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EXECUTIVE SUMMARY

Thirteen country teams involved in the International Health Partnership and related initiatives, and the Harmonization for Health in Africa Initiative met with development partners, and civil society representatives between 28th February and 1st March 2008. The countries were: Burundi, Burkina Faso, Benin, Cambodia, Ethiopia, Ghana, Kenya, Madagascar, Mali, Mozambique, Nepal, Niger and Zambia. The objectives were to:

- Share experience and promote learning about sector-wide approaches and harmonization and alignment of national and international agencies in support of the national health plans, strategies and budgets, including memoranda of understanding (MoU), codes of conduct and compacts.
- Share experience about bottlenecks caused by development partners that hinder the effective strengthening of national health plans to achieve their results.
- Hear from the international community on how they are planning to change their ways of working in order to support partner countries achieving the Millennium Development Goals (MDGs).
- Consider how in-country coordination of different global and regional initiatives could be further improved to strengthen health services, and what actions are required at country, regional and global level for these improvements to take place.
- Provide feedback on global inter-agency policy work currently under way aimed at improving international assistance to national health plans and strategies, and strengthening country mechanisms for monitoring and evaluation.

The first sessions provided an opportunity for countries to share their experience so far in preparing costed national health plans and strategies, and the instruments associated with them. Panel and plenary discussions covered what might be the value added of a "compact", the constraints in preparing such a commitment, and plans to proceed on a country by country basis. Discussions then focused on the different components of a compact. This covered the development and review of national health plans and strategies from the perspective of international donors, government and civil society. A later session focused on the national systems for monitoring and evaluation and the need for a common approach agreed with international stakeholders and initiatives. International donors were then asked to provide their perspective on how they plan to change the way they perform business in line with the Paris Declaration, and open discussion focused on constraints they face, and opportunities to change. Working groups, arranged by country, discussed all these matters in more detail and provided an opportunity for country specific discussion on the way forward.

The last day provided an opportunity for all countries to summarize their discussions and present these in a market place for more informal discussion with participants. A final session was used to map out the way forward which, in brief, covered:

- ***Current understanding on what is a 'compact':*** The meeting brought more clarity around the components of a country compact that commits development partners and governments to support one costed, results-oriented national health plan in a harmonized way that will ensure predictable, long-term financing from both national and international sources. It was agreed that a compact is a contract, through which the international community and the recipient country reach a broad agreement on concrete, agreed-on results, based on mutual accountability with obligations on both sides. More detailed guidance will be provided in March 2008.
- ***The common M&E framework.*** This has been agreed across agencies (covering inputs, processes, outputs, outcomes and impact) and now needs to be taken up at the country level and be linked to the planning and budgeting process, using the principles agreed, namely: collective action; alignment with country processes; balance between country participation and independence; harmonized approaches; capacity building and health information system strengthening; and adequate resources, both financial and human. A plan for doing this has now been agreed.

- ***Changing the way development partners do business:*** For the IHP and related initiatives to be a success, development partners will need to make changes to the way they do business, as agreed in the global compact that many signed in September 2007. Various changes are already underway and these ideas and experiences need to continue to be exchanged across countries and agencies, with more effective monitoring at country and global levels.
- ***Engagement with civil society:*** The global IHP compact signed by many partners and countries made a commitment for civil society to participate in the design, implementation and review of the partnership. At global level, a consultation process has started. It was also agreed that civil society be included in the bi-monthly dialogue with countries and development partners. At country level, country teams should strengthen the engagement of key stakeholders of civil society in the full IHP+ process (design, implementation and review of compact).
- ***Harmonized technical assistance:*** The Harmonization for Health in Africa initiative is central to efforts for developing country driven approaches for technical support that responds to country needs, and ensures quality and feedback mechanisms. The HHA will continue to provide support in the areas identified in the meeting.
- ***Inter-agency working groups:*** These will continue in areas requiring cross-agency sharing of knowledge and development of common approaches. For example in the work on national plans and strategies, results based financing, the common monitoring and evaluation framework and aid effectiveness in health.
- ***Monitoring the way forward:*** A matrix will be developed to help monitor progress and an independent review of progress by civil society will be commissioned to assess progress and impact of the IHP and related initiatives.
- ***High level political advocacy:*** High level events will be used to get endorsement of the process suggested in the IHP+ countries, to clarify what commitments have been made by national and international stakeholders, to inform wider stakeholders of progress and to mobilize additional resources.

The meeting was closed by the Minister of Health for Zambia who hoped that this meeting will now show evidence of the required changes actually happening, and appreciated the efforts of all participants.

INTRODUCTION

The IHP+/HHA meeting was held in Lusaka, Zambia, to take stock of efforts under way at country, regional, and global levels and, as ***Zambia's Minister of Health, The Honourable Dr. Brian Chituwo***, put it in his keynote remarks to the conference*, "to move forward the commitments made by the signatories to the IHP compact into action, aimed at putting in place the right approaches by Governments and our Development Partners in health for mutual commitment and accountabilities for effective delivery of aid for better health outcomes and making decisive progress towards MDGs."*

Thirteen country teams, complete with in-country development partners, attended the Lusaka meeting, along with representatives from multilateral and bilateral donors, and global and local civil society. The conference marked the first meeting of its kind since the launch of the IHP in London on 5th September 2007, and its broader evolution into IHP +, in partnership with the HHA.

The following report summarizes the results of the three organizing pillars for the meeting, namely: Stocktaking, Components of a Compact, Next Steps, and the Way Forward.

STOCKTAKING

The opening ceremony on Thursday, 28 February featured remarks by ***Dr. Simon Miti, Permanent Secretary, Ministry of Health, Zambia***, who welcomed the efforts of both countries and their national and global development partners to put in place policies and other measures to deliver better, more effective health outcomes, consistent with the alignment and harmonization hallmarks of the Paris Declaration for scaling-up for better health. The Permanent Secretary added it was clear that both governments and development partners recognized the urgent need to strengthen health systems more vigorously in order to achieve the health-related MDGs.

In following remarks, ***Dr Olusegun Babaniyi, the WHO representative, Zambia,*** suggested that by hosting the Lusaka meeting, Zambia was demonstrating its strong supportive membership of the IHP+ and its mission to renew the national, regional, and global impetus needed to reach the 2015 MDGs. In addition, the WHO Representative said that greater harmonization and alignment of donor and country development work was vital, along with greatly strengthened health systems. Describing Zambia's own efforts to reach its health-related MDGs, Dr. Babaniyi said that the country was finding progress difficult in the face of high burdens of HIV/AIDS, tuberculosis, malaria, diarrhoea, pneumonia, and malnutrition.

From the perspective of a global UN agency, ***Dr. Peter Salama, Associate Director, Health, UNICEF***, ventured that the Lusaka meeting was being convened at a pivotal time in the field of global health. 50% of the deaths of women and of children under five years of age still occur in Africa, he stated, but added that recently, some countries—Ethiopia, Mozambique, Madagascar and Nepal to name some of them—had shown a more than 40% reduction in these deaths over the last several years. Dr. Salama went on to describe efforts over recent weeks by an H-8 delegation to Japan—the current chair of the Group of Eight—to support the health sector through stronger health systems, and by aligning and harmonizing development health policy and strategies more generally.

The opening ceremony concluded with a keynote address by ***The Honourable Dr. Brian Chituwo, Zambia's Minister of Health*** (*full text attached in Annex 2)* who reminded his audience that nearly all countries in the Africa region had shown little progress towards the health-related MDGs, despite the relative increase in resources. He identified maternal and child health specifically as a key indicator that was substantially off-track in the Africa region.
During the period 2000- 2005, the Minister noted that birth attendance by skilled professionals was still only around the 40% mark for Africa—with rates around 25% in Burundi; 6% in Ethiopia; and 16% in Niger, while in other better performing countries, the coverage rate was 99% during the same period. Therefore, ***Dr. Chituwo*** argued, Africa could not achieve its health-related MDGs, unless development

partners committed themselves to better support national health plans and strategies, and to provide more long- term, predictable resources and support to strengthen national systems.

The Minister recalled the signing of the IHP Framework agreement on 5th September 2007, involving 26 signatories: 7 countries, 18 bilateral and multilateral partners, and the Bill & Melinda Gates Foundation, as the translation into practice of the Paris Declaration's principles for achieving the health–related MDGs, through better aid coordination and a focus on results. He underscored the importance of the IHP+ working in close tandem with the Harmonization for Health in Africa Initiative (HHA) in also reaching this objective.

"Imagine the better results we could have achieved over the years had we harmonized and aligned aid in this way," the Minister suggested to delegates in Lusaka.

In conclusion, the Minister said that improving health outcomes would also contribute to improved education results, and spur greater productivity and social cohesion among the wider community.

Session 1: OVERVIEW AND OBJECTIVES

This session provided an overview of recent initiatives for scaling up for better health, and how to better harmonize them. The meeting was also introduced to its two facilitators, ***Phil Hay, Communications Adviser for the World Bank, and Eddie Addai, Director of Planning for Ghana's Ministry of Health.***

The larger purpose of this inaugural session was to share experience in stocktaking on scaling up for better health, identifying bottlenecks, and engaging partners to improve country level coordination.

The "Initiative Circus," a regional perspective—in their joint presentation, ***Chris Mwikisa, WHO, AFRO and Barbara Bentein, UNICEF WCARO*** charted the various initiatives that were working in health at global, regional, and national levels.

Dr. Bentein characterized the HHA, for example, as bringing together various partners such as the African Development Bank (AfDB), UNAIDS, UNICEF, the World Bank, WHO and others, to better align, coordinate, and simplify their development work in the Africa region, along with a commitment to mobilize additional resources to help countries achieve their Millennium Development Goals. In terms of practical implementation, 'compacts' emphasized a common planning approach between countries and partners, based on verifiable results, and the inclusive participation of the private sector, civil society, and other key stakeholders, in order to achieve better health outcomes. Many countries had shown considerable progress in this area, and therefore it was vital to apply the 'best practice' experience of these countries to greatly reduce the confusion caused by the "Initiative Circus."

By way of broad background, Dr. Mwikisa observed poignantly that there are more than 200 partnerships at work under the general aegis of the MDGs: 35 targeting MDG1, 48 targeting MDG6. Among the most recent are the IHP, the Catalytic Initiative and the Norwegian Global Campaign. At regional level, various frameworks also exist, such as the African Union road map, maternal health strategies, various Memoranda of Understanding (MOU), all of which mean that numerous processes are taking place at the same time, with the same people, in the same countries, with the result that confusion is rife, hampering sustainability and predictable financing, and with the end results being huge opportunity and transaction costs.
Accordingly, Dr. Mwikisa suggested that harmonization at the global level through the H8, needs to be translated into compacts that are truly owned at country level, focusing on verifiable results.

The "World of Initiatives" and how this meeting relates to them—*Julian Schweitzer, World Bank*

Dr. Schweitzer suggested that the reason why global health initiatives are proliferating so quickly is because many low-income countries are falling behind in their efforts to reach their health-related MDG targets. Countries are faced with numerous health systems constraints, and need more predictable long-term financing to strengthen their health systems. Meanwhile, donors are still strongly inclined to plant their own 'flags' on aid programmes in countries, which he characterized as being 'donor darlings.' Consequently, progress towards the health-related MDGs are inadequate, health system constraints remain unresolved, along with problems of human resources, infrastructure, catastrophic health spending, and inefficient service delivery.

Dr. Schweitzer said that country governments are confronted with an incredibly complex array of development partners. It is clear that everyone needs to join forces to reduce the high burden of preventable illness and death and to embrace the objectives of the Paris Declaration. Nonetheless, progress has been made in a number of countries already. The vision driving the IHP+ at the country-level is to build on existing efforts: to have inter-agency country health sector teams; to coordinate long-term predictable funding; to commit to one monitoring and evaluation (M&E) system; one costed, results-oriented national plan and budget ("SWAps with teeth", as he described them); and to support country compacts in order to scale up effective coverage towards achieving the health-related MDGs.

Dr. Schweitzer concluded with a warning that the IHP+/HHA must start delivering tangible results within the coming months or risk losing the development community's attention on the MDGs. If this happens, climate change could become the new focus, given the issue's increasing prominence in discussions of global public goods.

Session 2: ENSURING THE COMPACT ADDS REAL VALUE

This session provided an overview of current views on country level compacts, and discussed the contribution of existing national health plans, harmonization and alignment efforts, and financing mechanisms such as MoUs, Codes of Conducts and others within current SWAp processes as possible bases for a compact.

Overview: Current views on 'compacts'—*Agnes Soucat, World Bank*

In recent years, Dr. Soucat noted, aid to Africa has increased significantly, with substantial bilateral and multilateral funds being allocated to health, and priority diseases such as HIV/AIDS. In a number of African countries, close to 20% of total health expenditures are now financed by external aid, posing a major problem with fragmentation since the money arrives at different times of the fiscal year, off-budget, and from multiple sources. The unpredictable nature of aid produces high transaction costs for recipient countries as well as causing aid volatility and doubts on aid effectiveness. The upshot is that as welcome as the financing is, countries find aid increasingly difficult to absorb and use effectively. An analysis of 14 case countries showed how aid was being disbursed:

- 30% not recorded in balance of payment;
- 20% in balance of payment but not in government spending;
- 30% earmarked to specific projects (some control, very often not); and
- 20% through budget.

The purpose of a compact to achieve the health-related MDGs is to improve aid effectiveness and provide a framework for increasing aid for health, which addresses fragmentation, volatility and reduces transaction costs.

A compact is a new business model to boost the SWAP for health-related MDGs results; a contract between the international aid community and recipient countries to reach concrete, verifiable results, based on mutual accountability and benchmarks. Obligation is on both sides to consolidate ONE single country plan, ONE single budget, ONE single policy and results framework, ONE single monitoring process, and in some situations, ONE single fiduciary process. The aim is to harmonize and rally donors

to a nationally organized process linked to measurable results, costed scenarios for scale-up and government leadership.

A compact is not a code of conduct nor is it legally binding. A compact is a MOU "with teeth", a mutually binding agreement, a contract that government and donors will sign, with clear benchmarks for development partners' and government performance against their commitment to fund one national health plan. Financing gaps are addressed per scenario, through multi-year commitments, with a disbursement calendar to reduce volatility, with alignment to country planning and budgeting, consolidating one budget planning process. This will condition the management of the assistance, with clear accountability for donors and government, integrated in country macro-frameworks, with joint schedules, clear donor mapping, financing gaps, joint matrices of policy milestones and results, with a planning and budgeting calendar and a joint validation process. The potential of a compact is to build consensus and inclusion of all stakeholders. Key issues will be the timing for trade-off and the role of Ministries of Finance in the endorsement of this process.

Panel Discussion: What is the added value of a compact? ***Representatives from Ethiopia, Mozambique, Cambodia, Ghana, and Ministry of Budget, Mali***

Ethiopia
With regard to the added value of the compact in Ethiopia, the representative outlined the following criteria: a) there should one budgeted plan for the health sector; b) it should allow for an evolution from project funding to one single budget funding; c) it should facilitate partners' commitment in moving towards an overall sectoral plan; d) it establishes a joint evaluation mechanism and joint annual review; e) it moves funds from bilateral accounts into a pooled global basket; and f) it contributes to strengthening mutual accountability and transparency.

Mozambique
The key elements of a successful compact should be: a) improved coordination between country governments and their development partners; b) focus on strengthening health systems, including human resources, c) improved procurement planning and management; d) engender more transparency and accountability; and e) joint analysis to identify problems in SWAps.

Challenges were identified, such as: the need to improve maternal and child health consistent with MDGs 4 and 5; the coordination of multiple stakeholders in the health sector; the need for more flexibility, predictability, and sustainability of funds; the exodus of trained health workers to jobs in OECD countries; the need to offer higher salaries and other compensation to retain trained national staff; and the need for improved coordination to reduce high transaction costs.

From the vantage point of Mozambique, a compact would add value if it endorsed the principle of one plan, one budget and one reporting mechanism, which would reduce transaction costs, integrate all earmarked funds into one plan and budget, and allow for all development partners to use one government plan and M&E framework and subscribe to one consolidated results framework.

Cambodia
The key recommendation for a compact is to close the policy disconnect between donors' headquarters and their country offices. In Cambodia, several mechanisms and tools have been put in place, which have increased funds for the health sector. The Minister of Finance has already doubled the budget for health and the percentage of national budget devoted to health has increased to 12%. Donors are now expected to fill the remaining gap.

Ghana
For Ghana, the added value of a compact should bring: a) increased resources to the health sector; b) flexible funds to respond to local priorities; c) a reduction of transaction costs while removing duplication; d) increased capacity to achieve results; and e) better coordination.

The representative from Ghana also raised the need to involve civil society at all stages of compact development.

Mali
In Mali, the PRSP PRODESS is a unique programmeming, implementation, monitoring and evaluation document that is based on the budget calendar. A MTEF is available in triennial and annual tranches and is included in the annual plan of the sector. As for the implementation of the Paris Declaration, an implementation plan has been developed. A budget support framework exists along with arrangement of all budget support and specific arrangements for the sector. Macro-economic matrices and performance indicators have been agreed with partners.
Added Value: The PRSP PRODESS uses national procedures, multiple partners, and uses the financial sector. A Joint Annual Review is conducted every year in November and June, to reduce the number of reviews organized by the health sector. There is now only one monitoring process. The PRSP PRODESS instrument allows Mali, through its commitments, to predict medium term assistance in the sector.

Session 3: PROGRESS & BOTTLENECKS IN DEVELOPING A COMPACT

This session asked countries to share their experiences in preparing a single costed, results-based national health plan, in a harmonized and aligned way, while ensuring its predictable, long-term financing.

Panel Discussion: Are we making progress? ***Representatives from Mali, Burundi, Zambia, and Nepal, Cambodia.***

Mali
Mali's development agenda is guided by a reference framework consisting of a Poverty Reduction Strategy Paper (PRSP) and a Sectoral National Plan (PRODESS), which includes the development of instruments for monitoring and evaluation. The leadership of the Ministry of Health is reinforced by the participation of civil society, which co-chairs with the government, in the harmonization of the planning cycle with the budgetary cycle. It is therefore necessary to facilitate political dialogue with donors in their budget support to reduce the number of procedures and facilitate the mobilization of additional resources (e.g., GAVI) in order to fill the gap and improve the predictability of funding. Nevertheless, a disconnect remains between donors at country and global level; instructions and guidance are not clear; parallel reviews and multiple audits exist in spite of the existence of a SWAp. Some partners have difficulty announcing the level of their commitment and certain resources remain targeted. There is an urgent need to receive clear directives to ensure sustainability, identify gaps, and to draw from lessons learned.

Burundi
Burundi emphasized that a consultation process between the national health sector and development partners has been in place since October 2007. This partnership has been reinforced since the signing of IHP+. A joint mission of all partners took place to develop a partnership framework for accelerated implementation of the national health plan. This framework was signed in February 2008, in the presence of the Minister of Health, Minister of Finance and partners. The framework aims to increase the efficiency of international aid, decrease duplication, and improve harmonization, resulting in improved health services both in quantitative and qualitative terms, with the preparation of a MTEF. The challenge is thus to improve coordination for the generalization of functional health districts, mobilize human resources, and reform paramedical training.

Zambia
Zambia described how they developed a health sector policy for harmonization towards SWAps, which had been mobilizing external aid since 1999. An MOU has been developed, based on a very robust coordination framework. However, 80% of the country's external aid is still allocated through vertical partners' programmes, producing huge unpredictability and volatility, and uncertain disbursement dates. Not surprisingly, this has a negative impact on implementation, which is further impeded by having to accommodate many different reviews and donor missions. Zambia felt this would improve considerably if resources flowed via basket funding.

Nepal
All development partners have signed up to the health sector reform under the government's leadership, with a regular monthly health partners' forum. The government could use the partners' forum with all stakeholders to discuss indicators, report on progress towards a compact, and draft a road map with timelines. Nepal wanted to know more about the potential added value of a compact; how to better harmonize development partners; whether the same partners could sign a compact at the country level, or was this something that necessitated the intervention of their respective head offices. In conclusion, Nepal noted that the main recommendation for a compact is whether or not it can leverage additional resources for health.

Cambodia
Cambodia is interested in developing a compact. However, they noted a recurring pattern that exists: when countries lead, donors fund; when countries implement, donors advise; but when a country fails, donors blame. This tendency illustrates erratic behaviour on the part of donors. Cambodia observed that during previous panel discussions, only country representatives spoke about their experiences in navigating bottlenecks en route to a possible compact. Where were the donor voices on these panels? Donors need to clarify how they plan to change their behaviour since they themselves are an obstacle to faster progress at country level.

In response, ***Agnès Soucat of the World Bank*** ventured that a compact can add value in three ways:

1. Through harmonized support that is integrated in the budget with donors committing to very specific performance benchmarks.
2. By a clear commitment from major financiers to mobilize money and respect their benchmarks.
3. By allowing countries to focus on achieving results though more predictable, long-term resources, once aid is effective.

Session 4: ROADMAPS TO DEVELOPING COMPACTS

The purpose of this session was for countries to share future plans to prepare the components of a compact and to develop formal compacts (if intended). How can we do better together, building on existing MoUs, Codes of Conduct, and SWAPs? How to bring most resources into a harmonized pool?

Panel Discussion: What are your future plans? *Representatives from Kenya, Niger, Benin, Burkina Faso, and Madagascar*

Kenya
Kenya noted that the country compact is still being developed. However some tools have been developed. Kenya has a Code of Conduct, which contains elements of a compact; a joint work programme between national authorities; and a MoU between Kenya's Health and Finance Ministries and all development partners in the health sector, with the exception of the global health initiatives—which is still an issue, and other third parties.

Some challenges have been identified, such as: the determination of benchmarks and monitoring indicators; predictability of aid and weak coordination; 'walking the talk' and weak accountability; and complex procurement procedures involving multiple partners that are not aligned with government systems.

Kenya added that they do not need to develop a compact as such, given that their current Code of Conduct has all the same elements as a compact. They also noted that only countries are held accountable for their actions; donors are seldom held responsible for their behaviour.

Niger
Niger noted that following the Paris Declaration on Aid Effectiveness, a maximum amount of resources for the fight against poverty has been secured; and a code of conduct, which is currently being revised, has been developed. Other actions include the continuation of work with partners towards a sectoral approach (health, education, rural development), advanced financial reforms, public procurement reforms, reinforcement of governance, sectoral coordination mechanisms with partners, partnership framework with principal partners (France and Belgium) for a common action plan, a joint follow-up and a review process at all levels of the health delivery system, signed for PDS 2005-2010 and DSRP.

Budget and planning tools have been implemented in Niger within the framework of the PDS; five-year scheme of work to define priority activities: MTEF 2005-2008; capital spending programme 2008-2015; annual planning process to involve all partners; and a monitoring and evaluation guide with partners.

The goals are to reach the MDGs, to implement the nutrition plan, the child survival plan, the maternal health roadmap, and the continuation of resource mobilization to speed up the implementation.

Bénin
Benin noted that the PNDS 2008-2017 is the framework document developed with the participation of all stakeholders. Other actions have been undertaken and others planned, such as a single monitoring plan, a review of the health situation, an analysis of bottlenecks in order to ensure a link between the PNDS and MDGs, the development of a Code of Conduct, an annual sectoral review for 4 years, and an annual performance audit of the health sector. The country is not yet engaged in a SWAp or in the development of the Compact. A workshop will be organized to share the lessons learned from this meeting and to analyze the relevance of a Compact.

Burkina Faso
Burkina Faso has no Compact yet. However, some instruments and mechanisms have been developed. In 2001, the PNDS was developed, and the budget is linked to the strategic plan. A sector round table

for resource mobilization was organized and mid-term reviews of the PNDS are conducted. Today, progress towards the MDGs is insufficient and the 2006-2010 period is focused on quick-win interventions to make greater progress towards achieving the MDGs. However progress is being made and the following instruments are in place: the multi sectoral framework, development of national health accounts over the last few years, a better coordination of partners, the installation of the performance criteria of the government, and prospects to develop criteria for partners. Burkina Faso is implementing a SWAP with 5 partners.

Madagascar
Madagascar elaborated that by the end of 2006 the health sector development plan was developed, thus enabling the SWAp process to start in 2007. Joint missions of UNFPA, UNICEF and WHO were conducted, and an International Conference on the SWAp was organized; the Madagascar Action Plan (MAP)which replaced the PRSP and whose objective is to reduce mortality by 50% in 10 years was developed; the health sector development plan was adjusted to be in line with the MAP; and an MTEF was developed. The development of a Compact is planned for the end of 2008.

COMPONENTS OF A COMPACT

Session 5: NATIONAL PLANS AND STRATEGIES

This session, introduced by **Dr. *Yaw Ansu (World Bank)***, highlighted the main attributes of a good national plan as being those that were linked closely with a PRSP, included a governance plan, had a sound technical basis, and a clear financial plan.

A presentation by ***Tim Martineau (UNAIDS)*** featured a progress report of a working group on the different dimensions in setting up effective national strategies and plans. This focuses on three work-streams: (1) on defining a set of attributes for sound national health strategies; (2) options for appraisal of these strategies; and (3) issues around HIV/AIDS and health plans.

A second presentation by ***Dr. Nejmudin Kedir (Ethiopia)***, described his government's views on what constituted an ideal national strategy and plan. These included:

- A systematic analysis of bottlenecks.
- A participatory process that ensures universal 'buy- in'.
- Agreement on key interventions.
- Agreement on mode of delivery.
- Establishing a communication strategy for the plan.
- Ensuring a human resource base and an efficient supply chain.
- Identification of the resource gap that needs to be filled, clearly identifying the local vs. external resources needed.
- Local and district plans linking to the national plan.
- The necessity of having one M& E plan.

A third presentation by ***Carol Nyirenda (CSO representative from Zambia)*** featured the views of national civil society on what constituted 'ideal' and sustainable national strategies and plans in health and HIV/AIDS. Her presentation highlighted the value-added characteristics of CSO involvement, and possible mechanisms to strengthen their involvement in the IHP+. The main value added was the advantage of bringing the views of health consumers to the table in order to hold governments accountable. Civil society representation should be formally codified, she said, with equal voice in the deliberations at all stages of a compact's development. In order for civil society organizations to be effective, plans need to include their financial support as well as their communication facilities. Given the importance of this discussion, a special session was held at the meeting on CSO engagement in IHP+, with a panel discussion involving World Bank, UNAIDs and Civil Society representatives from countries.

Issues arising during the subsequent discussion

Regarding the role of civil society, there were frequent comments relating to the need for active civil society at all levels of partnership strengthening. The emphasis should be on country plans, not merely those blessed by governments. As such, all stakeholders, including the private sector, and civil society, need to be regularly engaged. Concrete steps on how this participation would be carried out need to be outlined.

Looking at the planning process, as opposed to focusing on detailed, comprehensive plans, the emphasis of the planning process should be on ensuring that the national plan can help the country achieve their national priorities while ensuring the 'buy-in' of the major partners. A compact needs to go beyond quick wins. It needs to include plans for long-term development and health systems strengthening. The linkages between health and HIV/AIDS also needs to be strengthened; there needs to be consistency between HIV/AIDS components of health plans and health components of HIV/AIDS plans.

The lack of reliable data is a key hindrance to developing good plans, particularly at the sub national level. It is important to disaggregate data to sub national levels, so it is clear how differences at these lower levels can be specifically addressed. This should ensure the linkages of these plans, with results at the sub national level.

The validation process, after development of the plans, is very important, to ensure buy in for all, even those not involved in development of the plans. There is a need to make accountability mechanisms easier to understand, away from the broad terms relating to transparency, validation, international involvement, etc.

Finally, the success of the IHP+ is dependent on its ability to bring on board the big donor partners and understanding their requirements.

The participants then focused on country-based discussions, to report back to the Plenary the following day, focusing on:

1. How results focused are the existing national strategies and plans?
2. Is there ONE national strategy and plan for all health related MDGs?
3. How can National strategies and plans be improved (e.g. made more results-focused, and / or harmonized)?
4. Other relevant issues

Session 6: A COMMON FRAMEWORK FOR MONITORING PERFORMANCE AND EVALUATION.

Dr Hedia Belhadj, UNFPA, chaired this session, which acknowledged that the IHP+ requires a harmonized monitoring and evaluation effort that enhances the evidence base for intervention packages, reinforces both country and global needs to demonstrate results, and secures future funding. A common framework was proposed that has inbuilt demand for accountability and results whilst ensuring initiatives are well coordinated in monitoring performance, evaluation of progress and results in countries. The framework emphasizes the need to strengthen country health information systems as well as the need to enable evidence-based decision making.

Dr Ties Boerma of WHO described the framework development process, which started in October 2007 with the development of a working paper for a Technical Experts meeting in December. The paper subsequently received feedback and inputs from 8 countries, bilaterals, global partnerships and UN agencies. The framework addresses the current problem of having too many indicators and tools with little effort to address country capacity development. The framework is designed to be embedded in the

health development process with an emphasis on identifying health system factors, which are crucial for interventions scale-up whilst laying emphasis on accountability.

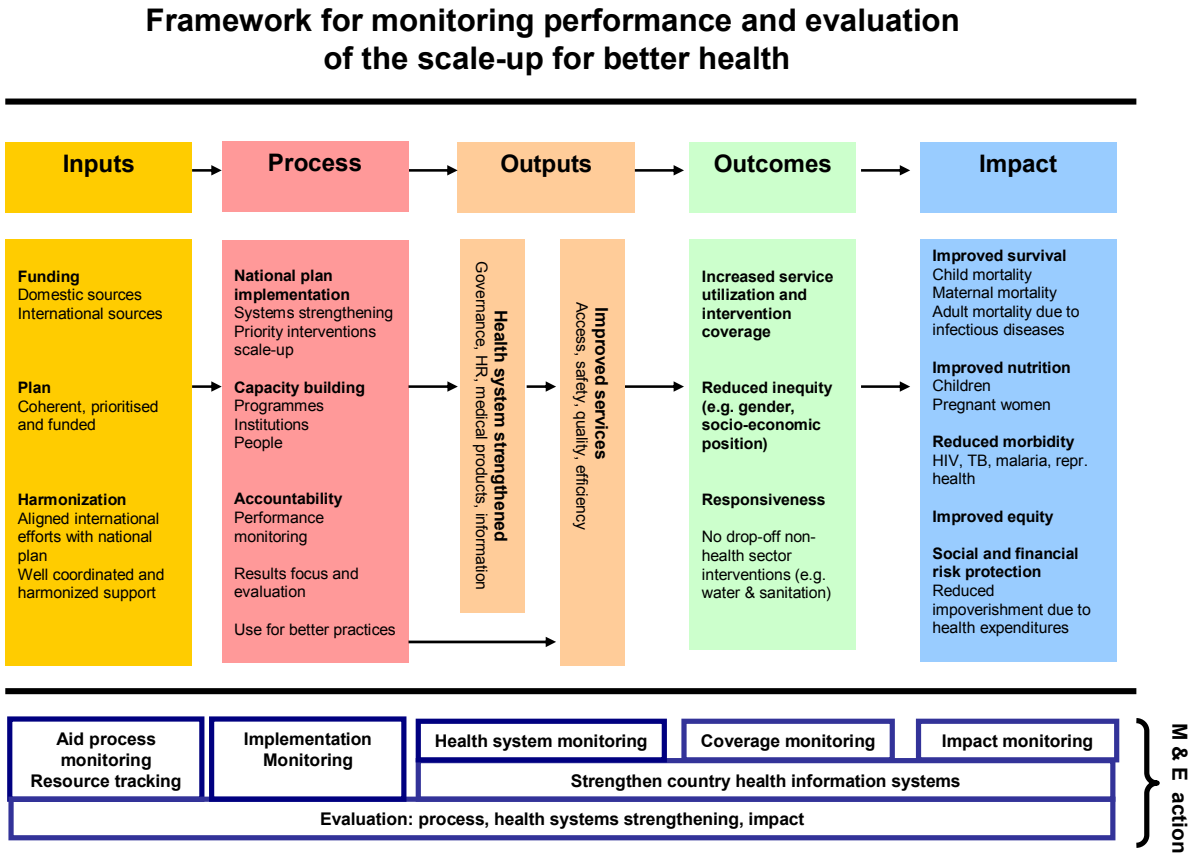
The common framework process carries three risks, which must be avoided:

1. It could lead to more indicators being developed and more reporting obligations – currently the number for various initiatives and programmes varies from 20 for Health for All, to 101 for World Fit for Children.
2. It could draw our attention away from capacity development for health information systems.
3. It could lead to evaluations planned and conducted outside the programme by external experts.

THE FRAMEWORK - THE EVALUATION PROCESS

The framework shows the sequence used in monitoring and evaluation frameworks from **INPUTS, to PROCESSES, OUTPUTS, OUTCOMES and IMPACT (**Figure 1).

Fig 1. Framework for Monitoring Performance and Evaluation of the Scale-up for Better Health



The framework is based on 6 principles enshrined in the Paris Declaration

1. **Collective action –** contribution of the collective effort rather that attribution based on individual organization efforts.
2. **Alignment with country processes –** building upon national processes that countries have established to evaluate and review progress of health sector plans.
3. **Balance between country participation and independence -** driven by country needs but conducted in an objective manner.

4. **Harmonized approaches to performance assessment** – using common protocols and standardized outcomes and measurement tools with appropriate country adaptations and leadership minimizing the separate evaluation efforts of individual initiatives.
5. **Capacity building and health information strengthening –** by systematic use of country institutions and systems in monitoring and evaluation to build capacity.
6. **Adequate funding –** about 5 – 10% of scale up funds set side for monitoring and operation research activities.

The framework proposes key issues to be addressed at country and global levels and sets FIVE goals with corresponding actions and responsibilities to be achieved in 2008. These include:

1. Aid effectiveness monitoring.
2. Integrating initiative specific plans into the common framework.
3. Alignment with national information systems.
4. Harmonization of international reporting requirements.
5. Health systems monitoring.

A number of issues were raised

1. A suggestion was made to focus only on outcome indicators.
2. There is a need to ensure that Headquarters of different agencies do not put demands on Country Offices to undertake separate reporting.
3. Data use should be encouraged at the point of collection as an incentive to ensure data quality.
4. Suggestions were made that data collection should prioritize information that supports service delivery of the most critical service delivery areas like availability of staff and drugs, which are lacking in most systems.
5. In principle reporting obligations should not go down to project level.
6. Strengthening capability to use data was seen as the crux of the matter.
7. Independent monitoring role of CSOs should be valued.

This session concluded with a brief overview by ***Agnes Soucat*** (World Bank) and ***Rudolf Knippenberg*** (UNICEF) on some of the emerging issues around results-based financing and budgeting. These discussions will now be taken forward in an inter-agency Task Force.

Session 7: HARMONIZATION AND ALIGNMENT: ARE WE WALKING THE TALK?

Opening the session, Chair, ***Dr Andrew Cassels, (WHO)***, noted how there has been considerable discussion in recent years on the need for greater harmonization and alignment in the health sector, and therefore, many of the issues being raised in the Lusaka meeting are not new. What ***is*** new, he ventured, is the current high-level of political support to address challenges, which provides a real opportunity to make progress.

Moving forward will require being *clear and specific* about what needs to be done. While the Paris Declaration sets out guiding principles, it is at a fairly high level of generality. The next step is to identify concrete actions in specific areas – such as predictability of financing; bringing a wider circle of development partners into national processes; harmonizing procurement rules; and establishing common approaches to the monitoring and measurement of results.

Panel Development Partners

Country groups were asked to spend 30 minutes identifying specific issues that would advance the aid effectiveness agenda in their countries. These were then put to a panel of donor representatives for response.

The following general questions were raised to guide discussion:

- How *far* and how *fast* partners can move with the Paris agenda?
- How to improve communication between HQ and country offices to ensure that the latter comply with commitments made by the former? How can compliance be enforced?
- Why do donors use different modalities in the same country? What guides the choice of modality in a specific instance? Is there a coherent approach between donor agencies?
- What guidance do HQs give their country offices in aligning and harmonizing around country plans and budgets?
- How to improve predictability - why are some funding commitments not honoured and, conversely, why are unplanned funds provided?
- Is there a common donor position on fiduciary issues? What drives donor assessment of fiduciary capacity? Do donors have a common approach?
- How can donors better harmonize missions?

Responses

- The level of delegated authority to country teams can vary greatly from donor to donor. Some programmes may be represented by very junior staff with no technical knowledge – resulting in inappropriate funding decisions.
- Donors that provide small amounts of resources often have unrealistic opinions about their level of influence over the planning processes.
- Many development partners said that while they were committed in principle to using national systems of financial management and procurement, in practice concerns about fiduciary risk prevented them from doing so. Accountability to tax-payers in developed countries remains a key issue for many partners. Nevertheless, the Paris Declaration and its associated commitments mean that many partners are making greater efforts than previously to provide pooled funding, use country systems, and align behind national systems, etc.
- The link between increasing levels of ODA and management of fiduciary risk will be crucial in the future, as new resources come on stream. This in turn is linked to finding mechanisms to validate national plans – so that funding can flow more quickly.
- It is important to acknowledge that slow progress towards more programmatic approaches is not always the fault of donors. Often, there is resistance to such approaches – for example from those who currently benefit from Project Implementation Units, or from targeted programmes that fear being subsumed in a national effort, and from CSOs. We need more country experience on this.
- It is important to acknowledge that fulfilling the Paris Declaration commitments will be more difficult in some countries than in others; we need to understand these different types of challenges better.
- EU donors are taking their commitment to a more rational 'division of labour' seriously; this aims to reduce the number of donors active in a sector. Delegated co-operation is one example of how this can work in practice.
- At global level, bilaterals should make better use of their place on the boards of multilateral institutions, including the World Bank Group, the Global Fund and GAVI, to increase the compliance of these organizations with the Paris principles. A stronger voice for countries on the boards of multi-laterals is also important.

- The Global Fund noted its commitment to the Paris principles. When the Global Fund was first established, there was an urgency to disburse funds, so project modalities were favoured. Now, there is reflection on whether those modalities are best suited to countries – and as a result, an effort is under way to make Global Fund procedures more flexible and country oriented.
- We need to live with the political reality of new initiatives, recognize the value of the dedicated political commitment that they bring, and learn to manage them. The reality is that most partners will retain a diverse portfolio of funding modalities into the future.
- It is important not to confuse the Paris Declaration with the development agenda – we have to ensure that the former supports and contributes to the latter, and is not an end in its own right.
- Finally, a question was raised as to whether IHP partners should identify a harmonization road map at the global level, as well as their own compact, before asking countries to do so.

Summing up: countries complain, donors explain. Points

- Donors and countries are on the same side and want the same results, so why have we ended up with such a complex aid system and such a variety of approaches?
- The answer is partly because there many different interests and stakeholders involved, often pulling in different directions. IHP+ presents a real opportunity to help bring things together.
- It's important to be clear and specific about what donors can and can't do differently. Ironically, global health partnerships are often leading the way in terms of pioneering new approaches and new ways of doing business.
- A better "division of labour" between development partners is crucial to managing the complex aid architecture. Partners must be able to represent each other.
- Procurement represents one of the most difficult issues in aid effectiveness, but tackling it is necessary if our efforts are to have credibility. DAC is developing a common framework on assessing procurement capacity – but is it applied consistently?
- Is pooled funding synonymous with effective aid? We need to consider this assumption carefully. Budget support can be turned 'on' and 'off', and may also reduce the scope for technical dialogue.
- Finally, several countries pointed out that they have embarked on a process to improve their national plans, to establish common monitoring frameworks, to improve co-ordination among partners. They now need donors to sign up and support this process. We need to make this support real - and not worry about the initiative that promotes it – and put a process in place to ensure that good plans get funded.

Session 8: FEEDBACK FROM COUNTRIES - NATIONAL PLANS AND STRATEGIES

***Dr Peter Salama, UNICEF*,** chaired this eagerly awaited session, where six countries (Cambodia, Ghana, Mali, Madagascar, Burundi, and Zambia) reported back to the plenary on the results of their discussions emanating from Session 5, and on planned changes to their national strategies and plans.

Cambodia

Cambodia is developing a health sector plan for the period 2018-2015. The plan will be implemented through three programmes: reproductive, maternal, neo-natal, and child health; communicable diseases; and non-communicable diseases. Health system strengthening is a key element to support these programmes. The plan will be implemented in two phases: a consolidation phase and a scale-up phase. Details of the implementation of the plan will be designed in a decentralized manner.

To monitor and evaluate the implementation, 20 core indicators will be surveyed as compared to 130 indicators before. The initial target will be activities that can produce immediate results.

Ghana
Ghana has developed one harmonized health sector plan with a 5 year work programme and annual plans. Government and partners have agreed on one harmonized budget to support the plan. The plan has been developed through an intensive consultative process including bilateral and multilateral partners and civil society. It contains key implementation elements and indicators. The current challenge is to align the partners around the implementation of the plan. At present, Cambodia's main donors are moving away from basket funding (pooled funding) to budget support while other donor resources are earmarked to activities that do not necessarily match up to the priorities set by the country.

Mali
Mali has developed a health sector plan for 10 years after a wide consultative process. The focus of the plan is the poor. The plan is costed and features different scenarios based on several budget forecasts. The plan is linked with the MDGs and has distinct district sub-plans. The current challenges are to make the plan more results-oriented and to develop strong public-private partnerships, including CSOs, to achieve better results.

Mali is concerned by the lack of alignment of many donors with the national plan, which was the result of multi-stakeholder work in which they took part.

Madagascar
Madagascar started its SWAp process 2 years ago. The country has one health sector plan with specific programmes focused on priority diseases and health issues. The plan still needs some fine-tuning in order to be more results-oriented. The development of the plan included participation of different stakeholders including the Ministry of Finance and civil society. As it is, the plan does not need any substantial change.

Zambia
Zambia is implementing its third Heath Sector programme. There is a strong coordination mechanism and the performance monitoring system (regular DHS, Malaria Indicator survey) is able to report on almost all indicators. A joint sector review is done on yearly basis.

Burundi
Burundi just started with a health SWAp. They have developed a national health sector plan which includes all health programmes with less integration. Several task forces have been set up to handle cross-cutting issues. The lack of human resources is the biggest constraint for the implementation of the plan.

Wrap up

The Chair summarized the session and raised two issues:
- The need to get the health planning process right -- for mutual accountability
- The need for donors to follow country priorities.

Most IHP+ countries have a national health sector plan developed and supported by health partners. But little has been achieved in terms of good M & E systems to link planning and budgeting with results.

Session 9: FEEDBACK FROM COUNTRIES on the 'ONE' Results Framework

As in the previous session, a group of selected countries (Zambia, Benin, Mozambique, and Nepal) reported back to the plenary on the results of their respective roundtable country team discussions.

Zambia
An overall framework for M&E exists within the national health strategic plan. This has evolved in an iterative manner since the health sector reform started in 1991 and currently includes the three 'ones'. Many other countries have learnt lessons from these efforts. Zambia has now 'matured' to sector investment plans and is currently drafting their third costed health sector investment plan. Strong coordination mechanisms have also matured over the years, reducing transaction costs and the current plan is really being developed in a collaborative way.

The health sector monitoring framework includes a) using the existing Health Management Information System (HMIS) from the health facility level, which has been in place for 6-7 years on a background of efforts over 10 years in all districts who are currently able to report on service delivery indicators and b) using population-based M&E frameworks, which include various population-based sources of information (e.g. demographic surveys for indicators) and disease specific analysis (e.g. malaria survey). Joint annual reviews and performance assessment to try and support service delivery levels. There is an overall need to build capacity for data collection, collation, analysis, feedback and effective communication. Human resource capacity is the greatest constraint.

Benin
Software is being used extensively to collect and analyze data but Benin is currently not able to integrate data from all partners or share best practices. The SWAp and compact monitoring will need analysis of real time data, which implies (1) acquiring new software to review data collection systems and (2) strengthening HR in HMIS.

Mozambique
Mozambique aims to improve the existing M&E framework but performance assessment frameworks will need to reflect concerns of global initiatives. Constraints include responding to the reporting requirements from different departments and donors. Reporting can be incomplete – especially from NGOs. Generally there is lack of investment in HMIS, but this requires building up and harmonizing with global initiatives indicators. Mozambique is looking forward to a common M&E framework from global partners. Good practices include complementing routine reporting with surveys to assess data validity.

Nepal
Routine data collection systems are in place from village to national levels, but parallel reporting exists in HIV/AIDS. Reports are reviewed annually; there are also biannual reviews with donors and periodic surveys. Good practices include annual production of population status and estimates and high-level M&E meetings. Civil society has started public auditing at the community level, which contributes to the reporting system. Weaknesses include weak links between M&E with planning and budgeting; difficultly in estimating the population; lack of implementation of results based M&E frameworks; and lack of an overall M&E plan or calendar or overall M&E framework for donors.

Nepal needs to strengthen M&E capacity, increase the skills at clinic and district levels, and raise the profile of M&E. A way forward includes instituting monitoring teams supported by tools and resources at all levels, data analysis at all levels, strengthening the interpretation of data, improving links to budgeting and planning at all levels, standardizing donor M&E framework, and institutionalizing the public auditing system.

Discussion

Ties Boerma (WHO): Constraints highlight the fact that M&E is a neglected area. Countries state that they have the basic elements in place and yet data remains poor. Zambia replied that most of their routine information sources are not analyzed and there is a need to strengthen the infrastructure to manage data.

Rudolf Knippenberg (UNICEF): What would it take over the next two years to ensure country indicators are linked to budgets and plans? how can we ensure that all the relevant MDG 4,5 and 6 indicators are the same internationally agreed ones and how can we ensure the figures are validated? It is these three criteria that will give teeth to the compact and results based financing.

Nepal: Results based frameworks should be meaningful to all partners and donors and there needs to be space in the compact itself for M&E.

The Global Fund strongly supports the common framework and toolkit for health systems monitoring. We all need to invest in data collection and analysis to be able to support these efforts, but data is not coming out – weak linkages remain between M&E and plans and actual use of information. The Global Fund endorses any recommendation that M&E should be 5-10% of funding. Why countries are reluctant to invest in M&E, and what can be done to prioritize this?

DFID: Can GAVI clarify whether countries can apply for monitoring issues in their proposals?

GAVI: If HMIS is regarded as a major health system bottleneck to increasing immunization coverage, then countries can apply for funding for HMIS. Of the 29 countries which have been approved, approximately 5% of total budget will be spent on strengthening in-country HMIS systems; 4 countries have specifically asked for funding on HMIS issues. GAVI also highlighted the dilemma of donors requiring more information and donors wanting to be more Paris friendly.

Canada: How will the IHP+ mechanism help donors come to a common agreement on indicators? IHP+ should bring together donors on agreement.

Mali: Human resource mapping and coverage tools are also very important.

DFID: Mozambique has 15 people to implement M&E in total – a significant build up of infrastructure is required. Global Fund forms and applications do not encourage consultants to get involved with the details required for M&E. Guidelines need to be clear and emphasize monitoring, perhaps make monitoring a condition in proposals to encourage countries to apply for such funding. If there are delays in reporting, the whole sector plan may be disrupted.

Norway: Teeth need to be sharpened by linking results to planning and budgets; some things will also come up with validation.

Mozambique: There is a need to strengthen the validation process and design a road map that requires more investment in Health Information Systems. There are concerns about validation of data at central level and this is totally dependent on health worker motivation, time and capacity as well as on the district level where no-one has the time or skills for monitoring or analysis. Basically the issue is one of human resources.

Zambia: DQA and performance assessments by district health information officers allow facilities for own self assessment using data that is being generated for HR at facility level. Global Fund support includes new tools but these are often applied in a vertical way. DHS are not cheap surveys; 5-10 % of all sources of all funds should be earmarked.

Nepal: Public / social auditing happens at village and settlement level – with health authorities, CSOs and local leaders. These surveys include reviewing what works, what does not, and lessons learnt. Promote accountability and transparency at service delivery level. Talk about processes and activities and what was and what was not conducted. Budget is allocated for this.

Burundi: need to learn the lessons from the AIDS response. The 3 ones has helped influence donor behaviour. Also strong investment in M&E – this has helped with programme design and with raising the profile.

Summary statement

Strong public health institutions have been built on investments into M&E (e.g., HIV/AIDS and immunization) and we already have the bare bones of a common M&E framework from the IHP+. The heads of the H8 agencies have now prioritized M&E and this could also be reflected in countries to increase focus on M&E within the IHP+. This will increase donor confidence.

If an emphasis is put on M&E within donor guidelines it is likely that countries will respond, e.g., The Global Fund in Round 7 encouraged the use of technical staff from agencies going through mock monitoring reviews, which helped increase the likelihood of approval.

Conclusions

- Agreed that there is a need for one national M&E framework.
- There are huge gaps in human resource capacity.
- There is a need to review and interpret existing data (e.g., cluster, MICS and DHS data).
- Three M&E framework conditions a) link with results based financing; b) feedback loops should help validate data and c) civil society and private sector should also be included.
- Public and social auditing (example from Nepal) show us how to become more inclusive and community orientated with M&E.

Session 10: FEEDBACK FROM DEVELOPMENT PARTNERS - HARMONIZATION AND ALIGNMENT

Chair- ***Dr Peter Salama, UNICEF***
Session objective: For Development Partners to report on planned changes to their behaviour with regards to harmonization and alignment.

Ethiopia
There are few development partners who have fully embraced the IHP+ philosophy. There is no SWAp, however all the elements of SWAp have been included but there has not been a discussion on modalities for sectoral/basket funding. IHP+ is therefore timely for Ethiopia and presents an opportunity for strengthening health systems. The main focus of the compact is to strengthen the health system and align the funding mechanism with the national system and ensure availability of resources at the Ministry of Health level. The compact must be politically robust to facilitate scale-up.

Kenya
The Code of Conduct (COC) has recently been signed in Kenya by some Development Partners, and this will be the "compact". IHP signatories who have not signed the COC are urged to do so. Areas of emphasis will be health systems strengthening; alignment with country processes, including joint funding arrangements and releasing money to government; reviewing COC annually to assess donor and government performance; and negotiating for new programmes with the Ministry of Health and partners. Other issues for HQ consideration include solving agency rigidity, predictability of funding, and donor incentives.

Burkina Faso
Burkina Faso is not a signatory to IHP and came as observers to the meeting. Burkina Faso needs to review SWAp indicators. Burkina Faso is planning for pooled funding to support the national plan and to include World Bank funding for nutrition programmes and Global Fund for malaria. Alignment of the Bill and Melinda Gates Foundation is needed for effective sector dialogues.

Niger
In the same situation as Burkina Faso: they have a development plan and an M&E system signed by all development partners. Areas for support include sectoral reform and technical support to improve the procurement and tender systems. Conduct evaluation to inform financial support to MOH plan. Niger is experiencing difficulty getting commitment from country even though there is goodwill. There is a need for more advocacy for implementation of health programmes.

Additional comments on Donor actions

Mozambique
The presence of many partners leads to increased transaction costs. There is a need to reduce the number of donors while keeping the level of funding the same. Unpredictable funding needs to be addressed at the global level. Overhead costs are very high and need to be reduced. There is a need to explore opportunities for maximizing the flexibility of funding sources, such as making PEPFAR funding more long-term and support the essential health package. In addition to mobilizing resources, IHP+ can also help resolve some of the existing problems with funding sources. Create robust plans to fill the financial gaps and ensure efficient use of resources.

Ghana
Harmonization creates fiduciary risks for donors. Donors should share the conditionalities for funding with countries to facilitate the process. Each country has characteristics, risks and requirements that donors have to comply with. There is a big difference between the health systems in developed countries and Africa so the M&E framework should have realistic indicators that take contextual differences into account.

Nigeria
While there is enthusiasm from donors and countries and many meetings, little progress is made. Why have we not moved beyond enthusiasm and why has it not been translated into action? In response to a concern raised about the decision making power of the donor representatives on some of the issues raised, the meeting was informed that the participants have no decision making power.

Benin
Sought clarification on whether there is a common understanding of disbursement conditions. They wanted to know what countries should be taking back home as many countries had presented challenges but had not received concrete responses to address the issues. In response, the missing link was identified as lack of involvement and communication from the Ministers/politicians in IHP+ countries to the H8, urging them to change the systems.

Netherlands
The work at hand should not be underestimated; African countries should come up with their own solutions. Harmonization should mean countries should accept what they can use and refuse funding that causes problems.

Summary

National plans are critical for increasing the confidence of Development Partners

1. Impetus to improve capacity building for results based financing.
2. M&E and data are critical.
3. There are global opportunities for additional funding such as PEPFAR, Global Fund, and GAVI.
4. There is a need to change incentives through annual reviews and incorporate donor performance assessment.
5. There is a need to work at country level to identify issues and work with institutions to solve them.
6. Development assistance to increase funding to countries to jump start activities.
7. This is both a political and technical process so there is a need to develop activism to take the process forward.

THE WAY FORWARD

This plenary session discussed the contents of a draft communiqué on next steps in the IHP+/HHA process to galvanize efforts by countries and donors to achieve the health MDGs.

1. Introduction

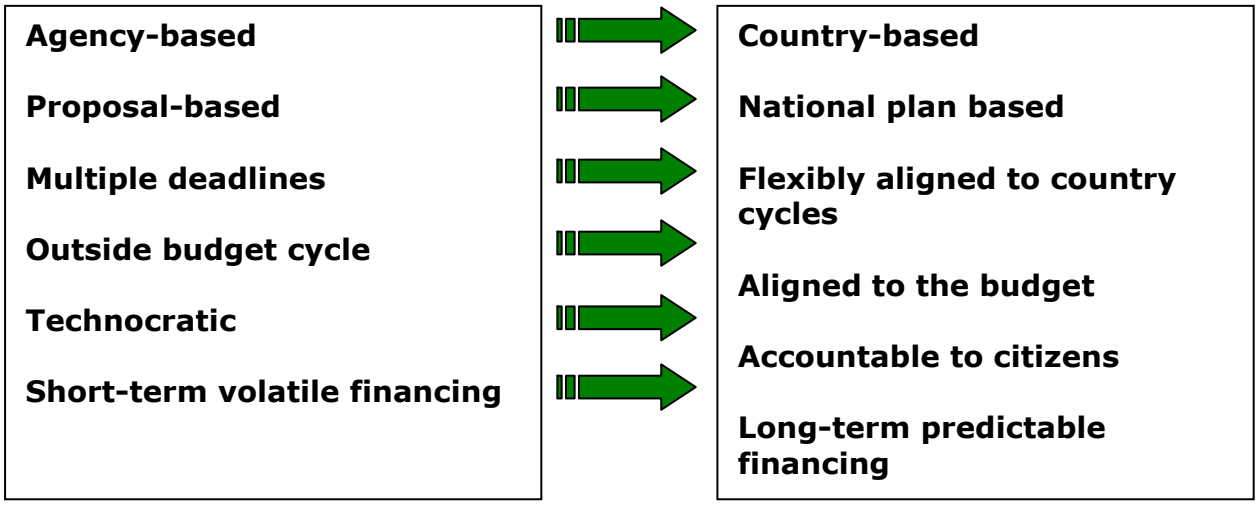
Thirteen country teams involved in the International Health Partnership and related initiatives, and the Harmonization for Health in Africa Initiative met with development partners, and civil society representatives between 28th February and 1st March. The objectives were to:

- Share experience and promote learning about sector-wide approaches and harmonization and alignment of national and international agencies in support of the national health plans, strategies and budgets, including MoUs, codes of conduct and compacts.
- Share experience about bottlenecks caused by development partners that hinder the effective strengthening of national health plans to achieve their results.
- Hear from the international community on how they are planning to change their ways of working in order to support partner countries achieving the MDGs.
- Consider how in-country coordination of different global and regional initiatives could be further improved to strengthen health services, and what actions are required at country, regional and global level for these improvements to take place.
- Provide feedback on global inter-agency policy work currently under way aimed at improving international assistance to national health plans and strategies, and strengthening country mechanisms for monitoring and evaluation.

The following sections describe a proposed way forward on issues discussed during the meeting.

2. Current understanding on what is a 'compact'

Central to the compact is the national strategic plan and how it will be used in the new aid environment that aims at putting into practice the principles of the Paris Declaration on aid effectiveness.



The meeting brought more clarity around the components of a country compact that commits development partners and governments to support one costed, results-oriented national health plan in a harmonized way that will ensure predictable, long-term financing from both national and international sources. It was agreed that a compact is a contract, through which the international community and the recipient country reach a broad agreement on concrete agreed on results, based on mutual accountability with obligations on both sides (see checklist below). The benchmarks represent the "teeth" to this process and will be monitored and evaluated in an open and transparent way. It was agreed that the 'compact' might come if different formats based on local circumstances and agreements, but some key elements were considered essential as described below:

However, the most important aspect of the compact is its process of development in country, building trust and common systems and ways of working. This process is by no means exclusive but should rather be seen as an inclusive engagement of all partners wishing to contribute to the achievement of results at country level.

The following elements were proposed for a checklist for the completion of a country compact. The final checklist will be distributed in March, noting that not all aspects have a consensus across all partners:

a. **ONE single country health plan** that includes the scaling up for health, nutrition, maternal, neonatal and child health, malaria, tuberculosis and HIV MDGs (MDGs 1, 4 ,5 and 6). This plan needs to integrate and be integrated with other planning processes, such as the multi-sectoral plans for AIDS, and into the country macro-economic framework.
b. **ONE single results framework** which is the basis for the monitoring process of the plan and the compact. This results framework will need to be linked to the plan, the budget, and include data collection and validation processes. It will specify clearly quantified results (outcomes/outputs), objectives and indicators which can be used to demonstrate progress towards reaching national health targets and the health-related MDGs
c. **One single policy matrix** which summarizes the key pieces of analysis and decision making required for the plan to be successfully implemented.
d. **ONE single budget** that will be the basis for funding. All external funding will be harmonized with the country's budget cycle. This does not mean that all funding needs to be in the form of budget support (see bullet j) but that donors who traditionally do not contribute to pooled funding mechanisms will allocate resources according to priority areas and line with timeframes described in the national health plan and budget.
e. **ONE single mutual monitoring and reporting process**, that is shared by all parties and forms the basis for the accountability of both national and international stakeholders.
f. **ONE single country-based appraisal and validation process for the country health plan** which includes key stakeholders and is accountable to citizens.
g. In some instances, ONE single fiduciary framework with a shared procurement and financial management procedure that should be aligned with country systems.
h. **Benchmarks for government performance**, which includes
    i. Measurable results targets for high impact interventions contributing to the health-related MDGs;
    ii. Costed scenarios for scaling up (at least three scenarios: needs based, resources based; and results based) and a phased budget that identify the financing gap;
    iii. Government commitments on domestic and general budget support allocations to health
i. **Benchmarks for development partner performance**
    i. Level of partner funds to fill the financing gap as per agreed upon scenario. This commitment should be in line with the medium term expenditure framework
    ii. Clear cross-partner agreement on a disbursement schedule linked to timetable for MTEF & national plan
    iii. Commitment to alignment with country planning and budgeting process
    iv. Commitment to alignment with common monitoring and reporting process
j. **Agreement on aid modalities**. The aid modalities need to be agreed upon with the appropriate country institution (Parliament, Cabinet, Ministry of Finance etc) according to

the government aid policy (e.g., budget support, pooled fund, project financing, funding non-state actors etc) and the policies of development partners.

k. **Process for resolution of non-performance and disputes.** A clear process for handling non-performance and resolution in cases of disputes and conflicts needs to be in place.

The following process is proposed to arrive at the completion (signing) of a compact, recognizing that all countries are at different levels in this process.

a. IHP+ core team will provide guidance on the elements of a compact in March 2008 and will facilitate a discussion by members of the Scaling Up Reference Group to achieve a consensus around the checklist.
b. Country teams develop and finalize the draft compact; depending on country circumstances and progress the time frame will vary from country to country and many countries have elements already in place.
c. Country team agrees on a process/mechanism for reaching consensus on the compact at country level that is acceptable to all stakeholders.
d. Possibly, organize a high level roundtable with all stakeholders in country. This round table could include for example, cabinet and parliament members, high level donor representation, citizen representatives etc.
e. Signing of compact and implementation

3. Monitoring and evaluation

The global M&E framework agreed across agencies (covering inputs, processes, outputs, outcomes and impact) now needs to be taken up at the country level and be linked to the planning and budgeting process, using the principles agreed, namely: collective action; alignment with country processes; balance between country participation and independence; harmonized approaches; capacity building and health information system strengthening; and adequate resources, both financial and human. To enable this to happen, the following actions will be required for all external health investments (i) using the framework as a basis to develop results focused evaluation frameworks for specific initiatives focusing on maternal newborn, child health, nutrition, HIV/AIDS, TB and Malaria; (ii) sharing and integration of evaluation plans and activities;
(iii) serious investment in evaluation, timely, with institutional capacity building link. As part of the roadmap to developing a compact, countries will therefore:

- Strengthen the M&E component in national health sector strategic plans and strategies and link this to planning and budgeting processes at all levels;
- Incorporate M&E of scaling-up initiatives in country plans and processes in a way that it strengthens the Health Information System (HIS) and is linked to analysis and use of data;
- Strengthen country HMIS in comprehensive manner by (i) addressing key information gaps: health systems, causes of death, & health impact, and (ii) support implementation of the Health Metrics Network framework for country health information systems, (iii) strengthen systems for analysis and validation of data; and (iv) reduction in the numbers of indicators being demanded by external agencies.

Investment in M&E systems is a priority for compacts and there is now a strong interest from external financiers. Financial resources for this could come from various sources, including UN agencies, development Banks and global health partnerships.

4. Changing development partner culture, behaviours and procedures

For the IHP and related initiatives to be a success, development partners will need to make changes to the way they do business, as agreed in the global compact that many signed in September 2007. Mutual accountability is key and will require periodic monitoring of global donor behaviours, policies and procedures. Suggestions for changing the way business is carried out included from those present:

- Increasing delegation of authority to country representatives;
- Ensuring country offices follow H&A policies agreed in HQ and that HQ policies take H&A policies developed at the country level into account;
- Cross-representation that maintains or increases resources but allows a reduction of numbers of bilateral and multilateral Development Partners in country;
- Use Board influence in multilateral agencies and partnerships to ensure adherence to the Paris Principles including the H&A policies;
- Review adherence to codes of conducts and compacts as part of annual health sector reviews;
- Peer review project portfolios and assist government in saying no to those whose transactions costs outweigh the benefits;
- Requesting country teams to give specific examples of needed behaviour change through informal and formal mechanisms.
- Amending policies and priorities to encourage longer term investments in the national health workforce.

Additional changes and developments may be specific for one or more development partners, for example:

- The implementation of the Global Fund board decision to finance validated national strategies, including consensus by partners as to the criteria and process for validation, will be a positive step in further advancing to the Paris principles.
- The lack of progress in harmonizing procurement policies across World Bank and UN agencies, was leading to continued delays in scaling up access to essential life-saving commodities. It was agreed that this was an unacceptable delay and all agencies and all partners should use their influence at the Board level of these organizations to assist in bringing forward a quick and urgent resolution. The World Bank and the UN agencies committed to take urgent action to resolve this burning issue.

For many of the changes to be successful, mutual accountability of national and international stakeholders, as agreed in the compact, will be key. To encourage these changes in behaviour, an independent review of progress with the IHP will include reviewing behaviour change and providing an open forum to feedback to Development Partners. Also, in the following few months development partners will be contacted at senior levels to inform them of the growing expectation of more resources being made available for health.

5. Engagement with civil society

The global IHP compact signed by many partners and countries made a commitment for civil society to participate in the design, implementation and review of the international health partnership. At global level, a consultation process has started with the development of a concept note that proposes several modalities of engagement. An initial step will be the inclusion of civil society in the bi-monthly dialogue with countries and development partners. At country level, there was a clear call for country teams to urgently strengthen the engagement of key stakeholders of civil society in the full IHP+ process (from design to implementation). This full engagement will ensure the accountability to citizens and all partners in this process.

6. Harmonized support for technical assistance and capacity development support

In Africa, the Harmonization for Health in Africa initiative is central to efforts for developing country-led, demand driven approaches for technical support. This should respond to country needs and timetables, and ensures quality and feedback mechanisms. This will help respond to critical areas identified in country, including:

- Development of costed, results orientated national plans and budgets
- Application of common monitoring and evaluation framework
- Harmonization and alignment of development partners
- Identification and removal of health systems bottlenecks, in particular human resources for health, in order to achieve desired results

For more information please contact the HHA Secretariat: Chris Mwikisa (mwikisac@afro.who.int).

7. Joining IHP. For more information on how to sign up to the International Health Partnership, please send an email to Bob Fryatt (fryattr@who.int), Nicole Klingen (nklingen@worldbank.org) or Rudolf Knippenberg (rknippenberg@unicef.org).

8. Inter-agency Working Groups

These will continue to complete their work according to agreed terms of reference and timetables, for example:

a. **National plans and strategies:** agreeing on criteria and mechanisms for appraisal and use of national strategies as a basis for funding decisions, and links between health and HIV/AIDs plans
b. **Results Based Financing:** facilitated by World Bank and Centre for Global Development.
c. **Common monitoring and evaluation framework:** taking forward agreements reached in this meeting.
d. **Aid effectiveness in health:** Preparing for the Accra meeting in September.

9. Monitoring of the way forward

The IHP+ core team will prepare a matrix, using information from country coordination and development partners work. This will help all stakeholders keep track of the progress of the process and the results achieved. This matrix will be available in mid March. In addition, the country teams will provide by mid March timelines on compact development. The IHP+ core team will facilitate an independent review process by civil society in order to evaluate the progress and impact of IHP+ at country level.

10. Report of Meeting

A full draft report will be available within one week of the meeting, with comments to be returned within two weeks. This will then be used to communicate the way forward and commitments made from all stakeholders.

11. High level political advocacy

Efforts will continue to widen the engagement of all partners that are committed to working with partner countries to achieve the health-related MDGs. The aim must be to look for a more binding global agreement engaging global senior politicians and cabinets to make these commitments become real.

High level events will be used to get endorsement of the process suggested in the IHP+ countries, to clarify what commitments have been made by national and international stakeholders, to inform wider stakeholders of progress and to mobilize additional resources. Key messages for these events will be prepared in advance by the IHP+/HHA core team. For 2008, these events include:

- HHA Ministerial meeting in Ouagadougou, April 25th tbc
- IHP+ Ministerial meeting during World Health Assembly, May 19-23
- TICAD and G8 meetings, May-July 2008
- Regional political forums, such as African Union, July 2008
- WPRO, SEARO and AFRO Regional Committees, Sept/Oct 2008
- Secretary General meeting on MDGs, September 2008
- OECD/DAC High Level Forum on aid effectiveness, September 2008

Annex 1

Inter-Agency, Inter-Regional
Country Health Sector Teams' Meeting
International Health Partnership & Related Initiatives (IHP+)
Harmonization for Health in Africa (HHA)

28 February - 1 March 2008
Lusaka, Zambia
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