Rapid Independent Review of the International Health Partnership

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Annexes:

List of Abbreviations and Acronyms

CPIA	Country Policy and Institutional Assessment
CSO	Civil Society Organisation
DP	Development Partner
ECOSOC	Economic and Social Council
EDC	Effective Development Cooperation
FM	Financial Management
FTE	Full-Time Equivalent
GAVI	The Vaccine Alliance
GF	Global Fund
GPEDC	Global Partnership for Effective Development Cooperation
GHWA	Global Health Workforce Alliance
JANS	Joint Assessment of National Health Strategies and Plans
JFMA	Joint Financial Management Assessment
PFM	Public Financial Management
PMNCH	Partnership for Maternal and Newborn Child Health
RT	Rapid Independent Review Team
SWAp	Sector Wide Approach
TWG	Technical Working Group
UHC	Universal Health Coverage
UNIATF	UN interagency taskforce on the control of NCDs
WB	World Bank

Executive Summary

International Health Partnership (IHP+), launched in 2007, is a group of partners committed to improving the health of citizens in developing countries through working together to put international principles for development cooperation into practice in the health sector.

In September 2015 the Sustainable Development Goals (SDGs) were adopted by the UN. IHP+ partners have agreed to embark on a transformation of the partnership towards an updated focus on health system strengthening towards the achievement of UHC. The transformed partnership is expected to help improve coordination of health systems strengthening support for UHC; sustain advocacy for UHC; and contribute to accountability for the achievement of UHC targets by 2030.

This executive summary outlines a rapid independent review of IHP+, undertaken as part of the transformation process.

When reviewing the Partnership it is essential to remember that IHP+ is not a funding organization or a special project, but an initiative trying to ensure that different stakeholders in national and global health are able to work together more effectively. IHP+ facilitates and catalyses change by keeping the global spotlight on progress in health development cooperation and results at country level, emphasizing country leadership in planning processes, and developing tools to build confidence and commitment to support national health strategies and plans. Hence, IHP+ cannot be held responsible for producing specific outcomes the way a project can because it has no mechanism to enforce adherence to the agreed commitments.

The review looks at these two dimensions of IHP+: How has IHP+ performed as an organisation (focusing on the Core Team), and how has IHP+ performed as a partnership (focusing on the developing country signatories and the DPs). When looking at how IHP+ has performed as a partnership, the Rapid Independent Review has used the Seven Behaviours as the reference.

Through an extensive document review, a series of key informant interviews, a country case study and a review of other similar partnerships and networks the Review Team (RT) has formulated 21 findings. These findings have subsequently been validated through a survey among half of the IHP+ signatory countries and the lead Development Partners (DPs) in these countries.

The major achievements of the Partnership have been formulated in nine findings. The review has shown that IHP+ has kept the Effective Development Cooperation (EDC) debate alive in the health sector, and that it has effectively promoted and helped countries establish and jointly assess national health sector strategic plans. It has also developed tools like the JANS that have been useful for improving national health sector strategic plans, and it has had buy-in from countries.

Furthermore, the review has shown that IHP+ tools and processes have supported the development towards one health budget, and that IHP+ has stimulated improvements in predictability and mobilization of *domestic* funding. The advocacy undertaken by the Partnership has contributed to increased financial management harmonization and alignment in recent years, and joint monitoring and accountability built on

national strategic plans is seen as useful in IHP+ countries. Finally, it has had strong CSO involvement since its inception.

Areas where progress has been more difficult are described in seven findings. Contrary to expectations, the review finds that despite signed agreements predictability of development support has declined, and that efforts towards getting funding on-budget have had limited effect. It is perhaps less surprising that, despite IHP+ initiatives, transaction costs related to development cooperation remain high. There is widespread agreement that IHP+ partners are not using country PFM systems to the extent they could, even if the quality of many country systems is sufficiently good to warrant their use. The review finds that there has been limited IHP+ engagement in relation to procurement and supply system strengthening, an area that is traditionally seen as being difficult.

One of the findings from the document review has been corroborated by almost all those interviewed, namely that DPs have been less willing or able to follow the Seven Behaviours than the IHP+ countries. This is the source of much frustration, and has been mentioned as "the elephant in the room".

Finally, there are only few good examples of technical support coordination and system learning between countries.

The review of the organisational aspects of the Partnership has given rise to five positive findings. Firstly, the review shows that the governance mechanism (the Steering Committee) is representative of the current membership. It also finds that the time-limited working groups have delivered useful work. The fact that the Core Team is split across two agencies, the WHO and the World Bank, has helped to keep health development effectiveness on the agenda at both and to engage both agency heads. Importantly, the lean structure (the nimble Core Team) is seen as an asset, and the Core Team functions well. The Core Team has been successful in communication and technical support to partner countries.

A couple of additional findings relate to more challenging areas: Core Team size and composition across the two agencies have varied over time, on occasion being below critical mass, and it has struggled sometimes to maintain profile and priority at WHO and the World Bank. The Core Team has had difficulties communicating effectively with development partners on how to change their behaviour to meet their commitments. This finding relates to the one above about DPs' lack of ability or willingness to follow the Seven Behaviours, despite public declarations to the opposite and their signing up to the compacts, and the wider issue of mutual accountability.

The review of four similar partnerships and networks[1] has shown that all of the four partnerships have much larger membership than the IHP+, managed through constituency-based boards or steering committees of variable effectiveness. Most of the four partnerships have been established in the context of an intergovernmental agreement through the wider UN system and relied much more than IHP+ on relatively formal intergovernmental or interagency agreements such as the Economic and Social Council (ECOSOC), the World Health Assembly (WHA) or a High-Level Forum. The GPEDC and the two NCD partnerships both have structures that separate developing countries from development partners (in

[1] Partnership for Maternal, Newborn and Child Health (PMNCH), Global Health Workforce Alliance (GHWA, currently evolving into Human Resources for Health Network), UN interagency taskforce on the control of NCDs and WHO non-communicable diseases Global Coordination Mechanism (NCD-GCM), and Global Programme on Effective Development Cooperation (GPEDC)

different ways), with explicit actions for each. Like the IHP+, all the Secretariats are small, flexible and dependent on voluntary contributions (although two get small resources through UN agency core budgets).

The appetite amongst developing countries for new or expanded accountability mechanisms is likely to be limited to areas where they can identify self-interest, such as: changing development partner behaviour; additional development resources; health systems strengthening; or health impact. Most of the partnerships are evolving to fit with the new SDG 2030 agenda, including redefining their purpose and mission and updating legitimacy and accountability mechanisms. They are also struggling to redefine their mandates in the context of SDGs and the IHP+ should ensure that, as it refines its own mandate, it harmonises with those of other related organisations.

The Review Team has distilled **seven lessons for the future operations of UHC 2030**. The lessons are not meant as detailed recommendations on the scope and structure of the new partnership; rather, they are intended to show directions and provide options for the current discussion. They are:

1. **Focus the scope of the new partnership on few issues**.

The coming discussions on the scope of the new partnership will most likely reflect the inherent temptation to include each and every aspect of UHC, as was the case during the UN's discussion on the overall SDGs. Interviewees have pointed out that the agenda of UHC is much broader than the EDC agenda; in order to establish a clear brand and avoid duplication of efforts, there is a need for the new partnership to discuss prioritization and how to focus the scope of the new partnership on few essential issues while maintaining EDC and HSS at the core of the agenda.

2. **Strive for high visibility and avoid replicating other partnerships and networks that work with similar issues.**

Clear scoping should help the new partnership to become *the* focal point for UHC. The proliferation of international health initiatives means that there will be a number of organisations that work with overlapping responsibilities. This calls for serious attention to collaboration and synergy on one hand and clear definition of the platform of IHP for UHC 2030 on the other. In this situation, the new partnership should strive for high visibility through a determined communication effort including the use of social media. The IHP+ is doing well in consciously using the website and the Twitter account to stress the importance of EDC. This experience should be the basis for an expanded media strategy that includes making a stronger connection between evidence, country examples, learning and advocacy so that communication and advocacy is better informed by country and development partner practice.

3. **Develop tools and promote their use to secure country buy-in.**

Build on the successes of the JANS tool and the PFM Assessments to allow processes to be country-driven. While tools are but one part of the overall picture, they have been repeatedly emphasized by interviewees as a major achievement. Building on this success, the new partnership could undertake to develop for instance common tools for HSS, possibly initially focusing on HSS in fragile countries.

4. **Maintain the 'double hosting' of the partnership.**

There has been unanimous support among those interviewed that the structure chosen for IHP+ has been a good arrangement, securing technical credibility and avoiding appropriation by one organisation.

5. **Consider options for choosing a more legitimate source of authority.**

The IHP+ has never had an intergovernmental agreement against which members can be held accountable, relying instead on partners signing global and/or national compacts. This has offered the legitimacy of membership while not requiring either significant resource investment or substantive behaviour change. As the membership expands, a more legitimate source of authority over members' behaviour may afford the IHP+ greater traction in holding members accountable for their actions, depending on the political momentum driving it.

6. **Consider creating separate accountability mechanisms for developing countries and DPs.**

Neither the GPEDC nor the NCD partnerships are exactly similar to the IHP+ but they do offer interesting examples of ways to approach different types of member in more tailored or targeted ways, such as separate accountability for UN agencies and countries (for example, NCDs) and the co-hosts bringing different partners to the table (for example, GPEDC: OECD-donors; UNDP-developing countries). The IHP for UHC 2030 may wish to consider creating separate accountability mechanisms for these two groups, given the lack of progress particularly by development partners in the past. If they do broaden membership to new constituents, they also need to think about how to engage them in accountability mechanisms.

7. **Keep the secretariat small and flexible.**

Those interviewed have consistently praised the small and flexible Core Team of IHP+. The new partnership should continue the course of *serving its partners* rather than creating its own power base and agendas. The Core Team or secretariat of UHC 2030 should remain lean and flexible, albeit with existing allocated posts actually filled in both WHO and the World Bank. High quality of staff is essential to maintaining IHP authority with partners, as is explicit support from senior management in both host agencies

1. Introduction

This report presents the main findings and conclusions of a rapid independent review of the International Health Partnership (IHP+) with the purpose of identifying what has worked well, what has not and why. The review was undertaken from September to November 2016 by a team of independent consultants[2] in response to the Partnership's Steering Committee discussions on the planned transformation of the IHP+ into the International Health Partnership for UHC 2030.

The review team wishes to thank the many individuals who took time out of their busy schedules to participate in interviews and fill in questionnaires. It is particularly grateful to the Core Team for sharing their knowledge of the daily workings of the Partnership.

2. Background

Since 2007, the year the International Health Partnership was founded, it has grown to comprise 37 country signatories and 29 health development partners, all committed to support a single country-led national health strategy and move towards using country systems to achieve better results in health reforms.

In September 2015 the world moved from focusing on the Millennium Development Goals to the more universal and ambitious Sustainable Development Goals (SDGs). IHP+ partners have been discussing how best the partnership can contribute to moving towards the health-related SDG. There is agreement on the need to expand the scope of IHP+ to include health systems strengthening (HSS) towards the achievement of universal health coverage (UHC), and to broaden the base of the IHP+ partnership to respond to the health-related SDGs. Developing countries strongly welcome this change.

The principle of the transformation of the IHP+ has been agreed at a strategic level; there is now a need to look at options for how this can be translated into practice. This transformation to UHC2030 will require changes to the focus and functions of IHP+. The overall aim of UHC 2030 would be to support a movement for accelerated, equitable and sustainable progress towards UHC as well as the other health targets in the SDGs, including global security and equity.

The main objectives of UHC 2030 would be to:

- Improve coordination of HSS efforts for UHC at global level, including synergies with related technical networks, alliances and partnerships
- Strengthening policy dialogue and coordination of HSS and UHC in countries, including adherence to IHP+ principles and behaviours in countries receiving external assistance
- Facilitate accountability for progress towards HSS and UHC that contributes to a more integrated approach to accountability for SDG3
- Build political momentum around a shared global vision of HSS for UHC and advocate for resource allocations to HSS.

[2] Anthony Ofosu, Ghana, Louisiana Lush, UK, Ulrika Enemark, Denmark and Esben Sonderstrup, team leader, Denmark.

In response to IHP+ Steering Committee discussions and emerging questions on how best to operationalise UHC 2030, the IHP+ Core Team has commissioned the present rapid independent review of IHP+. The review seeks to identify what has worked well, what has not and why, as well as lessons learned.

The methodology applied has included the following distinct features:

- A desk review of documents related to IHP+ and Effective Development Cooperation (cf. list of documents consulted in annex 3).
- Key informant interviews. The Review Team (RT) has interviewed Steering Committee members (present and former), the Core Team, leading officials in WHO and the WB, and representatives of multilateral and bilateral development partners and NGOs. A total of 25 interviews have been undertaken, cf. the list in annex 2.
- A country case study undertaken in Uganda.
- A review of other similar partnerships and networks.
- A developing country survey involving ministries of health and lead Health DPs in 18 countries, cf. summary survey report in annex 5.

3. What have been the main achievements of IHP+ and why?

3.1 Introduction

When formulating opinions on what have been the major achievements of IHP+ it is essential to remember what IHP+ was created to do, or, in other words, to be clear on what it is and what it is not. IHP+ is not a funding organization or a special project. Rather, it is an initiative trying to ensure that different stakeholders in national and global health are able to work together more effectively to make better use of resources, and by doing so help to accelerate improvements in health services and health outcomes.

IHP+ *facilitates and catalyses* change by keeping the global spotlight on progress in health development cooperation and results at country level, emphasizing country leadership in planning processes, and developing tools to build confidence and commitment to support national health strategies and plans. Hence, IHP+ cannot be held responsible for producing specific outcomes the way a project can because it has no mechanism to enforce adherence to the agreed commitments.

The Core Team is tasked with maintaining standards, increasing the influence of the partnership, advocating for the principles of effective cooperation (such as the Seven Behaviours), analysing development partner and country performance, producing and disseminating reports, persuading non-member countries to join, recording lessons learned, initiating and producing guidelines for joint assessments…but ultimately, effective cooperation depends on the signatories and the degree to which they change their behaviour because they see their interest in living up to the promises they signed up to in the compacts. When they do, progress on the outcomes becomes apparent.

The review looks at these two dimensions of IHP+: How has IHP+ performed as an organisation (focusing on the Core Team), and how has IHP+ performed as a partnership (focusing on the developing country signatories and the DPs).

The expected outcomes of IHP+ have developed over time. The first were those originally formulated in the Global Compact; later, the IHP+ formulated the Seven Behaviours which, in clear and appealing language well suited for a conscious branding effort, represent the most consistent formulation of IHP+ objectives. Also the five Areas of Work or the Six Issues of the 2014 Performance Report can be regarded as outcomes that the Partnership strives to achieve. When looking at how IHP+ has performed as a partnership, the Rapid Independent Review has used the Seven Behaviours as the reference[3] (box).

The Seven Behaviours of Effective Development Cooperation:

1. Agreement on priorities that are reflected in a single national health strategy and underpinning sub-sector strategies, through a process of inclusive development and joint assessment, and a reduction in separate exercises.
2. Resource inputs recorded on budget and in line with national priorities
3. Financial management systems harmonized and aligned; requisite capacity building done or underway and country systems strengthened and used.
4. Procurement/supply systems harmonized and aligned, parallel systems phased out, country systems strengthened and used with a focus on best value for money. National ownership can include benefiting from global procurement.
5. Joint monitoring of process and results is based on one information and accountability platform including joint annual reviews that define actions that are implemented and reinforce mutual accountability.
6. Opportunities for systematic learning between countries developed and supported by agencies (south-south/triangular cooperation).
7. Provision of strategically planned and well-coordinated technical support.

3.2 Achievements

1. The IHP+ has kept the Effective Development Cooperation debate alive in the health sector.

This achievement has been mentioned first or been otherwise emphasized by almost all the individuals with whom the RT has spoken. It is evidenced by the steadily growing number of members of IHP+, from initially 9 countries and 19 DPs to 37 countries and 29 DPS, and the (also growing) number of countries and DPs that take part in the monitoring rounds. It is not possible to say what would have happened had IHP+ not been there, but several persons interviewed have pointed out that the health sector is doing well in terms of EDC – in contrast to many other sectors where the Paris agenda has lost traction, and where other paradigms and discourses have taken precedence over the aid effectiveness agenda, despite the fact that it is more relevant than ever.

Keeping the EDC debate alive for almost a decade may sound like an intangible and not very concrete achievement. However, two factors should be considered: Firstly, to maintain focus and keep a steady course in times of changing development paradigms is no small feat. Secondly, the Partnership is in fact not

[3] The IHP+ 2016 Performance Report (which had not been published at the time of the Rapid Independent Review) uses the Eight Effective Development Cooperation Practices defined by the Global Partnership for Effective Development Cooperation (GPEDC). They represent the latest thinking on EDC; they are not, however, very different from the Seven Behaviours.

only keeping the debate alive, it is doing more: It is securing continued commitment to the principles as reflected in the escalating membership and the growing interest in participating in the monitoring activities.

There are many reasons why keeping the EDC debate alive is more relevant than ever. One is the proliferation of global health actors that leads to an increased risk of fragmentation and duplication of efforts, emphasizing the need for harmonization and alignment. Another relates to the continued need to build stronger health systems (as evidenced by the Ebola epidemic) and involve civil society and private sector actors in planning and execution of national plans.

The formulation, refinement and subsequent branding of the **Seven Behaviours** were important strategic elements in the efforts to keep the Effective Development Cooperation agenda alive. They are clear, intuitive and operational. Besides, considerable effort was put into making two animated films about EDC in health and financial management harmonisation and alignment. There was also a poster campaign to highlight the problems that service providers face, which put the necessity of EDC in very concrete terms. The concept has been praised by many of those interviewed who find that the Seven Behaviours dispel confusion around alignment and harmonisation. Along with the JANS concept the Seven Behaviours are what immediately comes to people's minds when IHP+ is brought up.

The finding is met with a high level of agreement in the country survey, cf. Annex 5.

2. The IHP+ has effectively promoted and helped countries establish and jointly assess national health sector strategic plans.

This achievement is at the core of what Effective Development Cooperation is about. Countries develop national health sector strategic plans, but the Partnership has set a standard for a robust and credible strategic plan by facilitating country grants, joint assessment and exchange of knowledge on performance frameworks and uniform indicators.

The number of countries that have established national health sector strategic plans is increasing. The 2014 monitoring round showed that 94% of countries that participated in the monitoring have jointly assessed strategies in place.

Establishing a national strategy that complies with agreed standards is the basis for any serious dialogue on harmonisation and alignment, and there is general agreement among those consulted by the RT that IHP+ has been instrumental in producing this outcome.

3. The IHP+ has developed tools like the JANS that have been useful for the establishment of better national health sector strategic plans.

One of the most successful activities of the Partnership has been the development and promotion of the Joint Assessment of National Strategies and plans (JANS[4]). To some, the concept of JANS is almost

[4] The JANS tool provides a common, comprehensive framework for assessing the quality of a national health strategy. The tool includes 16 attributes of a robust national health strategy, grouped into five categories: (i) situation analysis and programming, (ii) process (of strategy development), (iii) costs and budgetary framework for the strategy, (iv) implementation and management, and (v) monitoring evaluation and review. JANS assessments are usually conducted

synonymous with IHP+. The JANS tool has been used for national strategies as well as disease-specific strategies[5] (AIDS, TB…) and has been thoroughly evaluated and changed along the way, *i.a*. at an international conference in Hammamet in 2012 and a review of stakeholder needs in 2013. The main objectives of conducting a JANS have been to help improve the quality of the strategy or plan, to increase confidence in the strategy or plan and so secure more aligned financial and technical support, and to reduce transaction costs associated with multiple separate assessments.

The 2013 Review of Stakeholder Needs found that the JANS was a useful mechanism to coordinate their work. The JANS was found to help improve the quality of health strategies and the confidence of different funders in them.

Not all objectives had been equally met. While JANS have in all cases helped strengthen the strategy or plan, the links to funding decisions are less clear and may take longer to be seen. More incentives are needed to change partners' behaviour.

It is a major achievement that the JANS has been constantly developed and tuned to the needs of the members. However, the generally positive view of the JANS concept notwithstanding, no systematic monitoring or evaluation of the extent to which JANS has led to substantial changes in the national health sector strategic plan or increased alignment by DPs have been undertaken.

In the country survey the positive finding regarding JANS is confirmed by MoHs and DPs alike, cf. Annex 5.

4. IHP+ has buy-in from countries

Right from the beginning IHP+ has underlined that it is a partnership, not another global instrument run by Geneva or Washington. Global health initiatives are often very clear on what they want to achieve and, especially those with big budgets and country offices, can exert pressure on individual developing countries to achieve what they want. Besides, they almost inevitably wish to use their own monitoring frameworks which lead to high transaction costs in the countries in which they work. IHP+ is seen as a different global instrument that is making tools and information on good practices available; the Partnership's light touch structure and its way of working are valued by the countries, and they engage. In the words of one of those interviewed, IHP+ "was always built and cooked together. Joint cooking in the kitchen" – sometimes building on the relatively informal partnerships that had originally been established around SWAps and like-minded donors.

5. IHP tools and processes have supported the development towards one health budget

The 2014 Performance Report reports an increase in the proportion of expenditures by DPs that are aligned with the country results framework. Development of the JANS process and tools has provided a framework for development of one comprehensive country health strategy and corresponding budget within a budget process that is aligned with the country budget cycle. In many cases the Joint Annual Review Meetings (JAR) also include a review of priorities (and sometimes workplan and budgets for the coming year) and pledges for funding that provide the framework for developing the next workplan and budget[6]. This

by an independent team comprising international and national experts. They provide a report on the strengths, weaknesses and recommendations for the national health strategy.

[5] JANS have been undertaken in Ethiopia, Ghana, Kenya, Kyrgyzstan, Malawi, Mali, Mozambique, Nepal, Rwanda, Sudan, Togo, Uganda, Vietnam. Many countries have had more than one JANS.

[6] IHP+ (2013). Joint Annual Health Sector Reviews. A review of experiences.

increases transparency over funding commitments. The existence of a globally accepted framework and process – not owned by any funding agency in particular – has provided governments with a tool to insist on alignment of support including budget allocations, although there is still some way to go as such insistence requires strong leadership. To some extent this was already in motion with the SWAps in some countries, but the IHP+ has helped push this process further, spreading to more countries and involving more development partners.

6. IHP+ has stimulated improvements in predictability and mobilization of domestic funding

According to the performance reports both levels and predictability of domestic funding has improved[7]. While there may be many explanations for this, several interviewees mentioned improved internal collaboration in government structures as an outcome of IHP supported processes. Specifically, one contribution by IHP+ is the process for development of country compacts which specify commitments and therefore involves the Ministry of Finance as co-signatory. Thus, IHP-supported processes not only bring together development partners, but also key domestic stakeholders of vital importance for predictable funding flows[8].

7. IHP+ advocacy has contributed to increased financial management harmonization and alignment in recent years

Strengthening of PFM systems in partner countries has been a concern for decades. In the past massive investments have been made in (often uncoordinated) PFM capacity strengthening in ministries of health, and yet excessive transaction costs due to parallel assessments, financial management units, procedures, reporting and auditing prevail. This has proven to be a notoriously difficult area in which to achieve change and has been slow to take off. Although it is difficult to assess the counterfactual, it is reasonable to assume that IHP initiatives have contributed to recent progress.

IHP+ has facilitated increased use of joint financial management assessments, development of joint PFM capacity strengthening plans and for some large funders increased use of country systems. So far, FM collaboration has taken place in Sierra Leone, Liberia, Sudan, Burundi, DRC and Senegal.

In 2012 a thorough financial management harmonization review was undertaken based on document review and consultations with GAVI, GF and WB, inputs from other DPs and partner countries, as well as lessons from previous experience (SWAp, country level financial management assessments). It identified the need to further strengthen and use well-functioning country systems and to reduce transaction costs due to duplications and uncoordinated inputs. A guidance note on the process for Joint Financial Management Assessment (JFMA) was developed. In 2014, a Financial Management Technical Working Group was formed with a view to promote and facilitate a more harmonized and aligned approach to financial management[9], initially targeting seven countries[10]. IHP+ has developed a guidance note on

[7] While the 2010 monitoring round revealed limited progress, and mainly on budget execution, in 2012 half of the countries (10/19) had reduced the gap between allocation and disbursement of the national health budget, and 7 countries both increased the health budget and disbursements. By 2014, the average proportion of the national budget allocated to health increased from 8 to 10% and the number of countries reaching 90% budget execution had increased by 44% since 2012 (IHP+ Results Performance Report 2010, 2012, 2014).
[8] IHP+ (undated). Developing a compact/partnership agreement - is it worth the effort?
[9] TOR IHP+ Financial Management Technical Working Group. May 2014.

financial management harmonization and alignment and facilitated financial management assessments in the seven target countries which have resulted in increased alignment.
At target country level up to 8 development partners participate, JFMA have been undertaken in two countries with more planned, and one JFA has already been signed[11]. Joint assessments have resulted in joint support of financial management strengthening, for example in Sierra Leone[12] and Liberia, where funding from the Health Sector Pool Fund supports the Office of Financial Management and Internal Audit[13]. Partner countries are increasingly demanding IHP+ facilitation of harmonization and alignment of financial management as well as development of joint support for financial management[14]. The use of compacts has strengthened the collaboration between the Ministry of Health and the Ministry of Finance (e.g. Mali). Furthermore, it has helped focus attention on common and different financial management arrangements between and within funding modalities and provided a platform for articulating and discussing such issues among development partners at country level.

Advocacy for joint financial management assessments and shared approaches to responding to the findings of such assessments is being undertaken at global level among development partners. Work to support this through stronger evidence-based analysis has been initiated by IHP+ (FM-TWG) on the relationship between improved and harmonized financial management and health sector results. Although the outcome of the study is yet to be seen, this work is expected to provide a strong evidence-based reference for partner countries as well as development partners in mobilizing their systems to change behavior in terms of addressing the bottlenecks to harmonization and alignment of financial management. An early review of results in Ethiopia by funding through different funding channels suggests that funding through the government preferred channel provided better value for money (higher benefits to cost ratio, cheaper and cost effective unit costs, lower transaction costs and better sustainability)[15].

8. Joint monitoring and accountability built on national strategic plans is seen as useful in IHP+ countries

From the beginning IHP+ has emphasised the need for one platform for monitoring and accountability, assuming a catalytic role in identifying opportunities for raising the agenda, demonstrating feasibility and developing toolkits[16] .

Using the national strategic plans as the basis for a common monitoring platform has now become standard procedure in most IHP+ countries. IHP+ facilitated the process that led Development Partners and Heads of agencies to agree to substantially reduce the reporting burden imposed on countries. In this context, the agreement on and publication of the **100 core indicators** in 2015 was an important step[17] .

[10] The countries targeted were Burundi, Ethiopia, DRC, Liberia, Senegal, Sierra Leone and Sudan
[11] IHP+ 2016. Core Team Report for 2015.
[12] Travis P et al 2013. Effective Development cooperation in the health sector in Sierra Leone. Report of Joint Mission 4-8 November 2013.
[13] IHP+ 2013. Better results through effective development co-operation: the heart of the work we do.
[14] IHP+. 7th Steering Committee Meeting. Note for the Record. June 2016.
[15] Results and Effectiveness of the various Funding Modalities in the Ethiopian Health Sector. January 2013.
[16] Monitoring, evaluation and review of national health strategies. A country-led platform for information and accountability. IHP+/WHO November 2011.
[17] WHO 2015. Global Reference List of 100 Core Health Indicators

Furthermore, in 2016 the efforts to construct a common agenda to improve and sustain measurement and accountability systems at country level[18] culminated in the formation of the Health Data Collaborative[19]. The Health Data Collaborative intend to develop tools that can help countries obtain and analyse more accurate and reliable health data for monitoring SDGs, UHC as well as other national priorities. With presently more than 30 partners this initiative holds good promise for harmonization of monitoring and evaluation, systems strengthening and reduced administrative burden.

Although the joint monitoring that is done every two years at the initiative of IHP+ is said to be burdensome by both countries and partners, it was mentioned by some of those interviewed as a very good way of measuring progress on the seven behaviors that defines effective development cooperation.

The utility of joint monitoring and accountability is corroborated by the country survey, cf. Annex 5.

A more detailed account of accountability aspects can be found in Section 5.2.

9. IHP+ has had strong CSO involvement since its inception

Civil society engagement is not without problems. Many governments are wary of civil society involvement in sector planning and feel that CSOs are not transparent or accountable, and CSOs often perceive governments as closed and unwilling to engage civil society. Although interviews pointed out that this was an area where IHP+ had not done so well, there was an admission that IHP+ since its inception has had a strong CSOs involvement at all levels. At the global level, international and national CSOs are a part of the governing body of IHP+ called the Steering Committee. There is also a Civil Society Consultative Group which discusses CSO engagement with IHP+ issues, and IHP+ thematic working groups also include civil society.

Results from the CSOs survey conducted in 2012 show how some CSOs have contributed significantly to aid effectiveness in their countries[20].

4. Where has progress been more difficult and why?

1. Despite signed agreements predictability of development support has declined [21]

Development partners have signed on to Country Compacts or similar agreements to provide multi-year commitments and annual commitments in time to be included in the national planning processes. However, in practice this commitment is not complied with as much as could be expected. One challenge in this context is that IHP+ does not have any power to enforce the agreements made between partners. Partners can try to uphold a social control mechanism and hold each other responsible for complying with agreements made, but this appears to happen only to a limited extent. Another challenge is that for some DPs changing to multi-year commitments/programs may require a general change in the way of providing development aid. Such changes may involve decisions at higher political levels.

[18] Measurement and Accountabilty for Results in Health Summit, June 9-11 2015. Summary Report. World Bank, July 2015. & Roadmap for Health Measurement and Accountability. A common agenda for the post-2015 Era, June 2015.
[19] http://www.healthdatacollaborative.org/
[20] Engaging Civil Society to improve AID effectiveness in the Health Sector ihp+ results 2012.
[21] IHP+ Results 2015. 2014 Performance Report.

The finding that predictability has declined is challenged by 5 respondents in the country survey.

2. Efforts towards getting funding on-budget have had limited effect

The proportion of health sector development assistance on the national budget has declined since 2009[22]. This is a genuine problem for effective planning and monitoring in the sector and therefore a relevant concern. There may be several reasons why this has been difficult. First, there seems (still) to be different understandings of what on-budget means. For some development partners including their resource inputs on the national budget of a recipient country creates problems for accountability to own constituencies. The lack of progress could to some extent also be explained by a shift in the composition of development partners providing support directly to the health sector. If development partners with focus on aid effectiveness and on-budget health sector support shift their resources to general budget support (or withdraw from health to concentrate on other sectors), then the proportion of health sector support on budget would decrease, yet overall development support on-budget would not have changed. Furthermore, if remaining or new development partners have less tradition for on-budget support then more efforts would be required to improve the proportion of health sector support on-budget.

3. Despite IHP+ initiatives transaction costs remain high

Common tools and approaches do not necessarily meet all development partner requirements. Some development partners therefore continue to undertake their own parallel exercises, for example GF still do their own program costing. Standardised guidelines and requirements developed in DP headquarters are not sufficiently flexible to allow adaptation to national and join processes and procedures in a variety of different partner countries. Deviation from standard guidelines may require elaborate justifications and procedures. Compliance may be more attractive and all the more so, if the career system within DP organisations rewards those following the internal rules.

4. IHP partners are not using country PFM systems to the extent they could (given the quality of the system)

Approximately half of the countries in the 2013 CPIA were assessed as having sufficiently robust PFM systems. However, even in these countries the use of country systems is low. This may reflect a certain level of risk aversion combined with a wish to be accountable to constituencies; there appears to be a perception that stand-alone financial management set-ups are less risky and provide more value for money than using government systems. Recent initiatives mentioned above to provide more evidence on this is a step in the right direction. Furthermore, if internal organizational structures and guidelines are not consistent with the development cooperation principles agreed to in high-level meetings, i.e. if such agreements are not internalized in the organisation, then promotion practices are likely to discourage risk-taking behavior. Finally, there are also stakeholders within partner governments who prefer the flexibility from less transparent systems and less interference from own ministries of finance.
A cross-cutting explanation is that IHP+ is a partnership that can agree to the rules, but doesn't really have power to enforce agreements. However, even the opportunity to discuss the results of partner performance survey and shame bad performers has not been much used.

[22] Ibid.

5. There has been limited IHP+ engagement in relation to procurement and supply

Unclear division of roles in relation to procurement and supply management has resulted in limited IHP+ engagement in this area.

The fragmentation and inefficiency of procurement and supply systems and potential gains from increased harmonization and alignment is generally recognized and are reportedly a concern raised by partner countries. Nevertheless, looking back in the documentation it seems that IHP+ has had difficulty identifying its role in view of other initiatives working on harmonization, i.e. the Inter-Agency Supply Chain Group. In 2014, it was proposed that a possible role of IHP+ could be to review how efforts to harmonise PSM support and increase use of country systems are playing out at country level through monitoring and to provide a mechanism for feedback from countries for example through country case studies[23]. By end of 2014 it was decided by the Steering Committee that the IHP+ focus should be on learning from harmonization experience through selected case studies. Consequently, IHP has (appropriately) not been very active in promoting and facilitating progress on this EDC behaviour.

6. DPs have been less willing or able to follow the Seven Behaviours than the IHP+ countries

The purpose of defining and branding the Seven Behaviours was to re-invigorate the discussion on what was the essential goal, namely EDC. This discussion was started at the IHP+ meeting in Nairobi in December 2012, where participants identified a number of critical areas where international development partners needed to change their behaviour in order to accelerate progress on the MDGs. As mentioned in Section 3.2 the Seven Behaviours have been much appreciated for their clarity and to-the-point messages.

However, many of those interviewed by the RT have pointed out that the IHP+ countries have generally done better in adhering to the Seven Behaviours than have the DPs. There has been a trend among a number of DPs to focus more attention on showing results than on aligning. This trend was documented in the 2014 Performance Report; one of those interviewed called it “the elephant in the room”.

7. There are only few good examples of technical support coordination and system learning between countries

Most partners do not use government systems to procure Technical Assistance for countries. Although dual accountability of technical support to both partner and government is said to be the best approach, it has often been found to be absent[24].

There is no framework that will facilitate peer-to-peer learning among signatory countries (south-south), and there is little documentation of results and sharing of experience from this type of cooperation. With the exception of the publication on the current status and trends in South- South cooperation that was published by IHP+ there appears to be little knowledge and documentation on the South- South and triangular cooperation, and there is little evidence on the costs and benefits.

This is unfortunate, as one of the things that can help keep reforms on track is documented evidence of what works and progress made. For this to happen, capacity of national structures needs to be supported. However, in general TA has often been piecemeal and there has been a lack of continuity of high caliber TA

[23] IHP+ 2014. Potential roles for IHP in the area of procurement and supply management. Paper for IHP+ Steering Committee Novermber 12, 2014.

[24] IHP+. Demand and supply technical assistance and lessons for the health sector-Issues and challenges from rapid country review 30th October 2014

on health reforms. Overall development assistance is diminishing as a proportion of overall health resources, and this increases the need to focus on best models for influencing domestic resources rather than gap filling, which was sometimes the case.

5. How have the IHP+ structures and operations, and other contextual factors enabled or constrained IHP+ achievements

5.1 Structures and operations

5.1.2 Main achievements

1. **The governance mechanism – the Steering Committee – is representative of the current membership**

The IHP+ currently has 66 signatories to its 2007 Global Compact, including developing countries and development partners (multilaterals and bilaterals). Liberia, Japan and Myanmar are recent new signatories. A Steering Committee is responsible for setting overall strategic directions as well as oversight of IHP work plan and budget on behalf of signatories. The SC has 20 members that meet twice a year, including six developing countries, six multilaterals, six bilaterals and two CSOs. The SC approves Working Groups, reviews their recommendations and agrees on actions to be taken. Selected from Steering Committee members, the smaller IHP+ Reference Group convenes more regularly and supports the Core Team in implementing the work-plan.

Interviewees reported that the Steering Committee, Reference Group and Working Groups are broadly representative of the membership. It can be difficult to secure input from developing country participants, particularly for working groups where their participation was especially valued. This was mainly because Ministry of Health officials have limited available time. Otherwise, the overall impression from interviewees was positive towards the governance set up of the IHP+, and one that could well be used to take forward the IHP+ into its new role.

2. **Time-limited working groups have delivered useful work**

IHP+ Working Groups are time-limited groups of technical experts, drawn from countries, agencies and CSOs, that report to the Steering Committee on specific topics related to development effectiveness in health. Currently active groups work on: Intensified Action; Mutual Accountability; Information and Accountability; and Financial Management. There is also a Civil Society Consultative Group. Because the Core Team is so small, the IHP+ is heavily dependent on these various committees and working groups to agree commitments and hold each other to account for delivering on them.

3. **The Core Team split across two agencies has helped to keep health development effectiveness on the agenda at both and to engage both agency heads.**

The IHP+ secretariat is split across two agencies – the World Health Organisation (WHO) and the World Bank. The Core Team is responsible for managing the workplan and budget, supporting the Steering Committee and its various Working Groups and organising the biannual Country Health Team meetings.

Interviewees variously described this role as catalysing, facilitating and collaborating with signatories rather than prescription or implementing its own programme of work. Unlike larger partnership Secretariats, the IHP+ Core Team was felt by respondents to '*serve its partners*'[25] rather than creating its own power base and agendas. The IHP+ is not established as a partnership secretariat within WHO and the World Bank but is a line unit reporting directly within the respective agencies' management structures.

4. The lean structure is an asset and the Core Team functions well

The Core Team was widely reported in interviews as to have functioned flexibly and responsively, within the limitations of its extremely lean structure and staffing. Likewise, the 2011 strategic review referred to Core Team value in '*its neutrality, its professionalism and its capacity to manage complex issues and audiences*.'[26] Since inception, several reviews have been undertaken of the structure and operations of the IHP+, generally recommending retaining the lean Core Team structure, while acknowledging the responsibilities this placed on the signatories to deliver the agenda. The workplan has remained necessarily low on detail to enable flexibility and responsiveness by the Core Team to emerging agendas.

Interviewees also commented, however, that the risk of the lean and relatively low-ranking structure is that the Core Team has at times struggled to gain sufficient traction for their agenda among senior management at WHO and the World Bank. Similarly, the reliance on signatories to deliver the agenda has sometimes meant that key decisions have not been taken or commitments implemented.

The IHP+ budget for the 2016-17 biennium was just under USD 10 million.[27] Of this, IHP+ oversight and operations plus updating the partnership for the post-2015 context consumed just over USD 2.6 million, including the Core Team, the steering committee and other IHP+ management activities. Under a previous budget in 2015, a particularly low level of budget execution (58%) was due to severe staff shortages in the Core Team. In particular, the nature of the objectives that the IHP+ aims to achieve – influencing policy, changing behaviour – requires relatively little financial resources, although it does depend on people being prepared to put in time and effort.

5. The Core Team has been successful in communication and technical support to partner countries

The Core Team placed a huge premium on communicating with its members, particularly those from developing countries. It operates a well-resourced and regularly updated website, a newsletter and a Twitter account, to which the number of subscribers has risen steadily. As mentioned before, considerable effort also went into creating and producing advocacy materials around EDC in health and the seven behaviours including posters, postcards, bookmarks, and short films. In addition, the Core Team has published a multitude of reports over the years, including the highlight – the biannual IHP+ Monitoring Report – that reports on progress amongst members towards the seven effective development cooperation behaviours. The Core Team also operates an ad hoc and informal service to countries requesting advice on areas such as development cooperation, health planning and financing, monitoring and evaluation or joint annual reviews. The Core Team can, if requested, put together teams to conduct JANS or annual reviews.

[25] Interview respondent, September 2016
[26] Deville, L and M Taylor (2011) *Options for the Future Strategic Direction of the IHP+: Findings of a Consultation with Stakeholders*. Independent review by consultants.
[27] IHP+ (2015) *IHP+ Core Team Report.*

The Core Team has also organised a biannual Country Teams Meeting, with the last held in Cambodia in 2015. This was discussed by several interviewees as useful but, with larger membership of the IHP+, potentially becoming expensive, unwieldy and less useful to the country teams attending. Several respondents suggested shifting to regional rather than global country meetings, or some other sub-grouping system that could continue to facilitate South-South cooperation beyond regions. This would also ensure that country voice continues to be heard in relation to IHP+ EDC issues.

5.1.2 More challenging areas

1. **The Core Team has struggled sometimes to maintain profile and priority at WHO and the World Bank**

The Core Team size and composition across the two agencies have varied over time and it is currently budgeted to comprise a total of five senior posts (three at WHO and two at the World Bank) plus junior professional and administrative support. In the near future, it is likely that the weighting towards WHO will continue although the 2016-17 Strategic Directions review recommended that the World Bank should maintain at a minimum 1 FTE staff.[28]

At WHO, interviewees reported that human resources procedures have hindered the Core Team's ability to function during 2015. Recent staff shortages, partly due to burdensome human resources procedures at WHO, have severely restricted the Core Team's ability to deliver IHP+ workplan objectives. Likewise, despite a larger human resource allocation, over time the World Bank has reduced its actual staffing of the IHP+ from 3.5 to 0.5 FTE.

Some interviewees commented on the status of the IHP+ Core Team leads within the WHO and World Bank staff levels. The interviewees found that their low profile has afforded them greater flexibility and ability to seize windows of opportunity; however, their low rank was also seen as an indication of the lower priority accorded to the IHP+ objectives by WHO and the World Bank and the struggle they have had with getting effective development cooperation onto the institutional agendas, compared to for example, Ebola at WHO or the Global Financing Facility at the World Bank.

2. **For UHC 2030, a wider range of partners will need to be included in the IHP+**

Interviewees referenced a number of key constituencies that are not currently included in the IHP+ governance set up that will be important to bring in during the shift to UHC2030:

- Emerging economies and/or middle income countries (MIC)
- Various private sector stakeholders (including companies, faith-based organisations and philanthropies)
- Agency regional offices (especially those of WHO) as well as country offices (currently most agencies are represented at HQ level only)
- Parliamentarians' groups and local authority representatives

The difficulty for the IHP+ will be to balance incorporating the interests of an expanded set of constituencies while maintaining its acknowledged light touch, flexible mode of operation. It may be that

[28] IHP+ (2016) *IHP+ Strategic Directions 2016-17: Making the Most of Development Cooperation for the Health Related SDGs*.

there could be different levels of membership, including core signatories as currently but with a wider network option that could allow larger numbers to become involved through regional or functional hubs.

3. The Core Team has had difficulties communicating effectively with development partners

Where communication has perhaps been weaker is with development partner bilateral agency and multilateral agency headquarters, to follow up on the findings emerging from countries on their performance against the seven behaviours. Communication between the Core Team and development partners tends to be largely with Headquarters staff (for example, through presenting the biannual review to SC members and other development partner signatories). However, these staff do not always have direct control over country spending decisions and may therefore have limited sway in adjusting their agency's behaviour in relation to a specific EDC problem. Often, decisions on how to spend money and whether to meet EDC commitments take place at country level and/or within regional departments at the Headquarters level. This ability of the IHP+ to find ways to operate in the space between country programme and headquarter decision makers and help them to establish levers and mechanisms that actually change behaviour has been a key struggle from its inception. This is a complex and sensitive area and, going forward, the Core Team in both the World Bank and WHO must be staffed with people of sufficient seniority, calibre and energy to move forward with the agenda.

5.2 Accountability

1. The IHP+ has introduced several potentially effective accountability mechanisms through which both developing countries and their partners might be held to account

From the beginning, through its governance mechanisms and the functioning of the Core Team, the IHP+ was supposed to be able to hold its signatories accountable for the commitments they make in both the Global Compact and any agreed country compacts. However, the IHP+ has always struggled. The widespread view amongst interviewees was that, on the whole developing countries have improved their public planning and financial management systems (although not sufficiently for all) but that development partners have either failed to improve or, in some cases, got worse since 2007. The crucial governance question for the IHP+ is therefore: what could have been done differently?

The IHP+ introduced a number of mechanisms to promote adherence to compact commitments. The most intensive is the biannual mutual accountability reviews, by which countries and their donor partners report to each other on progress towards their commitments, and which has now been done five times. It has included variously:

- Self-reported performance against quantitative indicators
- qualitative exploration of reasons for adherence or otherwise to commitments
- subsequent country meetings to discuss findings
- CSO engagement on findings at country level
- engaging with development partners at HQ level (e.g. WHO)
- discussion of the results by Global Health Agency Leadership

However, interviewees reported that other accountability levers have not been so well fostered, such as: sufficient funding for CSOs to hold their governments accountable, which, despite Core Team efforts,

donors did not want to fund[29]; involving parliaments and local governments in holding both governments and development partners accountable for their commitments to effective health systems and financing; and information on why development partners did not meet their commitments[30].

2. Despite Core Team efforts, little progress has been made on how to use accountability levers and what processes might foster their better use

Furthermore, little discussion has taken place on what mechanisms and processes might need to be in place to use these levers, if they did exist, or the circumstances in which they work best. Respondents reported a sense that, if the IHP+ continues with the development effectiveness agenda as part of its future mandate, it needs to get smarter at identifying and reaching senior agency staff that are both interested in the development effectiveness agenda and able to set organisational incentives in order to change behaviour.

The IHP+ agenda was incorporated into the Global Health Agency Leaders' discussions in 2014, see the box. Some interviewees reported that this helped to raise IHP+ issues up the global health agenda. But others reported little follow up and that, to catalyse further action on effective development cooperation in health, engagement needs to be much more widespread amongst development partner agencies. The Global Health Agency Leaders also lack the authority to challenge development partners collectively to meet their commitments, particularly since, in some cases, they have failed to improve their own aid effectiveness.

Box: An example of high-level backing

The Fifth Informal Global Health Agency Leaders Meeting at WB HQ, April 2014 serves as a good example of how much-needed high level backing, in this case from the leaders of the WB and WHO, may further the cause of EDC.

The DG of WHO agreed to chair a working group of senior focal points from the participating global health agencies to work with countries to develop a rationalized results measurement framework. World Bank Group President Jim Yong Kim and the DG co-chaired the April 10, 2014 meeting, with the aim of discussing the working group's summary report and agreeing a way forward toward: 1) a common final list of indicators, 2) a reduced reporting burden for countries, and 3) operationalizing the agenda to improve monitoring of results and performance.

The DG, who had chaired the interagency Working Group on Indicators and Reporting Burden in the period October 2013 through April 2014, highlighted the primary recommendation of the Rapid Assessment of the Burden of Indicators and Reporting for Health Report: to cut the current number of indicators that development partners require for country reporting – estimated to be over 600 - by at least 50%. The Director, Health, Nutrition and Population of the World Bank Group, summarized the draft report on Global Core Indicators for Measurement of Health Results with its four key recommendations for DPs: 1. Use common, country-led platforms for results measurement and accountability as outlined by IHP+. 2. Agree on a limited, common core set of indicators. 3. Align reporting cycles of agencies. 4. Coordinate investments in strengthening countries' data systems and institutional capacity (including vital statistics, harmonized regular surveys, facility and administrative and data reporting systems).

5.3 Other contextual factors

1. Contextual factors impacting on the IHP+ are different at the global and the country level

Between 2007 and 2016, a variety of contextual factors impacted on the IHP+ ability to achieve its objectives. At the global level, reported contextual issues included: the level of high level political attention to the IHP+, among competing global initiatives and partnerships in the health architecture; shifts in the development effectiveness policy agenda from systems development to results orientation and to include a wider set of stakeholders; and

[29] This has been addressed through the Health Policy Action Fund (HPAF) to provide small grants to southern CSOs to engage in national health policy processes

[30] This is currently being addressed by a review of development partners' operating procedures to be published in early 2017.

the relative priority accorded to generic health systems strengthening compared to specific diseases (e.g. the 'three diseases' or Ebola) or interventions (e.g. vaccines or RMNCH services).

At the country level, a different set of factors were reported to impinge on success or failure, including: government willingness to change its own behaviour; government willingness to challenge development partners on their behaviours; the degree to which CSOs were engaged and able to participate in health policy debates; the income level and degree of security or fragility of the country; and the commitment by the country government to dedicate domestic resources to strengthening health systems.

2. The IHP+ has responded to changing context with flexibility and professionalism

The IHP+ signatories and SC have responded to these contextual factors in different ways and it is the combination of strength of influence and appropriateness of response that has determined the impact each has had on IHP+ outcomes. Examples of where the IHP+ was reported by interviewees as having responded well and benefited from context included: the recent response to UHC, capitalising on renewed interest in IHP+ objectives; and the ability to move quickly in response to country requests for assistance in managing their relationships with development partners.

Reported examples of less positive response by the IHP+ relate to new concepts in development assistance. Global health initiatives have become more results oriented in recent years, responding to pressures from their boards to show that effects may be attributable to the actions funded. Showing quick results is often not compatible with sustainability considerations, and the instruments used often have the unintended side effect of inhibiting or reversing EDC. In relation to the communication issues discussed above, such operational differences and technocratic, complex questions are often difficult to communicate effectively to senior management or politicians that make big decisions on aid financing and incentives.

Globally, the health agenda fluctuates frequently and somewhat unpredictably and the IHP+ will need to continue to be flexible and respond to ongoing shifts. Despite evolution in the global development cooperation and health agendas, the IHP+ continues to have an important role to play in reminding partners of their commitments and supporting countries to hold partners to account.

6. The comparative experience of four similar partnerships and networks

6.1 Introduction and background

To answer the second part of this question, the operations and experiences of four other similar global partnerships were explored. Using a long-list of potentially interesting global partnerships/initiatives provided by the IHP+ Core Team and supplemented by the consultant team, criteria for selecting those to receive further investigation included:

- They still exist, have a good baseline of information that is available online and a track record (have been active for more than 5 years);
- They operate in a similar functional way to the IHP+ - they are not funding mechanisms but convening, technical support and advocacy organisations;

- They have a broad health/development focus rather than too narrowly focused on a single disease or intervention.

Based on these criteria, of the above initiatives, the team selected to look briefly at: the Partnership for Maternal, Neonatal and Child Health (PMNCH); the Global Health Workforce Alliance (GHWA), which is in the process of rebranding as the Human Resources for Health Network (HRHNetwork); the Global Programme for Effective Development Cooperation (GPEDC); and the WHO non-communicable diseases Global Coordination Mechanism (GCM/NCD) and UN interagency taskforce on the control of NCDs (UNIATF).

6.2 Key lessons for IHP+ structure, governance and context from other partnerships

Detailed description of the purpose and operations, structure and governance, contextual factors and accountability of the four other partnerships are shown in Table 6.1 overleaf. Here we summarise the key lessons that emerge from this comparative overview and make suggestions for how these lessons might be relevant to the IHP+ as it evolves towards UHC 2030.

1. **All of the four partnerships have much larger membership than the IHP+, managed through constituency-based boards or steering committees of variable effectiveness.**

As the UHC mandate is potentially much broader than the previous IHP+ development effectiveness agenda, the new organisation needs to consider how to expand its membership to include both a larger number of developing countries, development partners and non-government organisations, as well as stakeholders from private sector, parliamentary and local government organisations and professional associations. As it expands, the steering committee will also need to evolve and establish new ways of working to manage a wider set of interests.

2. **Most of the four partnerships have been established in the context of an intergovernmental agreement through the wider UN system, such as the Economic and Social Council (ECOSOC), the World Health Assembly (WHA) or a High-Level Forum.**

The IHP+ has never had an intergovernmental agreement against which members can be held accountable, relying instead on partners signing non-binding global and/or national compacts. This has offered the legitimacy of membership while not requiring either significant resource investment or substantive behaviour change. Other partnerships looked at here have relied much more on relatively formal intergovernmental or interagency agreements, overseen by an authority such as the ECOSOC or WHA, to which members have to report annually (according to their respective processes). In the case of both the NCD partnerships and the GPEDC, the connection to these UN governance mechanisms also facilitated the participation of UN country teams through the UN Development Assistance Framework (UNDAF).

As the membership expands, a more legitimate source of authority over members' behaviour may afford the IHP+ greater traction in holding members accountable for their actions, depending on the political momentum driving it. Examples include the UNIATF NCDs agencies reporting to ECOSOC or the PMNCH working with governments within the UN Secretary General's Global Strategy for Women's, Children's and Adolescents' Health, to which 50 countries and 120 organisations have signed up.

Any advantage would need to be balanced against the potential transaction costs of both establishing and then monitoring an intergovernmental or interagency agreement, which can take years to achieve.

3. **The GPEDC and the two NCD partnerships both have structures that separate developing countries from development partners (in different ways), with explicit actions for each.**

Neither the GPEDC nor the NCD partnerships are exactly similar to the IHP+ but they do offer interesting examples of ways to approach different types of member in more tailored or targeted ways. The GPEDC is split between the OECD, which brings donors to the table, and UNDP, which brings reach to the country level. The two NCD partnerships separate accountability structures for UN agencies (to ECOSOC) and countries (to WHO, through a World Health Assembly resolution). The IHP for UHC 2030 may wish to consider creating separate accountability mechanisms for development partners and developing countries, given the lack of progress particularly by development partners in the past. If they do broaden membership to new constituents, they also need to think about how to engage them in accountability mechanisms.

4. **Like the IHP+, all the Secretariats are small, flexible and dependent on voluntary contributions (although two get small resources through UN agency core budgets).**

This finding lends support to the consistent interview responses that the IHP for UHC 2030 secretariat should remain lean and flexible, albeit with existing allocated posts actually filled in both WHO and the World Bank. High quality of staff is essential to maintaining IHP authority with partners, as is explicit support from senior management in both host agencies.

5. **The appetite amongst developing countries for new or expanded accountability mechanisms is likely to be limited to areas where they can identify self-interest, such as: changing development partner behaviour; additional development resources; health systems strengthening; or health impact.**

There has been a recent proliferation of accountability mechanisms, along with recognition that the processes at country level are at risk of becoming unwieldy. The IHP for UHC 2030 needs to consider how to contribute to harmonization and rationalization of accountability mechanisms rather than adding to country processes. In developing countries where public budgets are increasingly funded and managed domestically, these should also be focused on the evolving role of development assistance as a catalyst for specific development outcomes rather than as substantial budgetary support. Meanwhile, this latter role will remain in poorer, more fragile contexts suggesting the need for a nuanced, differentiated approach to monitoring country and development partner performance.

6. **Most of the partnerships are evolving to fit with the new SDG 2030 agenda, including redefining their purpose and mission and updating legitimacy and accountability mechanisms.**

The IHP+ still has a way to go in defining its new role, including what the implication is for health systems strengthening, how to maintain the focus on development effectiveness and how to improve their evidence on contribution to health outcomes. Others are also struggling to redefine their mandates in the context of SDGs and the IHP should ensure that, as it refines its own mandate, it harmonises with those of other related organisations.

6.3 Detailed findings on four partnerships

Table 6.1: Summary findings on four comparative partnerships in relation to purpose and operation, structure and governance, contextual factors and achievements

Name	Dates	Purpose/operations	Structure/governance	Contextual factors	Accountability
Partnership for Maternal, Newborn and Child Health	2005-16	The mission of the PMNCH is to increase the engagement, alignment and accountability of partners, by creating a multi-stakeholder platform that will support the successful implementation of the Global Strategy for Women's, Children's and Adolescents' Health, enabling partners to achieve more together than any individual Partner could do alone.	Secretariat: WHO; larger than the IHP+ with 8 core staff and supplementary consultants. Overseeing the PMNCH work are the Board (28 appointees), and executive committee (meets every 6 weeks), other committees and the Partners' Forum, agreed and defined in the PMNCH Strategic Framework and supported by the PMNCH Secretariat. Its 600 members include: developing countries, donor countries, NGOs, youth groups, private sector, professional associations, academics, multilaterals	Grew out of 3 previous partnerships on maternal, newborn and child health. Main current context is the EWEC Framework, as articulated in the UNSG Global Strategy for Women's, Children's and Adolescents' Health 2016-2030 and its associated targets.	PMNCH workplan is monitored according to a set of KPIs. The iERG met recently in London to discuss the latest version of the Background Paper on Accountability prepared by the Accountability Work Stream as part of the preparation for the revised Global Strategy on Women, Adolescent and Children's Health. Richard Horton, Lancet editor, has taken a strong interest and recently published in the Lancet berating countries and agencies for lack of progress on MNCH.
Global Health Workforce Alliance currently evolving into **Human Resources for Health Network**	GWHA 2006-16; HRHN 2016 onwards	Independent review: GHWA's two greatest legacies include: wide-scale introduction of thinking and planning in terms of complex adaptive systems to HRH issues; and the development of network learning and competencies that will serve as the foundation for the next iteration of global HRH efforts.	Secretariat: WHO; used to be separate from WHO HRH department but recently appointed a joint position. Only 2 additional staff paid with GHWA funds. Board of 20 appointees from different constituencies, can be complex to manage. More focused on work of Secretariat than on engagement with members around the world. Membership: 400 multi-constituency organisations with a stake in HRH. Independent Review	Independent review: After 10 years of work, GHWA leaves a substantial legacy: widespread understanding of the complexity of HRH issues, a proven framework for country-level action, a wealth of evidence for innovation, and an empowered stakeholder base.	Through a WHA resolution, member states adopted the 'WHO Global Code of Practice on the International Recruitment of Health Personnel'. The third Global Forum had its outcome document endorsed through the WHA, which led to member states making national commitments.

		GHWA's effectiveness in the areas of advocacy and convening has been recognized. GHWA has been the only independent platform at a global level with the mandate and capacity to bring together multisectoral HRH stakeholders (state and non-state) around a common agenda.	5 recommendations for the new Network model at WHO: 1. Effective leadership and priority setting based on shared vision, strong administrative capacity and budget. 2. Balance of "tight" and "loose" approaches, with frequent and structured opportunities for learning. 3. Vigorous communications strategy to influence high-level decision makers and non-health stakeholders. 4. Focus goals, priorities and membership. 5. Monitor progress on agreed goals and strengthen accountability and data collection.	In the SDG era, systemic challenges will persist, but the recommended considerations will help in establishing an effective new central hub for HRH. Objectives fit well with UHC and SDG agendas. Challenge however to get workforce issues into multisectoral development approaches, not just health.	There is also a WHO strategy which provides a basis for all countries to deliver against.
UN interagency taskforce on the control of NCDs and **WHO non-communicable diseases Global Coordination Mechanism**	2014-16	<u>UNIATF NCDs</u> The UNIATF on the Prevention and Control of NCDs coordinates the activities of 30 UN organizations and other inter-governmental organizations to support governments to meet high-level commitments to respond to NCD epidemics worldwide. <u>GCM/NCD</u> The GCM/NCD was established by the WHO Director-General in 2014. The scope and purpose of the GCM/NCD is to enhance the coordination of activities, multi-stakeholder engagement and action across sectors in order to contribute to the implementation of the WHO Global NCD Action Plan 2013–2020.	<u>UNIATF NCDs</u> Secretariat: WHO; small – 4 staff; all agencies have focal points that have a proportion of time allocated to the Taskforce. Biannual meetings to discuss progress. The commitments were made by Heads of State and Governments in the 2011 Political Declaration on NCDs, and implementation is through the WHO Global NCD Action Plan 2013–2020. The Task Force was established by the UN Secretary-General in June 2013 and placed under WHO's leadership. Its terms of reference were adopted by ECOSOC in July 2014. Its TORs and workplan come from ECOSOC and its budget comes from agency core budgets and other voluntary contributions. <u>GCM/NCD</u> Secretariat: WHO; small with 5-10 staff. The WHO GCM/NCD is led by all WHO Member States. Other participants include UN organizations and non-state actors such as NGOs, philanthropies, business associations and academic institutions. Its TORs and workplan are endorsed through the WHA and its budget comes from WHO core funding. Working parties from the members are formed through consultation and are endorsed through the	Political priority is through the Global Action Plan which contains objectives, roles and responsibilities for member states, WHO and other partners. The NCD agenda has been championed by the Russian government through ECOSOC. This has brought a different set of actors to the table than would be the case if it was a US or UK led initiative. SDG agenda will raise legitimacy of this work as under MDGs they struggled to gain recognition.	<u>UNIATF NCDs</u> Taskforce has a mandate and budget to implement at country level which is taken forward through the UN Country Teams. Globally, agreement between agencies is negotiated through the secretariat. ECOSOC can be used to hold agencies accountable by 'naming and shaming' but agencies are formally accountable to their own governing bodies. <u>GCM/NCD</u> Member states are accountable to the WHA and WHO technical departments gather information on performance. Focus is on information, policy dialogue and advocacy.

			WHA to gain legitimacy.		
Global Programme on Effective Development Cooperation	2012-16	To provide practical support and guidance and shares knowledge to boost development impact with a strong country focus to implement internationally agreed effectiveness principles at country level – country ownership, a focus on results, inclusive partnerships and transparency and mutual accountability. To track progress in the implementation of Busan commitments for more effective development co-operation through its monitoring framework comprised of a set of 10 indicators.	Secretariat: joint support team in UNDP/OECD reports to co-Chairs; UNDP brings reach to country level trough the resident coordinators and the UNDAF; OECD brings development partner accountability. Board: 3 Ministerial co-chairs + steering committee of 21 representing different constituencies. Membership: governments, bilateral and multilateral organisations, civil society and representatives from parliaments and the private sector. Working groups are established to take agenda forward but lack coordination and/or follow through mechanisms. They are looking to improve measurement of donor alignment and ownership rather than just focusing on resources on budget. Some working groups have independent monitoring processes.	The monitoring framework is currently being refined to fully reflect the 2030 Agenda and will contribute to the review of targets for SDG 5 and 17 and implementation of the Addis Ababa Financing for Development agreements. Agenda is still high priority in poorest countries. Includes: partnership, gains in knowledge, expertise to raise money themselves.	The GPEDC was created at the 4th High Level Forum on Aid Effectiveness in Busan in 2011. Mandate being renewed in Nairobi, 2016: clear work programme, clear lines of responsibility and steering committee doing things on behalf of membership. Annual monitoring process in 81 countries around indicators focused on strengthening developing country institutions, increasing transparency and predictability of development co-operation, enhancing gender equality, as well as supporting greater involvement of civil society, parliaments and private sector in development efforts. Similar problems to IHP+ with holding development partners to account. Need to engage political level as well as technical agency staff.

7. What lessons can be learned for future operations of UHC 2030?

The seven points outlined below are lessons derived from the team's study of the documentation on the Partnership's activities, from the 25 interviews with international health professionals with in-depth knowledge of IHP+ and from the review of comparative partnerships and networks. As such, they are not detailed prescriptions for the first workplan of the new partnership, but directions and suggestions for further discussion regarding the future of the partnership.

1. **Focus the scope of the new partnership on few issues**.
   The coming discussions on the scope of the new partnership will most likely reflect the inherent temptation to include each and every aspect of UHC, as was the case during the UN's discussion on the overall SDGs. Interviewees have pointed out that the agenda of UHC is much broader than the EDC agenda; in order to establish a clear brand and avoid duplication of efforts, there is a need for the new partnership to discuss prioritization and how to focus the scope of the new partnership on few essential issues while maintaining EDC and HSS at the core of the agenda.

2. **Strive for high visibility and avoid replicating other partnerships and networks that work with similar issues.**
   Clear scoping should help the new partnership to become *the* focal point for UHC. The proliferation of international health initiatives means that there will be a number of organisations that work with overlapping responsibilities. This calls for serious attention to collaboration and synergy on one hand and clear definition of the platform of IHP for UHC 2030 on the other. In this situation, the new partnership should strive for high visibility through a determined communication effort including the use of social media. The IHP+ is doing well in consciously using the website and the Twitter account to stress the importance of EDC. This experience should be the basis for an expanded media strategy that includes making a stronger connection between evidence, country examples, learning and advocacy so that communication and advocacy is better informed by country and development partner practice.

3. **Develop tools and promote their use to secure country buy-in.**
   Build on the successes of the JANS tool and the PFM Assessments to allow processes to be country-driven. While tools are but one part of the overall picture, they have been repeatedly emphasized by interviewees as a major achievement. Building on this success, the new partnership could undertake to develop for instance common tools for HSS, possibly initially focusing on HSS in fragile countries.

4. **Maintain the 'double hosting' of the partnership.**
   There has been unanimous support among those interviewed that the structure chosen for IHP+ has been a good arrangement, securing technical credibility and avoiding appropriation by one organisation.

5. **Consider options for choosing a more legitimate source of authority.**
   The IHP+ has never had an intergovernmental agreement against which members can be held accountable, relying instead on partners signing global and/or national compacts. This has offered the legitimacy of membership while not requiring either significant resource investment or substantive behaviour change. As the membership expands, a more legitimate source of authority over members' behaviour may afford the IHP+ greater traction in holding members accountable for their actions, depending on the political momentum driving it.

6. **Consider creating separate accountability mechanisms for developing countries and DPs.**
   Neither the GPEDC nor the NCD partnerships are exactly similar to the IHP+ but they do offer interesting examples of ways to approach different types of member in more tailored or targeted ways, such as separate accountability for UN agencies and countries (for example, NCDs) and the co-hosts bringing different partners to the table (for example, GPEDC: OECD-donors; UNDP-developing countries). The IHP for UHC 2030 may wish to consider creating separate accountability mechanisms for these two groups, given the lack of progress particularly by development partners in the past. If they do broaden membership to new constituents, they also need to think about how to engage them in accountability mechanisms.

7. **Keep the secretariat small and flexible.**
   Those interviewed have consistently praised the small and flexible Core Team of IHP+. The new partnership should continue the course of *serving its partners* rather than creating its own power base and agendas. The Core Team or secretariat of UHC 2030 should remain lean and flexible, albeit with existing allocated posts actually filled in both WHO and the World Bank. High quality of staff is essential to maintaining IHP authority with partners, as is explicit support from senior management in both host agencies.

Annex 1 ToR

Rapid Independent Review of IHP+

Terms of Reference

Background

In September 2015 the world moved from focusing on the Millennium Development Goals to the more universal and ambitious Sustainable Development Goals (SDGs). IHP+ partners have been discussing how best the partnership can contribute to moving towards the health-related SDG. There is agreement on the need to expand the scope of IHP+ to include health systems strengthening (HSS) towards the achievement of universal health coverage (UHC), and to broaden the base of the IHP+ partnership to respond to the health-related SDGs. Developing countries strongly welcome this change.

The principle of the transformation of the IHP+ has been agreed at a strategic level; we now need to look at options for how this can be translated into practice. This transformation to UHC2030 will require changes to the focus and functions of IHP+. As per the concept note, the overall aim of UHC 2030 would be to support a movement for accelerated, equitable and sustainable progress towards UHC as well as the other health targets in the SDGs, including global security and equity.

The main objectives of UHC 2030 would be to:

- Improve coordination of HSS efforts for UHC at global level, including synergies with related technical networks[31]
- Strengthening multi-stakeholder policy dialogue and coordination of HSS and UHC in countries, including adherence to IHP+ principles and behaviours in countries receiving external assistance
- Facilitate accountability for progress towards HSS and UHC that contributes to a more integrated approach to accountability for SDG3
- Build political momentum around a shared global vision of HSS for UHC and advocate for sufficient, appropriate and well-coordinated resource allocation to HSS

To facilitate implementation of these objectives as a multi-stakeholder platform, the following functions for UHC 2030 are proposed:

1) Reinforcing and complementing principles for coordination
2) Strengthening monitoring, review and remedial action
3) Knowledge management
4) Providing tools

Purpose

In response to Steering Committee discussions and emerging questions on how best to operationalise UHC 2030, the IHP+ Core Team is commissioning an independent review of IHP+ . The review will seek to identify what has worked well, what has not, and why, with a review of a selected number of other similar partnerships and related initiatives (see indicative list in Annex), and identification of recommendations.

[31] This includes networks, alliances and partnerships.

The review will help to inform future UHC 2030 operations and ways of working, including the updated work plan for 2017. This will help to maximise the added value of UHC 2030.

Methodology

This review will involve a mixed methods approach including a desk-based document review and key informant interviews along the following lines of enquiry:

1. What have been the main achievements of the IHP+ since its launch in 2007 and why?
2. Where has progress been more difficult and why?
3. How have IHP+ structures and operations, and other contextual factors enabled/constrained IHP+ achievements? What is the comparative experience of other similar partnerships and related initiatives?
4. What lessons can be learned for future operations of UHC 2030?

Potential documents include previous reviews of IHP+: the 2008 short term review of the IHP+, the BCG Review of Global Management Arrangements, "Options for the Future Strategic Direction of the International Health Partnership+: the Findings of a Consultation with Stakeholders", the 2016 report on "Feedback from IHP+ signatories and potential strategic directions" and progress reports produced by IHP+Results.

As for the key informants, representatives from at least a third of the current IHP+ signatories across all constituencies and with a geographical balance should be interviewed to reflect the diversity of the IHP+. It will also be necessary to include some key informants who can provide an assessment of the lessons that may be learned from comparable partnerships and initiatives, as well as drawing on existing reviews as available.

The workplan and detailed methodology will be approved by the Core Team before implementation of the review commences.

Deliverables

Deliverable	**Due date**
1. **Work-plan and detailed methodology** for review, including a list of the main documents for the desk based review, key informants to be interviewed, the comparable partnerships and initiatives that will be covered, and key questions	25th of August 2016
2. Desk review and case studies conducted	31st October 2016
3. **Report** including executive summary, findings, conclusion and recommendations (max. 20 pages)	14th November 2016
4. **Presentation** to UHC 2030 Steering Committee	December 2016

Annex 2 Schedule of interviews

IHP+ Rapid Independent Review. Interview Schedule		
Monday, 12 September		
09:00 – 15:00	IHP+ Core Team	
	TEAM 1	**TEAM 2**
15.30 – 16:00	Tim Shorten, Consultant on IHP+ monitoring Tel no. +44 (0)1379 898011 **Meeting room: E110 (near EB room)**	
16:00 – 16:30		Dr Delanyo Dovlo, WHO, Director, Health Systems Development, Reg. Off. for Africa Office tel. no. GPN 39388 or +472 413 9388 **Meeting room: E110 (near EB room)**
16.30 – 17:00	Agnes Soucat, WHO, Director, Health System Governance and Financing (on travel) Mobile no.: +41 79 2173447 **Office 1159, GPN 13448**	
17:00 – 17.30		Dr Anshu Banerjee, WHO, Director, Global Coordination **Room no.: 5047**
Tuesday, 13 September		
10:30 – 11:00	Phyllida Travis, WHO, Director, Health Systems, Regional Office in South East Asia Office tel. no. : +911123309325 **Meeting room: E110 (near EB room)**	
12:30 – 13:30	Lunch	Lunch
14:00 – 14:30	Joe Kutzin, WHO, Coordinator, Health Financing Policy **Room no.: 1162**	
14:30 – 15:00	David Weakliam former Irish Aid, and GHWA HRH Tel. no.: +353 86 6063271 **Office 1159, GPN 13448**	Jonna Jeurlink GAVI, Senior Manager, Public Policy Office tel. no. + 41 22 909 66 22 **Meeting room: E110 (near EB room)**
15:00 – 15:30		Leo Devillé, CEO, HERA Skype: leodeville2556 **Office 1063**
16:15 – 17:15	Max Dapaah, World Bank, Joint lead, IHP+ Office tel. no.: +1 2024582527; **Meeting room: E110 (near EB room)**	
17:00 – 17.30		Dr Kamiar KHAJAVI Principal Strategy Advisor, Global Health Initiative (USAID) Tel. +1-571-551-7128 **Office 1159, GPN 13448**

Schedule of interviews part 2		
22 September 14:30-15:15.	Ties Boerma, WHO, Director, Information, Evidence and Research, Office tel. no. +41 22 791 1481	Ulrika
20 September 10:30 – 11:15	Matthias Reinicke European Commission Office tel. no. +32 2 29 52772	Esben
20 September 14:00 – 14:45	Carole Presern, Global Fund (formerly Head of PMNCH) Tel. +41 796067247	Louisiana
20 September 16:00 – 16.45	Holger Thies, GIZ Germany Office tel: + 49 228 4460 3489	Esben
21 September 10:30 – 11:15	Gerard Schmets, WHO, Coordinator, Health System Governance, Policy and Aid Effectiveness Office tel no.: +41 22 791 3420	Ulrika
21 September 14:00 – 14:45	Viviana Mangiaterra, Global Fund Office tel: +41587911166	Ulrika
21 September 16:30 – 17:15	Brenda Killen, Director, Development Cooperation Director, OECD Office tel no.: 33 6 28 78 83	Esben
27 September 10:45 – 11:30 Wash. DC time (16:45 – 17:30 Geneva time)	Nicole Klingen, World Bank, former Joint Lead of IHP+ Office tel no. +1 (202) 458-7413	Esben
28 September 11:00 – 11:45 Wash. DC time (17:00 – 17:45 Geneva time)	Tim Evans, World Bank, Senior Director, Global Practice Office tel. no. +1 (202) 290-5034	Louisiana
13 October 10:00 – 10:30	Jane Edmondson, DFID, former Co-chair, IHP+ Steering Committee (now based in Bangladesh) Office no.: +880 2984 3095	Louisiana
27 September 15:00 – 16:00	Jarl Chabot, Independent Consultant, Chabot Consult	Esben
9 November 13:00 – 13:35	Bruno Rivalan, Head of French office at Global Health Advocates France. Northern CSO Representative	Esben
10 November 11:05 – 11:38	Dr. Boluwatife, Oluwafunmilola Lola-Dare, President of CHESTRAD International. Southern CSO Representative	Anthony

Annex 3

List of literature consulted

1. Beracochea, E (editor) (2015): *Improving Aid Effectiveness in Global Health.* Springer. New York.
2. Conway, S; Harmer, A; Spicer, N: *2008 External Review of the International Health Partnership and related initiatives*. LSHTM, London
3. *2010 Performance Report*. IHP+
4. *2012 Performance Report*. IHP+
5. *2014 Performance Report*. IHP+
6. *Core Team Report 2015*. IHP+
7. Devillé, L, Taylor, M (2011): *Options for the Future Strategic Direction of the International Health Partnership+: the Findings of a Consultation with Stakeholders*. Hera, Reet, Belgium
8. *Future strategic directions for IHP+ after 2011: Consolidating and accelerating progress*. SURG Discussion Paper June 2011
9. *IHP+ STRATEGIC DIRECTIONS 2016-17: Making the most of development cooperation for the health related SDGs.* Undated discussion paper. IHP+
10. *Future directions for IHP+: Sustaining and accelerating change. Phase III work plan and budget 2012-13*. IHP+ 2011
11. *Feedback from IHP+ signatories and potential strategic directions*. IHP+ 2016
12. *UHC 2030: Building an Alliance to Strengthen Health Systems*. Draft Concept Note – 17 June 2016. IHP+
13. *UHC 2030 Multistakeholder Consultation. Building a Partnership to Strengthen Health Systems*. 22-23 June 2016. Geneva, Switzerland. IHP+
14. *Seven Behaviours*: *How development partners can change for the better.* 2012. IHP+
15. Nordström, A,Travis, P*: Mission to Senegal 9-10 May 2013*. IHP+
16. *Joint Assessment of National Health Strategies and Plans. Combined Joint Assessment Tool and Guidelines. Version 3, August 2013*. IHP+
17. *Joint Assessment of National Strategies: A Review of Stakeholders' Needs.* April 2013. IHP+
18. *Joint Assessment of National Health Strategies (JANS). Consultation on Lessons Learned and Future Directions*. 22-24 February 2012, Hammamet, Tunisia. IHP+
19. JANS reports
20. *2016 Round of Monitoring. Development Effectiveness in Health. Guide for Participants.* IHP+
21. *Monitoring, evaluation and review of national health strategies. A country-led platform for information and accountability*. 10 November 2011. IHP+

Annex 4: Questions put to Other Similar Partnerships and Related Initiatives

Partnership/network operations

- How well has the secretariat/core team functioned?
- What has been its resourcing and is this sufficient?
- To whom does the secretariat report, at what level?
- How good is its relationship with its host organisation and how has this evolved?
- How effectively has the Core Team communicated with members?

Partnership/network governance

- How well has the partnership/networks' **governance** set up, in terms of membership and oversight, functioned? (steering committees, Boards, etc.)
- How representative is the Steering Committee of the membership?
- How well have the partnership/networks managed the input of working groups?
- What would you change if you could?

Accountability

- How do the partnership/networks hold members **accountable** for commitments they have made?
- What encouragements and sanctions do you rely on and have they worked?
- Are there differences between developing countries and donor countries and, if so, how have you addressed them?
- What are the key lessons and what would you change if you could?

Wider context

- What level of political priority have the partnership/networks had?
- What difference will the SDG/UHC context make to your organisation, its members and Board?
- What key adaptations have you made or are you planning?
- Do the political context and/or advocacy make a particular difference to your success and, if so, how has it worked to your benefit (or, if not, how has it impeded it)?

Annex 5 Country Survey

The country survey was undertaken from the 11th of November till the 2nd of December 2016. It was designed as an on-line closed question (Likert-scale) questionnaire survey with possibilities for adding individual comments to each question. The survey was intended as a validation of the findings of the RT. Participants were asked to state whether they disagreed, disagreed somewhat, neither agreed nor disagreed, agreed somewhat or agreed with the 21 questions which were identical to the findings of the rapid independent review (see the table below).

A sample size of 50% was used, corresponding to 18 randomly chosen countries out of a total of 37 signatory countries[32]. Two 'collectors' were used in the survey, meaning that respondents from ministries of health would use one weblink and lead development partners in the same countries would use another, thus enabling separate results analysis.

Of the 18 ministries and 18 DPs, 11 ministries of health (called countries in the table) and 9 DPs participated in the survey. This corresponds to a 56% response rate.

The tables below show the distribution of the responses. Generally speaking, 73% of the responses (256 out of a total of 352) were in agreement with the findings of the RT (responses of I agree or I agree somewhat) while 13% were in disagreement (responses of I disagree or I disagree somewhat). 16% neither agreed nor disagreed. The average value was 4 for the countries and 3.8 for the DPs; in other words, the overall level of agreement was 4, respectively 3.8, on a scale from 1 to 5, where 5 is total agreement. The results for each of the 21 questions can be seen in the tables below.

For question 1 (Keeping the EDC debate alive), question 3 (JANS), question 8 (Joint monitoring and accountability) and question 21 (CT difficulties in changing DP behaviour) agreement was particularly pronounced.

For question 6 (on predictability), question 7 (on harmonisation and alignment) and 10 (predictability) agreement was less pronounced. In the case of question 10, both Countries and DPs were split on the issue.

Transcripts of all the results of the survey, including comments from respondents, have been handed over to the Core Team. Access to the survey data is possible via a weblink (click on https://www.surveymonkey.net/results/SM-5KTD6Q8F/)

All questions	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Mean Weighted Average
Countries	11	12	26	64	83	4.0
DPs	7	14	31	48	56	3.8

[32] Afghanistan, Cambodia, Côte d'Ivoire, Comoros, DR of Congo, Djibouti, Ethiopia, Gambia, Guinea, Haiti, Mauritania, Myanmar, Nepal, Nigeria, Pakistan, Senegal, Togo, and Zambia

Question 1 The IHP+ has kept the Effective Development Cooperation debate alive in the health sector	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries	1			2	6	4.3
DPs		1	1	2	5	4.2

Question 2. The IHP+ has effectively promoted and helped countries establish and jointly assess national health sector strategic plans	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries	1			2	6	4.3
DPs	1	1		3	4	3.9

Question 3. The IHP+ has developed tools like the JANS that have been useful for the establishment of better national health sector strategic plans	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries			1	3	5	4.4
DPs	1			1	6	4.4

Question 4. IHP+ has buy-in from countries	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries			1	4	4	4.3
DPs		2	2	2	3	3.7

Question 5. IHP+ tools and processes have supported the development towards one health budget	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries	1			8	1	3.8
DPs			3	4		3.6

Question 6. IHP+ has stimulated improvements in predictability and mobilization of domestic funding	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries	1	1	2	6		3.3
DPs		1	3	2	1	3.4

Question 7. IHP+ advocacy has contributed to increased financial management harmonization and alignment in recent years	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries		3		6		3.3
DPs		1	3	3	1	3.5

Question 8. Joint monitoring and accountability built on national strategic plans is seen as useful in IHP+ countries	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries	1		1	1	7	4.3
DPs		1		2	5	4.4

Question 9. IHP+ has had strong CSO involvement since its inception	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries			2	3	3	4.1
DPs		2	2	2	1	3.3

Question 10. Despite signed agreements predictability of development support has declined	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries	3	1	1	3	1	2.8
DPs	1		3	2	1	3.3

Question 11. Efforts towards getting funding on-budget have had limited effect	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries	1		2	1	6	4.1
DPs	1		2	1	3	3.7

Question 12. Despite IHP+ initiatives transaction costs related to development cooperation remain high	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries			1	4	5	4.4
DPs	1		2	4		3.3

Question 13. IHP partners are not using country PFM systems to the extent they could (given the quality of the system)	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries		1	1	1	6	4.3
DPs				2	6	4.8

Question 14. There has been limited IHP+ engagement in relation to procurement and supply system strengthening	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries	2			5	3	3.7
DPs				2	4	4.7

Question 15. DPs have been less willing or able to follow the Seven Behaviours than the IHP+ countries	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries			2	1	7	4.5
DPs	1		2	1	2	3.5

Question 16. There are only few good examples of technical support coordination and system learning between countries	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries			1	3	6	4.5
DPs	1	1	2	1	3	3.5

Question 17. The governance mechanism (the Steering Committee) is representative of the current membership	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries		1	1	2	5	4.2
DPs		1	3	2	1	3.4

Question 18. Time-limited working groups have delivered useful work	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries		2	4	1	2	3.3
DPs		1	2	3	2	3.8

Question 19. The lean structure is an asset and the Core Team functions well	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries		1	2	2	4	4.0
DPs			2	2	3	4.1

Question 20. The Core Team has been successful in communication and technical support to partner countries	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries		2	2	4	2	3.6
DPs		2		2	3	3.9

Question 21. The Core Team has had difficulties communicating effectively with development partners on how to change their behaviour to meet their commitments	I disagree	I disagree somewhat	I neither agree nor disagree	I agree somewhat	I agree	Weighted Average
Countries			2	2	4	4.3
DPs				5	2	4.3