Transforming IHP+ into UHC2030:
Adjustments in governance and working arrangements

Background document: Seventh IHP+ Steering Committee Meeting, 21st June 2016

Introduction

In its meeting held on 8 April 2016, the IHP+ Steering Committee (SC) recommended expanding the mandate of IHP+, and transforming the IHP+ into UHC 2030. The recommendations was subsequently endorsed by the IHP+ Signatories and supported in the G7 Ise-Shima Leaders' Declaration. The Steering Committee needs to discuss and make decisions regarding the governance structure and the working of the new UHC 2030.

This background document outlines the decision areas to support the discussions on these topics during the upcoming Steering Committee meeting.

1. Proposed options for governance structure and updating global compact

a. Reconfiguring the Steering Committee

The decision to transition to UHC 2030 has important implications for determining the appropriate governance structure to be used, using the IHP+ Steering Committee as a base.[1] The existing Steering Committee composition and terms of reference are available in the Annexes I and II.

The IHP+ Steering Committee was established in 2013. Its membership was reviewed at the fifth meeting (18th November 2015) with the decision to maintain the existing members, including the Co-Chairs, and the inclusion of Japan as a new member.[2] This discussion was informed by a note prepared by the IHP+ core team.

It is envisioned that the IHP+ Steering Committee will transform into the UHC 2030 Steering Committee, with a reconfigured composition, and remain the primary decision making body for UHC 2030. The proposed constituency seats in the UHC 2030 Steering Committee will be filled on a temporary basis for next Steering Committee meeting (s). This is to ensure that potentially interested partners from the new constituencies can be involved in shaping the transformation. The transitional status of the Steering Committee will remain until a decision on the updated Global Compact is agreed (see section 1.b) and the temporary seats are filled by signatories. The IHP+ Steering Committee Terms of Reference will be revised to become the UHC 2030 Steering Committee TOR and adopted by the transitional Steering Committee.

[1] Note for the Record, 6th IHP+ Steering Committee Meeting, 8th April 2016.
[2] Note for the Record, 5th IHP+ Steering Committee Meeting, 18th November 2015.

Composition

Universal in scope and applicable to all countries and stakeholders, membership of UHC 2030 should broaden to include emerging economies, non-traditional donors, the private sector and parliamentarians.

The proposed composition of the UHC 2030 SC is as follows:

Constituency	Proposed Steering Committee Representation
Countries	12: including representation from low- middle- and high-income countries. There are currently 6 partner countries (3 LICs & 3 LMICs) and 4 bilateral development partners (HICs). This could be expanded to have representation from 2 upper-middle income countries
Multilateral agencies	4 (unchanged)
Civil society	3: one from LIC, one from MIC and one global
Private sector[3]	2: at least one from a developing country, preferably associations of service or financing providers
Foundations	1
Parliamentarians	1: for the Inter-Parliamentary Union
Total	**23**

For cost-effectiveness and decision making efficiency, it is proposed that the Steering Committee size should not exceed the above. The composition should be regularly reviewed and may need to adapt as the nature of the partnership evolves. There is an expectation that constituencies will be responsible for nominating their Steering Committee representatives, who will in turn consult with their constituencies for wider input in advance of the Steering Committee meetings. The Core Team will develop guidance to support the Steering Committee members in this outreach.

Like in the IHP+ Steering Committee, representatives are expected to be senior-level officials or high-level representatives in their own institutions with the necessary authority to provide strategic leadership in overseeing the work of UHC 2030 and reach out to other members in their constituency. While the Steering Committee may not be ministerial or similar level, it would be important to aim for the next level, ensuring sufficient instruction from and feedback to the top decision making level. UHC 2030 would explore opportunities to further leverage political leadership.

It is proposed to keep the rest of the existing structure: Core Team, Reference Group, Working Groups and Civil Society Consultative Group during the interim phase.

[3] Options for private sector representation were discussed during the 5th Steering Committee meeting. It was agreed that two private sector representatives should be included in the Steering Committee with at least one from a developing country and a preference for associations or networks of health service or financing providers.

Process for establishing the transitional Steering Committee

It is proposed that the Intensified Action Working Group (members from same organisations as those on the SC, which developped the IHP+ 2016-17 Strategic Directions for 2016-17) is revived to advise the Core Team on drafting of the updated Global Compact and establishing the transitional membership for the Steering Committee between now and December. Interested potential members of new constituencies proposed for UHC 2030 could be included in the group to advise on the process.

Decisions to be made by the Steering Committee:

The Steering Committee is invited to discuss and decide on:

- The reconfigured Steering Committee composition
- Revival of the Intensified Action Working Group to advise on establishing the transitional Steering Committee membership and drafting the updated Global Compact (see below).

b. Updating Global Compact

The IHP+ Global Compact (see Annex III) was agreed in 2007 as the basis for the partnership. It sets out the goals, and approach of IHP+ in supporting developing country health reforms, specifying partner commitments. All partner countries and development partners that are part of IHP+ have signed onto the Global Compact. No civil society organisations are currently signatories to the Global Compact.

This section sets out the approach and main adjustments for an updated UHC 2030 Global Compact that would be fit for purpose in the era of the SDGs, with proposed options for the format and a process for updating the Compact.

Approach

The following considerations will need to be taken into account in updating the Global Compact:

- Universality- applicable to all countries
- Multi-stakeholder inclusiveness- including governments from all income-levels, parliaments, civil society, the private sector and international agencies
- Coordination of support to health systems, promoting their efficiency and resilience
- Adherence to the principles and behaviours of effective development cooperation in countries receiving external assistance
- Promote sustainability by strengthening domestic resource mobilisation for health and efficient domestic spending
- Improving policy coherence
- Equity- progressive realisation of UHC to deliver on leaving no one behind
- Accountability with an emphasis on citizen voice, and mutual accountability between different stakeholders

Main adjustments to current IHP+ Compact

The proposed main adjustments for the Global Compact are listed below:

Focus area	IHP+	UHC 2030
Context/overarching goal	MDGs	SDGs, including UHC as an underpinning health target, health security, leave no one behind
Scope	Low- and middle-income countries	Universal, applicable to all countries, with tailored work depending on country context and priorities
Development cooperation	Aid effectiveness	Effective domestic resource mobilization and development cooperation
Signatory Partners	Primarily partner countries and bilateral donors, with multilaterals, philanthropic foundations Civil society, though represented on the Steering Committee, are currently not signatories	Broader, to include all countries, governments, parliaments, a more diverse range of CSOs, philanthropies, the private sector and possibly partnerships/networks part of UHC 2030
Commitments	A mix of collective and stakeholder-specific commitments	Common collective commitments by all stakeholders on principles and behaviours (to be considered: desirability of having UHC 2030 principles to replace or complement IHP+ 7 behaviours)

Format options

Three options for the format of the updated Global Compact could be envisaged:

1. A revised Global Compact, to replace the existing one
2. An addendum/cover note to the existing Global Compact
3. No Global Compact, but membership by application with a commitment to UHC 2030 values and vision as defined in a mission statement.

Process

With the guidance from the Steering Committee, the Core Team will prepare whichever option is agreed for the Steering Committee's approval at their next meeting, followed by a no objection approval from existing signatories with the option to opt-out.

Decisions to be made by the Steering Committee:

Steering Committee members are invited to:

- Confirm that the proposed main adjustments to the existing IHP+ global compact sufficiently reflect the broadened scope of IHP+ to UHC 2030
- Decide on whether the Global Compact should be revised, supplemented with a cover note/addendum, or discarded with members signing onto the UHC 2030 mission statement
- Agree on the process for signatories to endorse the updated Global Compact through a no-objection approval, with the possibility to opt-out
- Revival of the Intensified Action Working Group to advise on drafting the updated Global Compact and establishing the transitional Steering Committee membership (see above).

2. Next steps

The transformation process will involve the following next steps:

- June-September: Consultations on operationalizing UHC 2030:
    - June 22-23: multi-stakeholder consultation meeting in Geneva
    - July-September: online consultation and targeted constituency outreach
- June-September: rapid independent review of IHP+
- July-December: events to raise awareness of the IHP+ transformation to become UHC 2030, to include:
    - July: High-Level Political Forum side event (tbc)
    - August: TICAD6
    - September: UN General Assembly side event
    - October: WB/IMF Annual Meetings
    - November: Global Symposium on Health Systems Research
    - Regional events to be identified
- December: UHC 2030 transitional Steering Committee meeting to approve:
    - Updated Global Compact (depending on option decided upon)
    - New work programme for 2017 (including results framework)
    - Revised ToRs (Steering Committee, Core Team, Reference Group, Working Groups)

Annexes

I. IHP+ Steering Committee Composition

The current composition of the Steering Committee is as follows:

Constituency	Existing Steering Committee Representation
Partner countries	6: Governments of Ethiopia, Senegal, Sierra Leone, Kenya, Cambodia, Myanmar
Bilateral agencies	4+2: UK Department for International Development, German Federal Ministry for Economic Cooperation and Development, USAID, European Commission, Sweden Ministry of Foreign Affairs, Japan Ministry of Foreign Affairs
Multilateral agencies	4: The Global Fund/Gavi, the Vaccine Alliance; UNICEF/UNFPA; The World Bank; World Health Organisation
Civil society	2: Northern (Global Health Advocates) and Southern (Aga Khan University)
Total	**16**

II. IHP+ Steering Committee Terms of Reference

The IHP+ Steering Committee will be responsible for setting overall strategic directions and oversight of the Partnership.

ROLES AND FUNCTIONS

On behalf of all IHP+ signatories, whom the Committee represents:

- To shape IHP+ directions and activities and to make significant strategy and policy decisions.
- To approve the IHP+ work plan and budget, oversee progress with implementation, and discuss/advise how to address problems that arise.
- To agree terms of reference for Working Groups, review their recommendations, and agree on actions to be taken forward.
- To effect change in individual organizations and associated global health partnerships, by promoting the adoption of IHP+ principles and recommendations.
- To provide a forum for mutual accountability for results among IHP+ members.

INTERNAL ORGANIZATION

- The Committee will consist of 16 members who represent the different constituencies in the Partnership. Six members will be from partner countries; four from multilateral agencies; four from bilateral agencies and two from civil society.
- Representatives are selected through a transparent process. For the multilateral agencies, bilateral agency and civil society constituencies, each group will put forward a representative(s). For the country constituency, selection criteria of representatives will include geographical distribution, language balance and experience in IHP+ processes.
- Committee members will serve for a minimum of one year, with the possibility of a one year extension.

- Members will be of sufficient seniority to be able to represent their constituency, and influence subsequent dialogue and action related to IHP+ recommendations.
- The Steering Committee will meet twice per year, with one meeting being face-to-face. Additional sessions will be organized if issues arise that require discussion by the Committee.
- Meetings will be co-chaired by one country partner and one international development partner. The Co-Chairs will be selected by the Steering Committee, and will serve for one year with the possibility of a one year extension.
- Decisions will be taken by consensus.
- Meetings will have clear objectives and points for decision. The agenda will be prepared by the Core Team in consultation with the Reference Group and approved by the Steering Committee Co-Chairs. Materials will be distributed by the Core Team 3 weeks in advance. Comments and suggestions may be submitted by email before the meeting, during or after the meeting.
- Actions and next steps will be communicated by the Core Team within 2 weeks of each meeting to all IHP+ signatories.

III. IHP+ Global Compact text

International Health Partnership
A global 'Compact' for achieving the Health Millennium Development Goals
For signature on 5 September 2007
No. 10 Downing Street, London, United Kingdom

In 2000, we set ourselves targets enshrined in the Millennium Development Goals (MDGs). Since then we have also committed to achieve universal access to prevention, treatment, care and support for HIV/AIDS and universal access to reproductive health. As we approach the half way mark to 2015, the health-related goals are particularly off-track. Every day over 10,000 people are infected with HIV and over 22,000 become sick with tuberculosis. 28,000 children under 5 die ever day, while one mother dies in childbirth every minute. Yet we can prevent many of these deaths with simple, affordable measures. In addition to ensuring access to food, education, clean water and sanitation, access to basic health services is critical to reduce the death toll from the major killers including tuberculosis, malaria, AIDS, respiratory illness and complications in childbirth.

We are devoting more resources than ever before to tackle this crisis and lives are being improved and saved in addition to providing adequate resources, the international system, with country partners, needs to ensure collective efforts are effective and efficient by being well coordinated, focus on delivering accessible and sustainable health systems and by backing comprehensive country owned and developed health plans which produce tangible and measurable results. The creation of sustainable and fair structures for health systems financing is particularly important for building strong national health systems.

That is why, as part of a Global Campaign for the Health MDGs, we, the governments of developing and developed countries and the heads of the major agencies involved in improving health, commit to work effectively together with renewed urgency to build sustainable health systems and improve health outcomes in low and middle income countries. The goal of this partnership is to accelerate progress on the health-related MDGs. This will be achieved by increasing the numbers of people who have access to health services offering prevention, treatment and care to deal with their major health problems and promotion of healthy behaviour. The approach includes providing support to strong and comprehensive country and government-led national health plans in a well coordinated way, through strengthening and using existing systems for coordination, coordinating support to implementation of sector plans and shared accountability for achieving results.

As part of a Global Campaign for the Health MDGs, this compact reflects our global commitment. In the coming months, we will reflect these global commitments in strengthened country partnerships that reflect the unique situation in each country, channel support into country owned health plans and secure fair and sustainable financing of national health systems.

Next Steps

This compact is a key step in putting the Paris Declaration on aid effectiveness into practice in the health sector. It builds on the recommendations of the High Level Forum on the Health MDGs, work of the OECD DAC on health as a tracer sector, the One UN approach of the High Level Panel for System Wide Coherence, recent (2005/2007) G8 commitments on health, the 2006 UN General Assembly declaration on ADIS, the recommendations of the Global Task Team on improving AIDS Coordination among Multilateral Institutions and International Donors, the European Union development policies particularly those related to “MDG Contracts” and ongoing work of the European Commission on harmonisation and alignment and aid coordination among Member States and the ongoing Harmonisation for Health Initiative in Africa, as well as other key commitments, including those from the Paris Conference on Social Health Protection.

It is part of a broader Global campaign for the Health MDGs which recognises the need for urgent and collective action to address the off-track MDGs at the half way point to 2015 .The high level political campaign includes a range of complementary efforts including the Norwegian Initiative to accelerate progress son maternal and child health, the Heilingendamm G8 “Providing for Health” initiative on health financing, the World Bank’s efforts to test results-based financing, ongoing work of GFATM, GAVI Alliance, Bill and Melinda Gates Foundation and others.

The partners in each “first wave” country will identify how to take forward these commitments and agree measurable targets, drawing from current in-country processes. These will be reflected in the memorandum of understanding, code of conduct or a compact at country level to which partners will be held to account.

Additional partners will be invited and encouraged to join the IHP – both developing countries and international agencies. They will be expected to sign the compact as an indication of commitment to these underlying principles and ways of working in support of developing country health reforms. WHO and the World Bank will support the coordination of the initiative, working with the other partner organisations. An early task is to identify how to monitor and evaluate the imitative. We call for an independent evidednece0based assessment of results at country level and of the performance of each of us individually as well as collectively.

Civil society and other stakeholders have an important role in both the design and implementation of national plans and will be invited to participate in the design, implementation and review of the Partnership at global and country levels. Civil society will play a key role in holding all partners to account on performance and progress of the Partnership. Appropriate mechanisms for the broad participation of partners in national planning, implementation, monitoring and evaluation will need to be defined at the country level.

The signatories to this compact will meet each year to review progress against these commitments.

We collectively commit:

- To work together in more efficient ways to improve health care and health outcomes in low and middle income countries. Led by country governments acting with their civil society, we will tackle the challenges facing country health systems – particularly having enough trained health workers, in the right place and with the motivation, skills, equipment, commodities and medicines to do their work.
- To build on and use the existing systems at country level for planning, coordination, delivery and management of the health sector within the overall national development framework to achieve MDG related outcomes.
- To be held to account in implementing this compact.

We the international organisations and bilateral donors will:

- Accept national health policies and plans as the basis for providing funding and avoid introducing new plans or projects that are inconsistent with national health plans and priorities.
- Agree and use shared processes to support national health plans at country level. This includes a) a shared approach to reviewing national plans and sector management arrangements to minimise requirements for further assessments; b) agreement with governments on the sources and amounts of funding for the health plan; c) increased use of shared mechanisms for managing and accounting for funds, reporting on progress and reviewing performance.
- Contribute to funding national helath plans that address the whole health system – including public and non-state sectors. Funding can be for specific aspects of the plans but where possible, we will give flexible support to the plan, in accordance with our respective funding policies and guidelines. This includes funding for non-government services, either directly or via government and dealing with critical funding gaps.
- Review our policies and procedures at global level to enable better coordinated and loner term support at country level, including support to national health plans, flexible use of funds and use of shared appraisal, funding and reporting mechanisms.

- Work to ensure that disease and population specific approaches and those to achieve broad health system strengthening and mutually reinforcing. This may include revising existing health and disease specific programmes to make better use of the support.
- Test and evaluate ways to link our support to achieving results at country level, including success in strengthening health systems.
- Ensure our staff make this a priority, have incentives and are empowered to work in a coordinated way at country level.
- Be accountable for delivering the funding and technical support we commit for health. We will report annually on our performance at country and global levels.

We the governments will:

- Use our national health plans, that are embedded in our overall development frameworks, to guide development of health system and use of resources in the sector. Comprehensive health plans will incorporate priority programmes such as immunisation, tuberculosis, malaria, reproductive health and the health components of multisectoral HIV/AIDS plans.
- When it is time to update our health plans, we will work with the national stakeholders and international agencies to develop a common vision for the health sector, and identify targets and budgets that reflect this vision.
- Engage and involve our citizens and civil society so they know what to expect and can give feedback on performance.
- Implement our health plan as efficiently as we can, through stronger health and financial management systems, tackling the misuse of resources, and working with non-government organisations.
- Work to ensure increased public funding for health care and develop improved health financing mechanisms including risk pooling based on universal coverage in order to increase access for the poor and most vulnerable and protect people from excessive health expenditure within our national budget strategy and macroeconomic constraints.
- Be accountable to our citizens and report to our funders on progress in reaching the targets and disbursing the amounts budgeted in the plan.

We the other funders will:

- Use our support to further a coordinated multilateral approach to strengthen health systems against national plans.
- Hold organisations receiving support – and ourselves – accountable for measuring impact and directing funding toward demonstrated successes.
- Continue to invest in learning and evaluation to ensure the best possible linkages between our support and achieving results at the country level.

Signatories

These signatories represent the first wave of agencies and partners committed to the principles outlined in this text. This will be open to other partners willing to join as signatories over the coming months during design and implementation.