

# IHP+: Expanding predictable financing for health systems strengthening and delivering results

**Terms of Reference: 07 August 2008**

## Background

There is growing momentum to expand international financial support to strengthen health systems and deliver results in developing countries by scaling-up a variety of individual- and population-based services that are key to reaching the health-MDGs. This is based on the recognition that there needs to be considerable increase in predictable financing to improve health in developing countries if these global targets are to be reached. Weak health systems, and insufficient attention to delivering results are now seen to be the critical barriers to the effective use of additional funding for improving health outcomes.

A recent discussion facilitated by the IHP+ Core Team<sup>1</sup> looked at some options for expanding predictable, long-term financing for strengthening health systems. The notes from these early discussions are included as annexes and include: *Investing in a health system strengthening (HSS): What do we mean? (Annex A); What are the options for channeling HSS funds to national health plans and strategies? (Annex D)*. In addition, IHP+ inter-agency work continues on validation of national plans and strategies, common results and performance frameworks, and results based financing.

Some of the key conclusions of this initial discussion were (i) countries and donors should have a choice of financial instruments that could be used in different settings to support governments and Ministries of Finance in providing predictable financing to deliver on priorities and results outlined in national plans and strategies; (ii) different country scenarios should be used to illustrate where different instruments have value; for example some countries have well developed sector working, effective management, common M&E frameworks, and low fiduciary risk where pooled funds can be managed by government. Others are in a post-conflict situation where institutions are weak with high fiduciary risk, so funds would be channelled through intermediary agencies; (iii) more work is required to clarify and strengthen some of the arguments for expanding different mechanisms.

These Terms of References are to guide the work follow up work identified based on the initial discussions. A dedicated health economist will work with the IHP+ Core Team to help take this work forward, with guidance provided by a small inter-agency Technical Reference Group<sup>2</sup>.

## Phases of work

Commissioned work to start in early August 2008 and is divided into two phases:

- **Phase 1** (August - end September): Desk review of documentation to be used to prepare for the 25<sup>th</sup> September MDG Call for Action in New York, and also to develop

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<sup>1</sup> The IHP+ Core Team is based in Geneva, Washington DC, and Brazzaville, and is responsible for day-to-day coordination with all IHP+ development partners.

<sup>2</sup> World Bank (Mukesh Chawla), GAVI (Geoff Adlidge, Alice Albright), WHO (Andrew Cassels, David Evans), UK (Louisiana Lush), Australia (Tim Poletti), GHWA (Erica Wheeler), AHPSPR (Sara Bennet) with other to be confirmed (from Gates, EC, UNFPA, UNAIDS, GF, UNICEF)

draft terms of reference to help guide the work of a senior inter-agency group that will take on the follow up work.

- **Phase 2** (October - April 09): Follow-up work on a choice of options for predictable financing to deliver on results in national health plans and strategies in different country scenarios to be taken forward by a senior inter-agency group

These Terms of References cover the work that will take place in Phase I, which will result in documentation for the 25<sup>th</sup> September event and will also define the work to be taken forward in Phase 2.

## **Deliverables for Phase 1**

To be performed with the IHP+ Core Team and SuRG:

- 1. An analysis of existing mechanisms for Health System Strengthening:** Prepare a report summarizing (a) existing analyses of the degree to which existing mechanisms contribute to: health systems strengthening, performance based funding, and the leveraging of additional funds from domestic sources; (b) documented problems that countries and donors face in using funds for HSS through existing mechanisms. This would include reviewing relevant information and documentation related to:
  - The International Financing Facility for Immunization (IFFIm)
  - World Bank global/country multi-donor trust funds (MDTFs)
  - Global Fund and GAVI Alliance support to HSS
  - The European Commission and MDG contracts
  - Other innovative mechanisms that could be used for HSS investments (eg UNITAID)
- 2. Present options for improving on existing instruments;** building on the above analysis, prepare a set of options for improving on existing instruments, as well as considering potential new ones. This analysis should acknowledge the different country scenarios and the related management arrangements for taking these options forward, including any legal and fiduciary issues. Some initial discussion facilitated by the IHP+ Core Team on scenarios and possible management arrangements are summarized in Annex D. These options should all be linked to the principles and objectives of the IHP+, ie a country-led process building on existing country mechanisms, reduced transaction costs, and results based financing linked to frameworks agreed in national health plans and strategies<sup>3</sup>. This work will highlight more specific work that is required to clarify how the different mechanisms are best utilised, some of which have already been mapped out, for example:
  - a. IFFIm for HSS:** Given the interest by some developing partners to expand the use of IFFIm for health system strengthening, build on work already started by the IHP+ Core Team, summarized in Annex B, and complete a 2 page core script on:
    - (i) Areas of health systems strengthening that would be best addressed by the frontloading offered by IFFIm;
    - (ii) Global financial figures that could be expected for an expanded IFFIm<sup>4</sup>;
    - (iii) Management arrangements that would require to be reviewed based on different the different country scenarios, separating out how the funds are raised, and how they are disbursed (ie direct of via an intermediary);

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<sup>3</sup> A separate piece of IHP+ work will be shortly underway on how country health sector teams could be strengthened to deliver on IHP+ objectives.

<sup>4</sup> At a minimum, this could be based on assessment of what donors/IFFIm could realistically mobilize

- (iv) Summary of further work required to strengthen the cost-effectiveness arguments of IFFIm and to make operational an expansion of IFFIm.
- b. **World Bank Multi Donor Trust Funds linked to IDA:** There is now growing World Bank experience of using IDA for non-project based investments to support policies, performance and outcomes in countries that have adequate fiduciary and governance arrangements, summarized in Annex C. More work is required to (i) clarify the areas of health systems strengthening that are best suited to use of MDTFs in different country scenarios; (ii) Dissemination of existing experience with non-project, results based investments; (iii) clarify the different management arrangements that are linked to MDTFs.
  - c. **GAVI Alliance and Global Fund investments in HSS:** Both of the these institutions have a growing experience of strengthening health systems through performance funding linked to specific health outcomes (related to child health, HIV/AIDS, TB and Malaria). This experience is of wider relevance and should continue to be further consolidated and disseminated.
  - d. **The European Commission and MDG contracts:** The latest situation on these instruments has been discussed elsewhere<sup>5</sup>, including recent statements linking this type of budget to earmarking money for a specific sectors and performance targets that directly measure the outcome of policies.
  - e. **Other innovative mechanisms for HSS:** A considerable amount of work has already gone into this area<sup>6</sup> including the growing experience of UNITAID, an international drug purchase facility that is financed with sustainable, predictable resources using the tax on air tickets<sup>7</sup>.
3. **Set up a round table with Technical Reference Group:** In collaboration with the IHP+ Core Team, host a small round table on September 5<sup>th</sup> to review work programme and initial draft documents.
  4. **Prepare for UN Secretary-General's MDG Call for Action:** Prepare two documents to be ready by 25<sup>th</sup> September:
    - I. A report covering a summary of:
      - The case for removing health system bottlenecks through HSS investments (e.g. building on the case made in GF and GAVI Boards on HSS) and the link to improved results;
      - Summary estimates of global resources required based on already available actual health sector costings in IHP+ countries used to prepare national health sector plans and Medium Term Expenditure Frameworks as part of the IHP+
      - A summary of the work done on expansion of mechanisms for expanding HSS investments (sections 1 & 2 above) that could be used by the H8, IFFIm donors, GAVI/GF Boards and IHP+ development partners prior to the UN SG 25<sup>th</sup> September MDG Call for Action
    - II. Terms of Reference for Phase 2 on follow-up work to be taken forward by a senior inter-agency group to look options on predictable health financing to address finance

<sup>5</sup> <http://weca-ecaaid.eu/2008/07/14/the-mdg-contract-an-approach-for-longer-term-and-more-predictable-general-budget-support-june-2008/>

<sup>6</sup> <http://www.endpoverty2015.org/topics/innovative-financing-development>

<sup>7</sup> <http://www.unitaid.eu/>

gaps outlined in national health plans and the related compacts that are under preparation as part of the IHP+.

### **Timeline**

Define TOR and engage health economist	6 August
Develop work programme	11 August
Initial draft core scripts for instruments	25 August
Roundtable with IHP+ Technical Reference Group	5 Sept
Complete draft documents for final review	15 Sept
Circulate documents for MDG Call for Action meeting	25 Sept
Complete Phase 2	April 2009

**Budget:** (tbc)

## Annex A

### Investing in a health system strengthening (HSS): What do we mean?

#### Background

There is a growing recognition that there needs to be a considerable increase in funds to improve health in developing countries if there is to be significant progress in achieving the health MDG targets<sup>8</sup>. Weak national health systems are now seen to be the critical barrier to the effective use of additional funding for improving health outcomes<sup>9 10 11</sup>. The case for strengthening health systems in developing countries is based on strong cost-benefit arguments in the longer term (at least) focusing on economic productivity, quality of life and security<sup>12</sup>. For international development agencies the main driver is the attainment of the MDGs, and for the UN and civil society movements the case for stronger health systems is also made from the perspective of the right to access health services<sup>13</sup>.

The International Health Partnership and other related initiatives (IHP+) exist to improve the environment in countries for attracting investments for strengthening health systems and delivering results<sup>14</sup>. There are large number of mechanisms that can be used to mobilize resources for health, including cross-sectoral development funds, sector investments and earmarked investments for specific diseases or interventions. However there remains problems with unpredictable and overlapping instruments.

This note summarizes some recent efforts to agree on the scope for health system investments, and on the options for providing these funds to developing countries<sup>15 16</sup>. These efforts are all in line with the Paris Declaration on Aid Effectiveness, which emphasizes harmonization of efforts, alignment with national systems, ownership by developing countries, delivering results and mutual accountability for progress between national and international stakeholders.

#### Defining scope for international HSS investments

There is now general agreement on what a health system is: *"Within the political and institutional framework for each country, a health system is the ensemble of all organizations, institutions, and resources mandated to improve, maintain or restore health. They encompass both personal and population services and activities to influence policies and actions of other sectors to address the environmental and economic determinants of health"*<sup>17</sup>. It is now well accepted that to strengthen a health system, resources are required for both priority (eg disease specific) programmes as well as for the health system as a whole, covering both state and non-state sectors. Of particular importance for scaling up services is strengthening the sub-components to improve the performance of the health system as a whole<sup>18</sup>: *Delivering health services through a primary health care approach*<sup>19</sup>; *Financing and social*

<sup>8</sup> Health System Financing: Improving health outcomes and financial risk protection in low-income countries. *Paper jointly prepared by WHO and the World Bank, Elders Meeting, Atlanta, May 2008.*

<sup>9</sup> Assessment of the health system and policy environment as a critical complement to tracking intervention coverage for maternal, newborn and child health. Countdown Working Group on Health Policy and Health Systems, Cavagnero E, Daelmans B, Gupta N, Scherpier R, Shankar A. *Lancet*. 2008 Apr 12; 371 (9620): 1284-93

<sup>10</sup> Achieving universal coverage with health interventions. C. Victora, K. Hanson, J. Bryce, JP Vaughn. *Lancet* 2004 Oct 23-29; 364 (9444): 1541-8

<sup>11</sup> [http://www.g8summit.go.jp/doc/pdf/0708\\_09\\_en.pdf](http://www.g8summit.go.jp/doc/pdf/0708_09_en.pdf)

<sup>12</sup> [http://www.who.int/macrohealth/documents/tough\\_choices/en/index.html](http://www.who.int/macrohealth/documents/tough_choices/en/index.html)

<sup>13</sup> Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Hunt P. Human Rights Council; 7<sup>th</sup> session, A/HRC/7/11 Jan08

<sup>14</sup> <http://www.internationalhealthpartnership.net>

<sup>15</sup> <http://www.endpoverty2015.org/topics/innovative-financing-development>

<sup>16</sup> [http://www.diplomatie.gouv.fr/en/france-priorities\\_1/health-and-food\\_1102/sanitary-policy\\_2649/social-health-protection-in-developing-countries-who-will-pay-paris-7-may-2008\\_6310/index.html](http://www.diplomatie.gouv.fr/en/france-priorities_1/health-and-food_1102/sanitary-policy_2649/social-health-protection-in-developing-countries-who-will-pay-paris-7-may-2008_6310/index.html)

<sup>17</sup> Health Systems for Health and Wealth: the Tallinn Charter. June 2008

<sup>18</sup> [http://www.who.int/healthsystems/strategy/everybodys\\_business.pdf](http://www.who.int/healthsystems/strategy/everybodys_business.pdf)

<sup>19</sup> <http://www.who.int/management/district/phc/en/index.html>



## Case studies on health systems strengthening and results Kyrgyz republic<sup>32</sup>

*Kyrgyz Republic:* The Manas Taalimi National Health Reform Program (2006-2010) is being implemented under a Sector Wide Approach with government and development partners. A substantial Mid Term Review in 2008 looked at impact and showed: Financial barriers had decreased (proportion not seeking health care declined from 14.6% in 2001 to 3.6 % in 2007); Gift-giving to health care providers had declined (in 2001 32% gave 'gifts', reduced to 17% in 2007); access to pharmaceuticals has improved (proportion able to obtain prescribed items increased from 77% to 92%); and utilization of primary care and hospitals had improved.

## Brazil<sup>33</sup>

*Brazil.* The Family Health Program of Brazil is the main government effort to improve primary health care in Brazil. The impact on infant mortality covering a 13 year period from 1990 to 2002, covering 27 Brazilian states, was that IMR declined from 49.7 to 28.9 per 1000 live births. During the same time period average Family Health Programme coverage increased from 0% to 36%. A 10% increase in coverage was associated with a 4.5% decrease in IMR, controlling for all other health determinants ( $P < 0.01$ ).

## Mali<sup>34</sup>

*Mali.* In 1986, the Ministry of Health introduced a strategy, which continues today, to encourage newly graduated doctors to serve in rural areas. Doctors are contracted to work in underserved areas to deliver the minimum health package stipulated in the National Health Policy, either as part of a public health centre which has no doctor, or as a private practitioner. By 2004, 80 doctors (from Mali's estimated total medical stock of 529) had joined this scheme and were working in rural areas, where some had been for over five years. An assessment in 2001 found that service coverage in rural facilities with a doctor was higher than in those without. (WHR2006, Box 4.5 pp78)

## Vietnam<sup>35</sup>

*Vietnam.* In 1999, infant mortality rates were examined in relation to the density of health service providers. Many provinces do better than expected for their health worker density, while others do less well. An indicator was derived of the efficiency with which health workers in each province use the available health resources to reduce mortality, controlling for education and poverty. Efficiency ranged from 40% to 99% showing that health workers in some provinces performed better than in others, highlighting where improvements should be possible.

## Banladesh<sup>36</sup>

*Banladesh.* The first Health and Population Sector Strategy and the 5 year Health and Population Sector Programme (HPSP 1998-2003) focused on strengthening health system capacity (focusing on human resource development and improvements in service quality), community and stakeholder participation, improvements in the regulatory framework for public and private services, detailed actions to improve data collection, and detailed actions to strengthen program monitoring, evaluation and accountability. Over this period Bangladesh has made noticeable progress in reducing maternal mortality. MMR (derived using the sibling history method) declined from 514 per 100,000 live births during 1986-1990 to 485 during 1991-2000.

<sup>32</sup> Kyrgistan: Kyrgyz Health and Social Protection Project: Mid Term Review 2008; World Bank.

<sup>33</sup> Brazil: Evaluation of the impact of the Family Health Program on infant mortality in Brazil, 1990-2002. Macinko J, Guanais FC, de Fatima Marinho de Souza M. J Epidemiol. Community Health 2006; 60; 13-19.

<sup>34</sup> Vietnam: Prasad A, Tandon A, Sousa A, Ebener S, Evans DB. Measuring the efficiency of human resources for health in attaining health outcomes across provinces in Viet Nam: background paper for World Health Report 2006 at <http://www.who.int/hrh/documents/en>

<sup>35</sup> Mali: Pour une médecine générale communautaire en première ligne. Desplats D, Know Y, Razakarison C. Med Trop 2004; 64: 539-544.

<sup>36</sup> Securing Maternal Health through comprehensive reproductive health services: lessons from Bangladesh. Jahan R. American J of Public Health. July 2007, Vol 97; 7: 1186-1190

## Annex B

### Expansion of the International Finance Facility (IFFIm)

#### Background

IFFIm has been used to provide funds through the GAVI Alliance<sup>37</sup>. The case for IFFIm expansion to strengthen national health systems could mainly be made against the identified benefits/costs of more long term, predictable financing and frontloaded financing for health systems. The original arguments for IFFIm rested in particular on (a) the benefits of promising a market to private sector vaccine companies through predictability which changes private sector behavior and lowers vaccine costs and transaction costs and b) on the economic and health benefits of herd immunity. The original scope of the IFFIM included funding all 4 of GAVI's Strategic Goals – which included funding health systems. It is envisaged that the IFFIm may be expanded to fund a broader health systems agenda – through the IHP+ mechanism. The section below revisits the initial benefits of IFFIm as they may become more broadly applicable to an expanded IFFIm.

#### Making the case - predictability.

The IFFIM structure is based on a package of long-term, legally binding (up to 20 years) aid grants from 7 donor governments. The unusual aspect of this structure is the binding nature of the underlying donor commitments – which reduces the volatility typically seen in traditional donor aid funding. This characteristic of predictability benefits several areas of spending identified as core to health systems:

- **Human resources:** The main benefit for having long term, predictable funds will be on the HR side. This would allow investment in institutions that increase the production of skilled workers, and would permit longer term hiring of staff at lower cost than rolling short term contracts. It would have a positive labor market impact by allowing the workforce investment to be more focused on long term needs.
- **Strategic planning of the health sector:** As more funds become available to governments for health, there is a growing experience with strategic planning, linked to learning from common monitoring and some evaluations. Whilst the problem is particularly acute for expanding and retaining a skilled workforce, other elements in national health sector planning, such as renovating infrastructure, strengthening supply chains or investing in public-private partnerships, will also gain from longer term predictable financing. This is the rationale for the existing GAVI HSS window - that the multiyear immunization plans may not work well without complementary health systems investment.

#### Making the case - frontloading.

Subject to the prudential financial management policies that allow IFFIm to maintain its AAA-rating viz the capital markets, the IFFIm's ability to borrow against its base of donor grants allows it to deliver significant volumes of funding to programs. Potentially, this funding profile would serve the interest to undertake a large-scale effort to fund health systems in the near term. Combined with the binding nature of the underlying donor grants, IFFIm can deliver both one-time outsized funding in addition to longer-term predictable funding noted above. The merits of a front-loaded approach are:

- **More efficient use of resources:** If health system investment confers an efficiency benefit on future planned spending then frontloading these investments justifies its costs through a frontloaded profile of efficiency benefits. For example frontloading spending in health information systems, procurement systems, audit budgeting and accounting systems, will enable a more efficient allocation of health resources at an earlier date. These are precisely the areas that require reforms and donor attention, but have been avoided as it is "hard to see the babies being saved".

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<sup>37</sup> <http://www.iff-immunisation.org>

- **Responding to higher start up costs:** The use of frontloaded investments can help cover high start up costs for example training schools (for health staff), infrastructure investments and information systems.
- **Investing early in critical capacities:** The importance of strong leadership and governance in health, means it is important to invest early in the competencies of senior decision makers in health to ensure that they have the required leadership, analytical and communication skills.

### Management arrangements for expanding IFFIm

Whilst there are recognized costs to the use of IFFIm (see costing analysis) it is already active and has been able to secure large amounts of funds, through legally binding agreements and supply them in way that is sensitive to country plans and budgets. It has an existing legal and steering processes already present so its expansion would not require new management and distribution mechanisms. Given the investment that has already taken place in setting up IFFIm, it's use could expand greatly with little increase in administrative costs. The expanded IFFIm provides another mechanism for direct investment to countries in those with a compact and validated plans and strategies developed through IHP+. The IFFIm also provides flexibility in how funds are used and could use multiple channels to countries, including a WB based Trust Fund.

### Expanding IFFIm: What are the risks and drawbacks?

- **Ensuring continued longer term donor investments:** The bond proceeds are front loaded while the donor commitments underlying the bond proceeds are back loaded and usually shaped to fit inside of existing ODA budgets. IFFIm and other complementary options are needed to insure that funding overall is sustained beyond the lifetime of the IFFIm – which is currently just over 18 years.
- **Risks and risk mitigation of GAVI-HSS investments:** this has already been considered in some detail for the GAVI board, and could be further drawn on to make the case for IFFIm expansion<sup>38</sup>.
- **Frontloading and long term salary coverage:** From the perspective of developing a workforce, it will be important not to encourage frontloading from a long term stream of income. Long term commitments are required to overcome the constraint of long term salary related costs. More work is required to better understand the preferred balance of upfront and long term funding.

**Where is more work required?** It is not yet clear what aspects of health service expansion would benefit most from high 'kick start' followed by incremental growth in investments. An analysis of evidence and experience is required to guide decisions on how an expanded IFFIm for health system strengthening could be best utilized in countries.

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<sup>38</sup> GAVI-HSS: Board paper, April 2008

## Annex C

### Expanding donor grants through Multi-donor Trust Funds (MDTF) linked to IDA

Many governments are already expecting the World Bank to increase its support to the strengthening of health systems through IDA, agreed on a country by country basis. MDTFs would be used to reduce the cost of health system investments by blending bilateral donor grants with IDA low interest loans. The WB has considerable existing experience for using trust funds in this way, both globally, for example with the current support to Results Based Financing in health, and for individual countries linked to SWAps and budget support. The MDTF is a mechanism for holding and pooling funds from a variety of sources, thereby avoiding the excessive administrative costs of multiple donor agreements with countries.

#### Making the case - predictability

Given that the MDTF is a mechanism for pooling a large amount of funds from many donors, it could also provide a mechanism for ensuring a predictable source of long term financing for health systems strengthening if structured properly. In this situation, the main arguments for predictability, in particular putting into effect strategic planning of the sector (for strengthening cross-cutting systems as well as priority programmes), developing a basic level of health system capacity (ie arguments on 'thresholds'), and the need to invest in human resources, apply equally well for MDTFs linked to IDA.

#### Management arrangements for expanding MDTFs

As with IFFIm, management systems are already in place and many multi-donor trust funds are already used to invest in Sector Wide Approaches and the more recent Results Based Financing adjunct to IDA. The link with IDA is important as this large pool of funds provides the link to Ministries of Finance and performance related donor payments in developing countries. This means the MDTF can be used to leverage larger investments from IDA and the national MoF.

#### Expanding grants via the MDTF: what are the risks and drawbacks?

The key concerns are:

- **Short term commitments:** the main problem in the past has been that many countries only give commitments for relatively short periods - a few years, or sometimes only year on year, making long term investments in country health systems more problematic.
- **Complex projects:** In some cases IDA has previously been used to finance health sector projects that are perceived to be adding additional management burden where adequate national capacity is already in place.

**Where is more work required?** There is now growing World Bank experience of using IDA for non-project based investments to support policies and outcomes in countries that have adequate fiduciary and governance arrangements. This experience needs to be disseminated and built on, linked to what would work in different country scenarios. A sufficiently large pool of long term donor pledges to MDTFs would be required for countries to get the maximum benefits of predictable funding, and a streamlined management process as envisaged with the IHP+.

## Annex D

### What are the options for channeling HSS funds to national health plans and strategies?

#### Background

As more resources are raised globally for the strengthening of health systems, the arrangements for handling these resources efficiently, without setting up more management and governance structures, needs some consideration. Of most importance is to consider what is required in countries, and then consider what arrangements are required elsewhere to help facilitate the international financial support that has been agreed on a country by country basis.

#### How would all this be managed in countries?

For commitments being made in country compacts to be adequately managed in country, there is a need for good coordination with government, and sufficient transparency to satisfy an actively engaged civil society. Inter-agency country health sector teams might need to be more formally mandated to take on this role. Current coordination mechanisms, such as for the Global Fund through Country Coordinating Mechanisms, and health donor groups using Memoranda of Understandings may need to be strengthened or even combined, as agreed country by country. Country health sector teams would then have one of three basic roles with regard to overseeing and accounting for national health plan investments, with the possibility of a country occasionally moving from one group to the other (for example in times of long term crisis):

- i. **Low risk, and no intermediary** - where compacts have been agreed and national management and M&E/audit systems are strong enough for funds raised internationally to be passed on directly to the Ministry of Finance or health sector budgets. In this situation, the role of the country health sector team is to take part in the annual joint health sector reviews, report back on progress to global donors and to facilitate the annual external review.
- ii. **Medium risk, with intermediaries:** where compacts have been agreed but adequate national systems are still being developed, meaning funds must be channeled through the World Bank, GAVI the GF and other donors active in the country. In this situation the country health sector team has an operational role of coordinating resource inputs, defining health sector investment proposals, technical support as well as annual reviews.
- iii. **High risk, fragile state environments:** where compacts are still being developed and funds are mainly being transferred via WB projects, the UN and international NGOs. In this situation, the options for optimal investment may be focused on priority health programmes, NGO programmes and well targeted health system projects. The role of the country health sector team is to assist government in coordination of the multiple players providing health programmes in the country.

#### Management arrangements at the regional and global level

This would need to build on IHP+ arrangements, with an emphasis on using what already exists and avoiding the development of new management or governance arrangements. At the regional level, the main focus will be on responding to technical support and capacity building plans of countries using regional, and where necessary, global institutions. In addition, political forums will be used as now to advocate for more resources for health and for improved behaviors from global institutions.

At the global level coordination and oversight could be provided by a formally constituted Scaling Up Reference Group. Financial oversight of HSS funds would be provided by those institutions who are channeling funds to countries (WB, EC, Global Fund and GAVI) with

cross-country coordination provided through the IHP+ Core Team and the annual external review.

Where funds that are transferred directly to Ministries of Finance (for example through an expansion of IFFIm for health system strengthening), oversight could be provided by the IHP+ core team (located in Geneva, Washington and Brazzaville) in direct communication with Directors of Planning, Ministries of Finance and the partners that constitute membership of the country health sector team. Any disputes or fiduciary concerns would be handled on a country by country basis using the common dispute resolution agreements in individual country compacts.

### Options for channeling funds to countries

- i. **Ministries of Finance for investment in sectoral plans and strategies:** MoF would be the channel for funding in countries with compacts, "validated" health plans, well developed fiduciary and performance monitoring arrangements, and sufficient transparency to allow direct budget support. This is in effect an expansion of existing budget and sector support arrangements already in place in some countries and used by some donor countries and the EC.
- ii. **WB multi-donor trust fund linked to IDA credits:** For countries with compacts, but where fiduciary or other key managerial arrangements required on the ground are not thought adequate. In these circumstances, funds would be transferred using the WB using investments blended with IDA credits, and managed using longer term commitments to national health plans in combination with the country health sector team.
- iii. **Global Fund & GAVI linked to funding national HTM and Immunization strategies.** Both these global health partners are moving to strengthen the health system by funding national strategies through adaptation of their existing instruments. GAVI already attracts IFFIm funds to do this. The GF would benefit from what is agreed in a compact at country level as this will hopefully facilitate the new national strategy applications.
- iv. **UN or INGO's to build capacity in fragile states where governance and national strategies are weak:** For the regular UN work of building national capacities, then the existing UN channels would be used, linked to technical support plans agreed within country health sector teams. For those countries that are unlikely to have a full compact and/or adequate management and monitoring arrangements, then the UN, WB and other donors would provide the HSS funds to countries as now, through projects or proposals designed in country, or international NGOs specifically contracted for this purpose.

**Where is more work required?** In-country, good practice in country health sector team working needs to be agreed and more widely adopted. This would require improvements in incentives for agencies to better collaborate implement the agreements made in country compacts. Also, a better understanding is required on how international funding could best compliment national strategies for health care financing and social protection, and how to best link with other forms of funding locally (ie results-based structures)<sup>39</sup>.

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<sup>39</sup> A Inter-agency Task Force on Results Based Financing of health is currently underway, chaired by World Bank and Centre for Global Development