ihp+

2008 □ EXTERNAL

review

of the **international health partnership**
+ related initiatives

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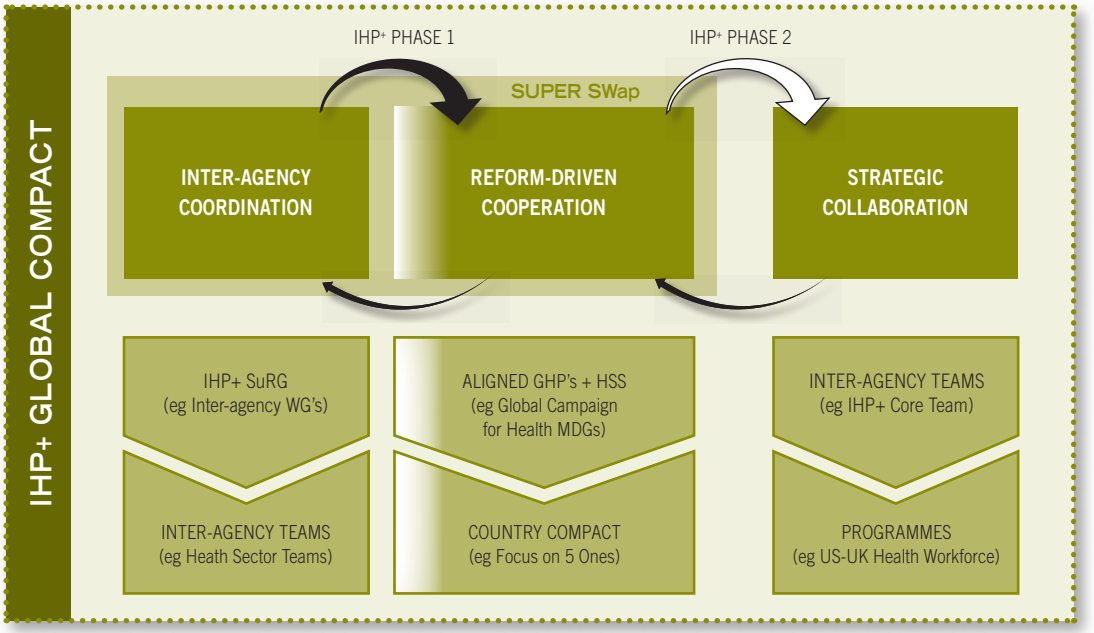
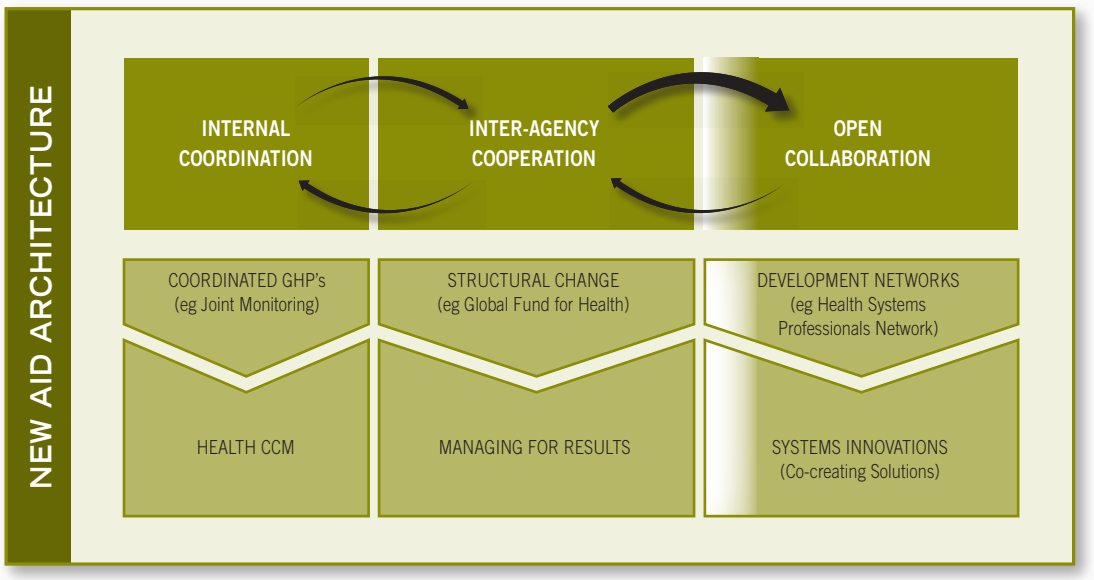
FIGURE 1: CONCEPTUAL FRAMEWORK

1. HARMONIZATION & ALIGNMENT PHASE

2. IHP+ REFORM PHASE



3. IHP+ RESULTS PHASE



preface

Moving from voluntary *harmonisation & alignment* to *mutual accountability* and *managing for results*

This first External Review of the *International Health Partnership and Related Initiatives* (IHP+) has been conducted primarily to start putting in place more formal mechanisms of accountability for the partners who signed up less than a year ago in September 2007 to a set of commitments defined in a *Global Compact* agreement.

These partners have agreed to cooperate more effectively to ensure that a handful of countries have a better chance of meeting their health Millennium Development Goals (MDGs). They are the same key institutions, donors and stakeholders that must be held responsible for whether these 2015 goals are met globally. If the IHP+ has the potential to contribute towards building a new *aid architecture* for this, we hope that the review will add to the conversations about what is possible and what still needs to change.

The IHP+ hopes to contribute towards strengthening national health systems for delivering scaled-up priority health services to the poor for producing *health results.* However, before reaching this *results phase,* we believe that development partners need to move from the current *phase of harmonization and alignment* that is characterised by voluntary aid effectiveness measures being taken by some partners in some countries, through a *phase of reform.*

The IHP+ provides the opportunity to bring about a phase-shift in development practice by fundamentally transforming the ways in which international agencies, donors, national governments and civil society cooperate[I] and collaborate to achieve results[II]. However, for this to happen, institutional boundaries need to be opened up and these organisations must start to operate with a different mindset, where attribution and control become less important driving forces, replaced by the higher aspirations of achieving the MDG's through cooperative *mutual accountability.*

It is still early days in the initiative and there is not yet enough evidence of change within the institutional machinery that is responsible for the *Aid Architecture* to know whether this is headed in the right direction. The IHP+ still needs to be tested by whether partners sign up to *Country Compacts* that will commit them to concrete deliverables - and what they do to implement these commitments over the next 12 months. It seems that reforming this architecture is more likely to be an evolutionary process that will continue to frustrate stakeholders because of the slow pace of change, rather than a revolutionary effort that will at least be adequate to achieve the high-level political commitments that have been made. Of most concern are the indications that donors are not following through on their funding commitments to the level of support that is needed to implement the validated and costed *National Heath Plans* that they have pushed for. Resolving this will depend on how effectively a global movement for health can be mobilised and how this can be translated into action at the local (sub-national) level within countries to make a real difference.

Conducting this review has been a privilege and a challenge that required an intensive effort over an extremely short period and I am grateful to my Review Team for their hard work and unfailing commitment to this task. We have benefited enormously from the contributions and critical advice of members of the *Independent Advisory Panel* that we brought together to add further expertise and credibility to the process. We wish to thank **Professor Gill Walt** (LSHTM, UK); **Professor Ruairi Brugha** (Royal College of Surgeons, Ireland); **Dr Thabale Jack Ngulube** (Centre for Health, Science and Social Research, Zambia); **David Wilkinson** (Independent Consultant and Khmer HIV/AIDS NGO Alliance (KHANA) Board Member, Cambodia); **Hailom Banteyergu**, (Miz-Hasab Research Centre, Ethiopia).

The IHP+ Interagency Core Team, under the leadership of Bob Fryatt and Nicole Klingen, has been extremely supportive in assisting the Review Team to undertake this work, including by facilitating access to respondents. Justine Hsu deserves special mention for her role in managing the Review on behalf of the IHP+ Scaling-up Reference Group.

Finally, we would like to express deep gratitude to the 100 respondents representing the full range of IHP+ partners at the international and country levels, for whom we hope that this report adequately reflects their voice.

We hope that this work will inform responsible action and contribute to the conversations about how to make the shared vision for global health translate into reality.

On behalf of the Review Team

Dr Shaun Conway (Team Leader)

Johannesburg, 25 August, 2008

contents

executive summary

The heads of the 8 major international organisations for health and of key bilateral donor governments signed a Global Compact in September 2007. In this, they agreed to be held politically accountable *for cooperating more effectively and with renewed urgency, at both the global and country levels, to strengthen health systems and scale up health care services, so that these produce health results*. The governments of 8 initial IHP+ partner countries agreed to cooperate by implementing their National Health Plans efficiently; strengthing health management systems; tackling misuse of resources; and to working with NGOs.

This Short-term Review of the IHP+ was commissioned by the IHP+ *Scaling-up Reference Group* to assess whether these partners are adhering to their commitments; to determine what progress has been made in securing and implementing Country Compacts in the IHP+ focus countries; and to review what progress has been made in implementing an IHP+ (interagency) common work-plan.

The review was undertaken by *Responsible Action* and the *LSHTM* between May and August 2008. This report is based on the opinions of 100 key informants who represented a cross-section of partner agencies, civil society and national ministries of health in the initial IHP+ countries and at the international level.

The key conclusions of this review are that:

1. The IHP+ has become established as a relevant response to addressing constraints to the health MDGs. However, its relevance is not widely understood. There are many who are still question what value this adds at the country level, especially in countries where measures to improve aid effectiveness have already been undertaken for some time.
2. Progress has been made towards preparing Country Compacts in 4 of the 8 initial IHP+ countries. However, there are some critical concerns about the Country Compact mechanism (detailed in the report). Real progress will depend on whether these agreements are signed by partners, including by the Global Fund and GAVI that do not have country-level representation or the mandate to make up-front funding commitments.
3. Most IHP+ partners have started to improve their harmonisation and alignment, although it is difficult to establish which of their actions could be attributed to their participation in the IHP+. A number of partners have not yet followed through with specific actions relevant to their IHP+ commitments.
4. Implementing the IHP+ is primarily a change-management process, which most partner institutions have not begun to invest in or to build the necessary competencies within their organisations to do business differently.
5. Whilst the conditions are being created at the country level for partners to work together in more mutually accountable ways, there is a real risk that the IHP+ could fail if partners do not take actions to reform and if the mechanisms for holding both donors and country governments to account are seen to be ineffective.
6. Transparency is seen as essential to ensuring accountability and this also depends on having reliable information available. The planned annual external monitoring and evaluation review of the IHP+ can potentially function as the key global accountability mechanism if this is well-designed.
7. It is still too early to assess what impacts or external effects that can be attributed to the IHP+, although this appears to be adding momentum to improved harmonization and alignment in some countries, mostly by building on existing country structures and SWAps. As the impacts of the IHP+ are likely to vary between countries, it is important to question whether the changes will be adequate to bring about the phase-shift that is needed for achieving the health MDGs.
8. Most IHP+ development partners place strong emphasis on performance-based financing, but country expectations for scaled up and longer-term financing based on MDG scenarios are likely to fall short. The failure by donors to meet their aid commitments is of critical concern.
9. The IHP+ is only sustainable if it starts to demonstrate its value by showing results, but measurable gains in health impacts will only be evident over the longer-term. In the interim, tracking improved service outputs - particularly for Primary Care services, needs to be the main focus. Operationalising the IHP+ Results Framework to track changes over time therefore needs to be prioritised. This requires urgent joint action to strengthen country management information systems.
10. The IHP+ process has started to properly engage civil society and this will be crucial to its success. Now the institutional partners need to learn how to cooperate with civil society as an equal partner to achieve reforms at the country level through providing the means for their participation in creating a movement for health.
11. The IHP+ has been well managed by the interagency Core Team that has made good progress in implementing the common work-plan. The SuRG has been an effective mechanism for global-level cooperation and dialogue, but this needs to have a more considered view of its strategic and operational roles going forward - particularly on its role in promoting institutional reforms. The constitution and Terms of Reference of Interagency Country Health Sector Teams, particularly the expected lead role of government, has been less well operationalised and will be crucial to ensuring that Country Compacts are cooperatively implemented.
12. Changes that take place through institutional reforms could potentially improve aid effectiveness beyond the IHP+ countries and even in other sectors.
13. The review raises a number of questions that need to be addressed for taking the IHP+ forward,

Recommendations are provided to Partners and the IHP+ Core Team. These focus on practical actions that need to be taken over the next 12-18 months in each of the following areas:

I. Improving how the IHP+ is communicated and understood to be relevant, both within partner institutions and amongst external stakeholders.
II. Investing in change management processes within partner institutions and through developing people's competencies to implement new ways of working.
III. Operationalising the IHP+ results framework and building in strong transparency mechanisms for mutual accountability.
IV. Working cooperatively to achieve reforms by partners identifying specific actions that need to be taken, making these explicit to other partners.
V. Focusing the IHP+ Interagency Core Team's efforts on the country level to promote and facilitate specific reforms, with suggestions for improved ways of working.
VI. Giving consideration to the idea of Local Health Partnerships that are underpinned by a People's Movement for Health, led by Civil Society.

II

the review

A. SCALING UP FOR BETTER HEALTH

The IHP was launched in September 2007[1], bringing together 26 signatories: 7 countries, 18 bilateral and multilateral partners, and the Bill & Melinda Gates Foundation to sign a *Global Compact for achieving the health related Millennium Development Goals*[2].

Central to the IHP+ is a *Global Compact* that defines its purpose and serves a public *mutually binding* agreement between signatories at the global level. It is intended to create reciprocal accountability between development partners and developing country governments *to cooperate more effectively and with renewed urgency, at both the global and country levels, to strengthen health systems and scale up health care services, so that these produce health results.* The IHP+ is expected to *create the sustainable and fair structures for health systems financing that are needed for building stronger health systems in low and middle-income countries.*

The IHP+ has been described as the translation into practice of the Paris Declaration[3] principles for achieving the health–related MDGs[4], through better aid coordination and a focus on results.

Mutual accountability and transparency are important principles of the IHP+. The heads of international organisations and bilateral donor governments participating in the partnership have agreed to be politically accountable for whether effective cooperation happens or not and for delivering the funding and technical support they have previously committed to the health sector. Recipient country governments have agreed to cooperate by implementing their National Health Plans efficiently; strengthening health management systems; tackling misuse of resources; and working with NGOs.

The rationale for the IHP+ has been well-described[5]. In essence, it is expected to strengthen national health systems to achieve health results by addressing long-standing fragmentation and unpredictability in official development aid for health, including the problems of[6]:

- Inefficiencies and duplication caused by the overlapping mandates of agencies;
- The complex *aid architecture* with its proliferation of global health initiatives that need to be managed, monitored and reported on at the country level;
- Lack of alignment of development assistance with country priorities or needs;
- Inconsistent levels of financing for health, such as increasing AIDS funding but inadequately funding other health priorities;
- Inadequate volumes and quality of aid financing that is mostly still restricted through earmarking and conditionality and tends to be focused on short-term priorities;
- External aid (including for AIDS, TB and Malaria) substituting domestic resources, rather than supplementing government budgets;
- Weak national health systems, with chronic under-investment in the health workforce and poor public administration; poorly functioning Health Management Information Systems (HMIS); and unreliable Financial Management Systems;
- Agency mandates and prohibitive ways of working that have created organizational deficiencies and liabilities, such as the lack of standardization and harmonisation across agencies;
- The failure of key health agencies to cooperate effectively with each other, or with country governments, to address these and many more problems.

Appreciating the complexity and scale of the challenges that the IHP+ is trying to address is important for understanding the context of this review. It is also relevant how the IHP+ fits within related development trends linked to the *Aid Effectiveness* agenda and to other reform initiatives such as the *One U.N.* (that is promoting systemwide coherence for the U.N. to deliver as one at the country level)[7]. The IHP+ arose from pre-existing developments, including the *High-level Forum (HLF) on the Health MDGs* (and *post-HLF* process)[8], and the *High-level Forum on Aid Effectiveness* (where *Health* is a *tracer sector*)[9].

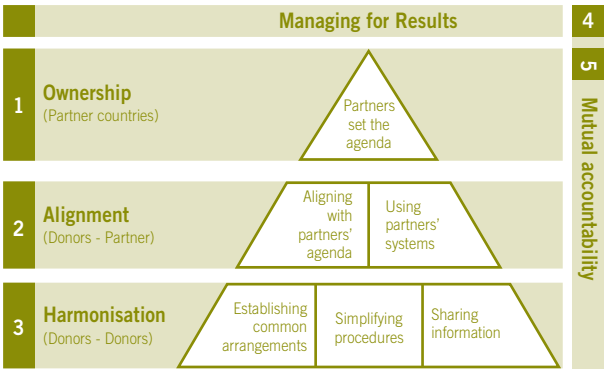
"Because donors have different - and often complex - rules and reporting requirements for the projects that they offer to fund, and because we don't have enough staff to manage projects in accordance with their rules and requirements, we can't actually make use of all of the funding that donors offer us for health" Dr. Tedros Adhanom, Minister of Health, Ethiopia (September 2007).[10]

The Paris Declaration on Aid Effectiveness[11] (in 2005) provids the basis for the IHP+. This describes how development partners need to reform the ways in which they deliver and manage aid *(summarized in figure 2) through:*

- *Better alignment with national priorities, systems and procedures*
- *Integrating aid with recipient countries' broader development agendas;*
- *Promoting collaboration between donors;*
- *Harmonising programmes to reduce fragmentation and duplication of donor aid and lessen transaction costs;*
- *Improving the predictability and increasing the timeframe of funding commitments;*

- *Improving donors' accountability and that of recipient governments by developing measures to reduce corruption and lack of transparency among recipient governments and to draw on and strengthen country systems for performance management;*
- *Strengthening leadership within countries; and increasing private sector and civil society involvement;*
- *Managing aid delivery to achieve results.*

FIGURE 2: Framework of the Paris Declaration on Aid Effectiveness



In the broader development context, there is evidently much more that needs to be done by donors and partner countries to implement the Paris Declaration. An evaluation published in July 2008[12] reported that *most donors have yet to prepare their publics (sic) and to adapt their legislation and regulations as necessary to allow for:*

- *Accepting and managing risks in relying on country and other donor systems, rather than insisting on applying their own;*
- *Agreeing to delegate greater decision-making power to in-country staff;*
- *Assuring more predictable aid flows.*

The report further concluded that partner countries still need to ensure that the responsibilities for development and aid are *shared more widely between different parts and levels of government, as well as with legislatures, civil society and the private sector, and citizens at large.*

The authors noted that *the role and importance of harmonisation within the Paris Declaration agenda may be changing, increasingly taking a back seat to the push for greater alignment with country systems.*

Even though there have been improvements towards greater harmonisation and alignment in many countries, progress is considered to be too slow and not radical enough to bring about the shifts that are needed to achieve the health MDGs. The IHP+ is now increasing the focus on mutual accountability and managing for results.

B. TAKING SHAPE

The IHP+ is led by an interagency steering group (the Scaling-up Reference Group or *SuRG*), that is responsible for providing oversight and strategic direction[13]. This is split into the *Business SuRG* and *Steering SuRG*. The first is jointly chaired by WHO and the World Bank and includes representatives of the 8 main multilateral agencies and institutions in health (Bill and Melinda Gates Foundation, GAVI Alliance, Global Fund for AIDS, TB and Malaria, UNAIDS, UNFPA, UNICEF, World Bank, and WHO), the *Core Team* and Civil Society representatives. The *Steering SuRG* includes donor partners, meets less frequently and the chair is rotated between donors. The SuRG also provides a forum for interagency cooperation to address identified bottlenecks to progress relevant to any of the IHP+ partners.

An interagency Core Team *based in Geneva, Washington DC and Brazzaville is responsible for the day-to-day coordination of the process and interfaces with all IHP+ partners.*

This team has been executing a work-plan[14] that covers the 18-month period from September 2007 to March 2009, funded by some of the key IHP+ partners[15].

Interagency thematic working groups at the global level have been established as temporary structures to take on specific areas of technical work relevant *to facilitating increased harmonization and alignment between development partners and national stakeholders (including civil society and the private sector).* It is expected that *they will exist only so long as the work produced is necessary and relevant to the IHP+ objectives, with an emphasis on the value added to the countries. Civil Society will participate in each of the thematic working groups*[16].

Country Health sector teams are described as being *the key component of the IHP+ process. These teams vary by country, but are led by representatives of the national government (Ministry of Health), and consist of development partners, including the country representatives of international health agencies (but not the Global Fund, GAVI and Gates Foundation that don't have country-level representatives); bilaterals; local civil society; private sector; or other implementing bodies at the country level*[17].

The IHP+ has focused on 8 initial countries[18], selected and invited to join because they were thought to have the conditions in place for the IHP+ to succeed as a proof of concept. This includes: Burundi; Cambodia; Ethiopia; Kenya; Mozambique; Mali; Nepal and Zambia[19].

The IHP was expanded by the Scaling-up Reference Group (SuRG) during 2008 to include a number of 'related initiatives' that were launched around the same period. This became known as the *International Health Partnership and Related Initiatives (IHP+)*. The related initiatives are either existing or new global health initiatives and partnerships focused on scaling up international support for achieving the health-related MDGs and include: the *Harmonization for Health in Africa* (HHA) initiative; the *Global Campaign for the Health MDGs*[20]*; the Catalytic Initiative*[21]*; the Providing for Health (P4H) Initiative*[22]*, and others*[23].

The partners backing these new initiatives are in many cases the same agencies and countries that have signed up to the IHP+. The sponsors of these initiatives have acknowledged that many of the problems originating from these initiatives tend to be driven by the interests of international agencies and donor governments, rather than through true consideration of country needs.

The Harmonization for Health in Africa initiative[24] was an existing partnership mechanism resulting from the *High-level Forum on the Health MDG's* that joined the IHP+ as the Africa region implementing mechanism of the Interagency Core Team. It brings together r*egional partners such as the African Development Bank (AfDB), UNAIDS, UNFPA, 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.*

The IHP+management arrangements have evolved as the initiative has taken shape. At the same time, there has been an increasing

interest in participation by additional countries and development agencies that have subsequently joined the IHP+, even though the benefits of this have not yet been proven[25]. Others have specifically decided not to sign up to the IHP+ at the global level.

A meeting of partners held in Lusaka, co-hosted by the IHP and HHA during February 2008, was a key early development that helped to define the IHP+. This brought together thirteen Country Health Sector Teams and development partners to discuss the results of country Stocktaking exercises - such as *bottlenecks to progress*; to talk about the proposed Country Compact mechanism, and to jointly agree on the way forward. Many of the subsequent developments in the evolving IHP+ process have been influenced by this. The meeting was also the first opportunity for global Civil Society representation, although this participation only happened after CS advocating to be included.

C. THE PURPOSE OF THIS REVIEW

The Review was designed to assess how accountable IHP+ partners have been in implementing their commitments and what progress they have made in the short-term. The founding document (Global Compact) of the IHP calls for *an independent evidence-based assessment of results at the country level and of the performance of each of the partners individually as well as collectively*[26]. This review is the first step in addressing this expectation, but comes only 9 months after the initiative was launched in September 2007. The work was commissioned by WHO and the World Bank, on behalf of the Scaling-up Reference Group.

The objectives of the review (described in the Terms of Reference[27]) are to assess:

- The degree to which the development partners and others who signed up to the IHP+ Global Compact are adhering to their commitments;
- Progress in securing and implementing Country Compacts in the IHP+ focus countries;
- Progress in implementing the IHP+ common work-plan (with a review of whether the management and accountability arrange-ments for this have been adequate).

It is too early to anticipate any results in health outcomes or to assess systematically whether the IHP+ is effecting how development partners are operating at the country level. Instead, the **focus has been on reviewing the extent to which the core expectations of the IHP+ are shared and being met** (or whether they are likely to be met), together with the reasons for lack of progress or success, from which to learn and improve.

The Review attempts **to identify the ways in which each partner has taken concrete steps towards achieving the vision of the IHP+, by building on reform processes for aid effectiveness that are already underway in most cases, and how well positioned they are to carry this forward**.

The review has identified significant challenges that lie ahead, not least of which are the expectation and real need for more resources and to build the capacity in countries to utilise these resources in ways that will demonstrate results. We have tried to represent an updated understanding of these challenges and of what is being done or needs to be done to address them, drawing on the suggestions of respondents and the advice of the Review Advisory Panel.

D. HOW THE REVIEW WAS CONDUCTED

The review was primarily based on interviews and consultations with key stakeholders. This was undertaken over a 3 month period in mid-2008 by an external Review Team[28], with the support of an independent advisory panel of 6 international and country-level experts[29].

The methodology, approved by the SuRG, is described in the Review Proposal[30] and Inception Plan[31].

This report is based on the opinions of 100 key informants[32] (listed in *Annex A*); our extensive review of available documentation (listed in *Annex B*[33]); participation in consultations with Civil Society and the SuRG, as well as a period of soliciting public responses through an online discussion forum.

The respondents interviewed were a representative cross-sect-ion of partner agencies, civil society and national ministries of health in the

TABLE 1: Cross-section of Respondents interviewed within countries

	MoH	WHO	WB	Civil Society	UNAIDS	UNFPA	UNICEF	Bilaterals
Burundi	√	X	√	√	X	√	X	√
Cambodia	√	√	√	√	√	√	X	√
Ethiopia	!	√	X	√	√	X	√	√
Kenya	X	√	X	√	√	√	√	√
Mali	√	√	√	X	√	√	√	X
Mozambique	!	√	X	X	√	√	X	√
Nigeria								√
Nepal	√	√	√	√	√	√	X	√
Zambia	√	√	√	√	√	√	X	√

Notes: Tick (√) indicates that at least one informant from the partner was interviewed.

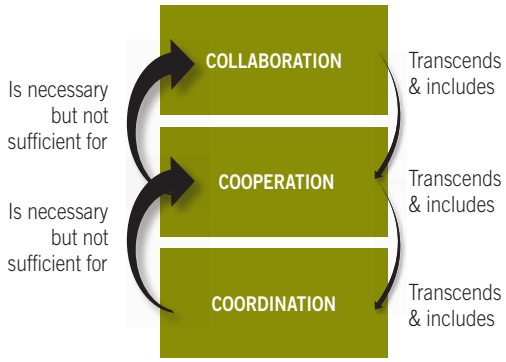
initial IHP+ countries and at the international level (as depicted in *table 1*). There was a good response rate and individuals were mostly extremely willing to participate and let us hear their opinions.

The IHP+ is variously described as *a mechanism for improving aid coordination*, a process for getting partners to *cooperate more effectively,* and necessary *for promoting collaboration*. Making the distinction between these closely related terms[34]: *coordination*, *cooperation* and *collaboration,* is useful because this has implications for how the IHP+ is conceptualised and put into practice, as described further in our conclusions.

For our analysis of the findings, we have applied a conceptual model that describes the IHP+ as a phased reform process moving from coordination, to cooperation and ultimately increasing collaboration to achieve results. This is graphically presented in *Figure 1 (inside the front cover)* and is further explained in its application throughout the report. This shows Partner actions being predominantly focused on coordination processes to start with (1); becoming more cooperative as the reform process is formalised through the signing of compacts, and then moving towards a more collaborative mode of engagement (2). The outcome of this is ***the vision of a new aid architecture*** (3) in which partners take collaborative action across their institutional boundaries to address challenges through innovation and by implementing co-created and co-owned solutions for strengthening health systems to achieve results.

Coordination is about organizing closely situated, related, or linked entities and activities so that they become more harmonious, efficient, and effective. This is necessary, but in itself not sufficient for **Cooperation**, which is about procedural compliance in a shared pursuit. This lays the ground for Collaboration, which is about the process of co-creating shared and emergent representations of problems, solutions, or results.

FIGURE 3: Progression from Coordination, to Cooperation to Collaboration for achieving results



The future should be built on solid cooperation that has been mainstreamed into the ways that the agencies conduct their business, as well as a structurally reformed and consolidated institutional architecture. Coordination can become mainly an internal function. This also shows the increasing role of country (bottom-up) processes, as the role of top-down processes decreases. There is an underlying premise that improving the ways of working between partners will produce better results (however these are defined).

E. THE LIMITATIONS OF THIS STUDY

This was a rapid review of expectations, based on emerging opinions at a relatively early stage of the IHP+ process, limited both by timing and scope (as directed by the Terms of Reference).

- There was little documentary evidence of results available at this stage (only 9 months since the IHP was launched).
- The review focused on multiple levels of accountability and across many organisations and countries, allowing very little opportunity for in-depth analysis.
- People's opinions count, but there was limited opportunity to hear collective opinions, or to systematically triangulate anecdotal evidence.
- We tried to make the review as *open* as possible, to gather feedback on emerging findings and to allow respondents to review their interview summaries, but the level of participation in these activities was limited by the short period available.
- There was *selection bias* in who was contacted as key informants. It was not feasible to interview individuals from organisations that are not part of the IHP+ who might have offered different or more critical perspectives. However, we did research all available Internet-based discussions and publications to obtain a broader range of views.
- The U.S. Government was contacted at the Global level (through the *Office of the Global AIDS Coordinator*), but no interviews were conducted with country-level U.S. agency staff, who would provide an important perspective as significant partners in many of the IHP+ countries.
- An important challenge was to capture an accurate view of the rapidly changing and evolving state of affairs over the period and it is likely that a number of the observations reported here will already have become obsolete by the time the report is published.

We hope that, despite these limitations, the study will contribute to evolving the conversations at all levels and by all stakeholders about how the IHP+ is understood and how this is translated into practice, in the interests of improving development and collectively taking much more responsible action.

III

findings

A. MOVING IN THE RIGHT DIRECTION?

There is converging opinion about what the IHP+ is expected to achieve. From more than 80 published (sometimes conflicting) statements[35], we distilled ten key areas of expectation that we feel define the IHP+ at this time[36], against which we asked respondents to assess progress to date. There was consensus across a wide range of individuals representing IHP+ partners and stakeholders that these statements capture what the IHP+ is trying to achieve.

The IHP+ was perceived by most respondents as serving a valid purpose, or was at least acknowledged as being relevant to addressing health-MDG constraints. However, not many people beyond those with a direct interest in the IHP+ seem to be aware of how this is being implemented - even within participating institutions and countries.

For almost all of these expectations, respondents felt that it was too early to tell whether they are 'on-track' or not. There were a range of views about how realistic they are, especially at the country level and about financing health plans, although very few concrete alternative expectations were suggested.

Short-term progress was measured as concrete actions that partners have taken as their first steps towards implementing the IHP+ vision. It is unrealistic to expect significant demonstrable change to have occurred across all partners and participating countries in the relatively short period since September 2007. We found it more useful at this time to review each partner's *readiness* to take steps in the right direction to start *doing the right thing* (as defined by the commitments they have signed up to)[37], and to assess what effects people perceive the initiative is starting to have.

One civil society respondent made the plea that "*it would be better to make slower progress and get it right, than to rush towards failure*".

B. BUILDING MOMENTUM

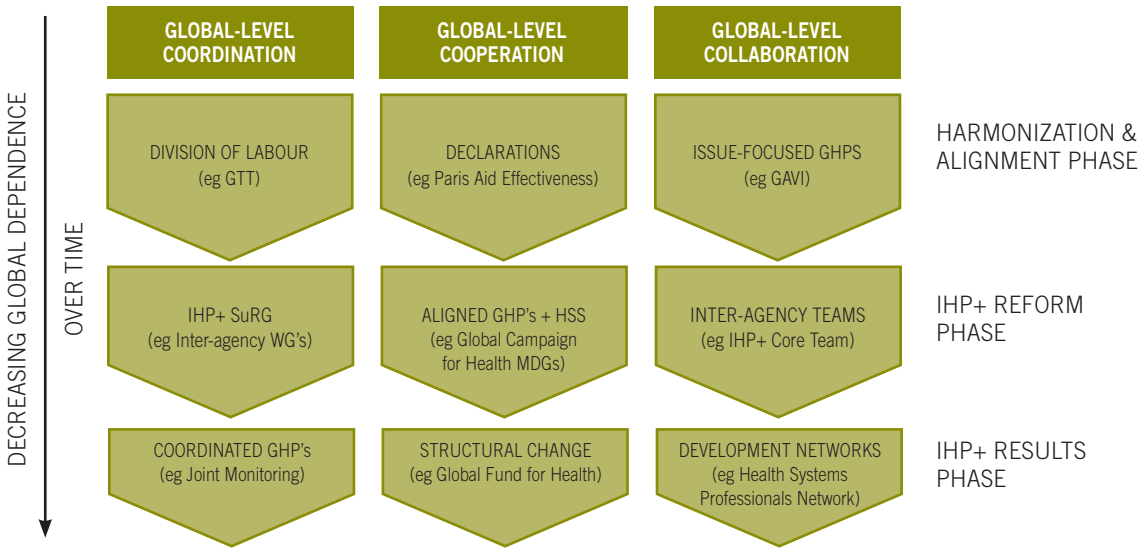
All signatories of the IHP Global Compact are expected to have made progress in following through on their specific commitments agreed in September 2007[38].

There has been increasing cooperation between development partners at the global policy level. At agency headquarters, partners have worked well together through the IHP+ steering group (SuRG)[39], its Inter-agency Working Groups[40] and the IHP+ Interagency Core Team[41]. They have jointly progressed work such as[42] drafting *Country Compact Guidance*[43]; developing a *Common Framework for Monitoring and Evaluation*[44]; convening partners and stakeholders to agree on common approaches in countries (the *Lusaka Consultation and Report*)[45], and are part of a broader effort to develop common approaches to validating and appraising national plans and strategies (and their sub-components)[46].

The IHP+ has established useful forums for these health agencies to jointly focus on aid effectiveness and health systems. This is helping to build consensus on policy issues such as the Global Fund's approach to *National Strategy Applications* (NSAs)[47], although progress in agreeing to one common validation framework has been slow.

There are indications that the IHP+ could produce the conditions for increasing cooperation between global partners, so these reforms now have the possibility to happen. Partners claim that they are now cooperating with a shared vision; strong political drive; in more regular and structured forums through which to interact; and are bound by their mutual agreement to the global compact.

FIGURE 4: Global Progress Expectations over time



This level of cooperation on health financing and systems strengthening did not exist previously, particularly amongst the key multilateral agencies in health, and is seen by many as an important step forward[48].

However, there are some respondents who felt the focus on *activities* at the international level has delayed progress in the real process of reform. They argue that substantive changes are still needed within these institutions to bring about different ways of doing business at the country level**.**

The overall impression of the people we spoke to is that most partners have not yet started to institutionalise the IHP+ and they are still perceived to be conducting *business as usual* at the operational level.

The multilateral agencies (WB, WHO, UNICEF, UNAIDS and UNFPA) have not communicated well what they are doing to implement their IHP+ commitments. These views were expressed by some respondents about their own organisations (particularly people working at the country level), as well as by individuals from other partner organisations. This was validated to some extent by reviewing organisations' websites and by searching for public statements by the partners.

The Reviewers' impressions of what progress each partner has been making is mainly based on reports by respondents. In most cases, the details of these actions could not be directly cross-validated and it was difficult to establish whether these could be attributable to their participation in the IHP+, as they have already been working on the aid effectiveness agenda. It is relevant though, that most partners have started to move in the right direction.

WHO and the World Bank have played an important role in leading the IHP+ process, but this has mainly been limited to headquarter-level teams working as the interagency Core Team and nominated technical leads participating in the SuRG Interagency Working Groups. There is little evidence that the IHP+ is well understood throughout the broader organisations, or that this has been responded to in all relevant technical and finance departments. Country offices have not seemed to respond to the IHP+ as a reform process and the impression is that they have managed this as yet another initiative. The complementary roles of WHO and The Bank at this level are important: WHO is traditionally seen as playing a more neutral and supportive role to the MoH, and the Bank because of its leverage with Ministries of Finance. Close working relations therefore need to be fostered at this level, which is happening in some, but not all countries. There is also the need to develop greater policy coherence. For instance, there is no explicit WB guidance on how IDA Credits for Health might be used to support the IHP+ objectives. WHO has not described how the IHP+ fits with the Primary Health Care agenda, or with the many disease-focused partnerships in which it has a key role as the technical lead (although work is being done to identify the *Positive Synergies* between vertical approaches and health systems strengthening).

UNFPA has established a good history of working towards improved harmonisation and cooperation at the international, regional and country levels, particularly through promoting and engaging in SWAps. In Ethiopia, along with other partners, UNFPA has supported the development of a pooled funding mechanism (the *MDG Fund*). Guidance Notes have been sent out to UNFPA Country Offices on SWAps and the New Aid Environment. An external SWAp Thematic Evaluation was conducted that positively acknowledged UNFPA's role.

UNAIDS has provided significant leadership on harmonisation and alignment of the AIDS response over recent years (promoting the 'three ones' principle[49]) and has been participating in the SuRG and its working groups (as well as in some country health sector teams).

UNICEF has focused on implementing the Catalytic Initiative (CI) as a *related initiative* that supports the objectives of the IHP+, ensuring that this includes IHP+ countries. The organisation has been an active participant in the SuRG and contributed to the Core Team's work (allocating 50% of a senior staff member's time), including by taking a prominent role in country missions through the Harmonization for Health in Africa (HHA) and in planning the Lusaka meeting. Working closely with CIDA, WHO and JHSPH, UNICEF has ensured that the M&E framework developed for the CI is aligned with the IHP+ framework. A new health systems unit has been established to lead on IHP+ related issues. UNICEF country offices have assisted the IHP+ process, most notably in Ethiopia, to develop the Country Compact. These *organizational shifts* within UNICEF are seen internally as crucial to the IHP+ because they could potentially influence how the considerable annual budget of the organisation (USD 1.5 billion for health-related work) is spent - predominantly in sub-Saharan Africa and Asia.

The Gates Foundation has engaged the IHP+ process through the SuRG and has done some internal thinking about the implications of the IHP+ for building effective delivery platforms.

The Global Fund has a number of processes underway that can be considered congruent with the IHP+ expectations. Historically the Fund has had a strong commitment to aid effectiveness and is undertaking a follow-up internal review of its adherence to the Paris Principles. The Fund is also preparing to implement the National Strategy Applications mechanism approved last year by its board; and is substantially reviewing its business model to streamline how it approves, delivers and manages grants. The Fund has been a strong participant in the SuRG and made substantial contributions to the design of the IHP+ concept. However, all of this has not yet changed the ways in which it is currently operating within countries - mainly because this is dictated by its operating mandate and model, but also because of the decisions of individual Portfolio Managers. There are both good and bad reports of the impacts this is having. For example, there are still specific complaints about the Fund's grant performance expectations and *conditions precedent*[50] (such as requiring specific additional management arrangements) that interrupt disbursements and make these aid flows less predictable.

The GAVI Alliance has taken commendable practical steps to put the IHP+ on the agenda of its Board; to explicitly investigate how the Alliance can respond to the IHP+ commitments; and has written to IHP+ country ministers of health to directly ask their advice about what GAVI should do differently. GAVI representatives have been active participants in the SuRG and IHP+ Interagency Working Groups.

The European Union is globally the largest contributor of development assistance, but does not have a strong country-level presence in health. The EU provides funding in some IHP+ countries (Mozambique, Zambia, Burundi, and Ethiopia - where it is the second-largest donor after the USG). The *EU Agenda for Action on the MDG's* commits to increased funding for national health plans, including through the IHP+ process[51]. The EC has supported the IHP+ through occasionally contributing to global-level discussions and has attended some *Steering SuRG* meetings (but not as a regular participant).

The governments of the UK and Norway (both originators of the IHP) are continuing to provide strong leadership through their specific actions, such as: providing catalytic funding within IHP+ countries; reviewing their institutional strategies; establishing a strong internal focus and communications on the IHP+; undertaking analytical policy work; publicly making long-term funding commitments; and keeping this a priority on the political agenda.

Other bilateral signatories (France, Netherlands, Italy, Germany, and Portugal) have been less visible in taking forward their commitments. But as they do not all have local presence or direct funding commitments in the IHP+ countries, their contributions need to be measured over the longer-term by how they meet their global aid financing commitments and by how they influence the multilateral agencies and other GHPs in which they participate. The EU Development Ministers meeting in June this year concluded that most European Donors have failed to meet their aid pledges[52] and this is likely to have implications for funding to meet the IHP+ promises of scaled-up support for National Health Plans. It is significant to note that a number of other bilateral donors have not joined the IHP+ as partners.

The US Government, although not a signatory of the IHP Global Compact (for political and legal reasons), remains the most important bilateral donor to coordinate with the IHP+ at the country-level and has indicated in-principle support for working with IHP+ partners *where there are appropriate opportunities*. In April 2008 US President, George Bush and the Prime Minister of the UK, Gordon Brown announced their joint intention to provide support for increasing the numbers of health workers across four African IHP+ countries (Ethiopia, Kenya, Mozambique and Zambia). Good progress has been made in taking this forward at the country level (especially in Mozambique - see the Case Study box on page 19), where specific opportunities for cooperation are being identified between the USG PEPFAR Programme and other IHP+ partners.

National governments in almost all of the initial IHP+ countries have responded by setting ambitious timetables for signing national country compacts. Ministry of Health respondents welcomed the new ways of working but remained circumspect about whether this will succeed. They want to see development partner commitments translated into action, particularly with regard to financing health sector plans. This is especially relevant in countries such as Mozambique, Ethiopia, Zambia, and Cambodia that have already started to address their commitments to the global compact, by having embarked on the process of improving their national plans; establishing common monitoring frameworks; and improving coordination among partners. One government respondent said: "*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*".

Governments do not yet seem to have realised the full political leverage of the IHP global compact to challenge development partners on their ways of doing business, or to make specific requests for change. Some Development Partner respondents see the possibility of governments having a stronger voice as a potential opportunity to lobby for changes within their own institutions.

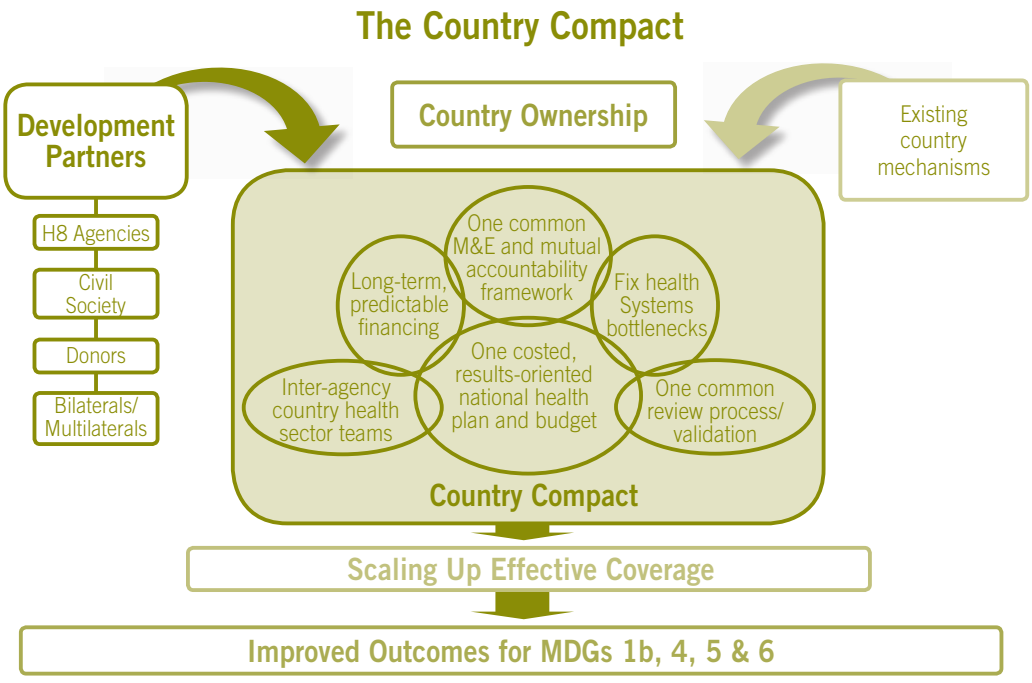
Real progress will be tested by what happens within countries over the next 6-12 months and there are significant risks of failure if development partners do not follow through with their commitments to countries.

C. PREPARING COUNTRY COMPACTS

It is expected that country compacts (or their equivalent) will be established to put in place "close to binding" commitments from Development Partners and government Ministries of Health and Finance to collaborate in supporting "one costed, results-based national health plan in a harmonized and aligned way"[53].

Partner activity within countries has been mainly directed towards drafting *Country Compacts*[54]. The process started with Country Stocktaking Reports in the initial 8 IHP+ countries (completed in March 2008) that analyzed the current situation and identified what

FIGURE 5: Schematic of the Country Compact process



would be required to achieve the IHP+ objectives[55]. These reports provided a useful starting point, although were not all of the same standard. Discussions were held in countries to agree on *roadmaps*[56] towards developing country compacts (or equivalent instruments).

Overall, good progress has been made towards drafting compacts in 4 of the IHP+ countries that have set ambitious timetables to have their compacts signed[57]. Ethiopia, Mali, Zambia**,** Mozambique (and possibly Nepal) are expecting to have their agreements in place by September 2008[58]. Some people see these timeframes as unrealistic because they do not allow adequate time to properly update national health sector plans and budgets (as a related exercise); to consult and to hold negotiations with development partners for getting their buy-in; and to conduct various due diligence processes, such as holding public consultations and parliamentary reviews that would make these agreements more legitimate. The experience in each country is very different and hugely depends on the context.

Although there is now a much better understanding of what a country compact is, this is not necessarily shared across all countries by all partners. The predominant view is that its purpose is to strengthen existing SWAp mechanisms by broadening participation in the SWAp and getting more partners to make explicit commitments to support implementation of the '5 Ones'[59] discussed at the Lusaka Consultation (and describe in the *draft guidance for developing country compacts)*[60].

The '5 Ones' are: a single national health plan; more predictable external funding over longer periods against a single budget; a single results framework for monitoring implementation of the plan and the compact; single monitoring and reporting process that meets that requirements of all partners; and one policy matrix that links all policies and decision-making procedures to support this approach.

Draft country compact guidance suggests that country compacts should specify in advance what actions the signatories will take to explicitly address constraints, and this should include the financial commitments they will make over stipulated timeframes[61]. There are criticisms that this guidance comes *after the fact* for the initial countries that have already moved forward with developing their compacts. It also has not been based on a proper analysis of what existing agreements have been established. Work is still being done on how to link country compacts to existing processes and instruments, such as Joint Health Sector Reviews; Medium-Term Expenditure Frameworks (MTEFs); partnership frameworks; MoUs; PRSPs, and Codes of Conduct. The draft guidance was criticised for being too *state-centric* and for not demonstrating an adequate appreciation for important principles such as equity and rights; the role of civil society; the need for donor reform; good governance; and multi-sectoral approaches.

Others see the Compact as a less prescriptive agreement for partners to commit to *working towards* the *IHP+ objectives*. In Kenya, Mozambique and Burundi (and possibly other countries), the view is that the Compact does not differ much from the existing agreements such as *SWap MoU's*, *Codes of Conduct* and *Partnership Frameworks*, some of which have only recently been agreed or updated and already contain many of the same elements as Compacts are expected to have. Existing agreements will be simply modified or ratified as the Compact in these countries. For this reason, some people feel that the Country Compact is yet another imposition on countries from the global level that is not relevant to countries and they question what value the IHP+ adds. This possibly reflects the lack of clarity on the differences between Country Compacts and other instruments that are relevant to the Sector-wide Approach.

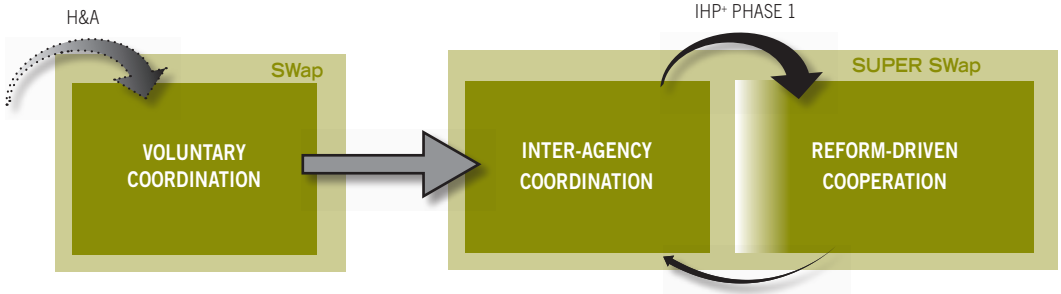
The MoH in Cambodia sees no rationale for the Country Compact because they have just completed an extensive review of their sectoral strategies, plans and partnership arrangements and have just ratified all the relevant agreements. However, some development partners feel that if the IHP+ process is not taken forward in Cambodia, this would be a missed opportunity to address some of the persistent problems preventing effective cooperation that have not yet been resolved.

Compacts could establish the *ground-rules* for partners to cooperate towards achieving the reforms that are necessary for moving towards a new development model for the health sector. Many respondents shared the view that Compacts should enable partners to evolve their commitments and reform their ways of working through a process of cooperation, rather than being prescriptive.

The first completed Compact (from Ethiopia)[62] provides a useful benchmark to build on or to compare with other countries. This agreement is differentiated from the existing Harmonization and Alignment (H&A) agreements in Ethiopia because it clearly states the government's preferences for channeling external contributions to the Health Sector (through a choice of 3 mechanisms[63]), and it requires Development Partners to give firm commitments to *moving towards* complying with these preferences in a defined timeframe. It establishes guiding principles; specific commitments and obligations; a collective target for the total expected level of aid; requirements for future management of development assistance; recognition of the need to address human resource shortages; as well as arrangements for monitoring compliance and resolving disputes.

The Ethiopia compact is not considered to be a legally binding document. It is well-crafted rhetoric that establishes high expectations for what the Government of Ethiopia would hope to achieve. At the time of this review, the Compact was being presented to partners for their commitment, but it remained to be seen whether all partners would be able to sign the agreement because of the specificity of the commitments.

FIGURE 6: Moving from SWAps to SUPER SWAps through increasing cooperation



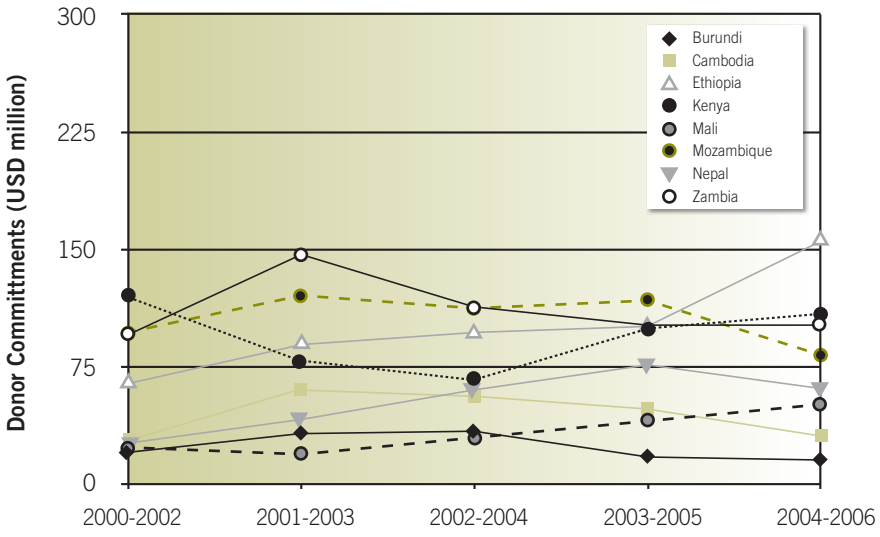
There are important concerns that still need to be addressed about the country compact mechanism. Deficiencies in the process of drafting country compacts reported from the country level and from our analysis of the July 2008 Ethiopia compact available at the time of this review raised the following issues:

- **How to balance inclusivity with specificity**, as some feel this requires trade-offs to widen the circle of participation at the expense of necessary details, such as disbursement schedules. As one respondent said: "we *want to see it as inclusive as possible; to include USAID and others who are not signatories; to avoid having an inner and outer circle of partners*".
- **Whether the agreement will be signed by key partners** such as the Global Fund and GAVI if they require upfront financing commitments, which these partners do not have the mechanisms or mandate to agree.
- **The lack of civil society participation in the compact development process.** This points to the fundamental question about how to ensure that CS has a role in promoting the reforms that are needed within countries, without undermining the sovereignty of governments. But it also demonstrates that there is opportunity for the IHP+ process to create the mechanisms for CS engagement that have not been in place before (Nepal provides a good example of this)[64]. The SuRG is developing guidance for CS participation in developing country compacts, led by CS representatives.
- **How to engage Global Fund and GAVI as country-level partners** when they don't have a country presence or a place at the table of the *interagency country health sector team.*
- **The implications for partners of having joint and several liabilities for meeting pre-agreed funding commitments**. The Ethiopia Compact presents some innovative approaches to this, including the concept of 'swing donors', but more technical work is needed to assess how this would work in practice, or whether other proposed underwriting mechanisms (such as multi-donor trust funds in the World Bank) might be the answer.
- **Not having explicit government funding commitments** is contrary to the reciprocity principle of the IHP+. Governments are expected to show increasing domestic expenditure in response to increasing donor contributions.
- **The government-centric focus** and lack of explicit acknowledgement of the contributions and roles of non-state providers and civil society (including the private sector). In practice, these stakeholders are likely to get left out when the compact is being implemented if they have not been explicitly written in.
- **Not showing linkages to other sectors relevant to health** misses out on addressing the determinants of health.
- **Not prioritising Primary Health Care as the basis for strengthening health services**, even though there have been renewed commitments to this.
- **How to deal with Universal Access commitments** and the linkages between national health strategies and multi-sectoral AIDS strategies.
- **The extent to which compacts are based upon principles of equity and rights**. Civil society advocacy groups expect compacts to provide assurances about meeting the needs of the poorest, most vulnerable and excluded populations and to include a commitment to removing user fees for essential care [65].

The important role of non-state providers delivering some priority health services to the poor needs to be more deliberately acknowledged by the IHP+ so that this is not overlooked in national health plans. Although reference is made to non-state providers and private sector engagement in the IHP+ documentation, this has not yet been taken forward through specific actions. A planned global consultation with the Private Sector has been postponed and the IHP+ Core Team is grappling with how to legitimately engage with this sector at the global level. Non-state service provision is an important consideration within most IHP+ countries and will need to be reflected in national health plans and budgets.

Many respondents questioned whether country compacts really can be *close-to-binding*, or enforceable in practice. An enforcement model that is flexible, rather than coercive is more likely to succeed. Partners will benefit from the flexibilities that are allowed and the IHP+ will benefit from increased partner compliance by promoting repeated voluntary compliance through reciprocal actions. For this approach to work, partners need to have the incentives to comply voluntarily and to reciprocate effectively. These should provide short-term payoffs that outweigh the long-term costs of noncompliance. A more detailed study of incentives and payoffs (*"what's in it for me?"*) could be useful.

FIGURE 7: Trends in ODA for Health to IHP+ Countries (3 year average)



Source: WHO, based on the OECD/DAC's Creditor Reporting System (CRS)

The Ethiopia Compact describes ambitious targets and benchmarks for implementing the compact and to assess progress over time. It has defined a schedule of 25 performance benchmarks and 9 targets over the period to 2010 - such as *90% of funds disbursed on time*. This should provide a summary of progress at a glance. Whilst this reflects the kind of ambitious and results-oriented thinking that the IHP+ is trying to promote and should set an example for other countries developing their Compacts, in the case of Ethiopia, these targets have not been collaboratively agreed with all the partners to whom they apply. This could make partners less willing to commit to such specific targets and could become a sticking-point to signing, or voluntarily complying with the Compact. The targets are a summary for all partners and it could be useful to have individual partner targets negotiated.

The global annual review of progress of the IHP+ could use these performance schedules to provide a picture of how each country is progressing, as well as to make an aggregate assessment at the global level of how partners are performing across the IHP+ countries. For this to be most useful though, the indicators and benchmarks measures will need to be standardised across countries.

Civil Society has commented that *to ensure that signatories can be held to account, all the goals and targets that Compacts set for governments and development partners must be time-bound, measurable and transparent*.

Most Development Partner and recipient government respondents agreed that having one budget does not imply that funds have to be pooled or channelled through government financial management systems, although this might be a longer-term ideal and the preferred mechanism depends on the country situation. By working through new-generation SWAps, Development Partners are expected to replace many of the donor-specific performance-related conditionalities they might have previously imposed, with a set of shared results that are jointly monitored through a single participatory monitoring, evaluation and reporting framework.

It is still not well understood whether the compact is really a new business model for existing mechanisms - particularly SWAps, or an instrument for reform that will improve cooperation between partners to be mutually accountable and to manage for results.

D. FINANCING FOR RESULTS

The IHP+ expects that in-country partners will agree on the amounts, sources and preferred mechanisms (such as SWAps) for mobilising significantly increased levels of financing for National Health Plans and to strengthen health systems, under the lead of the country government.

The IHP+ has created high expectations in recipient countries of significantly increased international funding. This seems justified, given that the guidance for developing Country Compacts says that compacts should *state what the IHP+ partners' commitments are to additional and longer-term financing, with clear targets for when this will be delivered*[66].

However, there is not yet consensus amongst the IHP+ Development Partners represented in the SuRG whether the IHP+ is primarily about *improving the effectiveness of existing aid*, or about *increasing the volumes of aid*. Whilst both objectives should be mutually reinforcing, the emphasis is relevant if the IHP+ will be judged on whether it has led to increased funding for national heath plans in the short-term.

Most of the increased costs of expanding health services are expected to come from domestic sources (for example, in keeping with the Abuja declaration[67]), using health financing and social protection policies that best serve those most in need. However, in all the initial IHP+ countries this will not be adequate, and partners acknowledge that there is a need for major increases in international resources to finance the gaps[68].

The Sector-wide approach (SWAp) is the mechanism through which most countries expect to increase the volume and predictability of financing for their national health plans. The IHP+ has informally been described as a process that will result in SWAps with teeth. There is considerable potential for the IHP+ reforms to move SWAps from being a voluntary coordination mechanism through which a few donors channel some of their assistance, to a new generation of SWAps. These SUPER SWAps (**S**caling-**U**p in **P**artnership for **E**ffectiveness **R**esults) would be possible if partners move into a more cooperative mode of engagement (as shown in Figure 4) to increase their mutual compliance with the Country Compact principles. This should be operationalised by development partners reciprocating with governments under the terms of the Country Compact to increase the value of assistance delivered in response to increasing harmonisation and alignment results in the immediate term, and measurable health results in the longer-term.

The different costing scenarios and technical approaches to developing national health budgets are confusing stakeholders. The compact guidance suggests that three different costing scenarios should be developed for national budgets: *needs-based*; *resource-based*; and *results-based*. Civil society questions why these estimates should be anything but *results-based* if national plans and strategies are expected to pursue *MDG results*.

This implies that national plans will be funded up to a budget level that will translate into an expected level of results. But the timeframes, costs and levels of need for each of these results varies widely across each disease priority or MDG area, so it is not valid to assume that more financial inputs will produce proportionately higher results for all health priorities. Funders need to consider the marginal health results that can be achieved for each of the priority areas and these need to be prioritised for each level of increased resources. Decisions must be made about rationalising resources to ensure the health impacts (or equity-adjusted health impacts[69]) are maximised for each additional dollar per person that becomes available.

It is unlikely that the full anticipated scale of donor funding will be met under any scenario and this has implications for whether the IHP+ will be considered to have failed. In real-terms, global trends in aid for health (other than AIDS spending) do not indicate that these expectations will be met. *Figure 7* shows trends in donor funding to IHP+ countries between 2000 and 2006 (based on OECD-DAC reports) and *Table 2* provides baseline figures for the aid disbursements of IHP+ donor countries. Assessing these trends is not straightforward, but it is relevant to consider observations that WHO[70] and others have made:

- Although health ODA has been increasing globally, more than half has been directed towards MDG 6 and a large proportion of funds is spent on technical cooperation, rather than on the direct costs of health service delivery.
- The total amount of flexible money available to countries for covering recurring health system costs, such as salaries, is low.

- The Paris Declaration target of 66% of aid flows to be channelled through programme based approaches is unlikely to be met for the health sector. This is relevant for assessing the *quality* of aid, not only the volumes.
- Even though the most recent G8 Summit produced an agreement to meet its $60 billion commitment on health within the next 5 years, this will be only a small proportion of what is really needed, if this money is delivered. Many G8 members will fail to meet their Gleneagles commitments without dramatic increases of up to 100% in the next couple of years to 2010.
- Within the G8 group there is wide variation as EU members set more ambitious targets that many are struggling to reach, while Canada, the US and Japan made less ambitious commitments and are a little closer to meeting them[71]. The UK's scorecard looks relatively good: its budgetary commitments will bring it close to a relatively ambitious 2010 target.
- There are already significant inequalities in the distribution of health resources across poor countries and if donors decide to exclusively scale up financing to the IHP+ countries to address this specific priority, the situation could worsen for other countries.

Funding flows will remain restrictive, even with new commitments having been made, unless additional funding sources and modalities can be found.

- The global funds for health (GFATM and GAVI) are constrained from making upfront commitments or even indicative allocations, although have begun to work through sector-wide approaches in some countries (*within their constraints)* and the Global Fund will start financing national strategy applications.
- New money that has been committed by Canada through the Catalytic Initiative[72] and is being programmed through UNICEF in what could be considered a more traditional approach (though the intentions are different) to only a few IHP+ countries.
- The World Bank Health Sector IDA Credits amount to $2-3BN per annum across all countries[73]. The UK is a significant bilateral donor in most IHP+ countries, but has already established its budgets for these countries and is unlikely to be able to scale up much beyond these existing commitments. The USG PEPFAR programme is already the biggest donor in many of the IHP+ countries but has a relatively narrowly focused mandate and business model.
- However, even taken together, these amounts are only a proportion of what will be needed to strengthen health systems for longer-term results, whilst continuing to ensure that more immediate priority health needs are addressed.

Resource mobilisation has to remain a high priority of the development partners leading the IHP+. High-level joint agency missions have been planned through the H8 to garner support for IHP+ countries. Key bilateral donors (most visibly the UK and Norway) are also continuing to press for global development health financing commitments to be met and they ensured this was again on the agenda of G8 (in July 2008 the G8 leaders confirmed a 5-year timeframe for their previously unspecified $60bn commitment)[74]. The UK is actively investigating the feasibility of another IFFm[75] for Health Systems.

Clearly a lot of political work needs to continue being done at the same time as the technical preparations in countries, in advocating for funding needs to be met.

Performance-based financing is an implicit expectation of the IHP+. This is driven by the need to demonstrate *health results* against the relevant MDG targets. Almost all IHP+ partners advocate financing for results. The Global Fund and GAVI have this as part of their operating mandate. National health plans are expected to describe *the implementation and management arrangements that demonstrate how resources will be deployed to achieve clearly specified results. This will require attention to staffing, procurement, logistics and distribution, financial management and supervision, and*

TABLE 2: Bilateral sources of ODA funds and use in countries engaged in IHP+ (from OECD/DAC 2007)

	ODA % GNI 2006	ODA US $ million	Increase on 2005	% ODA for health	ODA health US $ million	IN TOP 15 LIST FOR ODA IN 2005-6							
						Burundi	Cambodia	Ethiopia	Kenya	Mali	Mozambique	Nepal	Zambia
% ODA/GNI						**52.8%**	**7.7%**	**14.7%**	**4.5%**	**13.4%**	**23.3%**	**6.2%**	**14.3%**
UK	0.51	12459	12%	2.60%	324			■					■
Canada	0.29	3684	-10%	8.00%	295			■		■	■		
Netherlands	0.81	5452	4%	5.30%	289					■	■		■
US	0.18	23532	-18%	1.10%	259			■	■				■
Australia	0.30	2123	22%	11.50%	244		■						
EC	n/a	10245	-4%	1.80%	184			■			■		
Norway	0.89	2954	-2%	4.20%	124			■			■		■
France	0.47	10601	3%	1.10%	117								
Germany	0.36	10435	2%	1.10%	115								■
Japan	0.25	11187	-9%	0.80%	89								■
Spain	0.32	3814	20%	2.00%	76								
Sweden	1.02	3955	15%	1.50%	59			■	■		■		■
Portugal	0.21	396	2%	2.90%	11						■		
Switzerland	0.39	1646	-7%	0.60%	10						■	■	
Finland	0.40	834	-9%	0.80%	7			■	■		■	■	■
Italy	0.20	3641	-30%	0.10%	4			■			■		■

■ Signed the IHP ■ Potential signatories' ■ Reported as Contributing

the appropriate involvement of key actors from the public and private sectors, and civil society.[76]

There are concerns that this results focus could compromise scaling up funding because it tends to preference short-term outcomes, rather than the longer-term impacts of strengthening health systems.

Numerous additional challenges that have been raised about meeting financing needs. These include:

- The implications of IMF fiscal and monetary policies for increasing the necessary fiscal space[77] and how to get the IMF to promote more expansive policies that Ministries of Finance will be prepared to adopt;
- Macro-economic constraints within the current global economic climate that will reduce governments' scope for meeting commitments to spending on health;
- The requirement for donor funding decisions to be based on results that require information that will not realistically be available under current Health Management Information Systems (HMIS) constraints in these countries;
- There are legitimate donor concerns about the increasing fiduciary risks as their levels of ODA increase, especially in the context of weak public accounting systems within some recipient countries[78];
- Some development partners are concerned that countries are not making appropriate use of lending mechanisms to finance the capital costs of investing in the health service capacity and that the WB, IMF and Regional Banks should be taking a more prominent role in promoting this.

However, even given all these constraints, there are apparently existing donor flexibilities that can be better exploited in the short-term to invest in health systems strengthening activities.

- A recent study by WHO found that there are no regulatory constraints to any of the global aid financing mechanisms providing longer-term funding commitments[79];
- An analysis of PEPFAR funding in Mozambique revealed that in practice there are flexibilities in funding that allow for money to flow through the SWap and to pay for infrastructure costs, as well as health worker training and salaries (even if these are not fully directed towards AIDS services)[80];
- The PEPFAR programme is moving to a broader focus on health systems strengthening and has amended its County Operational Plan (COP 09) guidance and indicators accordingly;
- Both the Global Fund and GAVI have processes for funding health systems strengthening activities;
- Non-traditional sources of funding, both public and private, are potential new areas to explore. This includes a range of innovations in public-private partnership, creative capitalism[81] and social business[82].

There are strong calls from countries for donors to consolidate the global aid architecture to simplify health sector financing and to reduce transaction costs. Specific suggestions include merging the secretariat function of the Global Fund and GAVI.

There is further potential to reform the aid marketplace through innovation. The case for expanding IFFm, EC *MDG Contracts,* Multi Donor Trust Funds in the WB and other sources of innovative financing is being explored with GAVI, the WB, WHO and others. The Ethiopia Compact talks about the need for a global funding mechanism to underwrite national health budgets and smooth the market supply and demand for financing.

In some countries, donors are unwilling to tackle core financing issues until efficiency improves, but efficiency remains seriously constrained by the poor funding arrangements. There is optimism amongst some partners that the IHP+ is possibly a way of resolving this.

E. CHANGING WAYS OF WORKING

The IHP+ is expected to change the behaviours of international agencies and bilateral donors, so that they review their policies and procedures at the global level to enable better coordination and longer-term support at the country level. The staff of these agencies should also be incentivised and empowered to change the ways that they work.

It seems most relevant for the IHP+ to be seen as a process for accelerated reform that expects to get development partners, national governments and civil society to cooperate more effectively towards the same goals. This goes beyond *behaviour-change*, as many respondents spoke about the need for fundamental changes within their own and partner institutions.

Some people felt that they understood *what* the IHP+ is, but needed to know more about *how* to translate this into practice. Individuals also feel that they need to have the competencies and supportive systems within their institutions to be able to take the expected actions. *Table 3* summarizes some of the qualities that were mentioned as being necessary, categorized as behavioural, technical and systems competencies.

TABLE 3. Competencies for implementing the IHP+

AREA OF COMPETENCY	RELEVANT COMPETENCIES
Behavioural	• Personal belief in the IHP vision • Willingness to build cooperation through reciprocity • Exercising leadership • Flexibility to change ways of working • Being accountable
Technical	• Negotiation skills • Experience in Sectoral planning • Familiarity with rational approaches to resource allocation • Understanding economic analysis • Understanding approaches to HSS
Systems	• Aligned planning cycles • Harmonized reporting requirements • Aligned procurement rules • Preferential use of country systems

Ultimately, progress within organisations depends on individuals being empowered to take action, or to reciprocate appropriately to the actions taken by others. Lack of progress can conversely often be attributed to inaction by individuals, or to poorly informed actions. Through speaking to the broad range of stakeholder representatives, it seems that the majority have embraced the IHP+ as a catalyst for change, or as further stimulus for change already underway.

The contributions being made by these individuals need to be appropriately acknowledged to increase trust and organizational alignment. But there are still many partner representatives and advisers that do not yet seem to understand the potential or relevance of the IHP+.

The overall assessment is that IHP+ partner institutions have not systematically invested in building the necessary competencies of their staff and systems. However, there are some examples of progress:

- **The World Bank** has addressed legal constraints that placed procurement restrictions on UN agencies. This responds to a problem in Ethiopia where the procurement of bed-nets by UNICEF on behalf of the Ministry of Health had been blocked for more than a year because this was being funded by the Bank. This has now been resolved through an MoU between the Bank and UNICEF.
- **WHO** is piloting a new category of Technical Officer position focused on Aid Effectiveness and Donor Coordination through its WPRO Regional Office and Vietnam Country office.

TABLE 4: Behaviour Change Expectations, indicating progress

Expected Behaviour Change	WHO	WB	UNAIDS	UNICEF	UNFPA	GAVI	GFATM	EU	BILATERALS
Increasing delegation of authority to country representatives									
Ensuring country & HQ compliance with H&A policies and arrangements agreed at either level									
Cross-representation in country									
Use Board influence in multilateral agencies and partnerships									
Review adherence to codes of conducts and compacts as part of annual health sector reviews									
Peer review proposals and assist government in saying no to inappropriate offers									
Requesting country teams to give specific examples of needed behaviour change									
Amending policies and priorities to encourage longer term investments in the national health workforce									
Implementation of NSA and consensus by partners on criteria & process for validation									

KEY N/A Implemented No Change

Many respondents spoke about the need for better communications within their organisations. This applies both from the central level to countries, as well as from countries back to the policy level. Overall, it was evident that partners have not invested enough in change management processes and most have not even started to see that this is necessary to manage the IHP+ as a reform process.

It's important to build organizations around what works, rather than trying to fix what doesn't. Respondents spoke about needing to build on the changes that have already been taking place, for instance in how multilaterals have moved from projects to programmes to multisectoral programmes and now towards sectoral plans and national strategies. Initiative taken by institutional representatives at the country level must be rewarded and acknowledged. Subsidiarity is best promoted and protected by enabling people on different levels to act cooperatively on their own initiative. This requires understanding where the power of decision lies and empowering decision-making at the country level. It also requires assessing what are the capacity constraints in staffing at the country level. Many Agency staff in countries felt that they are not given the additional resources to manage new initiatives and processes that are introduced by teams of people at the headquarters level.

Specific suggestions have been made for the types of changes that partners and governments would like to see[83]. Some of these are summarised in *Table 3*, which also indicates the Review Team's impressions of whether these changes are starting to happen or not.

Most partners feel optimistic that the conditions in countries are starting to be more conducive to them making progress. This includes having established the shared vision of the IHP+; the forum for ongoing interaction through country health sector teams; strong political incentives for achieving short-term payoffs, such as the promise of more funds in return for results; and enduring commitments to cooperate in the form of the global and (in due course) signed country compacts. Country-level respondents generally expressed their preparedness to change the ways of doing business, particularly to build on what has already been achieved.

In many instances these conditions were already there before the IHP+, but lacked the political drive and accountability expectations. It would be informative to conduct detailed studies at the country level to better understand what changes have been happening and to learn how the IHP+ (or other processes) are contributing to this.

However, for most institutions, people at the country level say that they are still restricted from doing things differently by global policies and regulations: whilst people at the headquarters level say that they depend on decisions being made by country representatives.

There are clearly disincentives and internal rules within institutions that don't support IHP+ principles. Agency staff and government officials acknowledge that many of these are long-standing issues, such as:

- The level of delegated authority to country teams that can vary greatly across partners, so some programmes may be represented by very junior staff without relevant technical knowledge or experience – resulting in inappropriate funding decisions, or their inability to reciprocate appropriately to other partners.
- Lack of country presence of the Global Fund and GAVI, as well as of other agencies in some countries, which makes it difficult for them to engage in country processes, or to be in touch with new developments.
- Bilateral donors having a strong influence over government agendas, even if they make relatively small financial contributions.
- Concerns about fiduciary risk that prevent some Development Partners from using national systems of financial management and procurement. The accountability of bilateral agencies to their taxpayers remains a key concern for some partners.

- Poorly enacted division of labour between agencies, which results in territoriality and duplications.
- The need for attribution, or for contributions to be acknowledged (for example, U.S. Government funded assets must be labelled as *a gift from the American People*).

Delayed progress towards achieving more programmatic approaches is not always under the control of donors There can be resistance to this by recipients such as Project Implementation Units, NGOs and government departments. For example, in Cambodia there is the impression that entrenched interests are keeping certain issues (such as how salary support is allocated and sub-recipients are selected) off of the agenda of the CCM. This has been highlighted in a number of unpublished reports, but there is reluctance by the Global Fund to interfere, as these are seen by the Fund to be *country decisions* over which it does not have a mandate.

Donor politics at the country level also need to be taken into account. In countries where partners are aligned into 2 broad camps - one supporting the IHP+ agenda and the other more focused on project approaches - this creates complexities that further entrench positions and threaten donor relations. This was mentioned to be the case in Nepal and Cambodia, where the governments are cautious not to have exclusive arrangements with DPs.

> ***These days, smart organizations embrace transparency and are actively open in ways that make them far more effective and sustainable[84].***

The principle of development institutions collaborating openly to achieve more effective results still needs to be demonstrated in practice, but there are some emerging examples of genuine collaboration starting to happen:

- **The heads of the main health agencies, meeting informally as the 'H8'[85],** have not only continued to publicly advocate for change, but have also mutually agreed to a set of collaboration principles that include: sharing ideas openly and keeping each other informed of key strategic directions, as well as sharing data and statistics; creating opportunities to collaborate more closely while appreciating respective organizational complementarities; identifying shortcomings in collective work efforts and ways to resolve them; maximizing their individual and collective efforts to help countries and partners to achieve the MDGs; aligning organizational processes and communication activities to achieve these ends[86].
- **The World Bank and WHO are collaborating closely in jointly leading the IHP+ at the global level, which has been a notable achievement** and by all accounts this working relationship is proceeding extremely well. This follows decades of poor relations and territoriality between these agencies, both operating with a mandate in the health sector.
- **Country health sector teams** have the potential to create deep collaboration between partners. The Donor Group in Zambia has operated along these principles for some time, led by individuals who want to champion specific issues through collaborative working.

Although accelerated reforms are needed, the IHP+ is more likely to bring about evolutionary, rather than revolutionary, changes in the ways that development partners do business within countries.

F. CIVIL SOCIETY AS AN EQUAL PARTNER

The IHP+ process is expected to meaningfully engage Civil Society at the global and country-level in ways that are both participative and representative. Governments are expected to include this sector in their national health plans and to ensure that non-state service providers also receive funding and technical support.

Civil Society (CS) is considered to be an important partner of the IHP+[87]. Although this was a principle of the Global Compact, some CS respondents feel that this has only become a reality because CS took the initiative to engage the IHP+[88]. Enabling full CS representation in the steering group (*Business SuRG* and *Steering SuRG*) of the IHP+ has already proven beneficial (even though this has taken half a year to agree on). There now strong commitment within the SuRG to support CS participation, including through funding the costs.

Although CS engagement is happening at the global level, within some countries the lack of mechanisms for engagement remains a challenge that the IHP+ needs to address. Many CS respondents felt optimistic about the possibility for future engagement with Ministries of Health. Umbrella Civil Society Organisations (CSOs) within countries have an important role to play. Where there are well-established umbrella organisations, CS participation within countries is happening more effectively. Examples of this include MEDICAM in Cambodia, and AMREF in Kenya.

A guidance note on CS engagement at the country level is being developed under the lead of CS reprentatives. This is expected to be adopted as a common policy by all IHP+ partners, though this is new territory for some agencies. The progress that has been made so far is considered to be a significant step forward by both CS representatives and other partners within the SuRG.

Civil Society representation and the legitimacy of participants is still a challenge. This requires getting the balance right between international CS and country representation, of which partnerships such as GAVI and the Global Fund have much experience (the lessons from this were shared at an IHP+ global civil society consultation in Geneva during May 2008)[89]. One respondent felt that the SuRG is more obliged to react to vocal international NGOs, rather than to engage local CSOs, which skews its focus. The most active CS representatives in the health sector have been AIDS-focused, whilst those concerned with health services more broadly tend to be much less well-represented, lacking in experience and are under-resourced to participate effectively. CS respondents feel strongly that donors need to continue supporting civil society groups directly, to be effective in advocating for the needs of ordinary people, particularly the poor and most vulnerable or marginalised communities.

There is not necessarily consensus between all civil society organisations. Concerns have been raised by AIDS advocacy groups about whether the IHP+ will detract from existing commitments - particularly to further scaling up and sustaining global action on HIV and AIDS.

Civil Society feels that the IHP+ needs to more explicitly promote equity and human rights, as well as the belief that people are central to their own health. This criticism is validated by the absence of this language from any of the official IHP+ documentation. It contrasts with the hard-won recognition of these issues in the global AIDS response and by the advocates of sexual reproductive health rights.

If the Country Compact mechanism effectively allows governments to bypass any requirement to involve civil society, this could be a major step backward. In Ethiopia this seemed to be happening, as CS were not involved from the beginning in drawing up the Draft Country Compact and were only included at a later stage. Lack of CS involvement in Ethiopia and other countries is a key concern of CS respondents. This is echoed by the Global Fund, which has legally enshrined Civil Society participation in its constitution and is able to enforce civil society involvement in CCMs as a requirement for countries to access funding. The IHP+ cannot have an equivalent mechanism because of it is not a constituted entity.

The IHP+ needs to become more people-centred and link to existing civil society movements, such as the Peoples Health Movement.[90] *"The People's Charter for Health* states that: *It is now essential to build a concerted international effort to put the goal of Health for All in its rightful place on the development agenda. Genuine, people-centred initiatives must be strengthened to increase pressure on decision makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality."*

Civil Society incorporates a diverse range of stakeholders and perspectives, so it is not really valid to talking about engaging with this as a single entity. However, it is the principles of putting people at the centre of health and development and giving stakeholders a voice that will make the difference to whether the IHP+ will succeed as a movement for change. Particularly important is what happens at the local (sub-national) level to establish mutually accountable partnerships for managing all available resources to achieve results.

G. INFORMING ACTION & TRACKING RESULTS

The IHP expects that common processes and national systems will be used for monitoring and evaluating the implementation of national health plans. This needs to be linked to planning and budgeting processes at all levels of the health system.

Countries are expected to invest in their Health Management and Information Systems and to strengthen the M&E component of their National Health Plans.

There is no disagreement that countries need to invest more in the people and systems for managing information and for measuring results. The IHP+ *Common Framework for Monitoring Performance and Evaluation of the Scale-up for Better Heath*[91] was ratified at the Lusaka Consultation of Country Health Sector Teams. This is based on five principles: *Collective action; Alignment with country processes; Balance between country participation and independence; Harmonised approaches to evaluation and performance assessment; Capacity building and health information system strengthening; and adequate funding*. The IHP+ process is already increasing the emphasis within updated national health plans on Monitoring, evaluation and strengthening country health information systems. Partner support for this is expected to be reinforced as a commitment within Country Compacts.

However, implementing these commitments requires collective action that has not been achieved previously. Neither country-level stakeholders, nor any single global level stakeholder appears to have sufficient incentive to invest adequately in evaluation, and there

FIGURE 8: Framework for Monitoring Performance and Evaluation

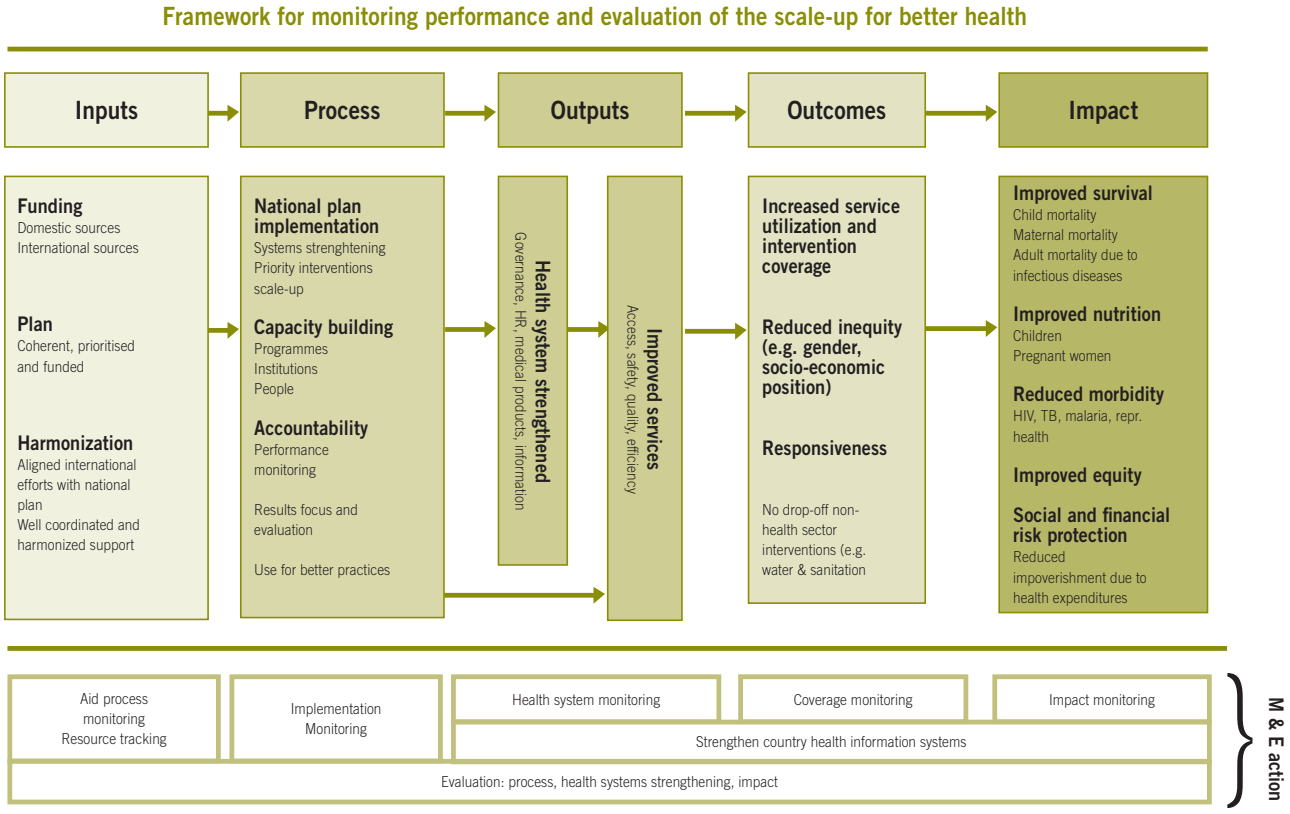


FIGURE 9: Expected progress over time at the country level

has rarely been agreement between partners to jointly invest in an evaluation. The IHP+ could potentially make progress in this area by improving cooperation and by being results-focused. Joint meetings have been held between the related initiatives and there is ongoing technical work being undertaken through the IHP+ interagency working group on M&E to agree on common approaches. Now specific cooperative action is needed within countries, together with financial committments towards monitoring performance; building health information systems by addressing major data gaps; and funding impact evaluations.

There is a disputed assumption that Harmonization and Alignment are necessary to improve health outcomes. The IHP+ Global Compact makes an explicit link between aid effectiveness and MDG results. But there are technical experts who question this hypothesis because it has not been proven and could be contrary to the evidence in some instances where nonaligned aid has had significant impacts. They feel that the success of the IHP+ must be measured by what health results it achieves, not by the proximal indicators of change in donor Harmonisation and Alignment.

Linking aid to expectations of performance has been a strength of the GHPs, but they have tended to dictate which outcome measures and what specificity of results are required within national M&E frameworks. Now it is important for performance to be measured more broadly, not just against the target diseases. But there are still concerns that the need to demonstrate short-term results will continue to strongly influence resource allocation decisions in favour of the disease-focused priorities, rather than towards investments in longer-term health systems strengthening activities, despite the *5-Ones* principle of the IHP+.

Monitoring the progress of partners in adhering to their commitments needs to be a core element of the IHP+ mutual accountability mechanism. Transparency and participation are seen as the key principles for achieving this. There are expectations amongst civil society in particular for the IHP+ to create the culture of openness and sharing of information. The potential of using networks to collect, analyse and share information has been proposed.

H. MANAGING THE IHP+

The IHP+ Core Team is expected to have ensured that the IHP+ process is well-managed and to facilitate access to high quality technical support, as required, to regional and country teams for their practical operations and for documenting experiences. At the same time, they have been expected to keep this an "institutionally light" process that avoids complicating the global health architecture and adding administrative burden to countries.

The SuRG and Interagency Core Team see the role of the Interagency Country Health Sector Team (CHST) as being central to taking the process forward[92]. However, the concept is still relatively new and respondents raised a number of issues about this mechanism[93]:

- What the real purpose of the CHST is, and how this differs from existing forums;
- Which of the existing arrangements for donor co-ordination and civil society engagement[94] to work through and what changes might need to be made;
- Whether agencies have sufficient capacity and presence in countries to contribute effectively to these teams;
- The need to improve communications with the global IHP+ Core Team and SuRG;
- Whether these teams would be adequately equipped to respond to political challenges such as ensuring that the MoF understands the necessity of implementing health sector financing reforms and how to get government to take leadership of the process;
- Who should be included in CHSTs (global IHP signatories as well as other partners in country).

Overall, how the CHST entity fits within the IHP+ still needs to be clarified and to find its relevance as a mechanism for building cooperation for reform within countries. There were some respondents who felt that CHSTs should have a formalised mandate with a legal status for overseeing and developing Country Compacts. The Global Fund CCM was put forward as a potential model.

Catalytic Funds have been provided by the IHP+ Core Team for country health sector teams to strengthen their ways of working[95] - for example by improving coordination between agencies and the government; analysing systems constraints; or holding national learning and consensus-building events. Five of the initial 8 IHP+ countries had prepared plans for this by May 2008, but it is not clear yet whether this has resulted in any useful outputs. Even though the amounts were relatively small, they have incurred disproportionate transaction costs within some WHO country offices and ministries of health.

The SuRG (steering group) of the IHP+ has been an effective mechanism for building interagency cooperation and dialogue at the international level. Besides providing overall direction to the IHP+ and overseeing the work of the Interagency Core Team and working groups, the SuRG has started to address agency-specific and interagency bottlenecks, as these are identified. There are two SuRG forums - the *Business SuRG* (with representatives from the 8 agencies, Core Team and Civil Society),which meets more frequently and the *Steering SuRG* that includes Donor countries. Participation by these Donors has been inconsistent and the purpose of the *Steering SuRG* has not yet become properly established.

It is not clear whether the purpose, membership and mandate of the SuRG makes this the appropriate forum to address agency reforms or to deal with *bottlenecks*. This is not the only global high-level forum that has been established for such a purpose. The Global Implementation Support Team (GIST) was formed in July 2005, based on the GTT recommendation that: *The multilateral system establish a joint UN system-Global Fund problem-solving team that supports efforts to address implementation bottlenecks at the country level.* No consideration has been given by the SuRG to how these two forums relate, even though the same institutions are represented on both. The GIST has only recently reformulated its terms of reference following a review that provides salient lessons for the SuRG. This reported challenges in:

- **Clarifying its mandate** (for instance, whether to focus on both country-level and global systemic bottlenecks; how to relate to country-level mechanisms; and whether to focus on short-term operational problems, or the longer-term institutional problems).
- **Governance and accountability**, including mutual accountability and the consistency of representation (high turnover of member representatives interferes with continuity; and the level of delegated authority, or seniority to take up issues at the management level within organisations or, if necessary, to influence institutional decisions).
- **Membership** (including questions about whether senior-level representatives could realistically take on the responsibility for addressing issues).
- **Operational considerations** such as how frequently to meet; how to select the chairmanship and what is the tenure of participants.

A key difference is that the SuRG is currently highly politically mandated and does have a direct link to heads of agencies to take up any high-level concerns (formally this is through the biannual H8 meetings, where the IHP+ is a standing item on the agenda).

The IHP+ Interagency Core Team has made good progress in implementing the joint work-plan. Reviewing the deliverables that have been achieved in the first half of this 18-month schedule of work, the Team has done well to almost completely execute the plan. The main remaining areas of work include: Harmonisation and alignment of Health Systems Research; Evidence and knowledge generation on health service delivery; and Consultation with private sector. This puts the Team in a good position to substantially update the plan for the second year of the IHP+. The Core Team has also done well to promote transparency in its communications and in keeping partners updated with regular reports.

In practice, this WHO-WB led Team has also driven the implementation of the IHP+ from the global level. This has had the effect of sometimes excluding some of the other partners. The team is very dependent on the leadership of specific individuals and the working relationships that have been established between the WHO hosted team based in Geneva and World Bank hosted team located in Washington, DC. The role of the HHA initiative as the Africa Region part of the Team is less clear, given the capacity constraints that exist in the WHO AFRO office, but the HHA has facilitated technical assistance to some of the IHP+ countries in the Africa region for updating their national plans and budgets in preparation for drafting Country Compacts.

There is a strong view within the SuRG that the Core Team should not become institutionalised as a secretariat. However, the Core Team workload is likely to increase substantially as countries begin to implement their Country Compacts and as more countries join the IHP+. The team will need to have the people and systems in place to continue promoting institutional reforms, strengthen communications and to provide substantive support to Country Teams.

The IHP+ is not yet achieving its stated commitment to being country-led and country-owned, as it is still being managed in practice as a global initiative. Driving policy and change from the country level would require decentralising and distributing key functions of the Interagency Core Team and Working Groups to the regional and country levels (together with the resources to make this work). Using collaboration tools more effectively could help make this feasible.

I. WHAT HAS CHANGED IN COUNTRIES

The IHP+ expects to build on and use the existing systems at country level for planning, coordination, delivery and management of the health sector within the national development framework, to achieve MDG-related outcomes.

Partners have begun using the IHP+ to add political momentum to existing Harmonization and Alignment activities in a few countries. The Aid Effectiveness agenda in countries was already in progress before the IHP+ (which was part of the rationale for initial countries being selected). So the degree to which the IHP+ expectations have been carried out has largely depended on people within partner organisations understanding what additional value this has to offer in the context of their work and then finding ways of using this to strengthen existing work. For instance, in Burundi[96] partners have used the IHP+ as an opportunity to provide impetus for the country's first MoU[97] and SWap[98] negotiations.

Partners have identified opportunities to take forward specific actions on policy, planning and budgeting for improved H&A to

support the Health Sector. These will allow the IHP+ commitments to be incrementally incorporated into SWAps, PRSPs, National Budgets, Sectoral Plans and other instruments in participating countries. WHO and the World Bank have agreed to provide specific technical leadership for this[99], where possible linking to pre-planned processes, such as the Mid-term Review in Zambia during August 2008.

The IHP+ is beginning to influence the scope and ambition of national health plans and budgets. For instance, in Mozambique the Human Resource Strategy and budget already under development have been increased in scale and ambition, most likely because of the IHP+ (see box[100]). The Ethiopia Country Compact presents funding scenarios that require doubling to quadrupling the current total sectoral budget up to $4 billion per annum, based on what is required to achieve MDG results[101].

This is raising concerns amongst development partners about how to manage the expectations of national governments and civil society when these projections require 'unrealistic levels of external donor support'.

As most partners seemed to be waiting for the country compacts to be agreed before taking further actions, some respondents felt this has been a missed opportunity for building collaboration and initiating reforms that could have started in the interim.

There are transaction costs associated with implementing any new development initiative or process. The experiences of Cambodia, Kenya (and Nepal) provide evidence that the IHP+ is less useful in creating added value in some countries and should probably not be entered into from the start, unless the benefits are clearly understood. There should be a screening procedure and selection criteria to make decisions about whether to invest IHP+ in each new country. However, within the current cohort of countries, it will be valuable to compare progress across the different contexts.

Overall there are still many questions within countries that already have strong H&A processes underway about what further value the IHP+ can add[102].

Mozambique has the opportunity to achieve greater cooperation in resourcing its ambitious proposed health workforce strategy.

Mozambique has one of the most critical shortages of health workers in Africa (1.26 health workers per 1,000 population). In April, 2008, the U.S. and U.K. proposed a joint programme of coordinated support to strengthen health systems in four African countries (Ethiopia, Zambia, Mozambique and Kenya). These countries will be assisted by the UK through the IHP+ process, and by the U.S. through the President's Emergency Plan for AIDS Relief (PEPFAR) and other activities.

The Ministry of Heath in Mozambique has been encouraged by these development partners to agree on an ambitious new Human Resource strategy that will dramatically increase numbers of health workers by 79% over 7 years to 2015.

This will require increased spending on human resources in the health sector from USD 59 M. in 2006, to 130 M in 2008, and up to 400 M. in 2015.

The ambition and scope of these plans has grown since the IHP+ was launched and through the strong indication of political support from the U.K. and U.S. governments. However, under existing commitments, donor financing for health in 2009 will be much the same as 2008.

Partners are now collaborating to jointly mobilise funds to support the Government in the initial scale-up to put in place sustainability mechanisms. This includes trying to mobilise additional funding from the GFATM and overcoming the latest rejection of the county's HSS proposal to GAVI.

DFID has committed to doubling its annual spend to USD 12-14 M, as part of the UK's IHP+ obligations. PEPFAR has agreed to contribute through its strong comparative advantage in supporting training (including pre-service training), and has significant potential to extend the work that it is already doing to integrate newly trained health workers into the health system.

There is clear potential and stated willingness to strengthen the partnership between PEPFAR and the Ministry of Health for increasing Health Workforce related activities against nationally defined priorities. This could possibly be further encouraged by the U.S. agreeing to participate in the IHP+ Country Compact mechanism.

IV

conclusions

BECOMING A RELEVANT INITIATIVE

1. **The IHP+ has become established as a relevant response to addressing constraints to the health-related MDGs.**
    - This has enrolled the participation of key partners who have signed a Global Compact agreement committing to its principles (although this has not yet been formally endorsed by the U.S. government and a number of other donors);
    - It has high-level continuing political support from the heads of the 8 major international agencies and partnerships in health, as well as from strategic recipient country and donor government partners;
    - Expectations of what it is intending to achieve are widely shared or acknowledged as being relevant by stakeholders representing the partners and countries involved in the initiative, including leading Civil Society Organisations;
    - It operates with a mandate that is country-led and country-driven, in line with the Paris Principles for Aid Effectiveness;
    - This has the potential to improve aid effectiveness for the health sector by placing particular emphasis on *Mutual Accountability* and *Managing for results,* which distinguishes this initiative from others.
2. **However, its relevance is not widely understood** throughout the participating institutions or by external stakeholders. This is partly because the purpose and objectives of the IHP+ have not been clear and were not well communicated by partners and the Interagency Core Team. Defining the details of IHP+ has been work in progress, responding to developments in an iterative way. The consequences of this are that:
    - Many people question the value that the IHP+ adds to existing aid effectiveness agreements and mechanisms within the heath sector. It is not appropriate to just add an *IHP+* label to country processes that already exist;
    - There is little appreciation that, in order to succeed, the IHP+ needs to achieve *accelerated reforms* within partner institutions, whilst building on the existing processes within countries;
    - People within countries are unsure about how the IHP+ and other initiatives linked to the 'Global campaign for the health MDGs' relate in practice and there is a sense that the aid architecture is becoming even more complex through the actions of global partners. There is also a perceived risk of the IHP+ becoming yet another institutionalized 'big initiative' that will need to be managed and will add transaction costs over time;
    - There is still confusion over the difference between the *IHP* and *IHP+* (whether these are the same or two related initiatives).
3. The relevance of the IHP+ still needs to be established in partner countries such as Cambodia that already have strong mechanisms for donor harmonization and alignment in place and in those that are not aid-dependent, such as Nigeria.

IMPROVING COOPERATION

4. **Specific progress has been made at both the global and country levels that has started to introduce more effective mechanisms for cooperation amongst multilateral agencies, bilateral donors, and civil society**.
    - The IHP+ has been operationalised as a *meta-initiative* that expects to bring together related initiatives that share the similar vision through a coordination process and a common work-plan that is shared amongst the partner agencies;
    - Participation mechanisms have been established for partners to undertake joint work through the Scaling-up Reference Groups (*Steering SuRG* and *Business SuRG*), the *Interagency Core Team* and *Working Groups* at the global level and through *Interagency Health Sector Teams* within countries;
    - Progress has been made in developing *Country Compacts*, with 4 of the initial 8 partner countries likely to have their agreements ready for partners to sign by the end of 2008;
    - Meaningful Civil Society participation has started to happen at the global level (after initial delays) and there is now a strong willingness amongst institutional partners to entrench this as part of the mechanism for holding agencies to account. In some countries civil society organisations have already been engaged in the process of drafting *Country Compacts* and in others there is optimism that the IHP+ could establish new mechanisms for participation;
    - This has generated optimism towards building the momentum on cooperative ways of working for supporting countries to achieve their health targets.
5. **However, the effectiveness of the IHP+ is only starting to be demonstrated,** as it is still too early to see results beyond some initial indications that partners are following through on their commitments.
6. **The experience of developing *Country Compacts* in the Initial IHP+ countries has raised some critical concerns amongst partners** where there has been lack of initial civil society involvement in the process (in Ethiopia); how to make the agreement *binding*; the implications to development partners of

their joint and several liabilities to meet funding commitments; the requirements for upfront financing indications; absence of explicit national government funding commitments; disagreement on which budget projections can be justified; their government-centric focus; and lack of acknowledgement of the specific roles and contributions of non-state service providers.

7. **Real progress will depend on whether *County Compacts* are signed** by partners, including by the Global Fund and GAVI that do not have country-level representation and are not mandated to make up-front funding commitments.

8. **It is crucial for specific action to be taken within countries over the next 6-12 months by all partners** (including those that are not signatories of the IHP+ Global Compact) to show real support for *one country plan* by participating in the country's preferred processes (in most cases, the SWAp), and to be held mutually accountable for managing this process so that it achieves results.

MAKING PROGRESS ON COMMITMENTS

9. **Most IHP+ partners have started to move in the right direction towards improving harmonisation and alignment**, although it is difficult to establish which of these actions could be attributable to their participation in the IHP+. Donor coordination has been increasing within many countries for some time and Partners have already been taking significant actions relating to the aid effectiveness agenda.

10. **However, a number of partners were perceived as not yet having followed through with actions relevant to their specific IHP+ commitments.**

    - The process to date has been more about participating in joint activities (mainly through the SuRG) than bringing about real institutional changes that affect the ways in which partners do business within countries.
    - This particularly applies to some bilateral signatories (France, Germany, Italy, Netherlands and Portugal), though not all the participating Bilaterals have local presence or direct funding commitments in the IHP+ countries. Their contribution needs to be measured over the longer-term by how they meet their global aid financing commitments and by how they influence the multilateral agencies and other Global Health Initiatives in which they participate.
    - The multilateral agencies (WB, WHO, UNICEF, UNAIDS and UNFPA) have not communicated very well what they are doing to implement their IHP+ commitments. This shows the importance of visibly demonstrating and communicating to other partners the concrete actions that are being taken, so these can be acknowledged and appropriately reciprocated.
    - Waiting for country compacts to be drafted and signed has been cited as justification for not having followed through on other specific commitments, which has incurred the opportunity costs of losing time and momentum on initiating institutional reforms to prepare for this.

11. **Implementing the IHP+ is primarily a change-management process** that requires the global institutions to reform specific 'behaviours' and to ensure that their country representatives conduct their business to a new level of expectatios. However, partner institutions have not yet started to invest in appropriate change-management processes or in building the necessary competencies within their organisations to do business differently. The starting point for managing this change is to acknowledge what each institution and its people are able to do right and to build on what is working.

12. **Beyond *institutional behaviour change*, the IHP+ also provides the opportunity for partners to consider what *structural changes* could be made to reform the aid architecture**. Suggestions included merging the secretariat functions of the GFATM and GAVI to create a consolidated *Global Fund for Health*.

ESTABLISHING MUTUAL ACCOUNTABILITY

13. **The conditions are being created at the country level for partners to cooperate in defining and committing to Country Compacts and for working together in mutually accountable ways**.

    - There is agreement that the IHP+ Country Compact (or its equivalent agreement framework) is intended to be the key tool for improving cooperation by binding development partners and the national government in each country to being mutually accountable for achieving the MDG results that they have globally committed to;
    - For most countries, the Sector-wide Approach (SWap) is the most appropriate process to build on. This will enable *non-IHP+* development partners to participate, with the option of signing up to the new agreement. For example, in some countries PEPFAR is already engaging in SWAps and the US Government could potentially sign up to *Country Compacts*.

14. However, to move from country resolutions (such as Codes of Conduct) and voluntary agreements (such as SWAp MoU's) to *Country Compacts* that ensure mutual accountability for results, will require a much more explicit focus on reforming the ways of agencies doing business, as well as structural reforms that will by their nature take longer to accomplish.

15. **There is a real risk that the IHP+ could fail** if partners do not take actions to reform and if mechanisms for holding both donors and country governments to account are seen to be ineffective.

16. **Transparency is seen as essential to ensuring accountability and this also depends on having reliable information available.** The planned annual external monitoring and evaluation review of the IHP+ can potentially function as the key global accountability mechanism if this is well-designed.

MANAGING FOR RESULTS

17. **It is still too early to assess what impacts or external effects that can be attributed to the IHP+**, although this appears to be adding momentum to improved harmonization and alignment in some countries, mostly by building on existing country structures and SWAps.

18. **The impacts of the IHP+ are likely to vary between countries** and at this stage it is unclear whether this will bring about revolutionary changes, or whether there will be a more evolutionary effect on improving aid effectiveness in the health sector. It is important to question whether the changes will be adequate to bring about the phase-shift that is needed for achieving the health MDGs.

19. **Most IHP+ development partners place strong emphasis on**

performance-based financing, but country expectations for scaled up and longer-term financing based on MDG scenarios are likely to fall short. Mobilising additional financing may be more realistic than getting longer-term commitments and it is more likely that there will be incremental changes in financing levels. In some countries, donors are unwilling to tackle core financing issues until efficiency improves, but efficiency remains seriously constrained by the poor funding arrangements. There is optimism that the IHP+ is possibly a way of resolving this.

20. **The IHP+ is only sustainable if it starts to demonstrate its value by showing results**, but measurable gains in health impacts will only be evident over the longer-term. In the interim, tracking improved service outputs - particularly for Primary Care services, needs to be the main focus.

21. **Operationalising the IHP+ Results Framework to track changes over time needs to be prioritised**. This requires urgent joint action to strengthen country management information systems.

PUTTING PEOPLE AT THE CENTRE

22. **The IHP+ process has started to properly engage civil society and this will be crucial to its success**. Now the institutional partners need to learn how to cooperate with civil society as an equal partner to achieve reforms at the country level that also embrace people at the local level through providing the means for their participation in creating a movement for health. This includes engaging all sectors of society and non-state providers.

IMPLEMENTING THE IHP+ PROCESS

23. **The IHP+ has been well managed** by the interagency Core Team that has made good progress in implementing the joint workplan. The SuRG (steering group) has been an effective mechanism for global-level cooperation and dialogue, but this needs to have a more considered view of its strategic and operational roles going forward - particularly on its role in promoting institutional reforms.

24. **The constitution and Terms of Reference of Interagency Country Health Sector Teams**, particularly the expected lead role of government, has been less well operationalised and will be crucial to ensuring that Country Compacts are cooperatively implemented.

25. **Changes that take place through institutional reforms could potentially improve aid effectiveness beyond the IHP+ countries** and even in other sectors.

UNRESOLVED ISSUES

26. **The review raises a number of questions that need to be addressed for taking the IHP+ forward,** particularly to understand how this can make a difference within countries. These require further consultation and research that was beyond the scope of this review.

    a. Is there a true association between the IHP+ harmonisation and alignment mechanisms (one plan / one budget / one reporting system / preferential use of government systems / increased public financing) and health results. How does this compare with alternative mechanims, or how can these approaches be improved further?

    b. To what extend are the problems of aid effectiveness *structural*, rather than *behavioural* and can the IHP+ address the underlying structural constraints of having multiple funding agencies and partnerships, (for example, by investigating the case for consolidation, such as merging the Global Fund, GAVI and UNITAID)?

    c. Is it feasible to reform the country mechanisms for coordinating aid flows from all global sources, for example by redefining CCMs to take on a broader health mandate.

    d. To what extent are government expectations of the IHP+ really about new money, rather than improving the effectiveness of existing resources?

    e. Can mechanisms be developed for the Global Funds to underwrite national health budgets?

    f. How can the IHP+ address equity and ensure allocative justice both across IHP+ and non-IHP+ countries, as well as in countries?

    g. Will the *single plan* approach weaken planning and reviews for disease control programmes and will the *single budget* approach lead to rationalization of AIDS control funding, with implications for global epidemic control?

    h. Is the IHP+ moving governments in a direction that is counter to the health sector reforms of the past decade, with too much focus on public sector as provider?

    i. Will increasing transparency and broadening participation improve aid effectiveness?

    j. What will be the most effective mechanisms for holding global partners to account?

recommendations

IHP+ partners and the Interagency Core Team are urged to initiate the following actions over the next 12 to 18 months:

1. Improve how the IHP+ is communicated and understood to be relevant, both within partner institutions and amongst external stakeholders.

1.1. Convey the message that the IHP+ is a movement for accelerating development partner and country reforms in the health sector. The Core Team should publish specific examples on the IHP+ website of what reforms are needed, as well as through other means.

1.2. Place greater emphasis on *the need for more effective cooperation* between all partners, so that their contributions can be harmonised, aligned and jointly managed to achieve health results, with mutual accountability. The Core Team should develop practical guidance and training for agency staff on cooperative ways of working.

1.3. Each partner must specify and demonstrate in an iterative way what immediate actions they will take within each country to honour their IHP+ commitments, and what they plan to do in the medium and longer term. Making this explicit to collaborating partners will encourage others to reciprocate in ways that are more likely to build further collaboration.

1.4. Increased financing for health must be considered a non-negotiable objective of the IHP+. Summaries of IHP+ development partner and national government funding commitments and disbursements should be maintained on the IHP+ website, and communicated through other means.

1.5. Simplify terminology by dropping the term *International Health Partnership and Related Initiatives (IHP+)*, to retain only the original 'IHP' label. References to *Scaling up for Better Health* are likewise redundant.

1.6. Identify and support organisational champions at the global and country levels of partner organisations to disseminate these messages and to strengthen information-sharing and collaboration networks across organisations.

1.7. Conduct a series of country-level consultations and launches in the lead-up to signing Country Compacts. Bring in other partners, including from civil society and the private-for-profit sector, to raise the profile of these events.

1.8. Communicate a vision of how the IHP+ might evolve as a process over the next 7 years (up to the 2015 MDG milestone).

2. Implement the IHP+ more effectively by investing in change management processes within partner institutions and through developing people's competencies to implement new ways of working.

2.1. Partner Institutions must provide supplementary budgets, staffing and training where these resources are needed to facilitate reforms and to meet the learning needs of the organisation. This can include practical actions such as conducting internal and cross-partner facilitated Appreciative Inquiry[103] exercises to identify what is already working and to build on each organisation's strengths and successes. The Core Team should document at least one case study example when this happens, and communicate this so others can learn.

2.2. The technical competencies of agency staff must be developed by making available appropriate training and professional development activities (for example, on *managing fiduciary risks*). The Core Team should help to identify and facilitate the development of these activities.

2.3. Decision-makers must be held responsible as individuals for their actions (for example by including *aid effectiveness* criteria in their performance assessments).

2.4. Incentives must be provided to promote behavioural competencies, such as acknowledging and publisicing examples of good practice.

2.5. Undertake internal assessments of organisations' institutional systems (including policies, procedures and technologies and how compatible they are with those of other organisations) to determine how they need to be reformed to make the organisation more competent at each operational level. Then put in place the plans to fix these systems (for example, to preferentially use country procurement mechanisms; align planning cycles; harmonize reporting requirements, etc.).

2.6. Commission an assessment into the case for structural reforms in the aid architecture (beyond behaviour change). Each of the options for structural reform should be subjected to an independent and transparent review and decision analysis. Compelling justifications should be given and contested with evidence, for why any proposed option would not produce better results over the longer-term. For example, this architecture review should consider the case for merging the secretariat functions of the Global Fund and GAVI (and possibly incorporate other funds, such as UNITAID).

3. Implement the IHP+ results framework and build in strong transparency mechanisms for mutual accountability.

3.1. Push for the recommended 5-10% premium on all donor funding to be spent on strengthening country health information systems and implementing the IHP+

monitoring, evaluation and results framework should be written into *Country Compacts.*

3.2. Develop transparency mechanisms as a core element of strengthening Monitoring, Evaluation and Reporting systems.

3.2.1. Continue to post reports on the IHP+ public website; make country and development partner monitoring and evaluation data accessible to researchers; and open up discussions about report findings and recommendations through country-level public meetings and online discussion groups. This should achieve visibility for partner actions.

3.2.2. Implement a donor reporting mechanism, similar to the business sector *Global Reporting Initiative* model[1], based on a *Donor Scorecard* that is completed at each operational level of the institution and published annually.

3.2.3. Establish a global open-access clearing-house of health indicator data for IHP+ countries and publish independent decision analyses for key decisions.

3.3. Ensure that learning and improvement are key outcomes of Monitoring and Evaluation, so that the IHP+ can evolve over time. It is particularly important for M&E to demonstrate and validate actions that have been undertaken by partners, so that these can become the basis for reciprocal actions by others. The timing for this iterative feedback needs to be as short as possible.

3.4. Conduct independent research to establish the validity of assumptions that Harmonisation and Alignment improves health outcomes.

3.5. Require a more structured approach in the planned annual reviews of the IHP+ over the next 3 years:

3.5.1. Focus primarily on inputs and behaviour change relating to partner reform in the first 12 months; the process of implementing the '5 ones' in months 13-24; and on measuring outputs and outcomes in the third 12 months (fourth year of the IHP).

3.5.2. Include in-depth studies of at least 2 countries nominated by the SuRG in each review cycle, linked to annual country sectoral reviews.

3.5.3. Conduct the review process collaboratively, involving policy makers, programme managers, civil society organisations and evaluation experts to improve the content and reliability of the findings, as well as to ensure buy-in to the recommendations from a wide constituency.

3.5.4. Publicly communicate the results to a broader range of stakeholders, for political accountability.

4. Partners must work cooperatively to achieve reforms by initiating and reciprocating the following actions.

4.1. The *World Health Organisation* must:

4.1.1. Strengthen its technical focus and capabilities on Health Systems Strengthening through its country offices.

4.1.2. Plan to restructure country offices so that these better represent the health sector priorities in IHP+ countries.

4.1.3. Update Country Assistance Plans, where relevant, to reflect the new priorities.

4.1.4. Provide the technical frameworks and evidence for establishing Local Health Partnerships

4.1.5. Develop policy guidance on how to link the IHP+ with health systems strengthening through implementing integrated Primary Health Care.

4.2. The *World Bank* must:

4.2.1. Play a more strategic role getting Ministries of Finance on board with the IHP+ process and report on lessons learned in doing this.

4.2.2. Devolve more authority for decisions to the country level, and independently review how this is working, in practice.

4.2.3. Communicate more explicitly to others what specific steps it intends to take, within its institutional mandate, to reform its ways of doing business.

4.3. The *Global Fund* must:

4.3.1. Effectively implement National Strategy Applications, as planned, by: learning from the experience of implementing the HSS mechanism; dramatically reducing the complexities that currently exist in its business model; and through proactively streamlining future NSA grants with existing project grants in recipient countries.

4.3.2. Exercise greater flexibility in permitting in-cycle changes to existing grants, so that these can take advantage of the new opportunities that arise under the IHP+.

4.3.3. Encourage countries to review their CCM membership and terms of reference to achieve a greater representation of interests that are supportive of alignment, harmonisation; health systems strengthening and Primary Health Care.

4.3.4. Consider redefining its mandate to fund activities that will have the added effect of strengthening comprehensive heath services for primary care in countries with high disease burden for AIDS, TB or Malaria. This focus should either replace or further clarify activities that are currently described as *Health Systems Strengthening.*

4.3.5. Investigate possibilities for delegated representation at the country level.

4.3.6. Establish more strategic linkages with the GAVI Alliance at the international level.

4.4. The *GAVI Alliance* must:

4.4.1. Establish more strategic linkages with the Global Fund at the international level.

4.4.2. Investigate possibilities for delegated representation at the country level.

4.5. Other multilateral UN agencies (UNAIDS, UNICEF, UNFPA) must:

4.5.1. Ensure that the UN Reform process and IHP+ reforms are synergistic, by undertaking a study of this and following through on its recommendations.

4.5.2. Contribute to the development of *Country Compacts* by relating these to other (particularly multi-sectoral) development processes in countries.

4.5.3. Undertake internal and cross-agency assessments of what competencies need to be developed within their country programmes for implementing the Country Compact.

4.6. Bilateral donors must:

4.6.1. Demonstrate that they will meet their stated aid commitments through immediately scaling up aid contributions (preferably through multilateral financing mechanisms), and provide evidence they have done so.

4.6.2. Review their modalities for bilateral funding in countries, to align with the IHP+ commitments.

4.6.3. Use their influencing positions on the boards of the multilateral institutions and global health partnerships and be more consistent in how they expect these agencies to cooperate, in line with the Paris Principles and to achieve IHP+ reforms.

4.6.4. Revise their institutional agreements with multilateral agencies, as appropriate, to expect higher levels of performance through cooperation and reform.

4.6.5. Advocate for a stronger voice for IHP+ countries on the boards of the multilateral agencies.

4.7. The *Gates Foundation* must consider

4.7.1. Using its influencing role on Board of the Global Fund and other Global Health Partnerships to promote the IHP+ reforms.

4.7.2. Leading the private sector agenda within the IHP+ and hosting technical collaborations to investigate innovative partnership models and how to scale up effective public-private partnership approaches.

5. The IHP+ SuRG and Core Team must focus over the next 12 months on facilitating and supporting increased cooperation between partners at the country level to achieve specific reforms.

5.1. Strengthen Interagency Country Health Sector Teams by committing more resources to their work, as needed.

5.2. Establish a collaborative, web-based global IHP+ rolling task-list that gets dynamically added to by partners and ticked off as actions are completed. This will help to focus partner interactions and to demonstrate actions that can be reciprocated by others. It will also enable tracking and alerting when commitments are not fulfilled and issues are not resolved. Similarly, put in place an issue-management system for the Core Team to track, allocate, follow up and monitor issues through an IHP+ 'hot-desk'.

5.3. Develop approaches to sharing good practices among IHP+ countries and follow up the Lusaka consultation with similar forums for collaboration and learning.

5.4. Do not plan to expand the global level Interagency Core Team or to institutionalize this as a secretariat.

5.5. Change how the interagency Working Groups of the SuRG operate to make these more collaborative and transparent. Include country participants, together with civil society.

5.6. Undertake a review of the SuRG Terms of Reference to clarify its mandate, membership, governance, accountability and operations (but do not cut down on the frequency of meetings, until the IHP+ objectives have been met).

5.7. Continue to support Civil Society involvement in the business and steering SuRG and treat CS as an equal partner.

5.8. At country level, proactively seek out civil society involvement in the Country Compact development process; promote representation of civil society in country health sector teams; work with national and local civil society to communicate what the IHP+ is; and facilitate broader civil society feedback into country health sector team discussions.

6. Consider the idea of Local Health Partnerships that are underpinned by a People's Movement for Health, led by Civil Society to promote meaningful coordination, cooperation and collaboration from the ground up[105].

6.1. The concept of Local Health Partnerships could be included in Country Compacts and promoted under the banner of the IHP+, based on the same principles and practices of harmonisation, alignment and financing for results.

6.2. These would be implemented at the level of health districts to strengthen Integrated Primary Health Care services.

6.3. Local Health Partnerships would be inclusive of all partners working together: including local government; the private sector; community-based organisations; public and non-state providers; and other local development agencies.

6.4. They could be an appropriate mechanism to engage non-state providers through validated approaches, such as Performance Contracting and Public-Private Mix.

6.5. Local Health Partnerships should implement the *People's Health Charter* by promoting community and individual self-reliance and participation in the planning, organization, operation and control of primary health care.

ANNEX A: Review Respondents

FIRST NAME	LAST NAME	TITLE	INSTITUTION	LOCATION
Cyprien	Baramboneranye	Managing Director for Resources	MOH	Burundi
Montserrat	Meiro-Lorenzo	Senior Health Specialist	World Bank	Burundi
Barbara	Piazza-Georgi	UNFPA Country Representative	UNFPA	Burundi
Rob	Yates	Health Adviser	DFID	Burundi
Jean-Paul	Yengayenge	Coordinator of Services	Orientation et Médiation à la Ligue Burundaise des Droits de l'Homme "Iteka"	Burundi
Jean-Marion	Aitken	Health Adviser	DFID	Cambodia
Becky	Dodd	Technical Officer for Donor Co-ordination and Aid Effectiveness	WHO	Cambodia
Alice	Levisay	Country Representative	UNFPA	Cambodia
Tony	Lisle	Country Coordinator	UNAIDS	Cambodia
Vandine	Or	Director of Department of International Cooperation	MOH	Cambodia
Michael	O'Leary	WHO Country Representative	WHO	Cambodia
Toomas	Palu	Lead Health Specialist East Asia and Pacific Region	World Bank	Cambodia
Sin	Somuny	Executive Director	Civil Society; MEDICAM	Cambodia
Paul	Weelen	Health Systems Development Adviser	WHO	Cambodia
Pierre	Blais	Counsellor, Permanent Mission of Canada to the United Nations	CIDA	Canada
Leslie	Payne	Senior Programme Adviser	CIDA	Canada
Tanya	Trevors	Health Specialist - Africa Health Systems Initiative	CIDA	Canada
Semira	Alhadi	Acting Director	Civil Society: Christian Relief Development Association	Ethiopia
Fatoumata	Ayorinde Nafo-Traore	WHO Country Representative	WHO	Ethiopia
Christopher	Fontaine	Monitoring and Evaluation Adviser	UNAIDS	Ethiopia
Marion	Kelly	Health Adviser	DFID	Ethiopia
Marina	Madeo	Health & HIV/AIDS Adviser	Italian Cooperation Agency	Ethiopia
Luwei	Pearson	Section Chief, Health	UNICEF	Ethiopia
Agnes	Soucat	Lead Economist	World Bank	Ethiopia
Marie Odile	Waty	Head of Health & Social Protection	French Development Agency	France
Jochen	Boehmer	Deputy Head of Divison, Education, Health, Population Policy	GTZ	Germany
Ruediger	Krech	Head of Section, Social Protection	GTZ	Germany
Guglielmo	Riva	Health Adviser	Directorate International Cooperation, Ministry of Foreign Affairs, Italy	Italy
Tony	Daly	Senior Health and HIV Adviser	DFID	Kenya
Peter	Kamau	Grants Manager	KANCO	Kenya
Humphrey	Karamagi	Health Systems Adviser	WHO	Kenya
Mette	Kjaer	Country Director	Civil Society: AMREF	Kenya
Michael	Mills	Team Leader	World Bank	Kenya
Erasmus	Morah	Country Coordinator	UNAIDS	Kenya
David Ojut	Okello	WHO Country Representative	WHO	Kenya
Dorothy	Rozga	Deputy Regional Director	UNICEF	Kenya
Stephen	Wanyee	Assistant Representative	UNFPA	Kenya
Yamina	Chakkar	Country Coordinator	UNAIDS	Mali
Fatoumata Binta T.	Diallo	WHO Country Representative	WHO	Mali
Mamadou	Diallo	Country Representative	UNFPA	Mali
Tonia	Marek	Lead Public Health Specialist	World Bank	Mali
Ignace	Ronse	Medical Officer	WHO	Mali
Thiecoura	Sidibe	Health Economist	UNICEF	Mali
Humberto	Albino Cossa	Public Health Specialist	World Bank	Mozambique
Hadi	Benzerrouge	WHO Country Representative	WHO	Mozambique
Mauricio	Cysne	Country Coordinator	UNAIDS	Mozambique
Maria	da Luz Vaz	Team Leader	UNFPA	Mozambique
Pilar	de la Corte	Health SWAp and M&E Adviser	UNFPA	Mozambique
César	Mufanequiço	National Coordinator	Mozambican Treatment Access Movement	Mozambique
Neil	Squires	Senior Human Development Adviser	DFID Mozambique	Mozambique
Elena	Borromeo	Country Coordinator	UNAIDS	Nepal
Susan	Clapham	Health Adviser	DFID	Nepal
Ugochi	Daniels	UNFPA Country Rep	UNFPA	Nepal
Rajiv	Kafle	President	National Association of PLWH in Nepal	Nepal
Mahesh	Maskey	Ex-adviser to MOH	Nepal Health Research Council	Nepal
Nastu	Sharma	Public Health Specialist	World Bank	Nepal
Yonas	Tegegn	Strategic Alliances in Partnerships Officer	SEARO WHO	Nepal
HSB	Tennakoon	Acting WHO Representative in WHO Nepal	SEARO WHO	Nepal
Marijke	Winjinroks	Senior HIV/AIDS Adviser	Dutch Ministry of Foreign Affairs	Netherlands
Jane	Miller	Health and AIDS Adviser	DFID Nigeria	Nigeria
Paul	Fife	Head, Global Health and AIDS Department	NORAD	Norway
Sue	Chandler	Policy Officer	DFID	UK
Vel	Gnanendran	Health Services Team	DFID	UK
Elaine	Ireland	Global Health Advocacy Officer	AIDS Alliance	UK
Anna	Marriott	Health Policy Officer	Oxfam	UK
Stewart	Tyson	Head of Profession, Health	DFID	UK
Mukesh	Chawla	Sector Manager, HDNHE	World Bank	US
Rudolph	Knippenberg	Principle Health Adviser	UNICEF	New York
Kate	Krackenberger	Consultant, Health, Nutrition, and Population	World Bank	Washington
Daniel	Kress	Senior Program Officer	Gates Foundation	US
Julian	Schweitzer	Director of Health, Nutrition and Population	World Bank	US
Olusegun	Ayorinde Babaniyi	WHO Country Representative	WHO	Zambia
Nicholas	Chikwenya	Principal Planner, Multilateral and Bilateral Cooperation	MOH	Zambia
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Ben	David	Health Adviser	DFID	Zambia
Dyness	Kasungami	Human Development Adviser	DfiD	Zambia
Sarai	Malumo	National Programme Officer	UNFPA	Zambia
Henry	Malumo	Advocacy and Campaigns Coordinator	Oxfam	Zambia
Catherine	Sozi	Country Coordinator	UNAIDS	Zambia
Rosemary	Sunkutu	Senior Population, Health & Nutrition Specialist	World Bank	Zambia
Geoff	Adlide	Head, Advocacy and Public Policy	GAVI	Geneva
Yves	Bergevin	Coordinator, Maternal Health Thematic Fund	UNFPA	New York
Ties	Boerma	Director, Department of Measurement and Health Information Systems	WHO	Geneva
Andrew Kennedy	Cassels	Director, Sustainable Development and Healthy Environment	WHO	Geneva
Helen	Evans	Deputy Executive Director	GFATM	Geneva
Robert	Fryatt	Health Systems and Services, IHP+ Core Team	WHO	Geneva
Juan	Garay	Health policies and programmes in Developing Countries	EU	Brussels
Frérederic	Goyet	Chief, Office of Policies for Social Protection and Health	EU	Brussels
Ian	Grubb	Senior Executive Adviser – Policy and Strategy	The Global Fund to Fight AIDS, TB and Malaria	Geneva
Teresa	Guthrie	Director	Centre for Economic Governance and AIDS in Africa	South Africa
Phil	Hay	Communications Adviser, Human Development Network	World Bank	Washington
Michel	Kazatchkine	Professor, Executive Director	GFATM	Geneva
Nicole	Klingen	Senior Health Specialist, Human Development Network	World Bank	Washington
Daniel	Low-Beer	Team Leader, Performance Strategy & Evaluation	Global Fund	Geneva
Jacqueline	Mahon	Senior Policy Adviser, Health Systems Strengthening	UNFPA	New York
Tim	Martineau	Director for the Executive Office	UNAIDS	Geneva
Colin	McIff	Multilateral Organisations Officer	OGAC	Washington
Chris	Mwikisa	Director of the Division of Healthy Environments and Sustainable Development	WHO AFRO	Brazaville
Catherine	Palmier	Development Officer, Health and Nutrition Division	CIDA	Canada
Sue	Perez	Federal Policy Director	Treatment Action Group	New York
Peter	Salama	Chief of Health	UNICEF	New York
Bjorg	Skandkjaer	Programme Officer, Advocacy & Public Policy	GAVI	Geneva
Dia	Timmermans	Senior Policy Adviser	UNFPA	New York
Pascal	Villeneuve	Director of Health	UNICEF	Geneva

ANNEX B: Key Documents Reviewed

TITLE	AUTHORS
Briefing Paper #4 - Aid Effectiveness	Action for Global Health
Burundi Stock Taking Report	
Cambodia Health Strategic Plan 2008 - 2015	Cambodia MOH
Cambodia Second Health Sector Program Final Appraisal Aide Memoire (Draft), 7 May 2008	World Bank
Cambodia Stock Taking Report	
Comments on the Concept Note on IHP+ Engagement of Civil Society, April 2008	
Ethiopia Stock Taking Report	
Evaluation of EC support to Mozambique	EC
Global Campaign for the Health MDGs Progress Report, April 08	
Global Fund Key Principles on National Strategy Applications	GFTAM
Global Health Partnerships – Deploying Vertical Financing to Support Horizontal Efforts - GHPS and Health Systems Strengthening in Cambodia	DFID Health Resource Centre
Global level management, IHP+	
Guidance on civil society engagement in country health sector teams	TAG
Harmonization for Health in Africa (HHA) An Action Framework	
Health Rights of the People - Civil Society Concerns, Nepal	Shanta Lall Mulmi, Resource Centre for Primary Health Care
IHP and HHA Interregional Country Health Sector Teams Meeting, Lusaka 28th Feb- 1st March 2008	
IHP Core Team Terms of Reference	
IHP Global Compact for achieving the Health MDGs Sept 2007	
IHP+ Progress Report Two 22nd May 08 Prepared for the 61st WHA	
IHP+ Update 1	
IHP+ Update 2	
IHP+ Update 3	
IHP+ Update 4	
IHP+ Update 5	
IHP+ Update 6	
IHP+ Update 7	
IHP+ Update 8	
Informal meeting of Global Health Leaders 19th July 2007	
International conference on Social Health Protection in developing countries: who will pay?	Action for Global Health
Kenya Health Sector Wide Approach Code of Conduct	Kenya MOH
Mali Stock Taking Report	
Minutes of IHP videoconference with Bilaterals, 27th Nov 07	
MOU Partnership Agreement between Burundi Government and Partners in the Health Sector	Burundi Government
Mozambique debriefing note on the IHP workshop	
Mozambique Stock Taking Report	
Nepal Stock Taking Report	
OECD DAC EC Peer Review 2007	OECD
Partnership in Health Sector, Nepal	Dr BR Marasini, Senior Health Administrator, Ministry of Health & Population
Presentation on the P4H Initiative	Dr. Ralf-Matthias Mohs
Progress Report One: Update on the IHP+. Report prepared for the H8 meeting Jan 28th 08	
Records concerns about WGs overlapping and duplicating efforts, but at the same time important to avoid fragmentation (possible questions: have the WGs agreed on coherent outcomes in TORs; developed concrete results; provided clarity on what will happen after the WGs report back?	
Report on the Technical Meeting of the PFH Initiative	
Report on the Technical Meeting on the 'Providing for Health Initiative', 29-30 Nov 07, Bonn	
Roadmap for Kenya Acceleration of Implementation of Interventions to Achieve Objectives of the NHSSP 2	Kenya MOH
Scaling Up for Better Health: Workplan for the IHP+	
SuRG Meeting Minutes Dec 07	
SuRG Meeting Minutes Jan 08	
SuRG Meeting Minutes Nov 07	
SuRG TOR Feb 2008	
The IHP PMG, Nepal	
The International Health Partnership: delivering the health MDGs Concept Note	
WHO & WB Response to Civil Society Engagement Draft Concept Note	WHO & World Bank
Zambia Stock Taking Report	

notes

[I] A conceptual model for evaluation has been developed by the Review Team that described the IHP+ as a process that builds on coordination efforts to achieve greater collaboration in order to undertake institutional reforms that will allow partners to work together with mutual accountability towards managing for results. Once this is achieved, partners will be able to collaborate more effectively to address the challenges in scaling up health services to deliver health impacts.

[II] There is growing evidence that organizations making their boundaries porous to external ideas and human capital, and collaborating more openly, tend to outperform those that rely on their internal resources and closed relationships. The business sector is already showing how the movement towards 'open standards' and 'open-source' production is operating as a powerful force for change and economic progress. These principles should apply even more to the organisations collaborating in the development sector and could become the key determinant of what results the IHP+ process can achieve.

[3] See www.dfid.gov.uk/news/files/ihp/default.asp

[4] Additional partners have joined the IHP+ subsequent to the launch and signed up to the Global Compact. They are: Countries – Benin, Burkino Faso, Ghana, Mali, Madagascar, Niger, and Nigeria; Donors – Australia, Finland, and Sweden; International Organisations – OECD-DAC. www.internationalhealthpartnership.net/ihp_plus_about_partners.html

[5] Paris Declaration on Aid Effectiveness - Ownership, Harmonisation, Alignment, Results and Mutual Accountability, High Level Forum, Paris, 28 Feb – 2 March 2005. www.oecd.org/document/18/0,2340,en_2649_3236398_35401554_1_1_1_1,00.html

[6] In 2000, heads of State and Governments acknowledged their collective responsibility for development and the alleviation of extreme poverty by the year 2015. They committed to 8 development goals, 3 of which are explicitly related to health: MDG 4: Reduce child mortality (where the target is to reduce by two-thirds, between 1990 and 2015, the under-five mortality rate); MDG 5: Improve maternal health (where the target is to reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio); MDG 6: Combat HIV/AIDS, malaria, and other diseases (where the targets are to have halted by 2015 and begun to reverse the spread of HIV/AIDS, and the incidence of malaria and other major diseases). See 'Health in the Millennium Development Goals' for more detail. www.hlfhealthmdgs.org/MDGchart%20en.pdf

[7] For one example of this see 'Health Systems and the Emerging International Health Architecture or the International Health Partnership +', Center for Global Development, January 2008. http://www.cgdev.org/doc/events/1.23.08/Health_Systems_Schweitzer.pdf

[8] For research on the effects of global HIV/AIDS initiatives see www.ghinet.org/outputs.htm

[9] For information about the *One U.N.* reform process see www.unsystemceb.org/oneun

[10] The High-Level Forum (HLF) on the Health Millennium Development Goals (MDGs) provided an opportunity for informal discussion between senior health policy makers and identify opportunities for accelerating action on the health-related MDGs. MoH and senior officials from developing countries, heads of bilateral and multilateral agencies, foundations, regional organizations and global partnerships were all represented. There have been three HLFs on the health MDGs: Geneva, January 2004; Abuja, December 2004; and Paris, November 2005. In June 2006 a Follow-on Meeting to the Post-HLF on the Health MDGs was held in Tunis, Tunisia where it was agreed that countries should develop robust and inclusive sector plans and increase domestic financing for health, whilst donors should respond more effectively to country needs, fulfill pledges to harmonize and align aid with country strategies, and provide long-term predictable financing. See www.hlfhealthmdgs.org

[11] See www.oecd.org/dataoecd/47/42/41018694.htm

[12] See www.dfid.gov.uk/news/files/ihp/supportive-quotes.asp

[13] See www.oecd.org/document/18/0,2340,en_2649_3236398_35401554_1_1_1_1,00.html

[14] Wood, B; D. Kabell; F. Sagasti; N. Muwanga. Synthesis Report on the First Phase of the Evaluation of the Implementation of the Paris Declaration, Copenhagen, July 2008 www.undg.org/docs/9219/Synthesis-Report.pdf pxi-xiii.

[15] The SuRG has 2 structures: the business SuRG that consists of two representatives of each of the H8 agencies and Civil Society (one northern, one southern) and oversees the regular business of the IHP+ and meets once a month by videoconference; and the steering SuRG that consists of the H8 representatives, representatives from bilateral and multilateral institutions, and Civil Society (one northern, one southern), meeting every two months and providing oversight and feedback from a broader group. See Terms of Reference. http://www.internationalhealthpartnership.net/pdf/SuRG_Terms_of_Reference.pdf

[16] Scaling up for Better Health, Work Plan for the International Health Partnership and related initiatives (IHP+). www.internationalhealthpartnership.net/pdf/02_IHP_Workplan_EN_Feb20_2008_FINAL.pdf

[17] The IHP+ has $7.35m to develop country compacts; $3.75m to generate and disseminate knowledge, guidance, and tools; $1.9m to enhance coordination and efficiency, and leverage aid delivery; and $14m to ensure mutual accountability and monitoring of performance. Appendix B, Work Plan of the IHP+, p19. www.internationalhealthpartnership.net/pdf/02_IHP_Workplan_EN_Feb20_2008_FINAL.pdf

[18] Interagency thematic working groups have been temporarily established on six strategic areas of the IHP+ process: National Plans, Strategies; Monitoring and Evaluation; Aid Effectiveness and Health; Results-Based Financing; Health Services Delivery (Work not yet started); Health Financing and Social Protection (Work not yet started. This work will be taken forward as part of the Providing for Health (P4H) work-plan, which is under development).

[19] IHP+ Management Structure, June 2008. http://www.internationalhealthpartnership.net/ihp_plus_organization.html

[20] The 8 countries are: Burundi, Cambodia, Ethiopia, Kenya, Mali, Mozambique, Nepal, and Zambia.

[21] A number of West African countries were included in initial discussions and were included in the Lusaka meeting.

[22] On 26th Sept 2007, three weeks after the launch of the IHP in the UK, the Global Campaign for the Health MDGs was launched by Norwegian Prime Minister Jens Stoltenberg in New York. Whereas the goal of the IHP is to improve coordination of support by international health organisations and major donor countries for developing countries' National Health Plans, the Global Campaign focuses specifically on health outcomes for women and children in accordance with MDGs 4 and 5. 'The Global Campaign for the Health Millennium Development Goals'. www.norad.no/default.asp?V_ITEM_ID=9263

[23] The Catalytic Initiative to save a million lives (CI) was launched on Nov 26th 2007 with $105m CDN from the Canadian government. The CI hopes to catalyse the work of the IHP by using existing country processes to monitor and track the results of health programmes in participating countries. The aim is to help the IHP identify and scale-up health services, initiatives, and projects that have proven effective. Information provided through private correspondence with Review Team, but also see www.internationalhealthpartnership.net/ihp_plus_about_initiatives.html.

[24] The Providing for Health initiative (P4H) launched in June 2007 following the G8 summit in Heiligendamm, Germany, is an international forum for dialogue and collaboration on the financing of health systems in poor countries, with the specific goal of promoting social health protection. WHO & GTZ Report on the Technical Meeting on the 'Providing for Health Initiative, Bonn, 29-30 November 2007. www.internationalhealthpartnership.net/pdf/P4H_Meeting_Report_Bonn_Nov_2007_EN.pdf

[25] Other related initiatives include: The Health Metrics Network; MDG Africa Initiative; and Global Health Workforce Alliance

[26] See www.who.int/healthsystems/HSS_HIS_HHA_action_framework.pdf

[27] The limited capacity of the IHP+ Core Team to respond an expanding list of countries is likely to compromise the potential of succeeding in fewer countries that can generate lessons for scaling up the IHP+ concept. Although there are some criticisms about the selection of first-line countries having been strongly influenced by the UK, this was useful because the UN agencies cannot make such preferential selections. However, as WHO and the IHP+ is now jointly hosted by the World Bank and WHO, which cannot exclude any member state from its programmes, so the IHP+ cannot restrict participation. This could become a challenge under the current operating model if the demand from countries increases, in which case it could be relevant for the IHP+ to revisit its model.

[28] Global Compact. www.internationalhealthpartnership.net/pdf/IHP_compact.pdf

[29] Evaluation Proposal, Short-term External Review of the IHP+, abridged version 16th April 2008, Responsible Action. www.internationalhealthpartnership.net/pdf/IHP_Short_term_Review_Proposal_Abridged.pdf

[30] The Review Team members are: Dr Shaun Conway, Team Leader and Director of Responsible Action, UK; James Fairfax, Development Analyst with Responsible Action, UK; Dr Andrew Harmer, independent global health policy analyst; and Dr Neil Spicer, Lecturer at the London School of Hygiene and Tropical Medicine, London.

[31] Dr Mandeep Dhaliwal, Independent Consultant, UK and India; Professor Gill Walt, London School of Hygiene and Tropical Medicine, UK; Professor Ruairi Brugha, Royal College of Surgeons, Ireland; Dr Thabale Jack Ngulube, Centre for Health, Science & Social Research, Zambia; David Wilkinson, Independent Consultant and Khmer HIV/AIDS NGO Alliance (KHANA Board) Member, Cambodia; Hailom Banteyergu, Miz-Hasab Research Centre, Ethiopia.

[32] Evaluation Proposal, Short-term External Review of the IHP+, abridged version 16th April 2008, Responsible Action. www.internationalhealthpartnership.net/pdf/IHP_Short_term_Review_Proposal_Abridged.pdf

[33] Inception Plan, Short-term External Review of the IHP+, Responsible Action. www.internationalhealthpartnership.net/pdf/IHP_Inception_Plan_EN_Responsible_Action_FINAL.pdf

[34] See human-scale.wiki-neon.adaptavist.com/display/IHP/Interview+Respondents

[35] See human-scale.wiki-neon.adaptavist.com/display/IHP/Core+Documents

[36] Coordination is about organizing closely situated, related, or linked entities and activities so that they become more harmonious, efficient, and effective in their current state. This is necessary, but in itself not sufficient for Cooperation, which is about procedural compliance towards a shared pursuit. This in turn is necessary, but not sufficient for Collaboration, which is about the process of co-creating shared and emergent representations (of problems, solutions, or other products).

[37] Inception Plan, Short-term External Review of the IHP+, Responsible Action, Annex C. www.internationalhealthpartnership.net/pdf/IHP_Inception_Plan_EN_Responsible_Action_FINAL.pdf

[38] Inception Plan, Short-term External Review of the IHP+, Responsible Action, p8. www.internationalhealthpartnership.net/pdf/IHP_Inception_Plan_EN_Responsible_Action_FINAL.pdf

[39] Interviews with respondents focused primarily on 15 key statements of expectation developed by the review team.

[40] Inception Plan, Short-term External Review of the IHP+, Responsible Action, p8. www.internationalhealthpartnership.net/pdf/IHP_Inception_Plan_EN_Responsible_Action_FINAL.pdf

[41] The SuRG provides oversight, coordination and a steering function to the IHP+ Core Team. The SuRG has two components - a group that oversees regular business of the IHP+ core team (currently meeting monthly) and a wider group that provides a strategic oversight of the IHP+ (meeting every two months). Because its composition is made up of representatives from all international health agencies, civil society and development partners (for the steering SuRG) the strengths of different institutions are combined and members can take issues/potential bottlenecks back to their agencies to discuss and address. The Terms of Reference can be found at www.internationalhealthpartnership.net/pdf/SuRG_Terms_of_Reference.pdf

[42] Working Groups are responsible for generating necessary and relevant knowledge work to facilitate increased harmonization and alignment between development partners and national stakeholders (including civil society and the private sector). There are four active working groups: Aid Effectiveness and Health; Monitoring and Evaluation; National Plans, Strategies and Budgets; Results-Based Financing.

[43] The interagency Core Team is responsible for coordinating the efforts of the international health agencies and the required support for the country interagency 'health sector' teams. See Annexe 1 of the IHP+ Work Plan, p11: www.internationalhealthpartnership.net/pdf/02_IHP_Workplan_EN_Feb20_2008_FINAL.pdf

[44] Other sections of this report describe related additional areas of progress.

[45] Development of a Country Compact Guidance Note, Draft #1– June 8, 2008. Shared with Review Team but not yet finalised.

[46] A common framework for monitoring performance and evaluation of the scale up for better health, M&E Working Group, IHP+, Feb 2008, www.internationalhealthpartnership.net/pdf/IHP_Monitoring_and_Evaluation_EN_FINAL_%20June_2008.pdf

[47] Interagency, Inter-Regional Country Health Sector Teams' Meeting, February 28th – March 1st, 2008, Lusaka, Zambia. The purpose of the meeting was to share experience and promote learning about the IHP+ process in-country – SWAPs, harmonization and alignment of national and international agencies in support of the government's national health plans; to share experience about bottlenecks; hear from other IHP+ partners how they were fulfilling their commitments – including behaviour change; consider how improvements could be made to strengthen health services; and provide feedback on ongoing global inter-agency policy work. www.internationalhealthpartnership.net/pdf/IHP_Lusaka_WayForward.pdf

[48] This is being undertaken by the National Plans and Strategies Working Group, coordinated by Andrew Cassells and Rania Kawar at WHO.

[49] In the spirit of the Paris Principles of Aid Effectiveness, the Global Fund Board decided in 2007 to establish a modified application process for supporting national strategies, called National Strategy Applications (NSAs). This approach will enable requests for Global Fund financing based primarily on an existing national strategy, which has been validated against agreed criteria using a non-Global-Fund-specific validation approach jointly agreed among partners. The Global Fund called upon partners to such a shared validation approach for national strategies and to allow, where relevant, the use of certified strategies as the basis for applications for funding. The NSA approach is expected to lead to a strengthening of the national strategies, improved support for country priorities, better donor harmonization and to reduced transaction costs while enabling a common focus on results and mutual accountability. A strategy for the Global Fund: Accelerating the effort to save lives', p36. www.theglobalfund.org/en/files/publications/strategy/Strategy_Document_HI.pdf

[50] The main multilateral agencies in health are the WHO, World Bank, GFATM, GAVI, UNFPA, UNICEF, UNAIDS, and Gates Foundation.

[51] See http://www.unaids.org/en/CountryResponses/MakingTheMoneyWork/ThreeOnes/

[52] See http://myglobalfund.org/forums/p/1549/3002.aspx

[53] EU Agenda for Action on the MDGs details health milestones for 2010. http://www.actionforglobalhealth.eu/news/eu_agenda_for_action_on_the_mdgs_details_health_milestones_for_2010

[54] See register.consilium.europa.eu/pdf/en/08/st09/st09907.en08.pdf

[55] Scaling up for Better Health, Workplan for the International Health Partnership and related initiatives (IHP+), p3. www.internationalhealthpartnership.net/pdf/02_IHP_Workplan_EN_Feb20_2008_FINAL.pdf

[56] At the meeting in Lusaka, 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". Interregional Country Health Sector Teams Meeting, 'Proposed Way Forward', p2. www.internationalhealthpartnership.net/pdf/IHP_Lusaka_WayForward.pdf

[57] The stock taking exercise was to provide status updates to ensure common understanding of country progress among global and regional audiences. They provide summary information on national health policies and strategies, reforms, problems and events. www.internationalhealthpartnership.net/ihp_plus_countries.html

[58] A Roadmap defines the steps a country will make to develop its Country Compact. The process is government-led, with assistance form the country health sector team. Initially, work is based on existing national health plans, and is revised through Joint Annual Review. 'Scaling up for better health', Work Plan for the IHP+, p3. www.internationalhealthpartnership.net/pdf/02_IHP_Workplan_EN_Feb20_2008_FINAL.pdf

[59] Three to four IHP+ countries plan to have country compacts completed in 2008 (i.e. Ethiopia, Mali, Zambia, and possibly Cambodia). Ethiopia circulated its final draft Compact on 27th July.

[60] Three to four IHP+ countries plan to have country compacts completed in 2008 (i.e. Ethiopia, Mali, Zambia, and possibly Cambodia). Ethiopia had already circulated a final draft Compact (dated July 2008) at the time of the review.

[61] The '5 Ones' are: a single national health plan; more predictable external funding over longer periods against a single budget; a single results framework for monitoring implementation of the plan and the compact; single monitoring and reporting process that meets that requirements of all partners; and one policy matrix that links together all policies and decision-making procedures to support this approach.

[62] Development of a Country Compact Guidance Note, Draft #1– June 8, 2008. Shared with Review Team but not yet finalised.

[63] Scaling up for Better Health, Work Plan for the International Health Partnership and related initiatives (IHP+), p9. www.internationalhealthpartnership.net/pdf/02_IHP_Workplan_EN_Feb20_2008_FINAL.pdf

[64] Ethiopia Compact, 29 July 2008 http://human-scale.wiki-neon.adaptavist.com/display/IHP/Ethiopia+IHP+Compact

[65] The Ethiopia Compact proposes three channels for funding that are all aimed at achieving the goals of the national health plan: central budget support (via MoF); health sector funding (for donors working through the SWAp); and non-state funding,

[66] Progress is being made in Nepal on agreeing how civil society can engage more systematically with the government. The Association of International NGOs in Nepal(AIN) has been in consultation with Government ministries and conducted a successful joint workshop in July 2008 to review the potential of the IHP+ and how this could be taken forward.

[67] Oxfam's comments on the draft IHP+ roadmap and country compact focused on meeting the needs of the poorest, guidance on costing scenarios, abolition of user fees, and human resources, amongst others. human-scale.wiki-neon.adaptavist.com/display/IHP/Oxfam

[68] Development of a Country Compact Guidance Note, Draft #1– June 8, 2008. Shared with Review Team but not yet finalised.

[69] Africa Health Strategy; African Union: www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY.pdf

[70] 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.

[71] Hauck K, Smith P, Goddard M. The Economics of Priority Setting for Health Care: A Literature Review. World Bank, 2004

[72] An analysis of increased health aid flows over the last 10 years, WHO (Paulo Riva) using OECD/DAC aggregated Aid statistics and the Creditor Reporting System, which are the most reliable sources of data on health aid, covering all traditional (OECD/DAC) bilateral and multilateral donors and major partnerships such as the Global Fund and the GAVI Alliance. Based on data up to 2006, so this is not up to date.

[73] DATA Report 2008 www.one.org/report/

[74] Canada's contribution of $105 million over five years to the Initiative will train over 40,000 health workers and provide much-needed treatment for diseases such as malaria, measles and malnutrition - pm.gc.ca/eng/media.asp?id=1911

[75] Source: web.worldbank.org/WBSITE/EXTERNAL/EXTABOUTUS/EXTANNREP/EXTANNREP2K7/0,,contentMDK:21494173~menuPK:4244276~pagePK:64168445~piPK:64168309~theSitePK:4077916,00.html

[76] The 5-year timeframe was considered by some G8 leaders to be a compromise on their call for this funding to be committed over the next 3 years.

[77] The International Finance Facility for Immunisation (IFFIm) is a partnership between UK, France, Italy, Spain and Sweden launched on 9th September 2005. Innovative financing mechanisms such as this are needed to help deliver and bring forward the financing urgently needed to achieve the M DGs. www.hm-treasury.gov.uk/documents/international_issues/international_development/development_iff.cfm

[78] The International Health Partnership: Delivering the health MDGs – Concept Note, p4-5. www.who.int/healthsystems/IHP%20_concept_note.pdf

[79] IMF Policy Discussion Paper, Understanding Fiscal Space, Heller, P, March 2005 http://www.imf.org/external/pubs/ft/pdp/2005/pdp04.pdf

[80] Presentation by Teresa Guthrie, Centre for Economic Governance and AIDS in Africa, May 2008, Geneva.

[81] Personal Communication, Andrew Cassels, WHO.

[82] Based on a study jointly commissioned by DFID and PEPFAR: Campbell J. Stilwell B. *Mozambique: Taking forward action on Human Resources for Health (HRH) with DFID/OGAC and other partners*, May 2008.

[83] Described by Bill Gates in his speech 'A New Approach to Capitalism in the 21st Century', Prepared remarks delivered at the World Economic Forum, January 24, 2008, Davos, Switzerland http://www.creativecapitalismblog.com/creative_capitalism/2008/06/bill-gates-crea.html

[84] Social Business Entrepreneurs Are the Solution, Grameen Bank, Bangladesh http://www.grameen-info.org/index.php?option=com_content&task=view&id=217&Itemid=172

[85] Interregional Country Health Sector Teams Meeting, Lusaka, 28 February – 1 March 2008. www.internationalhealthpartnership.net/pdf/IHP_Lusaka_WayForward.pdf

[86] See Global Reporting Initiative http://www.globalreporting.org/AboutGRI/WhatWeDo/

[87] The Health Eight (H8) refers to leaders of the eight global international health agencies: WHO, World Bank, GAVI, UNICEF, UNFPA, UNAIDS, the Global Fund to fight AIDS, Tuberculosis and Malaria, and the Bill and Melinda Gates Foundation. They meet on an informal biannual basis to discuss challenges to scaling up health services and improving health-related MDG outcomes, particularly for the poor.

[88] 'H8' Informal Meeting Summary, Prangins, Switzerland, 28 January 2008. Document shared with Review Team.

[89] CS engagement is thought to be important particularly because CS is believed to have a wealth of experience, knowledge and legitimacy at the country level. This is believed to potentially add value to the IHP+ process: through applying pressure on policy makers; for ensuring accountability and transparency; to promote improved and meaningful coordination; and by facilitating communication through networks of people. As this term encompasses a wide range of actors, it is relevant to distinguish between civil society organisations that represent the interests of people who are the beneficiaries of health services, and non-state providers of services.

[90] The fact that CS were not encouraged (though did, ultimately, by organising a meeting themselves) to participate in the Country Health Sector Team meeting in Lusaka in February 2008 was cited as an example.

[91] See Global Civil Society Consultation Report http://www.internationalhealthpartnership.net/pdf/IHP_CSO_Comments_Apr_4_2008.pdf

[92] Peoples Health Assembly II, Cuenca, 2005. www.phmovement.org/pha2/

[93] A common framework for monitoring performance and evaluation of the scale up for better health, M&E Working Group, IHP+, Feb 2008 http://www.internationalhealthpartnership.net/pdf/IHP_Monitoring_and_Evaluation_EN_FINAL_%20June_2008.pdf

[94] Videoconference Note-for-the-Record, International Health Partnership and Related Initiatives (IHP+) , Meeting of WHO's Director-General and Development Partners, 5 June & 3 July 2008 http://www.internationalhealthpartnership.net/pdf/IHP+%20Dev_Partners_VC_Minutes_EN_03_05_June_2008.pdf

[95] The IHP+ process is able to assist governments to develop their Country Compacts through Country Health Sector Teams (CHST). The IHP+ Work Plan indicates that these teams are intended to be government-led, include representatives from key IHP+ stakeholders – including civil society and the private sector – and provide demand-driven technical assistance.

[96] Agencies involved in taking forward national plans for HIV/AIDs and strategies have coordination groups for working with government and other national agencies; The Global Fund has mandated Country Coordination Mechanisms to oversee the development and implementation of country proposals to the Global Fund; Similarly, groups exist in many countries to over see the development of proposals submitted to the GAVI Alliance; In addition, the government in many countries will have a number of groups to over see a variety of functions linked to the implementation of national health policies and plans, some of which will involve international agencies, for example committees on monitoring and evaluation, health information systems, and procurement.

[97] The IHP+ Budget Plan allocates to each Initial IHP+ country a budget of $800,000 to strengthen country level coordination mechanisms; $150,000 allocated for cross-country guidance on health sector coordination; and $100,000 to develop country level compacts. Scaling up for Better Health, Workplan for the International Health Partner ship and related initiatives (IHP+), Appendix B p 19 - www.internationalhealthpartnership.net/pdf/02_IHP+_Workplan_EN_Feb20_2008_FINAL.pdf

[98] A post-conflict country that has only started to coordinate its development assistance and is rebuilding its national institutions.

[99] The Memorandum of Understanding (MoU) is a joint Partnership Framework between the Government of the Republic of Burundi and the Technical and Financial Partners in the Health Sector. human-scale.wiki-neon.adaptavist.com/display/IHP+/MOU+Partnership+Agreement+between+Government+and+Partners+in+the+Health+Sectorone

[100] A SWAp is a medium-term collaborative process to develop sectoral policies and strategies. It requires sound understanding of resource availability and expenditure plans; management systems by governments and donors; institutional reform and capacity building, in line with agreed policies; and structures and processes for negotiation and review of sectoral performance against jointly agreed milestones and targets. Cassells, A. 1997. A guide to sector-wide approaches: Concepts, issues, and working arrangements. whqlibdoc.who.int/hq/1997/WHO_ARA_97.12.pdf

[101] **Country work proceeding on:**

- Joint Health Sector Review: Madagascar (May 2008), Ethiopia (March-April 2008), Zambia (February-March 2008), Kenya, and Mozambique (April 2008).
- MTEF: Madagascar, Mozambique, Kenya, Zambia, and Mali.
- SWAp: Zambia, Mozambique, Kenya, Madagascar, and Nepal.
- Partnership Framework: Burundi, and Mozambique;
- MoU: Ethiopia, Mozambique, Zambia.
- PRSP: Burundi, Cambodia, Madagascar (2nd generation), Mali, Mozambique, and Zambia.
- Code of Conduct: Ethiopia, Kenya, and Mozambique.

Country work planned for:

- MoU: Mozambique, Madagascar and Burundi.
- SWAp: Cambodia, and Burundi.

[102] Compact between the Government of the Federal Democratic Republic of Ethiopia and the Development Partners on Scaling Up For Reaching the Health MDGs through the Health Sector Development Programme, July 2008. human-scale.wiki-neon.adaptavist.com/display/IHP+/Ethiopia+IHP+Compact

[103] Based on the Appreciative Inquiry approach. More information available at the Appreciative Inquiry Commons

[104] www.globalreporting.org

[105] Primary health care is recognised as the most appropriate approach to addressing the complex health problems in developing countries. This has been well established through extensive country experiences and evidence gathered over the past 30 years. It has been the focus of a number of recent conferences, leading to renewed commitments to primary health care, including formal recognition by African Health Ministers African in Burkina Faso during April 2008 through the Ouagadougou Declaration that urges member States to "2. use priority health interventions as an entry point to strengthen national health systems, based on the Primary Health Care strategy, including referral systems; and expedite the process of decentralization through district health systems, to improve access, equity and quality of health services in order to better meet the needs of the populations;". To achieve this, the international community has been called upon to: "provide coordinated and cohesive long-term technical and financial support to countries for development and implementation of health policies and national health development plans consistent with internationally-agree health goals including MDGs; and support Member States to translate the recommendations of this conference into concrete actions".

key expectations of the IHP+

I. *All signatories of the IHP Global Compact are expected to have made progress in following through on their specific commitments agreed in September 2007.*

II. *Country compacts (or their equivalent) will be established to put in place "close to binding" commitments from Development Partners and government Ministries of Health and Finance to collaborate in supporting "one costed, results-based national health plan in a harmonized and aligned way".*

III. *In-country partners will agree on the amounts, sources and preferred mechanisms (such as SWAps) for mobilising significantly increased levels of financing for National Health Plans and to strengthen health systems, under the lead of the country government.*

IV. *The IHP+ will change the behaviours of international agencies and bilateral donors, so that they review their policies and procedures at the global level to enable better coordination and longer-term support at the country level.*

V. *The staff of these agencies should also be incentivised and empowered to change the ways that they work.*

VI. *The IHP+ process is expected to meaningfully engage Civil Society at the global and country-level in ways that are both participative and representative.*

VII. *Governments are expected to include the private sector in their national health plans and to ensure that non-state service providers also receive funding and technical support.*

VIII. *The IHP+ Core Team is expected to have ensured that the IHP+ process is well-managed and to facilitate access to high quality technical support, as required, to regional and country teams for their practical operations and for documenting experiences. At the same time, they have been expected to keep this an "institutionally light" process that avoids complicating the global health architecture and adding administrative burden to countries.*

IX. *Governments are expected to implement their National Health Plans efficiently by strengthening health management systems, tackling misuse of resources, and working with NGOs.*

X. *The IHP+ expects to build on and use the existing systems at country level for planning, coordination, delivery and management of the health sector within the national development framework, to achieve MDG-related outcomes.*

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