International Health Partnership and Related Initiatives (IHP+)

IHP+ Core Team Report
May 2010 – April 2011
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Background
IHP+ was created in 2007 to accelerate better health results in low and middle income countries by putting the Paris principles on aid effectiveness into practice in health. Developing country and development partner signatories to the Global Compact\(^1\) committed to achieve this by supporting ‘strong and comprehensive country and government-led national health plans in a well-coordinated way’. This annual Core Team report is based on IHP+’s Phase II work plan, and focuses on country experiences over the last year. Drawing on this, and changes in the global environment, it considers some implications for IHP+ after the end of its current work plan in December 2011.

Globally, overall levels of health aid have been sustained, despite the economic downturn, though it is unclear how long this will last: OECD predicted a lower rate of growth in overall ODA in 2010. Intense domestic budget pressures in donor countries are reflected in the increasing emphasis on value for money, and in some cases cuts in bilateral and multilateral funding. New aid policies among IHP+ donors have begun to influence country activities. Beyond, but relevant to IHP+, the US Global Health Initiative has an intensified effort in a sub-set of countries it supports to ‘build on existing country-owned platforms to foster stronger systems and sustainable results’, and five of these are IHP+ signatories\(^2\). The Global Fund’s reforms to its grant architecture are being implemented, and the joint effort by GAVI, Global Fund and the World Bank to align health system funding with national plans and simplify fiduciary and monitoring arrangements under the rubric of the health system funding platform will report on progress in mid 2011. There is a wider debate on global health governance under way\(^3\). The Fourth High Level Forum on Aid Effectiveness in November 2011 will be a key milestone as it takes stock of progress in implementing the Paris principles on aid effectiveness.

Snapshot of IHP+ achievements in 2010/11

- IHP+ continues to grow, with new signatories in Africa, Asia and Latin America;
- There is evidence of progress on how effectively partners are delivering and using health aid — though progress is uneven, according to the IHP+Results 2010 annual performance review. Many more IHP+ signatories participated in this exercise compared with 2009;
- There is a growing country momentum behind the activities IHP+ supports, repeatedly voiced at the 3\(^{rd}\) Country Teams Meeting in Brussels, and linked to a call to document results;
- Civil society engagement in national planning and review processes is improving;
- Joint assessment of national health strategies is expanding; experience has been formally documented in five countries;
- Revised or first-time country compacts were signed in four more countries - Benin, Nigeria, Niger, Uganda. Seven more are in development. In Togo a protocole d’entente was signed;
- There is rising momentum behind efforts to advance one platform for monitoring and review of national health strategies, which needs consolidation.

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\(^1\) [http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_global_compact_EN.pdf](http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_global_compact_EN.pdf)

\(^2\) Ethiopia, Kenya; Nepal, Mali, Rwanda

\(^3\) Ad hoc advisory meeting on Global Health Governance March 11 2011, Geneva
New IHP+ partners
IHP+ now has 52 partners: 27 developing countries and 25 development agencies. It includes signatories from Africa, Asia, the Middle East and Latin America. New members in the last year are Cameroon, Chad, El Salvador, Pakistan and Sudan. For the first time, developing country signatories are in the majority. Annex 1 has the complete list.

Box 1 IHP+ signatories

<table>
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<tr>
<td>Low-income countries</td>
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<td>27</td>
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<tr>
<td>Bilateral Donors</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>International organizations and foundations</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
<td>52</td>
</tr>
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Main areas of work, progress, challenges, next steps
IHP+ was created to help accelerate progress towards the health MDGs. The Phase II work plan states clearly that IHP+ work is based on the following principles:

- Keep a focus on health results;
- Build on what already exists, in national health policies, systems and coordination mechanisms;
- Enhance country-led health development, by getting more stakeholders to unite around one strategy;
- Reduce transaction costs from multiple initiatives, by changing ways of working of different partners;
- Longer term, more predictable financing;
- Promote mutual accountability.

This report focuses on the following lines of work outlined in the IHP+ Phase II work plan:

1. Support for national planning processes;
2. Joint assessment of national health strategies and plans;
3. Country compact development;
4. Moving towards one results monitoring framework;
5. Promote mutual accountability by monitoring progress against compact commitments.

The report also includes sections on progress on harmonization among international agencies; the role of civil society in IHP+; and a final section on IHP+ management, communications and finance.
1 Support for national planning processes
The 3rd IHP+ Country Teams Meeting in Brussels reinforced the centrality of sound national health strategies and plans for improving alignment and harmonization with national priorities and for developing a common platform for monitoring progress. IHP+ is helping to generate greater attention and support for national planning processes, reinforced by activities such as joint assessment, compact development, one M&E platform etc. This section focuses on another dimension: wider engagement in overall planning and resource negotiation processes.

Progress during 2010/11
Globally, during 2010/11 many countries have been renewing national health strategies and plans. Over half the 27 IHP+ countries have been doing so, together with negotiations for resources, both domestic and external.

There has been increased demand for partner support and engagement in these processes. International agencies work through their in-country staff, backstopped by regional offices, regional development networks such as HHA, and headquarters. Informal reports suggest that the UN agencies, development banks and many bilateral agencies with staff in-country are stepping up engagement. There is evidence from sources such as the IHP+ Results 2010 report that other health development partners including NGOs and CSOs are being more systematically involved in plan development.

Lessons learned
Plans need resources, and this involves negotiations. The 3rd Country Teams Meeting examined what was known about effective negotiation processes with Ministries of Finance and/or development partners. The importance of both political and technical dimensions was recognized. Key messages were:

- Ensure health is a priority in (higher level) national development plans. Emphasize health as an investment;
- Develop high quality, convincing, comprehensive and realistic health plans. This involves paying attention to stakeholder support and ownership; costing; monitoring and evaluation, with a focus on results and proper communication - taking account of Ministries of Finance perspectives;
- Ensure performance and accountability mechanisms are in place;
- Conduct effective dialogue with all stakeholders, in particular civil society and Parliament;
- Develop diplomacy, advocacy, leadership and negotiation skills in the Ministry of Health.

2 Joint assessment of national strategies and plans (JANS)
Joint assessment is a shared approach to assessing the strengths and weaknesses of a national strategy that is accepted by multiple stakeholders and can be used as the basis for technical and financial support. The expected benefits are enhanced quality of national strategies and greater partner confidence in those strategies, which in turn result in more predictable and more aligned funding. It is not a new idea, but a systematic approach was lacking. In 2008/9, an IHP+ inter-agency working group developed a draft tool and guidelines for joint assessment and the

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4 http://www.internationalhealthpartnership.net/en/news/display/country_planning_cycle_database
5 IHP+ countries developing new national health plans in 2010/11: Burkina Faso, Burundi, Chad; Democratic Republic of Congo, Djibouti, Ethiopia, Madagascar, Kenya, Nepal, Niger, Nigeria, Sudan, Uganda, Viet Nam, Zambia
6 Harmonization for Health in Africa
7 For example, the European Commission is starting to invest in strengthening negotiation as well as planning processes
IHP+ SURG recommended it should be used with a few interested countries. This was considered the best way to improve the tool and develop practical guidance on joint assessment processes.

**Box 2: Principles of the Joint Assessment of National Strategies**
- Country demand driven
- Country led
- Builds on existing country processes
- Includes an independent element
- Engages civil society and other relevant stakeholders

**Progress during 2010/11**
The tool is a public good and a growing number of IHP+ and non IHP+ countries are using it at different stages of their planning cycle to review national health sector strategies and plans. The tool is now available in English, French, Portuguese, Russian and Spanish. Five countries had intense IHP+ support in the last year (Nepal, Uganda, Ethiopia, Viet Nam & Ghana) and in these countries the JANS process has been formally documented. These five countries used the JANS tool to review sector strategies. The process has been adapted by countries to their differing contexts, but all used the tool unchanged, and adhered to the agreed JANS principles (Box 2). Participation has been broad, and included non IHP+ signatories; ‘non-resident’ agencies such as GAVI and Global Fund, and NGOs and CSOs. A review of five countries’ experiences with JANS, plus the individual country JANS reports, scoping missions and lessons learned are available on the IHP+ website.\(^8\) Others have also reported using the JANS Tool e.g. Zambia and Bangladesh, and in 2011 Rwanda, Mali and non-IHP+ countries such as Malawi, Mongolia and Kyrgyzstan will do so. Countries participating in the Global Fund NSA process will be expected to use the JANS tool for disease strategy assessments, which has generated a set of questions about relations between sector and disease strategy assessments.

**Box 3: Country experience with JANS: quotes from Country Health Teams Meeting participants**

- **Dr Enkossa, FMoH Ethiopia**: The JANS process enhanced the quality of and partners’ confidence in the strategy and system for implementation. It provided an inclusive, structured, comprehensive framework for engagement in strategy development. More partners including US, GAVI are aligning their plans with the strategy. The transaction costs [of preparation] were lower.
- **Dr Ezati, MOH Uganda**: The JANS process broadened consultations and brought a “fresh, external, non-biased perspective”.
- **Dr Long, MOH Vietnam**: The JANS process significantly improved quality of the 5-year health plan. Outcomes: more trust and confidence from development partners; more streamlined support to the sector.

**Lessons learned**
Experience has been positive
- The multi-agency endorsement of the JANS tool gives it significant legitimacy at country level. The tool and guidelines are reported to be useful and relevant.
- There are quite commonly dual objectives of a JANS - to improve plan quality and to help inform funding decisions. Clarity on those objectives is key as they influence the timing and approach to joint assessment.

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\(^8\) [http://www.internationalhealthpartnership.net/en/documents/category/joint_ass_1253609049](http://www.internationalhealthpartnership.net/en/documents/category/joint_ass_1253609049)
• Countries have - based on their specific context and preferences - shown that JANS can successfully be implemented in many different ways but still adhere to the principles.
• The JANS process helped improve countries’ health sector strategies, and partners’ confidence in country strategies increased following the JANS.
• Having an international element to the JANS, with strong expertise, helps to build the credibility of the assessment and bring in fresh perspectives.
• There is less evidence so far of impact on funding decisions. Nepal’s Joint Financing Arrangement is an important development9.

The JANS Tool, Guidelines, and a FAQ are available on the IHP+ website.10 These are dynamic instruments and processes, and based on countries’ feedback on the need for greater clarity in some sections, some limited amendments are being made to the JANS Tool, and a paper on options for conducting a JANS is being prepared.

3 Developing effective partnerships: the role of partnership agreements including compacts
Country compacts and similar partnership agreements aim to define the relationships between governments and development partners, by outlining their respective roles, responsibilities and accountabilities. They signal the aspirations of national and international partners to work more effectively together and align to national strategies. They are not legally binding agreements but they have moral and political traction. They can contribute to improved alignment of partners’ funding with national priorities and to increased use of local systems. When they include a realistic and specific system for monitoring adherence to the commitments made, they provide a basis for mutual accountability. Altogether, 20 of IHP+’s developing country signatories have some form of partnership agreement or a precursor, sometimes called 'statement of intent' - listed in Annex 2.

Progress
In the last year, four country compacts or similar agreements were signed by Governments and development partners - Benin, Nigeria, Niger and - currently in the process of being signed - Uganda. Seven are under development: Burkina Faso, Burundi, DRC, Djibouti, Senegal, Sierra Leone and Togo (where a protocole d’entente was signed in 2010). In Niger, Togo, Sierra Leone and Uganda NGOs and CSOs have or are expected to sign.

A desk review of the scope and content of 10 partnership documents found that most had clear objectives, had clear links to planning processes and were comprehensive in scope, but that some - particularly the earlier ones - put less emphasis on indicators for monitoring adherence, and aid modalities were not always very explicit. A review11 of four recent compact development processes, and discussions in the Country Teams Meeting, identified the following 'encouraging outcomes' as a result of the development process:
• consensus was built in support of the implementation of a country plan, with increased confidence, participation and support of development partners;
• increased government leadership and engagement of non-health ministries;

9 Signed by a mix of pooling partners (AusAID, DFID, World Bank, GAVI) and non-pooling partners (USAID, UNICEF, UNFPA, WHO)
10 http://www.internationalhealthpartnership.net/en/about/i_1253621551
11 http://www.internationalhealthpartnership.net/CMS_files/documents/background_document_developing_c_EN.pdf
• stronger mutual accountability mechanisms and new ways of joint working;
• development of concrete, country level actions to achieve Paris and Accra commitments;
• increased transparency around future donor funding plans; and
• strengthened country teams or health partners groups.

Box 4: Country experience with developing compacts: quotes from Country Teams Meeting

Dr Goyito, Secretary General, MOH Benin: The country compact has strengthened MoH leadership and brought not only a better understanding of health issues and challenges for other sectors (e.g., ministries of development, foreign affairs, administrative reform), but also more engagement of those sectors in finding solutions.

Dr Lecky, MOH Nigeria: Without the Compact, there would not have been a Joint Annual Review developed in Nigeria. It also brought better dialogue with other government ministries (especially finance).

Dr Hertel, Sida Uganda: Development of the new Compact brought civil society and private sector into the discussions and they will sign. The new Compact also includes stronger indicators for monitoring partner performance than existed in the past.

Lessons learned
The main recommendations from the Brussels meeting were:
• Compact development should not be delayed until all agencies are ready to adhere to them; however, some ‘minimum’ pre-requisites need to be in place for an effective compact: the core partners need to be involved, and sector plans serve as rallying points for the discussion on commitments.
• Non-government actors active in health, including civil society, should discuss how they can be part of a compact and what their responsibilities are.
• Compacts should include agreed results, indicators and targets that can then be monitored. There needs to be more focus on the mutual accountability role of a compact, and how to deal with partners who are not meeting commitments.
• Where harmonization of procedures requires global action between agencies, this can be done under the aegis of IHP+: Any progress should be communicated to countries.
• Countries should be encouraged to share experiences in compact development.

Altogether, the main message was that the process of developing a compact can be as important as its content for strengthening the partnership:

'the value of an agreement is greater than the sum of the words in it'.

4 One platform for monitoring and review of national health strategies
A sound country-led platform for monitoring and review of national health strategies is the foundation for performance review, policy dialogue, action and accountability. Common monitoring frameworks exist in a number of IHP+ countries, but important challenges remain in making a common platform operational. Since it began, IHP+ has supported efforts to strengthen country monitoring and review processes. At global level, a common monitoring and evaluation framework was developed in 2008, based on consultations with countries and development partners.12 A monitoring toolkit came out in 2010, with a set of indicators and related measurement strategies for the main components of health systems.13

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12 IHP+ common monitoring framework
13 health systems monitoring toolkit
Progress during 2010/11
During 2010/11 global attention to results and accountability has increased, as have requests for country support - a sign of more readiness for collective action by development partners. An increasing number of agencies are participating in strategy development/assessment and joint annual review processes, all of which use data generated from national monitoring systems. In the last year, multi-agency reviews of national monitoring systems included reviews in Mozambique, Benin, Uganda, Nepal and Sierra Leone, resulting in consolidated country-led road maps for strengthening them.\(^{14} \text{15}\)

Lessons learned
There is progressively greater clarity on how to move this agenda.

- Five key elements of a country-led monitoring and review platform are agreed: a sound national health strategy, which specifies monitoring mechanisms aligned with main objectives; a strengthened M&E plan that addresses critical data gaps; strengthened country mechanisms for performance review and action; increased institutional capacity to support regular monitoring; alignment of partners around one platform.
- The Country Teams Meeting reinforced these messages, with some added points: national information needs are the priority, but global reporting also needs to be managed; developing one monitoring platform requires more than consensus on a manageable set of indicators; joint annual reviews can encourage greater use of data, and so be an impetus for greater data quality and completeness.
- IHP+’s role is catalytic: by demonstrating that progress towards one common platform is feasible; by identifying opportunities to raise this agenda, e.g. during plan development; by facilitating responses to country demand for support; by encouraging partners to provide more unified support to strengthen monitoring and review systems; and to progressively align their reporting needs and systems with those at national level.

5 Promoting Mutual Accountability
The commitment to mutual accountability is one of the most important tenets of IHP+. There are a few examples of countries undertaking systematic reviews of country partnership mechanisms, but it has not been that widespread (Ethiopia and Kenya are two examples). All signatories to the IHP+ Global Compact have committed to be held to account, through an independent review mechanism, but the challenge has been to put it into practice. The first round of monitoring by the independent consortium IHP+Results in 2009 helped keep the spotlight on commitments by IHP+ signatories, and on the importance of mutual accountability. It encountered many challenges but derived useful lessons on how to monitor and present results in this complex area.

Progress in monitoring IHP+ signatories’ individual and collective performance during 2010/11
IHP+Results worked with an IHP+ inter-agency group to develop a more systematic, less onerous approach for the 2\(^{nd}\) round of monitoring, and also collaborated with the OECD/DAC survey group. The revised approach \(^{16}\) includes a set of standard measures based on Paris Declaration survey indicators but adapted for health, and simplified report cards\(^{17}\). Data collection from countries and development agencies was made more flexible and interactive, with country joint

\(^{14}\) Agencies involved include WHO, GAVI, Global Fund, UNICEF, USAID, CDC, World Bank
\(^{15}\) Link to JANS country reports
\(^{16}\) IHP+Results 2010 monitoring process
\(^{17}\) Ten standard measures for IHP+ governments and 12 for development agencies
review processes used where possible. In July 2010, the SuRG approved the revised approach. Half of all IHP+ signatories participated in this second round, over double the number in the previous year. The 2010 IHP+Results performance report, with country and agency scorecards, was published in April 2011. The report is a rich source of information. It concludes that, among signatories participating in the review, there has been overall - albeit uneven - improvement in the effectiveness of how aid is delivered and used in the health sector.

**Box 5: IHP+Results 2nd round of monitoring: participating signatories**

**Country governments:** Burkina Faso, Burundi, DRC, Djibouti, Ethiopia, Mali, Mozambique, Nepal, Niger, Nigeria

**Development partners:** AusAID, Belgium, European Commission, GAVI, Global Fund, Netherlands, Norway, Spain, Sweden, United Kingdom, UNAIDS, UNFPA, UNICEF, WHO, World Bank

**Lessons learned**

- The new tools are better; the approach is feasible, and the findings provide a sense of progress over time. The indicators and tools could be further improved but this should not be a major task.

- Although this is currently a global review process, some countries such as Nepal and Burundi are already using the tools and findings to strengthen mutual accountability at country level.

- Discussion of the results is more important than their production. During 2011, the findings will be discussed in a side event at the World Health Assembly; at the 4th High Level Forum on Aid Effectiveness in Busan, and in individual country and development agency meetings.

**Opportunities to review progress**

**International meetings**

With a very crowded international agenda, and limited resources, the key event for the partnership in 2010 was the Third IHP+ Country Health Sector Teams Meeting in Brussels in December. IHP+ signatories and other interested parties (OECD, United States, Japan) participated: over 200 people from 23 partner countries and 24 bilateral and multilateral agencies. The agenda was structured to allow maximum exchange of experience. The most striking feature of the meeting was the sense of drive and enthusiasm for the IHP+ agenda from developing countries. The main messages from the meeting were:

- The aid effectiveness agenda matters as much - if not more - today as it did five years ago. There are real costs when aid is ineffective. In short, it is indeed 'worth the effort'.

- There is clear progress on advancing aid effectiveness principles. Aid effectiveness and results go hand in hand, and there is a real need to properly document how this progress translates into results.

- The IHP+ momentum generated around developing one health strategy/plan and its implementation must be maintained. Getting alignment is a messy business, and takes both leadership and compromise.

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19 Germany and ILO also expressed interest and hope to participate in future surveys.
• New ways of working through joint action and collective responsibility need to be consolidated. More focus is now needed on more effective monitoring platforms and on mutual accountability.

Country joint reviews as a way to improve mutual accountability
Most countries have some form of joint annual health sector review but, as the IHP+Results 2010 Annual Performance Report notes, there is considerable variation in how these are conducted. Not all of them involve a mutual review by national governments, development partners and civil society organizations on how effectively aid is being delivered and used to achieve results. As that report states, better understanding of how mutual accountability processes work in practice is needed.

Progress on harmonization among international agencies
A selective rather than comprehensive overview is given here, focusing on areas particularly supported through the IHP+ work-plan.

Harmonizing quality assurance in pharmaceutical procurement
Harmonization of donor procurement policies is one of the six action points from the 2009 IHP+ Ministerial Review, because of the workload resulting from different agency standards for recipient countries. Within the framework of the Interagency Pharmaceutical Coordination (IPC) Working Group, IHP+ is supporting work to harmonize standards for quality assurance of essential medicines procured with donor funding. This complements the WHO pre-qualification procedure for HIV/AIDS, TB and malaria drugs. Work is at an early stage. The first step is an overview of existing standards, systems and procedures for assuring quality in procurement of medicines. It will lead to suggestions for practical steps for greater harmonization.

The health systems funding platform
While not part of the IHP+ workplan, the health systems funding platform (‘the platform’) is closely linked to IHP+ in that it is based on the IHP+ principles; shares similar objectives of both aid effectiveness, and better and more equitable health services and health outcomes; and uses a number of IHP+ tools. It is a mechanism for making better use of funds for health system strengthening (HSS). At country level, the platform aims to make the financing of HSS more transparent and efficient, and to simplify funding channels and financial management procedures. In practice such country discussions automatically include other funding agencies (for example the Joint Financing Arrangement that was signed in Nepal20), but at global level, the agencies primarily involved are GAVI, Global Fund and the World Bank, facilitated by WHO. Activities are organized around use of existing funds, and obtaining new funds.21 The activity of greatest relevance to the goals of IHP+ is the funding of national health sector strategies/plans based on a joint assessment of that strategy. This involves all 3 agencies and is being rolled out in 4-5 countries in 2011. The Platform agencies are committed to using the IHP+ common M&E framework as the basis for tracking progress with strategy implementation. An inter-agency working group is reviewing ways to harmonize financial management and fiduciary risk assessment policies and procedures.

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20 See footnote 9
21 Health systems funding platform web link
The role of civil society in IHP+

Civil society engagement in policy processes at country level is increasing. There is CSO participation in joint assessment of national strategies and compact development (referred to elsewhere in this report). The Civil Society Health Policy Action Fund managed by Oxfam provides grants to country-level CSOs to engage in national policy dialogue and oversight processes. At the global level, IHP+ CS representatives have created a Civil Society Consultative Group. There was a lively session on experiences with civil society’s role in policy dialogue at the Brussels meeting. There is CSO engagement in the oversight of IHP+ via the annual IHP+ Results monitoring process. IHP+ CS representatives are also involved in the Alliance of Southern CS Organizations in Global Health, which aims to get wider engagement, accountability and more coherence in Southern CS voices in the many global health agencies and partnerships.

Progress during 2010/11
This section focuses on three items not mentioned elsewhere in the report.

a) Civil Society Consultative Group (CSCG): This group, which has Northern and Southern CS representation, was formed by IHP+ CS representatives in early 2010, to get more inputs on IHP+ activities. It mostly works virtually, but in October there was a one-week series of civil society meetings called "The African Dialogue on Health and Accountability" (the 'Nairobi meetings') which included a meeting of IHP+ CSCG members. The IHP+ CSCG decided it will concentrate on CSO involvement in (a) Health policy dialogue and the Joint Assessment of National Health Strategies and Plans; (b) Monitoring, tracking and accountability; (c) advocacy and communication. This CG meeting also concluded that investment in CS actions within IHP+ need to be better harmonized between global and country level.

b) Civil Society Health Policy Action Fund: The IHP+ Phase II work plan includes support to CS engagement in policy dialogue at country level through a small grants programme managed by Oxfam and called ‘the Civil Society Health Policy Action Fund’[22]. The programme runs to September 2011. An independent committee selected 13 grantees from nine IHP+ countries, out of 110 applications. While around half the recipient NGOs have a HIV/AIDS thematic focus, most have a general health policy dialogue or monitoring component to their activities with these funds. Disbursements began in August 2010. The grantee reports from January 2011 show progress in implementing activities, albeit with some challenges in planning and reporting, and some slipping timelines. The range of activities includes: analysis of progress against country compact commitments (Nepal); advocacy for more funding for health at national level (Uganda); baseline surveys on access to health services (Kenya and Uganda), and on access to free health care at local level (Nepal); analysis of challenges in implementing free health care policies (Sierra Leone); new CSO coalitions for health advocacy formed (Nigeria); participation in development of national policy documents (Burkina Faso); e-forums on key health issues set up in Kenya, Nepal.

c) Southern CS communications hub: This hub has been established by CHESTRAD. Activities over the last year include: establishing an online database of southern health CS coalitions and networks, enabling activities of the Alliance of Southern CSOs; providing an SMS alert system to those CSOs; organization of the Nairobi meetings; providing information on CSOs to be targeted to support global efforts such as the Accountability Commission; scaling up health professional

education and the UNSG’s Strategy on Maternal, Neonatal and Child Health; improving southern CS engagement in country dissemination of the IHP+Results report.

Lessons learned

- Civil society engagement in country level policy and performance monitoring processes is increasing, but there are challenges in managing representation and coordination. There are reports that developing ways to influence health policy processes, and the policy processes themselves, take time.
- Over the year, stronger links between the different IHP+ civil society activities have been created, but greater coherence is possible, would be beneficial and should be nurtured.
- Progress is being made, but looking ahead IHP+ needs to consider whether it needs to adapt the ways it fosters civil society engagement, including opportunities for greater coherence between country and global activities, as well as future support for activities carried out in the Phase II workplan.
IHP+ management and communications

Management arrangements
New IHP+ management arrangements were introduced in January 2010. The Scaling-up Reference Group (SuRG) includes all IHP+ signatories, while the Executive Team has a representative sub-set. Most meetings are by videoconference (VC).

There were two SuRG VCs in 2010, in February and July. These focused on two issues: how to conduct the 2nd round of monitoring against Global Compact commitments by IHP+ Results, and progress on the Joint Assessment of National Strategies and Plans (JANS). The Brussels meeting was in effect the 3rd SuRG of the year. Participation by country partners improved: the July SuRG included 12 countries, and was held in English and French. However the technical logistics were complicated and alternative approaches are needed as IHP+ grows.

The Executive Team held 8 videoconferences in 2010. All meetings have discussed specific topics, and seen fair and active participation of H8, bilateral and civil society representatives. However, the intended representation of IHP+ countries on the Executive Team has never really taken hold, and different approaches need to be discussed. Annex 3 gives the list of team members.

The Core Team has remained small as intended. IHP+ largely and indeed increasingly works through country, regional and HQ staff from signatory development and government agencies.

Advocacy and communications: promoting IHP+ principles with partners and other stakeholders
In 2010, communication efforts focused on communicating progress through some key events and the annual IHP+ Core Team Report; maintaining the web site and disseminating country experience with JANS and compacts.

Highlights include the signing of the IHP+ Global Compact by 10 new country partners during the World Health Assembly in May 2010, which was attended by many other existing signatories; a technical side event on mutual accountability during the same World Health Assembly, and the 3rd meeting of country health sector teams in Brussels in December.

IHP+ finances: income and expenditure 1 April 2010 - 31 March 2011

1) Overview of all income, expenditure and balance of funds April 2010 - March 2011
The IHP+ phase II work plan is from April 2009 - December 2011. Funds for phase II in fact arrived in March 2010. Sources include AusAid, Sweden and the UK, and IHP+ has also leveraged funds from Norway and Spain to WHO. In April 2010 there was a confirmed income of US$ 8.2 million. During the year another US$ 1.8 million became available from carry-over, released funds and a new tranche from DFID. The balance of funds on 1 April 2011 was US$ 4.2 million.
Phase II income on 1 April 2010 (in US$) $8,266,200
Additional funds becoming available during 2011 $1,805,475
Total expenditures 1 April 10 - 31 March 11 $5,827,895
Resulting balance of funds 1 April 2011 $4,243,780

2) **Known income on 1 April 2010, and planned and actual expenditures April ’10 -March ’11**

Given that actual Phase II income was less than planned, priorities have had to be set.
Expenditures across the 4 workplan areas remain in the same proportion as planned, but within individual areas some activities were dropped, or expenditures reduced. Country level expenditures account for 56% of total spending this year - mainly country grants but also JANS, common M&E platform development and country civil society grants.

<table>
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<tr>
<th>Work plan activities March 2010 - April 2011</th>
<th>budget allocations approved at start of Phase II ($)</th>
<th>planned Phase II allocations of known income, Apr2010 ($)</th>
<th>Actual encumbrance and expenditures Apr10- Mar11 ($)</th>
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<tr>
<td>Area 1 <strong>Country level activities</strong>: country grants; WB/WHO CO support; implementing JANS; implementing common M&amp;E framework; Oxfam CSHPAF grant**</td>
<td>9,365,000 (54%)</td>
<td>4,448,200</td>
<td>3,301,350</td>
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<tr>
<td>Area 2 <strong>Global level activities</strong>: working group on procurement; Civil society consultancy group meeting</td>
<td>1,000,000 (6%)</td>
<td>498,000</td>
<td>268,220</td>
</tr>
<tr>
<td>Area 3 <strong>Mutual accountability</strong>: IHP+Results 2nd round of monitoring; Country Health Teams Meeting)</td>
<td>4,500,000 (25%)</td>
<td>2,075,000</td>
<td>1,326,200</td>
</tr>
<tr>
<td>Area 4 <strong>IHP+ Management and communication</strong> (core team financial support and communications)</td>
<td>2,555,000 (15%)</td>
<td>1,245,000</td>
<td>932,125</td>
</tr>
<tr>
<td><strong>Totals in US$$</strong></td>
<td><strong>17,420,000</strong></td>
<td><strong>8,266,200</strong></td>
<td><strong>5,827,895</strong></td>
</tr>
</tbody>
</table>

* Breakdown: 17 country grants plus local WHO/WB support $2.4 million; JANS $241,000; Oxfam CSHPAF grant $410,000; common M&E platform $200,000;
** Oxfam grant: $100,000 accounted for in last report

3) **Expenditure priorities for 2011, from 1 April balance of $4.2 million**

<table>
<thead>
<tr>
<th>Workplan activities April - December 2011</th>
<th>Planned allocations of budget balance, April - December 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area 1 <strong>Country level activities</strong>: country grants with WB/WHO CO support; implementing JANS; implementing common M&amp;E framework; compact development</td>
<td>2,400,000</td>
</tr>
<tr>
<td>Area 2 <strong>Global level activities</strong>: Civil society consultancy group and other global CS activities</td>
<td>100,000</td>
</tr>
<tr>
<td>Area 3 <strong>Mutual accountability</strong>: IHP+Results 3rd round of monitoring; 50% cost of a country health teams meeting</td>
<td>1,000,000</td>
</tr>
<tr>
<td>Area 4 <strong>IHP+ Management and communication</strong> (core team financial support, communications)</td>
<td>500,000</td>
</tr>
<tr>
<td><strong>Totals in US$$</strong></td>
<td><strong>4,000,000</strong></td>
</tr>
</tbody>
</table>

13
**IHP+ country grants status**

Since the start of IHP+, country grants have been provided to catalyse more coordinated support for development and implementation of national health plans. Over the whole duration of IHP+ a total of US$6 million has been allocated to country grants. Out of this, approximately $4.3 million has been spent, and $0.6 M committed to activities, leaving a balance of around $1 million that is currently not committed.

Since April 2010 eight IHP+ countries have secured first tranches of grants (Djibouti, DRC, Mauritania, Niger, Senegal, Sierra Leone, Togo and Uganda) and Nigeria received a second tranche. A total of 16 countries now have grants (see graph). Grants are becoming smaller for two reasons: IHP+ income has been less than planned and more countries have joined. Second, country expenditures have often been slower than intended, and in some cases have had to be recovered because they expired. Over the last year grants of up to $350,000 were approved, but first tranches were limited to $100-200,000. Delays in fund transfers to countries (an early problem) are now rare.

Country activities have been carried out mostly as planned. Approximately three quarters of expenditures are related to plan development (including budgeting and preparatory studies). Other areas of expenditures include support for national coordination mechanisms; joint reviews, development of compacts and CSO engagement. The added value and management of country grants will be reviewed as part of the debate on future strategic directions for IHP+. In some countries grants are not requested as local partners fund these types of activities, but this is not universal practice, and for some countries the IHP+ country grants represent a small but strategic source of funding.
Looking ahead

IHP+ has evolved since September 2007. The number of developing country signatories now exceeds development agency signatories. IHP+ has become progressively more country-focused in its activities, on the grounds that this is where the practical interactions between governments and partners around national health plan development and implementation occur. The 3rd Country Health Sector Teams meeting in Brussels was notable for its sense of energy, and for the increasing emphasis on joint action and collective responsibility.

The most recent feedback on progress and achievement comes from the Brussels meeting25, and the independent 2010 annual performance report by IHP+Results, just published 26. Their main messages are consistent. IHP+Results reports that country governments and development partners have made progress on how effectively they are delivering and using health aid. While gains have been made, both reviews note that progress is uneven and slower than initially hoped: for example, there is a considerable momentum around supporting one health plan based on a country’s own priorities, but less progress on strengthening and using country systems to manage resources, and development agency HQs remain slow to change procedures and ways of working.

In the Brussels meeting, participants were asked to identify what - collectively - should be continued and what should be done differently in the future, at country and global level. There was a significant degree of agreement:

- The set of efforts to improve quality, confidence, leadership and commitment to national health strategies should be maintained.
- Some areas need more focus - especially the development of effective monitoring platforms and mutual accountability.
- The use of country systems in general remains limited, but there is a shift to more collective responsibility for strengthening country systems. This shift needs active support.
- There is an urgent need to demonstrate results better.

This Core Team report summarizes progress in each area of the IHP+ workplan up to end March 2011. There has been significant progress to report. The report also sets out some implications for IHP+ beyond December 2011, when the current workplan ends. Discussions about future strategic directions for IHP+ have begun. IHP+’s mandate is to be a time-limited catalyst for better health systems and health outcomes by putting 'Paris into practice' within signatory organizations, not to be a permanent institution. IHP+ signatories stress that IHP+’s achievements need to be consolidated, and accelerated where possible. A ‘future directions’ discussion paper is being prepared. It will be based on feedback of what has worked well and less well, and will reflect changes in the global health environment since 2007. The paper will set out a draft agenda for IHP+ over the next two years, for debate.

All IHP+ signatories are encouraged to participate in this important upcoming debate: achieving IHP+’s goals, and ensuring it is ‘fit for purpose’, depends on the continued commitment and engagement of the signatories themselves.

25 http://www.internationalhealthpartnership.net/CMS_files/documents/3rd_ihp_country_health_sector_te_EN.pdf
26 IHP+Results Annual Performance Report 2010 www.ihpresults.net
## Annex 1: IHP+ partners

<table>
<thead>
<tr>
<th>Partner Country/Organization</th>
<th>Partner since</th>
<th>Partner Country/Organization</th>
<th>Partner since</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Development Bank</td>
<td>September 2007</td>
<td>Mali</td>
<td>October 2007</td>
</tr>
<tr>
<td>Australia</td>
<td>May 2008</td>
<td>Madagascar</td>
<td>May 2008</td>
</tr>
<tr>
<td>Bill &amp; Melinda Gates Foundation</td>
<td>September 2007</td>
<td>Mauritania</td>
<td>May 2010</td>
</tr>
<tr>
<td>Belgium</td>
<td>January 2010</td>
<td>Mozambique</td>
<td>September 2007</td>
</tr>
<tr>
<td>Benin</td>
<td>September 2009</td>
<td>Niger</td>
<td>May 2009</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>October 2009</td>
<td>Nigeria</td>
<td>May 2008</td>
</tr>
<tr>
<td>Burundi</td>
<td>September 2007</td>
<td>Nepal</td>
<td>September 2007</td>
</tr>
<tr>
<td>Cambodia</td>
<td>September 2007</td>
<td>Netherlands</td>
<td>September 2007</td>
</tr>
<tr>
<td>Cameroon</td>
<td>June 2010</td>
<td>Norway</td>
<td>September 2007</td>
</tr>
<tr>
<td>Canada</td>
<td>September 2007</td>
<td>Pakistan</td>
<td>August 2010</td>
</tr>
<tr>
<td>Chad</td>
<td>March 2011</td>
<td>Portugal</td>
<td>September 2007</td>
</tr>
<tr>
<td>Civil Society – Northern</td>
<td>February 2008</td>
<td>Rwanda</td>
<td>February 2009</td>
</tr>
<tr>
<td>Civil Society – Southern</td>
<td>January 2009</td>
<td>Senegal</td>
<td>September 2009</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>November 2009</td>
<td>Sierra Leone</td>
<td>January 2010</td>
</tr>
<tr>
<td>Djibouti</td>
<td>July 2009</td>
<td>Spain</td>
<td>January 2010</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>September 2007</td>
<td>Sweden</td>
<td>May 2008</td>
</tr>
<tr>
<td>European Commission</td>
<td>September 2007</td>
<td>Togo</td>
<td>January 2010</td>
</tr>
<tr>
<td>Finland</td>
<td>May 2008</td>
<td>Uganda</td>
<td>February 2009</td>
</tr>
<tr>
<td>France</td>
<td>September 2007</td>
<td>United Kingdom</td>
<td>September 2007</td>
</tr>
<tr>
<td>Germany</td>
<td>September 2007</td>
<td>United Nations Development Program (UNDP)</td>
<td>September 2007</td>
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<tr>
<td>International Labour Organization</td>
<td>September 2007</td>
<td>Vietnam</td>
<td>May 2010</td>
</tr>
<tr>
<td>Italy</td>
<td>September 2007</td>
<td>World Bank</td>
<td>September 2007</td>
</tr>
<tr>
<td>Kenya</td>
<td>September 2007</td>
<td>Zambia</td>
<td>September 2007</td>
</tr>
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</table>
Annex 2: Compacts or equivalent partnership agreements: status as of 31 March 2011

<table>
<thead>
<tr>
<th>Country</th>
<th>Compact or similar agreement (name)</th>
<th>Status as of 31/03/2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>Compact</td>
<td>Signed in 2010</td>
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<tr>
<td>Burkina Faso</td>
<td>Compact</td>
<td>Recruiting consultants to start the process</td>
</tr>
<tr>
<td>Burundi</td>
<td>MoU</td>
<td>Signed in 2008; compact planned in 2011</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Joint partnership arrangement</td>
<td>Signed 2008</td>
</tr>
<tr>
<td>DRC</td>
<td><em>Memorandum d'entente</em></td>
<td>Signed 2009</td>
</tr>
<tr>
<td>Djibouti</td>
<td>Compact</td>
<td>Recruiting consultants to start the process</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>compact</td>
<td>Signed 2008</td>
</tr>
<tr>
<td>Kenya</td>
<td>Code of conduct</td>
<td>Signed 2007; no compact planned</td>
</tr>
<tr>
<td>Mali</td>
<td>compact</td>
<td>Signed 2009</td>
</tr>
<tr>
<td>Mozambique</td>
<td>compact</td>
<td>Signed 2008</td>
</tr>
<tr>
<td>Nepal</td>
<td>Health development partnership</td>
<td>Signed 2009</td>
</tr>
<tr>
<td>Niger</td>
<td>compact</td>
<td>Signed 2011</td>
</tr>
<tr>
<td>Nigeria</td>
<td>compact</td>
<td>Signed 2010</td>
</tr>
<tr>
<td>Rwanda</td>
<td>MoU</td>
<td></td>
</tr>
<tr>
<td>Senegal</td>
<td>compact</td>
<td>Planned 2011</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>compact</td>
<td>To be signed end May 2011</td>
</tr>
<tr>
<td>Togo</td>
<td><em>Protocole d'entente</em></td>
<td>Signed in February 2011; compact being developed</td>
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<tr>
<td>Uganda</td>
<td>compact</td>
<td>draft Oct.2010, signing in progress</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>Statement of intent</td>
<td>Signed 2009</td>
</tr>
<tr>
<td>Zambia</td>
<td>MoU</td>
<td>MoU signed in 2006</td>
</tr>
</tbody>
</table>
Annex 3: IHP+ Executive Team

Members of the IHP+ Executive Team participate on behalf of one of the following four constituencies: bilateral partners, civil society, developing countries, and Health 8 agencies (H8).

### 2010 IHP+ Executive Team membership

<table>
<thead>
<tr>
<th>Institution</th>
<th>Name</th>
<th>Alternate</th>
<th>Representing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bilaterals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AUSAID</td>
<td>Timothy Poletti</td>
<td></td>
<td>Bilaterals</td>
</tr>
<tr>
<td>DFID</td>
<td>James Droop</td>
<td>Susan Chandler</td>
<td>Bilaterals</td>
</tr>
<tr>
<td>European Commission</td>
<td>Juan Garay/Jason Lane*</td>
<td>Diane Van Daele</td>
<td>Bilaterals</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Monique Kamphuis</td>
<td></td>
<td>Bilaterals alternate</td>
</tr>
<tr>
<td>Sweden SIDA</td>
<td>Anders Molin</td>
<td></td>
<td>Bilaterals alternate</td>
</tr>
<tr>
<td><strong>Civil society</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACOSHED</td>
<td>Lola Dare</td>
<td>Mayowa Joel</td>
<td>Civil Society (southern)</td>
</tr>
<tr>
<td>Treatment Action Group</td>
<td>Sue Perez/Elaine Ireland*</td>
<td>Nouria Brikci (Save the Children UK)</td>
<td>Civil Society (northern)</td>
</tr>
<tr>
<td><strong>Developing countries</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td>Abdoulie Jack and Gandham Ramana</td>
<td></td>
<td>Developing country</td>
</tr>
<tr>
<td>TBD</td>
<td></td>
<td></td>
<td>Developing country</td>
</tr>
<tr>
<td><strong>Health 8 agencies (H8)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAVI Alliance</td>
<td>Ranjana Kumar</td>
<td>Geoff Adlide</td>
<td>H8** (GAVI / GF)</td>
</tr>
<tr>
<td>Global Fund</td>
<td>Rifat Atun</td>
<td>Johannes Hunger</td>
<td>H8** (GF / GAVI)</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Aoua Diallo-Diawara</td>
<td>Karl Dehne</td>
<td>H8** (UNAIDS / UNFPA)</td>
</tr>
<tr>
<td>UNFPA</td>
<td>Jacqueline Mahon</td>
<td></td>
<td>H8** (UNFPA / UNAIDS)</td>
</tr>
<tr>
<td>UNICEF</td>
<td>Ian Pett</td>
<td></td>
<td>H8** (UNICEF / WHO)</td>
</tr>
<tr>
<td>WHO</td>
<td>Carissa Etienne</td>
<td>Wim Van Lerberghe / Phyllida Travis</td>
<td>H8** (WHO / UNICEF)</td>
</tr>
<tr>
<td>World Bank</td>
<td>Cristian Baeza</td>
<td>Nicole Klingen</td>
<td>H8 (WB / Gates Foundation)</td>
</tr>
</tbody>
</table>

*The second person named became the representative part way through the year.
**GAVI and Global Fund alternate monthly; the other agencies alternate (bi)annually.
International Health Partnership and Related Initiatives (IHP+)

IHP+ Core Team Report
May 2010 – April 2011

www.internationalhealthpartnership.net