE MEASURES (SPMS)	Indicators developed and agreed by the IHP+ Working Group on Mutual Accountability. SPM were designed to track the implementation of development partners' and country governments' commitments as set out in the IHP+ Global Compact. They are based as closely as possible on the Paris Declaration indicators.
TECHNICAL COOPERATION (ALSO REFERRED TO AS TECHNICAL ASSISTANCE)	Is the provision of know-how in the form of personnel, training, research and associated costs. Technical co-operation includes both free standing technical co-operation and technical co-operation that is embedded in investment programmes (or included in programme-based approaches).

IHP+RESULTS STANDARD PERFORMANCE MEASURES (SPMs) THAT HAVE BEEN AGREED BY IHP+ SIGNATORIES

LINKED TO PARIS TARGETS

	IHP+ GOVERNMENTS		IHP+ DEVELOPMENT PARTNERS	
	Standard Performance Measures	Target	Standard Performance Measures	Target
	1G: IHP+ Compact or equivalent mutual agreement in place.	An IHP+ Compact or equivalent mutual agreement is in place.	1DP: Proportion of IHP+ countries in which the partner has signed commitment to (or documented support for) the IHP+ Country Compact, or equivalent agreement.	100% of IHP+ countries where the signatory operates have support for/commitment to the IHP+ compact (or equivalent) mutually agreed and documented.
PD3	2Ga: National Health Sector Plans/Strategy in place with current targets & budgets that have been jointly assessed.	A National Health Sector Plan/Strategy is in place with current targets & budgets that have been jointly assessed.	2DPa: Percent of aid flows to the health sector that is reported on national health sector budgets.	Halve the proportion of aid flows to the health sector not reported on government's budget(s) (with ≥ 85% reported on budget).
PD4	2Gb: Costed and evidence-based HRH plan in place that is integrated with the national health plan.	A costed, comprehensive national HRH plan (integrated with the health plan) is being implemented or developed.	2DPb: Percent of current capacity-development support provided through coordinated programmes consistent with national plans/strategies for the health sector.	50% or more of capacity development support to each IHP+ country in which the signatory operates are based on national health sector plans/strategies
PD9			2DPc: Percent of health sector aid provided as programme based approaches.	66% of health sector aid flows are provided in the context of programme based approaches
	3G: Proportion of public funding allocated to health.	15% (or an equivalent published target) of the national budget is allocated to health.	3DP: Percent of health sector aid provided through multi-year commitments.	90% (or an equivalent published target) of health sector funding provided through multi-year commitments (min. 3 years).
PD7	4G: Proportion of health sector funding disbursed against the approved annual budget.	Halve the proportion of health sector funding not disbursed against the approved annual budget.	4DP: Percent of health sector aid disbursements released according to agreed schedules in annual or multi-year frameworks.	90% of health sector aid disbursed within the fiscal year for which it was scheduled.
PD5a	5Ga: Country procurement systems either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	Improvement of at least one measure (ie 0.5 points) on the PFM/CPIA scale of performance.	5DPa: Percent of health sector aid that uses country procurement systems.	Reduce by one-third the aid not using public financial management systems (with ≥ 80% using country systems).
PD5b	5Gb: Country public financial management either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	Improvement of at least one measure on the four-point scale used to assess performance for this sector.	5DPb: Percent of health sector aid that uses public financial management systems.	Reduce by one-third the aid not using procurement systems (with ≥ 80% using country systems).
			5DPc: Number of parallel Project Implementation Units (PIUs) per country.	Reduce by two-thirds the stock of parallel project implementation units (PIUs).
PD11	6G: An agreed transparent and monitorable performance assessment framework is being used to assess progress in the health sector.	A transparent and monitorable performance assessment framework is in place to assess progress in the health sector.	6DP: Proportion of countries in which agreed, transparent and monitorable performance assessment frameworks are being used to assess progress in the health sector.	Single national performance assessment frameworks are used, where they exist, as the primary basis to assess progress in all countries where the signatory operates.
PD12	7G: Mutual assessments, such as joint annual health sector reviews, have been made of progress implementing commitments in the health sector, including on aid effectiveness.	Mutual assessments (such as a joint annual health sector review) are being made of progress implementing commitments in the health sector, including on aid effectiveness.	7DP: Proportion of countries where mutual assessments have been made of progress implementing commitments in the health sector, including on aid effectiveness.	Annual mutual assessment of progress in implementing health sector commitments & agreements (such as the IHP+ country compact and on aid effectiveness in the health sector) is being made in all the countries where the signatory operates.
	8G: Evidence that civil society is actively represented in health sector policy processes - including health sector planning, coordination & review mechanisms.	At least 10% of seats in the country's health sector coordination mechanisms are allocated to civil society representatives.	8DP: Evidence of support for Civil Society to be actively represented in health sector policy processes - including health sector planning, coordination & review mechanisms.	All signatories can provide some evidence of supporting active civil society engagement in 100% of IHP+ countries in which they are active.

These Standard Performance Measures from the basis of IHP+Results reporting framework in 2010. For more information on these Measures, see www.ihpresults.net/how/methodology/spm/

PARIS INDICATOR The box is indicating a connection the the Paris Declaration Indicator. For more information, please visit www.oecd.org/dataoecd/57/60/36080258.pdf

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