

ihp results

Progress in the International
Health Partnership & Related
Initiatives (IHP+)

2016
PERFORMANCE
REPORT



Governments and development partners have made commitments to increase the effectiveness of development cooperation, most recently in the Busan Partnership agreement and reconfirmed in various high level meetings. Based on these commitments, partners in the International Health Partnership (IHP+) have highlighted seven practices that contribute to improved development cooperation effectiveness:



A strong single national health strategy is supported by both government and development partners; they agree on priorities reflected in the national health strategy and underpinning sub-sector strategies through a process of inclusive development and joint assessment, and a reduction in separate exercises.



Resource inputs are recorded on the national health budget and in line with national priorities, with predictability of government and development partner funding.



Financial management systems are harmonised and aligned, requisite capacity building done or underway, and country systems strengthened and used.



Procurement/supply systems are harmonised 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.



Joint monitoring of process and results is based on one information and accountability platform; joint processes for mutual accountability on EDC are in place, such as Joint Annual Reviews or compact reviews.



Technical support is strategically planned and provided in a well-coordinated manner; opportunities for systematic learning between countries are developed and supported by agencies through south-south and triangular cooperation.



Civil society operates in an environment that maximises its engagement in and contribution to health sector development



Private sector has the space to participate in the development and implementation of effective, efficient and equitable health policies*

(*) The eighth practice on private sector engagement was added by IHP+Results in consultation with IHP+ Core Team. All these practices were assessed in the 2016 IHP+ monitoring round.

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Acronyms and Abbreviations

AFD	Agence Française de Développement
AIMS	Aid Information Management System
BTC	Belgian Development Cooperation
CCM	Country Coordinating Mechanism (Global Fund)
CDC	Centers for Disease Control (USA)
DFID	Department for International Development from the UK
CPIA	Country Policy and Institutional Assessment (World Bank)
CRF	Country Results Framework
CRS	Creditor Reporting System (OECD/DAC)
CSO	Civil Society Organisation
DAD	Development Assistance Database
DP	Development Partner
DRC	Democratic Republic of Congo
EC	European Commission
EDC	Effective Development Cooperation
GAVI	Global Alliance for Vaccines and Immunisation
GIZ	German Agency for International Cooperation
GPEDC	Global Partnership for Effective Development Cooperation
HSS	Health System Strengthening
JANS	Joint Assessment of National Strategies
JAR	Joint Annual Review
JFA	Joint Financing Agreements
KfW	German Development Bank
MDG	Millennium Development Goal
MOH	Ministry of Health
MOF	Ministry of Finance
MTEF	Medium Term Expenditure Framework
NHA	National Health Accounts
ODA	Official Development Assistance
OECD/DAC	Organisation for Economic Cooperation and Development/Development Assistance Committee
PFM	Public Financial Management
PSM	Procurement and Supply Management
PPP	Public Private Partnership
PS	Private Sector
SDG	Sustainable Development Goal
SSC	South-South Cooperation
TrC	Triangular Cooperation
UHC	Universal Health Coverage

Performance on IHP+ indicators in the 5th monitoring round

Legend

Progress <small>(at least 3% increase over 2014 monitoring round)</small>	Stagnation <small>(within +/- 3% of results in the 2014 round)</small>	Decline <small>(at least 3% decrease from 2014 monitoring round)</small>	Not comparable with 2014 monitoring round	Not applicable
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	Government	Development Partners
Health sector strategies and mutual accountability		
Proportion of countries with a national health sector strategy in place and proportion of development partners that align their programmes with national priorities	100%	100%
Proportion of countries with a comprehensive monitoring and evaluation framework in place and proportion of development partners that exclusively use the national monitoring framework	80%	47%
Mutual accountability mechanisms are in place and used by development partners	80%	73%
Health sector financing commitments		
Proportion of government health sector budget execution and proportion of development partner health sector support budget execution	86%	71%
Proportion of governments that have a 3-year rolling budget or MTEF in place and proportion of development partners of which the government has information about their next 3 years forward looking expenditure plans	66%	35% ⁺
Proportion of countries where the contributions of development partners are (at least partly) reflected in the national budget and proportion of development partner support to government registered in national health budget	77%	53%
Use of national management systems		
Proportion of countries where the public financial management system adheres to good practices (CPIA) and the proportion of support using national financial management procedures (development partners)	55%	53%
Proportion of countries with sufficient development partner support for strengthening public financial management system	NA	50%*
Proportion of countries with a government-led plan for procurement and supply systems and proportion of development partners that use national procurement and supply systems at least for some procurement	93%	41%
Proportion of countries with sufficient development partner support for strengthening public procurement and supply systems	NA	100%*
Proportion of countries with an agreed national technical assistance (TA) plan and the proportion of development partners that provide TA in accordance with this plan	21%	Not assessed
Recipient institutions are involved in developing the terms of reference and in the selection of TA	79% ⁺	96% / 85%*
The proportion of countries where the ministry of health benefits from south-south or triangular cooperation (SSC or TrC) and the proportion of development partners that supports this type of cooperation	67%**	79%#
Support for engagement of CSO and private sector in health policy dialogue		
Proportion of countries where CSOs participate in health policy dialogue and proportion of development partners that have institutional mechanisms to involve CSOs in programme development and oversight; and use them	93%	80% / 70%
Proportion of governments that have feedback mechanisms in place to CSOs	77%	NA
Proportion of governments and development partners that provide either financial resources, training or technical support to CSOs	83%	66%
Proportion of countries where the private sector participates in health policy dialogue and proportion of development partners that provide support for private sector participation in national health policy dialogue	63%	70%
Proportion of development partners that provide financial or technical support to the private sector	NA	49%
Proportion of governments that have feedback mechanisms in place to the private sector	63%	NA
Proportion of development partners that include private sector organisations in stakeholder consultations and other participatory structures for their programme	NA	70%

⁺ As reported by government

* As reported by development partners

** 20/30 countries reported they either benefit greatly, most of the time or sometimes from SSC or triangular cooperation

Not all development partners had the same understanding of SSC or triangular cooperation

Executive Summary

The International Health Partnership (IHP+), launched in 2007, is in its tenth year of operation. IHP+ is a group of partners committed to improving the health of citizens in developing countries. The partnership is open to all governments, development agencies and civil society organisations (CSOs) involved in improving health and willing to adhere to the development effectiveness principles as outlined in the IHP+ Global Compact for achieving the health-related Sustainable Development Goals (SDGs). In 2016, IHP+ included 37 government and 29 development partners and evolved into the International Health Partnership for UHC 2030 (UHC2030). The name IHP+, however, continues to be used in this report when referring to performance in 2014 and 2015.

The 5th IHP+ monitoring round started in 2016 and tracked progress on the implementation of eight practices for effective development cooperation (EDC). Under the direction of the ministries of health in IHP+ partner countries, quantitative and qualitative data were collected and analysed for indicators of performance for each practice. The number of participating governments increased from 24 in the 4th round to 30 in 2016. Thirty-five development partners participated, including bilateral development agencies, UN agencies, development banks, global health initiatives and private foundations. When information on the performance of governments and development partners was available from previous monitoring rounds, progress was assessed against the results of the 4th monitoring round (2014), and trends among those IHP+ partners (14 countries, 14 development partners) who participated in the three latest rounds (2012-2016) were analysed. Additional information was collected in an on-line survey and in focus group discussions with CSO and private sector representatives. In 24/30 countries, the results of the assessments were discussed among health sector partners. In the remaining countries they were provided to each participant for validation. Action plans to overcome bottlenecks and constraints in the implementation of EDC practices were so far developed in 15 countries, and pilot initiatives to integrate EDC monitoring in national performance monitoring frameworks were launched in Togo and Sudan. In parallel, 14 development partner agencies participated in a global review of policies, procedures and practices related to EDC.

Commitment 1: Establish strong health sector strategies that are jointly assessed and strengthen accountability

Commitments

A strong single national health strategy is supported by both government and development partners; they agree on priorities reflected in the national health strategy and underpinning sub-sector strategies through a process of inclusive development and joint assessment, and a reduction in separate exercises.

Joint monitoring of process and results is based on one information and accountability platform; joint processes for mutual accountability on EDC are in place, such as Joint Annual Reviews or compact reviews.

Achievements

Partner alignment with health sector strategies, and participation in joint strategy assessments and joint sector reviews have strengthened, but need to be matched by increased reliance of development partners on national performance monitoring frameworks and systems. Mutual accountability mechanisms are not sufficiently inclusive and conditions for meaningful participation by civil society and private sector organisations are often not met.

There has been progress since the 4th IHP+ monitoring round. All participating governments have a health sector strategy, most often developed and assessed with participation of development partners. All development partners confirmed that they align their programmes with national health sector or sub sector priorities. Many development partners participate in joint sector or sub-sector strategy assessments (JANS), but not consistently in all countries. Most development partners continue to require additional sector or sub-sector strategy assessments for defining their own programme.

Most governments have established comprehensive health sector performance monitoring frameworks but less than half of the development partners rely exclusively on these. Most development partners monitor additional indicators that are not included in the national framework and maintain monitoring frameworks and processes that are specific to their programme. This was also confirmed by the global review of development partner policies.

Most governments have established mutual accountability mechanisms for health sector performance such as joint annual sector reviews (JARs). Development partners increasingly participate in these mechanisms. Governments report the participation of CSOs in about 75 percent of the national strategy assessments and health sector reviews, and private sector participation in about 50 percent. CSOs, however, state that participation is not sufficiently inclusive and conditions for meaningful participation are often not met. Private sector representatives in most countries consider their participation pro forma and not meaningful. The absence or weakness of national representative bodies for civil society and the private sector are cited by governments and development partners as major constraints.

Commitment 2: Improve the financing, predictability and financial management of the health sector

Commitments
Resource inputs are recorded on the national health budget and in line with national priorities, with predictability of government and development partner funding.
Achievements
The health sector budget execution rate calculated for all participating governments in 2014 (24) and 2016 (30) has increased, but among the 14 governments that have participated since 2012 it declined in 2016 after an initial increase in 2014. Information about three-year forward looking expenditure estimates remains stagnant for governments and development partners, as well as on-budget registration of development partner funds.

Governments increasingly execute their health sector budgets according to schedule but the execution rate of development cooperation budgets for health declined compared to the assessment in 2014. Only two-thirds of governments establish and publish health sector expenditures for the next three years. Governments continue to be poorly informed about the three-year forward expenditure plans of development partners.

In about three-quarters of the participating countries at least some development cooperation funds are reflected in the national health budgets, in total covering 53 percent of development partner funds for the public sector. The levels of on-budget registration are comparable to previous monitoring rounds. Some countries have not established budgetary mechanisms that permit the registration of international cooperation funds, and some development partners are not aware that on-budget registration increases transparency and improves national health planning.

Commitment 3: Establish, strengthen and use country systems

Commitments
Financial management systems are harmonised and aligned; requisite capacity building done or underway, and country systems strengthened and used.
Procurement/supply systems are harmonised 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.
Technical support is strategically planned and provided in a well-coordinated manner; opportunities for systematic learning between countries are developed and supported by agencies through south-south and triangular cooperation.
Achievements
Development partners make better use of national public financial management systems than assessed in 2014, although not better than in 2012. Only half of them use national procurement systems. Most development partners provide technical assistance in agreement with recipient institutions. Few governments have sector-wide technical assistance plans and fewer development partners use them.

Governments in almost all countries confirm that programmes to strengthen national public financial management (PFM) systems are in place. Development partners in half of the partner countries report that sufficient support to strengthen the systems is available. In the global review of development partner policies, seven of the 14 ODA agencies confirmed that strengthening national PFM systems is an explicit objective of their health sector support programmes, and nine of them stated that the use of national PFM systems is a default option for health sector support to governments. However, the proportion of governments with reliable public systems for budget execution, financial reporting and auditing has not increased according to assessments by the World Bank. In countries with relatively robust systems there is a slight increase in the development cooperation funds that are disbursed using national budget execution procedures compared to the 4th monitoring round, but among the partners with serial data since the 3rd round it is at the same level as in 2012.

Most governments have national systems for health sector procurement and supply management (PSM). Almost all agree that the systems require strengthening, and half of the governments consider current development partner support for this task to be insufficient. In contrast, development partners in all countries consider that governments receive sufficient support to strengthen PSM systems. The use of the public sector PSM systems by development partners is limited. Although 42 percent among them use it for some procurement, this often only applies to national and small volume procurement. In the global review of development partner policies, only five of the 14 ODA agencies stated that strengthening national procurement systems was an explicit objective of their agency's health sector cooperation programme.

Development partners involve governments and other recipients of technical assistance in the development of terms of reference and the selection of staff, but governments report lower performance on this indicator. Only a minority of governments have a national health sector technical assistance plan, and only one government reported that international development partners always adhere to this plan. Some development partners question the utility of sector-wide planning of technical assistance and prefer more targeted sub-sector or programme-specific plans. In the global review of development partner policies only three of the 14 ODA agencies stated that they have an explicit policy demanding technical assistance to be provided under a sector-wide technical assistance plan developed jointly by governments and development partners. Access to south-south technical cooperation by governments remains modest despite reports by most development partners that they provide support for this modality.

Commitment 4: Create an enabling environment for the participation of civil society organisations and the private sector in the health sector

Commitments
<p>Civil society operates within an environment which maximises its engagement in and contribution to health sector development.</p> <p>Private sector has the space to participate in the development and implementation of effective, efficient and equitable health policies.</p>
Achievements
<p>Governments and development partners continue to provide support for CSOs to engage in health policy, but this support is not inclusive. Overall, engagement with and support for the private sector are weak. Lack of, or weakness of nationally representative bodies for both CSOs and the private sector are identified as major constraints to stronger engagement. In the majority of countries, private sector health services are not captured in the national health information systems.</p>

Almost all governments report civil society participation in the development, implementation and monitoring of health policies, but many recognise that the quality of participation could be improved and broadened. Three-quarters of governments have mechanisms to provide feedback on health policy and programme decisions to CSOs. Most governments provide either financial resources, training or technical support to CSOs to facilitate their participation in the national health partnership.

Most development partners have institutional mechanisms to involve CSOs in programme development and oversight, and the majority report that they use them. They are less concerned about including a broad range of civil society organisations, and more with the overlap of their own programme focus with the organisations' profiles. Inclusiveness, for many development partners, is a national issue to be addressed by governments. Among all participating development partners, the level of support of CSOs is slightly higher than in the 4th monitoring round. However, among those with serial data for the last three rounds, the support weakened when compared to 2014, but was still above 2012 levels. Only ten percent of development partners mentioned specific objectives of their CSO support that could be linked to strengthening CSO participation in the health dialogue, such as support for networking, advocacy or watchdog activities. Of the 14 agencies that participated in the review of development partner policies, 13 confirmed that they support the participation of CSOs in health sector policy processes.

CSOs that responded to the on-line survey or participated in focus group discussions rate their support by government and by development partners considerably lower. A small number of organisations receive frequent financial, technical and training support and are closely involved in national health policy discussions and in programming decisions of development partners. For the majority, however, this support is rare or absent, and the involvement in programme and policy discussions peripheral. They are invited to participate after decisions have already been made. Although more than half of the CSOs are part of a network or coalition to facilitate their participation in the health policy dialogue, the lack of a representative voice for CSOs was raised in several countries by governments, development partners and some CSOs.

Two-thirds of governments report private sector participation in the national health policy dialogue, and mechanisms to provide feedback to the private sector, although many among them acknowledge that the participation is limited and the feedback not systematic. Private sector health services are only fully captured in the national health information system in six countries. Weak capacity of ministries of health to work with the private sector, and weak capacity to manage and enforce systems for accreditation and assurance of service quality were mentioned by governments as well as by private sector participants in focus group discussions.

A considerable proportion of development partners include private sector organisations in stakeholder consultations or involve them otherwise in their programme development and implementation. In the global review of development partner policies, eight of the 14 ODA agencies confirmed that their policies and strategies included explicit statements about promoting the involvement of the private sector in health sector development. However, the main feedback from the private sector focus groups is that involvement with development partners as well as with government is weak and rarely systematic. Lack of nationally representative bodies for the private sector or a platform for dialogue with government is identified as a major constraint to stronger engagement.

The interface of development cooperation and humanitarian assistance in health

Humanitarian assistance funding for the health sector is largely provided outside the framework of the EDC mechanisms and processes established at country level. Humanitarian aid has its own principles and systems for coordination, but there is a need among development partners to develop a consensus about the interface between development cooperation and humanitarian assistance in health and the application of EDC principles.

Data collection on humanitarian assistance for the health sector was attempted in eight countries with overall high levels of humanitarian assistance funding because of recent or long-standing crises. Information provided by development partners suggest that between zero and 76 percent of international health sector support for any country may be channelled through humanitarian assistance. The reliability of these data is, however, questionable because the humanitarian assistance budgets of some development partners are not differentiated by sector, and the country-based development agency staff is not fully informed about all humanitarian interventions of their own agency or country. Only one of the eight ministries of health reported that it was fully informed about humanitarian assistance funding in the health sector.

Conclusions and the way forward

To achieve progress in effective development cooperation in the health sector, partner governments and development partners should enhance their efforts to meet the commitments of the IHP+ global compact. To achieve this, governments and development partners should implement actions to overcome identified constraints and bottlenecks. Furthermore, IHP+ partners should continue to review and update the framework of EDC practices and the monitoring framework to adapt them to the evolving context of international cooperation in health. For this purpose, the report provides 30 recommendations.

Recommendations for government partners focus on continued efforts to strengthen systems and mechanisms for mutual accountability, performance monitoring, budget planning and financial administration, public financial management, procurement and supply management, technical assistance planning, south-south cooperation, and the more inclusive involvement of civil society and the private sector.

Recommendations for development partners are for greater use of joint strategy assessment and joint sector reviews in guiding and monitoring their own cooperation programmes, continued support for strengthening national information systems for health and vital statistics, a more systematic and transparent approach to communicating forward-looking expenditure plans and the on-budget registration of cooperation funds, continued support and greater use of national public financial management and procurement and supply management systems, capacity support to ministries of health for the coordination and management of technical assistance and the engagement in south-south technical cooperation, and enhanced advocacy for the involvement of civil society and private sector organisations in the national health dialogue. In the development partner countries, an additional effort is also required to communicate and discuss EDC principles with private sector actors and other government entities that are increasingly involved in delivering programmes within the national ODA envelope.

Recommendations for the UHC2030 partner group include a review of the framework of EDC practices in terms of its applicability to cooperation with middle-income countries, emerging economies and fragile states, as well as to the intersection of humanitarian assistance and development cooperation in health. Several recommendations focus on the future of EDC monitoring, including to improve the cooperation and alignment with the GPEDC monitoring process, to ensure the commitment of development partners to UHC2030 monitoring, to review the constraints in the application of EDC principles identified by the global review of partner policies, procedures and practices, to continue the country-based approach to monitoring under the leadership of the national ministries of health, to further explore opportunities for institutionalising EDC practice monitoring in country systems, and to review the monitoring tools on the basis of lessons learned in the implementation of the 5th monitoring round.

In response to the health-related sustainable development goals (SDGs) adopted in 2015, the IHP+ steering committee and IHP+ signatories agreed to expand the scope of the IHP+ to include coordination of health systems strengthening (HSS) towards the achievement of universal health coverage (UHC), and to broaden the base of the partnership to respond to the health-related SDGs. The new 'International Health Partnership for UHC 2030', created in September 2016, will continue to work on improving effective development cooperation in countries receiving external assistance, but will broaden its scope to also focus on HSS and domestic spending in all countries and promoting accountability and advocacy for UHC as well as knowledge-sharing. One challenge for UHC2030 will be to maintain the interests of governments and development partners in effective development cooperation. Holding governments and development partners accountable for their commitments and assessing effectiveness of development cooperation should continue and can best be done within a framework that captures all financial resources, including domestic financing, and that links resource inputs and health system strengthening with the overall goal of reaching the health-related SDGs. In order to take into account the new global aid architecture and the overall goal of universal health coverage, there is a need to revisit the content and the application of the EDC framework.

Lessons learnt from the approach of the 5th IHP+ monitoring round

The approach adopted by the 5th IHP+ monitoring round was a large step in the evolution of EDC performance monitoring. Compared to the 4th round, the scope of data collection was increased by collecting more qualitative information which resulted in a more meaningful analysis of the main findings for discussion at national level. However, it also increased the complexity and the transaction costs of monitoring.

For the first time, skilled national experts were engaged in each country. They were familiar with government and sector stakeholders and supported the ministries of health in collecting, validating and analysing the information. This was a key factor of success in most countries.

Discussion of findings and the development of action plans were included for the first time after two pilot experiences in Mali and DR Congo in 2014. This added value to the IHP+ monitoring process, although not in all countries. Leadership of government and full engagement of development partners at country level was a key to success.

The engagement of the GPEDC focal points and of the ministries of finance in the monitoring process and the subsequent discussions of findings was weak or absent in most countries. More collaboration between GPEDC and IHP+ monitoring would potentially enhance the value of both processes.

The global review of partner policies, procedures and practices among 14 participating development partner agencies that was included for the first time in the monitoring process provided insight into factors at institutional, national and global levels that may facilitate or constrain the implementation of EDC practices. The study raised several issues that could inform the approach and scope of future monitoring rounds. The methodological approach should, however, be reviewed. The political context in which national ODA policy is formulated and implemented is highly complex, and should be taken into account when scoring EDC behaviour of development partners. This does not diminish the need to continue holding IHP+ partners accountable for their commitments at global and country levels.

SUMMARY TABLE OF GOVERNMENT PERFORMANCE

	The national health strategy has been jointly assessed	Joint assessment of progress towards targets has been undertaken in the last two years (LJAs, MTRs, etc.)	Government funds are disbursed predictably	Government resources are planned over more than one year	Health sector resources reflected in the national budget include contributions of individual development partners	Country public finance management systems are of good quality (CPA = or > 3.5)	Agreed national TA plan for the health sector exists	Government supports meaningful engagement of civil society organisations	Government provides sufficient private sector and timely information to facilitate their input into health policy processes	
	EDC1	EDC5	EDC2A	EDC2B	EDC2C	EDC3	EDC4	EDC6	EDC7	EDC8
Afghanistan	✔	✔	🔄	✔	✔	✔	✔	✘	🔄	✔
Benin	✔	✔	🔄	✔	✔	✔	✔	✔	✔	✔
Burkina Faso	✔	✔	✔	✔	✔	✔	✔	🔄	✔	✔
Cambodia	✔	✘	✔	✔	✔	✔	✔	✘	🔄	?
Cameroon	✔	✔	✔	?	✔	✘	?	✘	?	✔
Cape Verde	✔	✔	✔	✔	✔	✔	✔	✘	✔	✘
Chad	✔	✘	✔	✔	✔	✘	✔	✘	🔄	✘
Comoros	✔	✔	🔄	✘	✔	✘	✔	✘	🔄	✔
Cote D'ivoire	✔	✔	🔄	✘	✔	✘	✔	✘	🔄	✔
DRC	✔	✔	🔄	✔	✔	✘	✔	✘	✔	✔
El Salvador	✘	✘	✔	✘	✘	?	✘	✘	🔄	?
Ethiopia	✔	✔	🔄	✔	✔	✔	✔	✔	✔	✔
Gambia	✔	✘	✔	✘	✔	✔	✔	✘	🔄	✔
Guinea	✘	✔	🔄	✘	✘	✘	✔	✘	🔄	✘
Guinea Bissau	✘	✘	🔄	✘	✘	✘	✔	✔	🔄	✘
Liberia	✔	✔	🔄	✔	✔	✘	✔	✘	🔄	✔
Madagascar	✘	✘	🔄	✘	✔	✘	✘	✘	🔄	✘
Mali	✔	✔	🔄	✔	✔	✔	✔	✔	✔	✔
Mauritania	✔	✔	✔	✘	✘	✘	✔	✘	🔄	✔
Mozambique	✔	✔	✔	✔	✔	✔	✔	✔	🔄	✔
Myanmar	✘	✔	✔	✘	✘	✔	✔	✘	🔄	?
Nigeria	✔	✔	🔄	✔	✘	✔	✔	✘	🔄	✔
Pakistan	✘	✔	✔	✘	✔	✘	✔	✘	✔	✔
Senegal	✔	✔	🔄	✔	✔	✔	✔	?	✔	✔
Sierra Leone	✔	✘	✔	✔	✔	✔	✔	✘	🔄	✘
Sudan	✔	✘	✔	✔	✔	✔	✔	✔	✔	✔
Togo	✔	✔	🔄	✔	✘	✘	✔	✘	✔	✔
Uganda	✔	✔	✔	✔	✔	✘	✔	🔄	✔	✔
Vietnam	✔	✔	✔	✔	✔	✔	✔	✘	?	✔
Zambia	✔	✔	✔	✔	✔	✔	✔	✘	🔄	✔

Rating symbols illustrate whether respectively the government and/or the development partners have **achieved the target** ✔, whether there is **evidence of action** 🔄 or **no evidence of action** ✘. Action is assessed by demonstrated evidence of work delivered against the indicator.

The number of countries for which the development partner has provided information is presented between brackets in table 2.

- ✔ Target achieved
- 🔄 Evidence of action
- ✘ No evidence of action
- ? No data available
- 🇸🇩 Country system under development

SUMMARY TABLE OF DEVELOPMENT PARTNER PERFORMANCE

	EDC1	EDC5	EDC 2A	EDC 2B	EDC 2C	EDC 3	EDC 4	EDC 6	EDC 7	EDC 8
	DP participates in joint sector or sub-sector assessments of strategic plan (JANS)	DP participates in mutual accountability processes (JAR, MFR, etc.)	DP funds are disbursed predictably	Government has information about DP expenditure plans for three years ahead	Government has information about DP expenditure plans for three years ahead	DP uses country public finance management systems (in countries with CPA = or > 3.5)	DP uses national procurement and supply systems	DP provides TA support according to the national health sector TA plan (only in countries where this exists)	DP supports meaningful engagement of civil society organisations	DP provides financial or technical support to strengthen the private sector in health
AFDB (1)	?	?	✓	✓	✓	?	?	?	?	?
Australia (2)	✓	✓	✓	?	✓	✓	✓	N/A	✗	✓
Belgium (5)	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Canada (5)	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Carter Centre (1)	✓	✗	✓	✗	✗	?	✗	✓	✗	✓
Clinton Health Access Initiative (1)	✓	✓	?	✗	?	?	✗	N/A	✗	✗
Denmark (1)	?	?	✓	✓	✗	✗	?	?	✗	?
European Commission (12)	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Food and Agriculture Organization (1)	✓	✓	✓	?	?	✗	✗	N/A	✓	?
Foundation FAIRMED (1)	✗	✗	✓	?	✗	?	✓	N/A	✓	✗
France (6)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gates Foundation (3)	?	?	✓	?	✗	✗	?	?	✗	?
GAVI (25)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Germany (2)	✓	✓	✓	✗	✗	✓	✗	N/A	✓	✓
Global Fund (29)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ireland (4)	✓	✓	✓	✗	✓	✓	✓	✗	✓	✓
Italy (4)	✓	✓	✓	✓	✓	✓	✓	✓	✗	✗
Japan (7)	✓	✓	✓	✓	✓	✗	✗	N/A	✓	✓
Korea (2)	✓	✓	✓	?	✓	✓	✓	N/A	✓	✓
Luxembourg (2)	✓	✓	✓	✗	✓	✓	✓	N/A	✗	✗
Monaco (1)	?	?	✓	?	✓	?	?	N/A	?	?
Netherlands (4)	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Portugal (1)	?	?	✓	✗	✗	✗	?	N/A	✗	?
Spain (5)	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓
Sweden (3)	✓	✓	✓	✓	✗	✗	✓	N/A	✓	✓
Switzerland (3)	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗
United Kingdom (6)	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
UNAIDS (8)	✓	✓	✓	✗	✓	✓	✓	✗	✓	✓
UNFPA (22)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
UNICEF (28)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
United States (14)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
UNODC (1)	✓	✗	✓	?	✗	✗	✗	N/A	✓	✗
WHO (27)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
World Bank (16)	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓

1. Introduction

This report from IHP+ Results (IHP+R), for the members of the International Health Partnership (IHP+) and other stakeholders in global health, reports the findings of the 2016 IHP+ monitoring round on the effectiveness of development cooperation. IHP+, launched in 2007, is in its tenth year of operation as a group of partners committed to improving the health of citizens in developing countries. The partnership is open to all governments, development agencies and civil society organisations (CSOs) involved in improving health and willing to adhere to the commitments of the IHP+ Global Compact for achieving the health-related Sustainable Development Goals (SDGs). IHP+ currently has 66 signatories to the Global Compact (37 developing countries and 29 development partners as of April 2016).

The IHP+ partners work together to implement international principles for effective development cooperation (EDC) in the health sector. The 'seven behaviours' for EDC in the health sector were initially formulated at the fourth IHP+ meeting of country health teams in Nairobi in December 2012. These behaviours are based on the commitments made at the Fourth High Level Forum on Aid Effectiveness in Busan in 2011, which also established the Global Partnership for Effective Development Cooperation (GPEDC) focusing on overall development cooperation.

Since 2011, global development effectiveness objectives have evolved, building on the findings of the GPEDC monitoring process. At the first GPEDC High Level Meeting in Mexico City in 2014, participants stressed the importance of domestic resource mobilisation; broadening and strengthening south-south and triangular cooperation; maintaining development cooperation for middle-income countries; and partnering with the private sector to achieve development results. During the second GPEDC High Level Meeting in Nairobi in 2016, participants re-iterated their commitment to eradicate poverty and fast-track inclusive and sustainable development, and acknowledged the scale and ambition of the new Sustainable Development agenda to achieve effective development cooperation and inclusive partnerships. The meeting stressed the importance of the people-centred, universal and transformative approach to development of the 2030 Agenda for Sustainable Development.

In response to the newly-agreed health-related sustainable development goals, the IHP+ steering committee and IHP+ signatories agreed to expand the scope of the IHP+ to include coordination of health systems strengthening (HSS) towards the achievement of universal health coverage (UHC), and to broaden the base of the partnership to respond to the health-related SDGs. The new partnership will continue to work on improving effective development cooperation in countries receiving external assistance, but will broaden its scope to also focus on HSS and domestic spending in all countries and promoting accountability and advocacy for UHC as well as knowledge-sharing. The establishment of the 'International Health Partnership for UHC 2030' was announced in September 2016 by the Director General of WHO at a high-level meeting during the UN General Assembly in New York.

To date, IHP+ has organised four monitoring rounds to assess signatories' performance on implementing aid effectiveness commitments (in 2007, 2010, 2012 and 2014). The 4th IHP+ monitoring round assessed four of the seven behaviours. The 5th IHP+ monitoring round started in 2016 and tracked progress against eight EDC practices (Table 1) which broadly map onto the seven behaviours, using indicators for both IHP+ partner governments and development partners. In addition to government and development partners, the data collection also included civil society and private sector organisations.

Table 1: Effective development cooperation practices in the health sector

The eight effective development cooperation practices		Measured in 2014	Measured in 2016
	A strong single national health strategy is supported by both government and development partners; they agree on priorities reflected in the national health strategy and underpinning sub-sector strategies through a process of inclusive development and joint assessment, and a reduction in separate exercises.		
	Resource inputs are recorded on the national health budget and in line with national priorities, with predictability of government and development partner funding.		
	Financial management systems are harmonised and aligned, requisite capacity building done or underway, and country systems strengthened and used.		
	Procurement/supply systems are harmonised 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.		
	Joint monitoring of process and results is based on one information and accountability platform; joint processes for mutual accountability on EDC are in place, such as Joint Annual Reviews or compact reviews.		
	Technical support is strategically planned and provided in a well-coordinated manner; opportunities for systematic learning between countries are developed and supported by agencies through south-south and triangular cooperation.		
	Civil society operates in an environment that maximises its engagement in and contribution to health sector development*		
	Private sector has the space to participate in the development and implementation of effective, efficient and equitable health policies**		

(*) The 7th practice on civil society participation was measured in 2014 and in 2016, using different indicators.

(**) The 8th practice on private sector engagement was added by IHP+R in consultation with IHP+

2. The way performance was monitored in 2016

2.1. OVERALL APPROACH

2.1.1. Main features of the 2016 monitoring round

The following features were agreed with the IHP+ Mutual Accountability Working Group and the IHP+ Intensified Action Working Group for the 5th round of monitoring effective development cooperation in health:

- Monitoring is voluntary and is not limited to IHP+ signatories
- Monitoring of development cooperation practices is conducted at country level, with the aim of institutionalising processes of data collection and discussion of findings for improved mutual accountability
- Monitoring combines quantitative data and qualitative information to better understand reasons for and barriers to behaviour change
- Civil society organisations (CSOs) are included
- In addition, agencies' policies, practices and procedures to assess compliance with EDC practices are assessed separately

During the inception phase, the IHP+ Core Team agreed to include an indicator for private sector engagement, involving the private sector for the first time in the monitoring process.

2.1.2. Approach and scope

The 5th IHP+ monitoring round integrated lessons from previous rounds. To document trends, the established methodology was maintained during this round. However, the scope of data collection was widened to (1) include eight EDC practices; (2) be more inclusive in collecting the views of civil society organisations and the private sector; (3) include qualitative information to allow for more contextualised and meaningful interpretation of results in order to enable a more informed country dialogue; (4) support institutionalisation of EDC monitoring in national performance monitoring systems; and (5) further align IHP+ monitoring with GPEDC monitoring, using several GPEDC indicators as well as data in countries where GPEDC used the health sector as a pilot sector. A discussion of the findings was also supported in country with a view to developing an action plan addressing the main country-specific priorities related to EDC. In line with the 4th monitoring round, all data collected (including from development partners) were validated by governments, with the aim of fostering accountability at country level for commitments made in country compacts.

In each participating country, IHP+ Results (IHP+R) encouraged the ministry of health to lead the monitoring exercise, with support provided by a helpdesk and, for the first time, by a national expert supported by an international expert during the whole process from data collection to national discussion of the findings and development of the country-specific action plan. In addition, a web-based survey of civil society organisations was undertaken, and focus group discussions were held with civil society organisations and private sector representatives in most of the 30 countries. For the first time, a complementary in-depth review of the policies, practices and procedures related to EDC of 15 development partners was carried out through document reviews and interviews with senior agency officials.

Finally, institutionalising the monitoring of EDC practices in country-based systems was piloted in a number of countries. This process is still ongoing.

2.2. METHODS¹

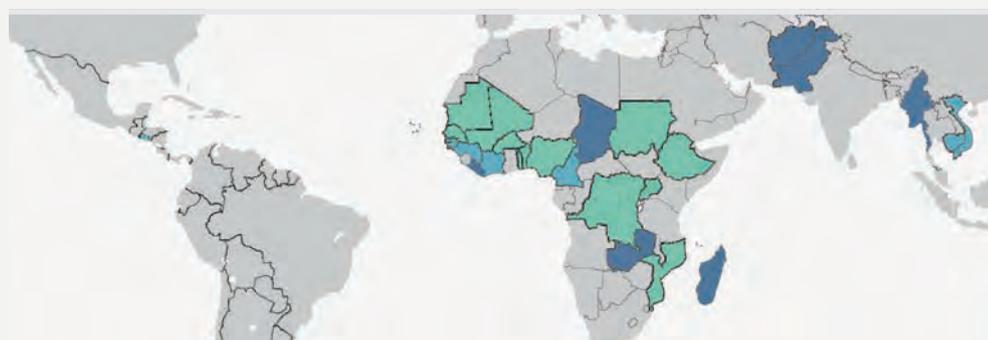
2.2.1. Participants and data sources

The performance of governments and the development partners in the 30 countries (six more than in 2014) that participated in the 2016 monitoring round was assessed on the basis of two questionnaires. These questionnaires collected quantitative and qualitative information about the status of the health sector strategy, health sector financing, public finance and procurement management, technical assistance, south-south and triangular cooperation and engagement of civil society and private sector stakeholders in a chosen fiscal year within the period 2014 to 2015. The qualitative questionnaire explored constraints and opportunities for more effective cooperation in the health sector. The participating countries are listed in Table 2.

¹ A detailed description of the methodology is provided in Annex 2.

Table 2: Countries participating in the 2016 monitoring round

Participants 2012, 2014 & 2016		Participants 2014 & 2016	First time participants	
Benin	Mozambique	Cambodia	Afghanistan	Pakistan
Burkina Faso	Nigeria	Cameroon	Chad	Zambia
DR Congo	Senegal	Cape Verde	Comoros	
El Salvador	Sierra Leone	Cote d'Ivoire	Gambia	
Ethiopia	Sudan	Guinea	Liberia	
Mali	Togo	Guinea Bissau	Madagascar	
Mauritania	Uganda	Vietnam	Myanmar	



In total, 35 development partners participated. Among them, 18 provided data in four or more countries. The analysis of development partner performance focused primarily on these 18 partners. The participating development partners are listed in Table 3.

Table 3: Development partners and number of countries in which they participated

Four or more countries			Less than four countries		
Development Partner	Type	Countries	Development Partner	Type	Countries
Global Fund	Multilateral	29	Gates Foundation	Foundation	3
UNICEF	Multilateral	28	Sweden	Bilateral	3
WHO	Multilateral	27	Switzerland	Bilateral	3
GAVI	Multilateral	25	Australia	Bilateral	2
UNFPA	Multilateral	22	Germany	Bilateral	2
World Bank	Multilateral	16	Korea	Bilateral	2
European Commission	Multilateral	12	Luzembourg	Bilateral	2
USA	Bilateral	12	AfDB	Multilateral	1
UNAIDS	Multilateral	8	Brazil	Bilateral	1
Japan	Bilateral	8	CHAI	Foundation	1
UK	Bilateral	6	Carter Centre	Foundation	1
France	Bilateral	6	Denmark	Bilateral	1
Belgium	Bilateral	5	FAIRMED	Foundation	1
Canada	Bilateral	5	FAO	Multilateral	1
Spain	Bilateral	5	Monaco	Bilateral	1
Ireland	Bilateral	4	Portugal	Bilateral	1
Italy	Bilateral	4	UNODC*	Multilateral	1
Netherlands	Bilateral	4			

* The UN Office of Drug Control (UNODC) administered the 'One UN' programme in one country

The questionnaires were completed by the ministries of health and development partners with support by a local health expert mobilised by IHP+R. The support of a national expert was a new feature of the 2016 monitoring round.

Over four hundred civil society organisations responded to an on-line survey with a response rate of 43 percent. Focus group discussions were attended by 229 representatives of civil society organisations and by 176 private sector stakeholders.

Additional data on policies and practices of leading development partner organisations were collected through document reviews, a self-completed questionnaire and interviews with senior staff of 14 international development agencies between December 2016 and March 2017.

As in previous monitoring rounds, publicly accessible databases were used in the analysis

2.2.2. Monitoring framework

The 2016 monitoring round used a broader framework than previous rounds, covering all eight EDC practices compared to only five in 2014. The framework included eight new indicators for which data were collected with qualitative survey tools developed in collaboration with the IHP+ Core Team based on questions from the 2016 GPEDC monitoring round. The eight EDC practices, translated into monitoring issues and indicators for both government and development partners, are presented in Table 4.

Table 4: Monitoring issues and performance indicators²

#	Issue	Government indicators	Development Partner indicators
1	Partners support a single national health strategy	National Health Sector Plan/ Strategy in place with current targets & budgets that have been jointly assessed	Extent to which JANS (or equivalent) are used in programming decisions, and to which programmes are aligned with national priorities
2a	Health development co-operation is more predictable	Proportion of health sector funding disbursed against the approved annual budget	Percentage of health sector aid for the government sector disbursed in the fiscal year for which it was scheduled
2b		Projected government expenditure on health provided for 3 years.	Extent to which governments are aware of 3-year expenditure plans provided by DPs
2c	Health aid is on budget	Health sector resources reflected in the national budget include contributions of individual development partners	% of health sector aid scheduled for disbursement that is recorded in the annual budgets approved by the legislatures of developing countries
3	Developing countries' Public Financial Management (PFM) systems are strengthened and used	Country PFM systems either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these	Amount of health sector aid disbursed for the government sector that uses national PFM systems in countries where systems are generally considered to adhere to broadly accepted good practices, or to have a reform system in place
4	Developing countries' procurement systems are strengthened and used	Extent to which a government-led plan for procurement and supply management systems exists that is supported by development partners	Extent to which procurement and supply management systems are harmonised and aligned; and national systems are used or strengthened
5	Mutual accountability is strengthened	Extent to which an inclusive mutual assessment of progress in implementing agreed health sector commitments exists	Extent to which mutual assessments have been made of commitments in the health sector, including on aid effectiveness
6	Technical support is coordinated and south-south/triangular cooperation supports learning	Extent to which an agreed national TA plan exists, informed by the national health strategy, on which all DPs are basing their support.	Extent to which technical assistance is provided in accordance with an agreed national TA plan
		Extent to which the MOH is benefitting from SSC and/or TrC	Extent to which developing partners are supporting south-south and triangular cooperation
7	Civil society engagement	Evidence that civil society operates within an environment that maximises its engagement in and contribution to health sector development	
8	Private sector engagement	Evidence that private sector has the space to participate in the development and implementation of effective, efficient and equitable health policies	

2. With the following exceptions: indicator 1DP and 2Gc are new; indicator 2DPb has been modified and indicator 8 has been added by IHP+R in consultation with IHP+

2.2.3. Data analysis and validation

Data collected and validated by the ministries of health in the participating countries were analysed by the national expert with support of the IHP+R helpdesk. Country reports and presentation materials were produced for a national meeting of stakeholders to discuss and validate the findings and to develop action plans for more effective development cooperation in health. Meetings were organised by governments in 24 countries.

For the 2016 Progress Report, aggregates and averages of the performance indicator values were calculated.³ Where appropriate they were weighted by the volume of funds disbursed in countries and by development partner. The qualitative questionnaires, the on-line survey returns and the focus group discussion protocols were analysed by counting frequencies of responses and through content analysis. Indicator trends over the last three monitoring rounds (2012 to 2016) were calculated for the 14 countries and 14 development partners that participated in all three rounds. The analysis was limited to five indicators for which data were collected in all three rounds. Datasets from earlier monitoring rounds were not available.

For the global review of development partner policies, procedures and practices, data collected through document reviews, self-assessment questionnaires and interviews with multilateral and lead ODA agencies in development partner countries were triangulated with findings from the 2016 monitoring round. Reports summarising the findings were validated by each participating agency.⁴ Responses to the self-assessment questionnaires were scored, resulting in a performance ranking table of participating development agencies per EDC practice that is presented in a synthesis report of the review.

2.3. LIMITATIONS ⁵

As in previous monitoring rounds there were important limitations in the data collected.

Not all health sector partners present in each country participated in the monitoring round. Statistics such as the proportion of on-budget health sector support only include the disbursements of participating partners and do not reflect total international support to the sector. The number of development partners that participated in the monitoring round in each country is illustrated in Figure 1.

Figure 1. Number of participating development partners in country-level IHP+R monitoring



In several countries, a considerable proportion of health sector support was disbursed through humanitarian aid channels. These funds are not captured in the reports of health sector cooperation in line with OECD guidelines on ODA. Information on humanitarian aid disbursements for health was therefore collected from development partners in eight countries with high levels of humanitarian aid funding.⁶ However, only limited data were provided and the information was therefore not used in the analysis of EDC indicators.

Participation in IHP+ monitoring is voluntary, and a participation bias by development partners towards countries with better EDC indicator performance can therefore not be excluded. All collected data are self-reported. Although steps for data validation were included in the methodology, they could not always be implemented as systematically as planned because of time and resource constraints, increasing the probability of reporting biases.

In some countries, state functions in the health sector are highly devolved, however, only national or federal ministries of health participated in the monitoring round, with the exception of one provincial government in Pakistan. The results therefore do not provide a complete picture in countries with highly decentralised health sectors.

3. Average rates of quantitative indicators are calculated as the average of the execution rates in each country or for each development partner. For the aggregate rate of financial indicators (funds disbursed predictably, aid on budget and use of PFM systems), all reported expenditures for development partners are summed and divided by the sum of all budgets. Only budgets and expenditures to the government sector are included in these calculations. For the qualitative indicators, results were calculated as an average.

4. For all agencies except USAID which declined full participation

5. A detailed discussion of limitations is provided in Annex 2

6. Afghanistan, Chad, DRC, Guinea, Guinea Bissau, Liberia, Mauritania and Sierra Leone

The limited number of participating civil society and private sector organisations in some countries raises a question on the representativeness of data collected. However, the findings were discussed and validated in the subsequent national discussion in most countries, and the aggregate sample of over 400 civil society organisations allows for a relatively robust analysis of responses at the global level.

Despite the preparation of detailed guidelines and the availability of a national expert to support data collection, not all questions or concepts were fully understood by respondents. The indicator for 'aid on budget' was subject to several misinterpretations. The questions about 'procurement and supply management systems' should have been disaggregated into the two components. The indicator of 'forward looking expenditure' is time-sensitive and the response depends on the timing within a programme cycle when it is collected.

The global review of development partner policies, procedures and practices was carried out before final analysis of the 2016 country-level monitoring data. This limited the possibilities of more focused discussions with each participating agency on the main findings, bottlenecks and opportunities as reported by their country-based representatives, and thereby to contextualise the documented or reported development partner policies. The self-assessment questionnaires completed by each agency risk over or underscoring agency-specific performance. Scores based on self-assessment should be interpreted with caution. Other limitations of the policy and practice review are presented in annex 2.

3. The performance of IHP+ partners

This section presents the performance of IHP+ partners as assessed by the indicators for adherence to EDC practices (see Table 6 in Section 2.2.2) organised under the headings of the four IHP+ partner commitments:

1. **The commitment to establish strong health sector strategies that are jointly assessed and to strengthen accountability**
2. **The commitment to improve the financing, predictability and financial management of the health sector**
3. **The commitment to establish, strengthen and use country systems**
4. **The commitment to create an enabling environment for the participation of civil society organisations and the private sector in the health sector**

Performance on meeting the commitments was analysed using the responses of governments and development partners to the quantitative and qualitative questionnaires, as well as the results of the civil society survey and of the focus group discussions with representatives of civil society and private sector organisations. Trends are presented when serial data from the 2012 and 2014 monitoring rounds exist. Results of a limited review of the interface of development cooperation and humanitarian assistance for health are also presented. Where relevant for development partner performance, reference is made to the global review of development partner policies, procedures and practices.

3.1. ESTABLISH STRONG HEALTH SECTOR STRATEGIES THAT ARE JOINTLY ASSESSED AND STRENGTHEN ACCOUNTABILITY

Governments: All participating countries had a health sector strategic plan, most often jointly developed and jointly assessed. Civil society organisations were involved in about 75 percent of the assessments and private sector representatives in about 50 percent. Comprehensive sector performance monitoring frameworks existed in 80 percent of countries but were poorly used by development partners.

Development partners: Programme priorities were aligned with national sector or sub-sector priorities. Many development partners participated in joint sector or sub-sector strategy assessments, but not consistently in all countries. Separate assessments at sector or sub-sector level remained a requirement for most development partners. Development partners were willing to align programme monitoring to national monitoring frameworks and systems, but used them for programme monitoring only about half of the time. Participation in joint annual reviews continued to increase over the past three monitoring rounds but was still below the agreed target of 90 percent.

Civil society and private sector organisations: Civil society organisations confirmed their participation in strategy assessment and accountability mechanisms, however they believed that participation was not sufficiently inclusive and conditions for meaningful participation were often not met. Private sector representatives participating in focus group discussions expressed the opinion that their participation was mostly pro forma and not meaningful.

3.1.1. Jointly assessed and supported single national health strategy (EDC indicator 1)

Performance of governments

All participating countries had a health sector strategy in the fiscal year covered by the assessment. In the majority of countries, it was developed with the participation of other government ministries, civil society organisations and development partners. This participation was, however, sometimes very limited. Four national health strategies were developed without input from other ministries, two without input from civil society and ten with the participation of only one civil society organisation. Participation of international development partners was limited to the WHO in two countries and to three UN agencies in another country. With few exceptions, participation by private sector organisations was limited.

Performance of development partners

All development partners confirmed that their programme priorities were aligned with national health sector or sub-sector priorities except one respondent who did not answer this question. Development partners in 28 of the 30 countries reported that there had been a joint assessment of the national health strategy, although the ministries of health confirmed this in only 24 of these countries. Overall, 74 percent of development partners reported that they had participated in a joint assessment of the sector or a sub-sector strategy. Among the 18 development partners that participated in four or more countries, the reported participation in joint strategy assessments ranged from 33 percent to 100 percent. Almost half of all development partners (49%) stated that they required a separate sector or sub-sector strategy assessment that is specific for their programme. Among the 18 development partners who participated in four or more countries this requirement ranged from zero to 83 percent. These statistics are presented in Figures 2(a) and 2(b).

Figure 2.(a) Participation in joint sector or sub-sector strategy assessments

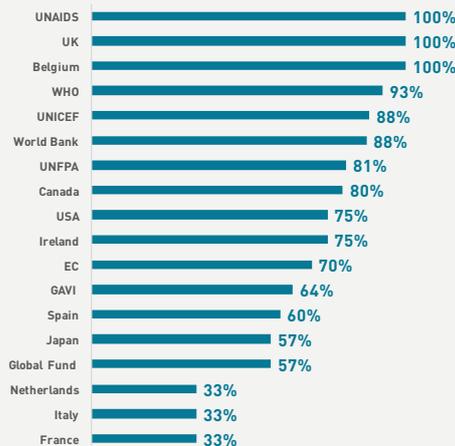
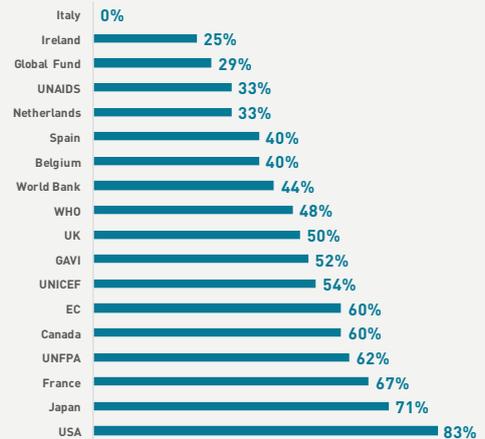


Figure 2.(b) Requirement of separate sector or sub-sector strategy assessment



In the global review of development partner policies, procedures and practices, all representatives of the participating ODA agencies affirmed that supporting sector or sub-sector national plans was their default option for health sector collaboration. This was supported by the review of policy and strategy documents and by reviews conducted by the Multilateral Organisation Performance Assessment Network (MOPAN) and by the UK Multilateral Aid Review (MAR). Most agencies stated that they participate in JANS or similar joint health strategy assessments, and 11 that they did this consistently in all countries of cooperation. However, only two of them rely solely on the joint assessment for the definition of their own programme support.

3.1.2. JOINT HEALTH SECTOR PERFORMANCE ASSESSMENTS FOR ACCOUNTABILITY (EDC INDICATOR 5)

Performance of governments

Country compacts or equivalent multi-partner agreements were reported by 20 of the 30 government respondents. They included targets for governments in 19 countries, targets for development partners in 18, for civil society organisations in 14 and for the private sector in 11.

Comprehensive health sector monitoring and evaluation frameworks were in place in 24 countries and, according to responses from governments, were used consistently by development partners in ten countries. The frameworks were not used by development partners in four countries. In the remaining ten the practice of development partners was described as mixed. Use of the national monitoring and evaluation frameworks by development partners was more likely if they had been involved in its development.

Many government respondents did not distinguish between joint assessments of national strategies (JANS) and joint annual reviews (JARs). Most frequently, respondents referred to annual sector reviews, mid-term reviews or final strategy reviews. Two-thirds of government respondents also mentioned other mechanisms for mutual accountability, including technical working groups, programme-specific governance structures such as the Country Coordinating Mechanism, annual health conferences and coordination fora at the decentralised level.

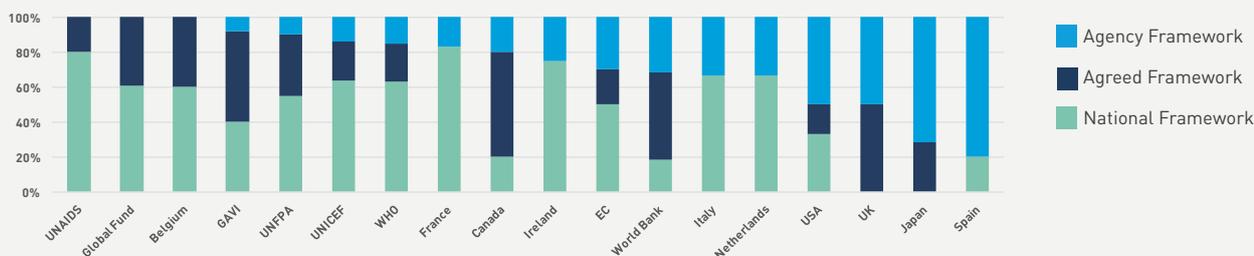
Twenty-two governments reported that a joint annual health sector review, mid-term review (MTR), or similar exercise had been conducted within the last two years. Reasons for not conducting a review included the political or security context, or that procedures for such an exercise had not yet been established. Governments in only half of the countries believed that development partners used the joint reviews for adjusting and aligning their health sector support. Civil society organisations were included in 17 reviews, and private sector organisations in 11.

Two-thirds of the government respondents confirmed that joint reviews of sub-sectors of the health system continued to be necessary for more detailed assessments of special initiatives, for instance for tuberculosis control or for the response to HIV. One-third, however, thought that comprehensive joint reviews could cover all health sector domains.

Performance of development partners

Thirty of the 35 development partners answered questions about the use of national performance monitoring frameworks for their programme. Among them, 46 percent stated that they used the national sector or sub-sector framework for programme monitoring, 33 percent used an agreed framework that was not identical to the national framework, and 20 percent used their own agency-specific framework. The 18 development partners who participated in four or more countries reported the use of national frameworks in 48 percent of cases, the use of agreed frameworks in 25 percent, and agency-specific monitoring and evaluation frameworks in 27 percent. The responses differed substantially among partners as illustrated in Figure 3.

Figure 3. Use of national, agreed and agency-specific performance monitoring frameworks 7,8



Most development partners expressed their willingness to fully align their programme monitoring with national health sector or relevant sub-sector monitoring frameworks and systems. However, 30 percent stated that they needed to monitor additional indicators that were not part of the national framework either because the framework was weak or because they had specific monitoring requirements that were not covered by national indicators. Thirty percent did not make full use of national monitoring data because of limited data availability and concerns about data quality; and 25 percent considered that the national monitoring and accountability system in the partner country was generally too unreliable.

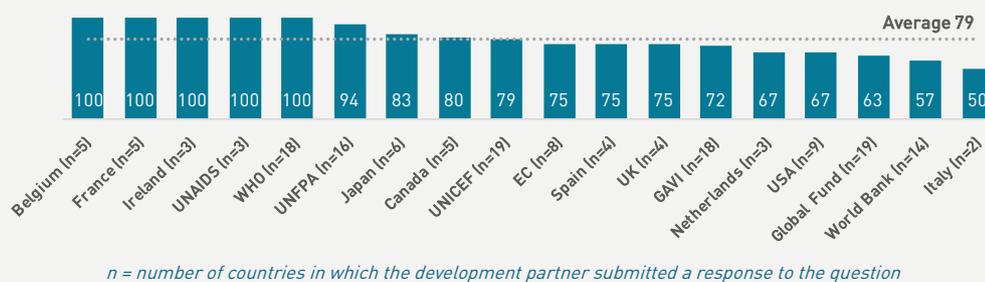
Twenty-nine development partners answered the question about participation in joint health sector reviews in the 22 countries where such reviews took place, with 78 percent confirming their participation. Figure 4 illustrates the number of development partners that reported their participation in each of the 22 countries.

Figure 4. Number of development partners reporting participation in joint sector reviews



Among the 18 development partners who participated in four or more countries, the participation rate in joint reviews was slightly higher at 79 percent. The rate of participation by each of the partners is illustrated in Figure 5. Five of them participated in the joint reviews in all countries for which they provided data.

Figure 5. Participation in joint annual reviews or similar exercises within the last two years (%)



7. Very few development partners provided multiple responses, referring to different programme channels. These were adjusted by selecting only the highest level (agreed or national framework) response
 8. Development partners are sorted by the percentage use of agency specific monitoring frameworks (dark blue bar).

In the global review of development partner policies, procedures and practices, ten of the participating ODA agencies confirmed that using the national performance monitoring systems was their default or preferred option. However most of them also required the monitoring of additional indicators that were not included in the national framework, and only a few explicitly discouraged the use of additional indicators.

3.1.3. Views of civil society and the private sector

In the on-line survey, almost two-thirds (63%) of CSO respondents fully or partially agreed with the statement that they were consulted by government in the design, implementation and monitoring of health policies and programmes. Very few of their organisations received financial support from government to participate in multi-partner consultations, but more than half (57%) stated that they received support from development partners, at least occasionally. In focus group discussions, CSO representatives expressed the views that opportunities to participate in multi-partner processes for strategy development and accountability was selective, and that meaningful participation was often not possible because governments provided relevant information too late, when decisions had already been made.

Representatives of private sector organisations who participated in focus groups in 24 countries stated that involvement of the private sector in strategy development and sector monitoring was absent or limited to ad hoc selective consultations. Governments in 19 countries had reported consultations including the private sector, but focus group participants stated that these consultations were poorly promoted and attended, highly selective and not perceived as true fora for partnerships.

3.1.4. Trends in meeting the commitments for strategic alignment and mutual accountability

Three consecutive rounds of performance assessments, from the third round in 2012 to the fifth round in 2016, used sufficiently similar indicators and data collection methods to allow an analysis of trends of selected quantitative data. Fourteen countries and 14 development partners participated in all three rounds. Only the fifth round included the collection of qualitative data.

According to development partner reports in 2012, only 9 of 14 countries had instituted mechanisms for mutual accountability such as regular joint annual sector or sub-sector reviews. In 2014 this had increased to 11 and in 2016 to all 14. Among all development partners, participation increased as illustrated in Figure 6, in part because there were more mutual accountability mechanisms in more countries. The trend is identical whether calculated for all development partners in each round, or only for the 14 development partners who participated in all three rounds⁹.

3.1.5. Constraints and opportunities

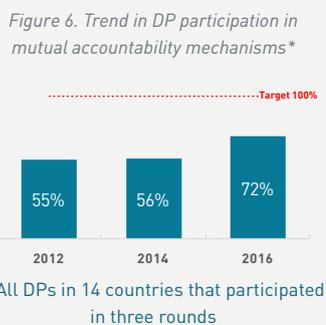
Constraints

Governments did not mention any constraints for establishing strong health sector strategies and mechanisms for shared accountability for sector performance. Increased involvement of civil society and the private sector in these processes and mechanisms, however, was constrained by the lack of representative bodies for civil society and the private sector in many countries.

The main reasons cited by **development partners** for not participating in some joint strategy assessments included that the sub-sector covered by the strategy was not of interest to the partner, that the development partner was not invited to participate, or that the partner did not have the necessary resources at country level. These last two responses were provided primarily by GAVI and the Global Fund. Both agencies expressed intentions to increase their participation in future.

Two main reasons were provided for requiring separate assessments. Bilateral agencies, the European Commission and the World Bank cited requirements for the implementation of agency-specific evaluation cycles for all project funding. Specialised UN agencies and global initiatives referred to their support to specific sub-sectors as their core business, requiring both joint and separate sector assessments and evaluations.

Many development partners referred to the quality of national performance monitoring frameworks as a constraint to improving shared accountability for health sector performance. National performance monitoring frameworks were felt to have too many indicators, to be insufficiently results oriented, to be insufficiently specific for the sub-sector or programme area of interest to the development partner, or fragmented into disease-specific components without integration at the health systems level. The contradictions in this list of constraints illustrate the fact that development partners are not a homogenous group. Other constraints mentioned included the weak capacity of ministries of health to collect, analyse and use reliable health information data for decision-making and the fact that health information systems in many countries do not cover the services of private not-for-profit and for-profit providers.



9. The participation rate in 2016 in Figure 6 (72%) is lower than the average in Figure 5 (79%) because it is calculated only for the 14 countries with three-year serial data rather than for all 30 countries that participated in 2016.

Opportunities

Opportunities to increase strategy alignment and mutual accountability mentioned by **governments** were mostly country-specific. Most refer to planned events such as mid-term strategy reviews, JARs, development of health sector financing strategies, regular coordination meetings (also at provincial and district levels), technical working groups, signing of country compacts, or the introduction of program-based budgeting by the ministry of finance. IHP+ was mentioned by several respondents as a mechanism to increase mutual accountability.

Development partners referred frequently to upcoming joint health sector assessments or reviews. UN joint collaborative programming, the Country Coordination Mechanism for Global Fund grants and health partners' fora were also mentioned as opportunities for advancing the commitment for greater mutual accountability.

Initiatives to strengthen joint accountability for health sector performance mentioned by development partners included improving national performance measurement frameworks by greater alignment with global health indicators, strengthening national health information and performance monitoring systems, and establishing a national platform for joint decision-making. Joint accountability for results would be strengthened if national systems captured a more realistic picture of sector performance. Examples of efforts for greater alignment of monitoring frameworks mentioned by development partners included the partnership between the European Union, WHO and Luxemburg that was actively promoting the use of national performance monitoring frameworks and supporting quality improvements of national health information systems. Guidance provided by the Global Fund's Operational Policy Manual under the 2017-2022 strategy was also mentioned, recommending a move to harmonised tools and encouraging collaboration with partners as part of the assessment process.

Actions to increase civil society and private sector participation in strategy assessment and sector performance monitoring were, according to many development partners, within the remit of government. Civil society inclusion was not easily influenced by international development partners because it often depended on the level of trust between government and civil society in the country.

3.2. IMPROVE THE FINANCING, PREDICTABILITY AND FINANCIAL MANAGEMENT OF THE HEALTH SECTOR

Government expenditures for health ranged from four percent to 17 percent of total government expenditures. The average among the 14 countries that participated in the last three monitoring rounds decreased steadily. The average execution rate for the health sector budget was 86 percent. Among the 12 countries with serial data since 2012, it decreased compared to 2014 but remained above the 2012 level. In two-thirds of the countries a 3-year rolling budget or medium term expenditure framework (MTEF) was in place. In 23 of the 30 countries some development cooperation funds were recorded on budget, and in a further four countries otherwise documented.

Development partners executed on average 78 percent of their annual budgets, ranging from 45 percent to 100 percent per country. Ninety-five percent of the US\$ 4.8 billion disbursements to government were made by 18 development partners who had an aggregate budget execution rate of 73 percent, well below the 90 percent target.¹⁰ Governments confirmed that they were aware of 35 percent of the development partners' three-year expenditure plans. Development partners' communication with health ministries on forward expenditures improved slightly compared to 2014, but remained well below target. Almost all development partners reported that their budgeted resources were known to the government, but only 53 percent of the resources were registered in the national budget. The level of on-budget registration was comparable to previous monitoring rounds.

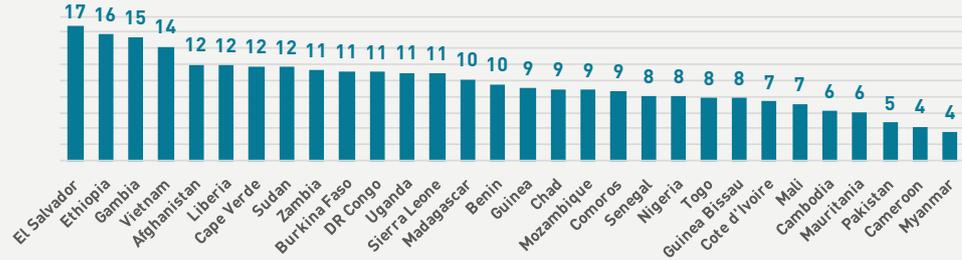
3.2.1. Health sector budgets execution (EDC indicator 2a)

Performance of governments

The execution of government health sector budgets was assessed against the background of the estimated proportion of general government expenditure allocated to health published in the WHO global health expenditure database for 2014. Government expenditures, which include development cooperation funds channelled through national budget execution procedures, varied greatly, representing between four percent and 17 percent of government expenditures. This is presented in Figure 7.

¹⁰ Average rates are calculated as the average of the execution rates in each country. For the aggregate rate, all reported expenditures are summed and divided by the sum of all budgets. Only budgets and expenditures to the government sector are included in these calculations.

Figure 7. Government expenditure on health as % of general government expenditure 2014

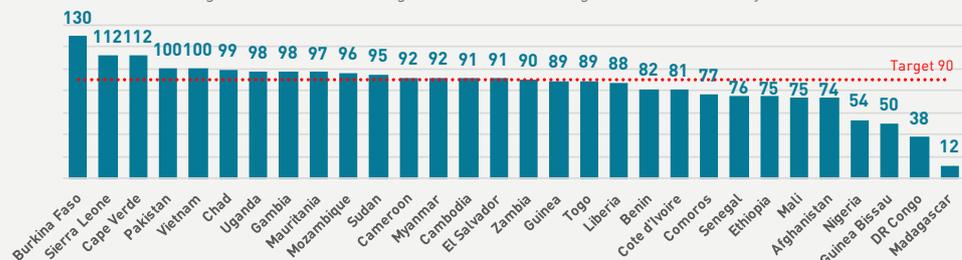


Source: www.who.int/health-accounts/ghed/en/ (accessed 11/05/2017)

Almost all governments (27/29) reported some under-funded health systems components. The lists are long and include all health systems building blocks.¹¹ Over-funding of some programmes or components was reported by seven governments. Two of them referred to HIV, tuberculosis and malaria programmes; performance-based financing and public-private partnership were mentioned once.

Respondents were asked about budget execution in the selected fiscal year and about the availability of forward expenditure estimates for the subsequent three years. The fiscal years selected varied from country to country but most were within the period of the 2014-2015 calendar years. Execution of the national health budget was above the target of 90 percent in 16 of the 30 countries. Reported budget execution rates are presented in Figure 8.

Figure 8. Execution (%) of government health budgets in selected fiscal year



The very low budget execution reported by the government of Madagascar is an artefact because of an administrative problem of posting expenditures prior to closing the accounts for the fiscal year 2015. Other governments that reported significant under-disbursements cited primarily the non-release or late release of the funds by the national treasury, under-disbursement or late disbursement of on-budget contributions by development partners, or complex public procurement procedures that delayed planned investments. Over-disbursements were related to the Ebola epidemic in Sierra Leone, the payment of accumulated debts in Cape Verde, and to late partner contributions and post hoc budget adjustments in Burkina Faso.

When over-disbursements of national health budgets are capped at 100 percent, the average budget execution rate in the 30 participating countries is 83 percent. If the data from Madagascar are removed, the average rate increases to 86 percent.

Performance of development partners

Development partners reported the budget scheduled for disbursement to government as well as the actual disbursement in the selected fiscal year. Overall, 33 development partners submitted 222 reports of disbursements totalling US\$4.8 billion. When over-disbursements were capped at 100 percent of the budget estimate for the period, the average performance of development partners in terms of executing their budgets in all countries in which they participated was 78 percent. The rates differed by country as illustrated in Figure 9. In eleven countries, development partners reached a target of 90 percent budget execution.

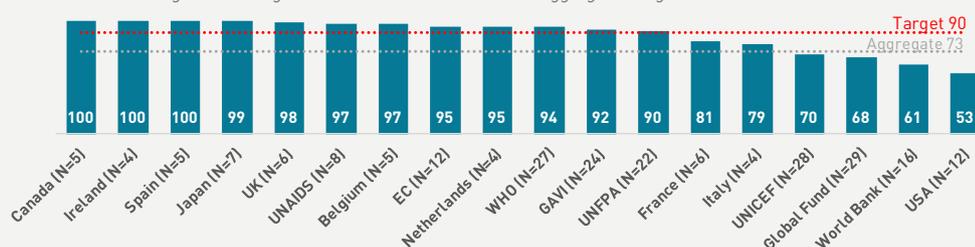
11. According to the WHO model: (i) service delivery; (ii) health workforce; (iii) health information systems; (iv) access to essential medicines; (v) financing; and (vi) leadership/governance

Figure 9. Average execution rates of development partner budgets by country (%)



The 18 development partners who participated in at least four countries reported disbursements of US\$ 4.6 billion with an aggregate budget execution rate of 73 percent against a target of 90 percent. For this calculation, disbursements were also capped at 100 percent of the budget estimate in each country. The results are presented in Figure 10¹².

Figure 10. Budget execution rates of 18 DPs and aggregate budget execution rate (%)*



* N = numbers of countries in which the DP participated. Only development partners who participated in four or more countries are included.

Twelve of the 18 partners disbursed more than 90 percent of their budgets. The aggregate was nevertheless low because the three development partners with the largest budgets reported the lowest execution rates. Large over-disbursements of more than 150 percent of budgets were reported in three countries, due to responses to crisis situations or carry-over of funds from the preceding year.¹³ Reasons for under-disbursements included delays in implementation and failure by government partners to meet contractually agreed performance targets, delays in reporting, over-estimation of needs, as well as political decisions to hold back funding in cases of suspected corruption or human rights concerns.

3.2.2. Forward expenditure estimates for the next three years (EDC indicator 2b)

Performance of governments

Of the 29 government respondents who answered the question about forward-looking expenditure estimates, 19 (66%) replied that a medium-term expenditure framework (MTEF) or three-year rolling budget estimate was in place.

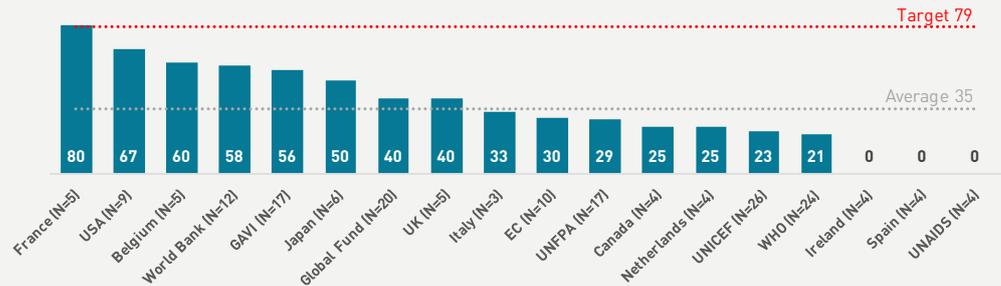
Performance of development partners

Development partners were asked about their practice of informing governments of their three-year forward looking expenditure plans, and government respondents were asked about their level of knowledge of these plans. The responses submitted by ministries of health differed somewhat from those provided by development partners. One of the reasons may be that development partners negotiated cooperation agreements and budgets with ministries of finance or of international cooperation. Detailed information may not have been communicated to the ministries of health. To be consistent with previous monitoring rounds, only the information received from governments is reported. The statistics were adjusted by removing non-responses by governments from the denominator. Figure 11 presents the levels of awareness about each development partner's 3-year forward expenditure plan as reported by governments. The statistics are not weighted by the size of the cooperation budgets.

12. Average rates are calculated as the average of budget execution rates in each country. Aggregate rates are calculated as the execution rates of the sum of budgets for all countries

13. In the calculation of aggregates, over-disbursements in countries were adjusted to 100 percent budget execution

Figure 11. Government awareness of 3-year expenditure plans by DP (%)*



*N = number of countries in which governments provided a response. Only development partners who participated in four or more countries are included.

Most development partners provided forward-looking expenditure plans for two rather than three years. WHO, for instance, establishes and negotiates biennial programmes and budgets. It is therefore surprising that five of 24 ministries of health reported that they were informed about expenditure plans by WHO for the next three years, although this might be explained by overlaps between fiscal and calendar years. Development partners who provided three-year forward-looking expenditure estimates but were assessed in the second or third year of their programme cycle would only be recognised for the period remaining in their programme.

Reasons cited by some development partners for not providing three-year forward-looking expenditure estimates included that funding was not yet secured, or that the ministry’s resource mapping tool demanded only information for the next year.

In the global review of development partner policies, procedures and practices, all representatives of the participating ODA agencies confirmed that their agencies’ cooperation funding was known to governments, however only eight agencies had a strict requirement to inform governments, and two stated that this was dependent on the country context. None of the agencies had a strict requirement to contribute all or part of their funds to a pooled fund or similar type of joint financing mechanism.

3.2.3. Registration of development cooperation funds in the budget (EDC indicator 2c)

Performance of governments

Contributions from some development partners were recorded in the national health budgets in 23 of the 30 countries. Not all participating governments have budgeting procedures that allow the registration of development cooperation funds in the national budget. In some countries, only funds paid to the ministry of finance for general or sector budget support are registered, in others, development cooperation funds are recorded in a budget annex or a separate government document, sometimes as a lump sum and not always specified by sector. Three governments responded that there were no provisions for registering development partner contributions in the national budget, nor did they indicate that the funds were published in any other official document.

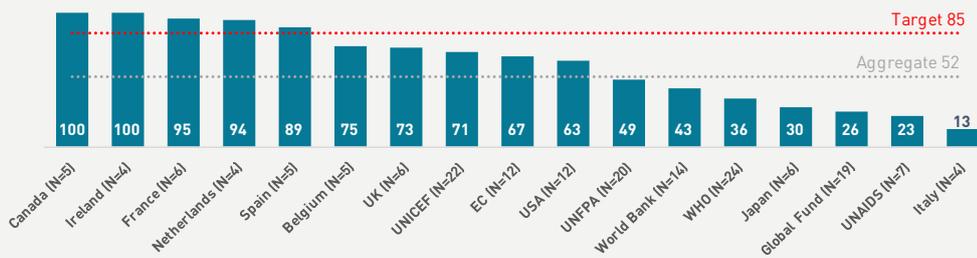
Performance of development partners

Development partner respondents were not always aware whether resources were recorded in the national budget. GAVI, for instance, only provided information about on-budget funds in three of 25 countries, responding with ‘not known’ in the remaining 22. GAVI confirmed not to monitor health aid on budget as it excludes the largest portion of GAVI’s no-cash vaccine support to countries (75% of GAVI funding). The funds budgeted by all development partners who reported both the amount of government sector support and the on-budget amounts totalled US\$2.43 billion, with US\$1.32 billion (53%) registered in the national budget or an equivalent official document. At country level, the calculated proportions varied widely from zero to 100 percent, but they were highly dependent on the number of development partners who provided data in each country. An analysis of performance by country is therefore not informative.

Limiting the analysis of performance to the 17 development partners¹⁴ who participated in at least four countries, the aggregate proportion of funds disbursed to governments in 27 countries that were registered in the budget or an equivalent document was 52 percent. The performance of the development partners is presented in Figure 12.

14. GAVI is not included because it provided data for on-budget support only in 3/25 responses

Figure 12. Cooperation funds to government reported in the national budget (%)*



*N = number of DP responses that included both the numerator and the denominator value. Only development partners who participated in four or more countries are included.

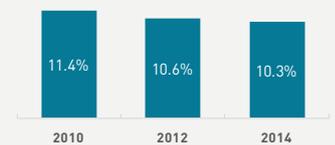
Despite the relatively low proportion of on-budget registration, almost all development partners (30/34) reported that all their budgeted resources were known to government. About 59 percent of all cooperation funds were disbursed under an overall agreed financing framework according to reports submitted by the 34 development partners.

3.2.4. Trends in meeting the commitment for improved health sector financing, predictability and financial management

Average general government expenditures for health as a proportion of general government expenditures in the 14 countries declined over the four years between 2010 and 2014 (Figure 13). Only three countries, El Salvador, DRC and Nigeria recorded a higher proportional expenditure on health in 2014 than in 2010.

Only 12 governments provided data on health budgets and expenditures in each round. Similarly, only 13 development partners provided data on budgets and disbursements of cooperation funds to governments. The 13 partners accounted for 76 percent of all funds budgeted for disbursement to government reported in the 2016 monitoring round. The trends in the budget execution rates by governments and development partners are presented in Figures 14(a) and 14(b). Over-disbursements in each of the three rounds were capped at 100 percent.

Figure 13. Trends in the percentage of government expenditures on health*



* 14 countries that participated in three rounds
Source www.who.int/health-accounts/ghed/en/ (accessed 11/05/2017)

Figure 14.(a) Trend in national health budget execution*

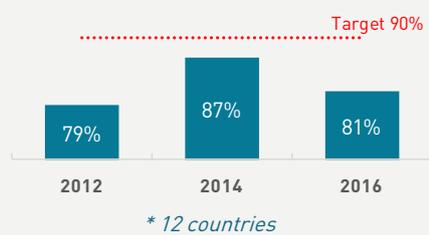


Figure 14.(b) Trend in development cooperation budget execution*



Information on government forward expenditure planning for health was not collected in previous monitoring rounds. In the 2014 and 2016 monitoring rounds, ministries of health and development partners reported on forward-looking expenditure estimates of cooperation funds over the next three years. The information from the two sources differed considerably. In most cases, development partners considered that their transparency about forward expenditures was greater than it was perceived to be by ministries of health.

Information provided by governments is presented in the trend analysis in Figure 15. The data represent the percentage of development partners who provided forward expenditure estimates for health sector cooperation to governments in the 21 countries that participated in both the 2014 and 2016 monitoring rounds as reported by governments. Only the 14 development partners who provided data for both monitoring rounds were considered.

Figure 15. Trend in forward expenditure estimates of development funds cooperation budget execution*



* Funds of 14 DPs in 21 countries as reported by governments

Figure 16. Trend in the registration of DP funds in national budgets*



The result for development partner three-year forward expenditure plans reported by governments in 2016 in Figure 15 (24%) is considerably lower than the result reported in section 3.2.2 (37%) because of the selection of countries and development partners included in the trend analysis. Available data on forward expenditure estimates for the limited number of countries for which trend analysis was possible suggest that the predictability of health sector support by development partners has increased since the 2014 monitoring round. However, the information on budget execution by government and by development partners over three monitoring rounds indicates that data are quite unstable, and that a change between two monitoring rounds does not necessarily establish a robust trend.

Information about the proportion of development partner funding to governments that was registered in the national budget was collected in all three monitoring rounds. Data over three rounds were available from 11 countries and 14 development partners, reflecting between US\$0.9 billion and US\$1.7 billion in each round. Figure 16 presents the trend in the proportion of funds that were registered in national budgets. It indicates that on-budget registration has changed little and remains well below the target of 85 percent.

3.2.5. Constraints and opportunities

Constraints

Governments identified many constraints to the achievement of a balanced budget with sufficient funding of key priorities. Domestic constraints included the constrained national fiscal space, lack of evidence-based planning and budgeting, absence of a national health financing strategy, weak capacity of the health ministries to negotiate their budgets with ministries of finance, and emergency situations due to epidemics and other crises. The inter-ministerial relationship with the ministry of finance and the late release or non-release of funds by the treasury were also cited as a cause for under-disbursements of the national health budget.

Constraints related to the relationship with development partners included weak or absent joint planning by development partners, unreliable financing, earmarked financing for specific programmes, complex procedures, and reluctance of development partners to use public financial management systems and procedures. The delayed release of on-budget development partner funds was cited by several governments as a cause of under-disbursements.

Development partners noted that they did negotiate their public-sector health sector cooperation programme with governments and kept governments informed about forward expenditure plans. However, when monitoring data were collected towards the end of a cooperation programme, forward looking expenditure plans may not have been available. The constraints for recording cooperation funds in the national budget cited by several development partners indicate that the concept and process were not always well understood. Some partners mentioned constraints that applied to budget support rather than to on-budget registration. Other constraints included a misalignment of budgeting cycles, government budgeting procedures that lacked transparency or that precluded the registration of international funds in the national budget, and a lack of understanding of the utility and benefits of on-budget registration.

Opportunities

Governments mentioned few opportunities to improve health sector financing. More transparent financial management by the ministry of health to reduce fiduciary risks and increase the confidence of development partners was mentioned by one respondent. Budget decentralisation and an aid management platform were mentioned by another.

Development partners suggested that the flow of information on multi-year spending plans could be improved by regular portfolio reviews, strengthening mid-year and annual reporting across partners, strengthening national budgetary processes, as well as biannual reviews of forecasts, contracts and disbursements. Annual sector reviews provide an opportunity for updating information. The functionality and use of the development assistance databases maintained by the ministries of finance or ministries of cooperation could be improved as well as the inter-ministerial communication between the ministry of finance and the ministry of health. Joint financing agreements (JFA) were cited as an opportunity to increase the on-budget registration of funds.

Development partners in Ethiopia reported a JFA and resource mapping procedure that also captured funding from NGOs. GAVI mentioned its intentions to further enhance the predictability of funding through 5-year planning and strict involvement of ministries of finance in all funding proposals. Predictability of funding is increasingly becoming a concern for the Global Fund, with expectations that predictability will be enhanced under the new funding model. All countries received letters with their allocations for 2017-2019 in December 2016, confirming that the Global Fund aims at ensuring 3-year predictability.

3.3. ESTABLISH, STRENGTHEN AND USE COUNTRY SYSTEMS

Governments: Sixteen participating countries had a robust public financial management (PFM) system as indicated by a CPIA score equal or greater than 3.5, largely unchanged since 2010. Governments in almost all countries confirmed that initiatives to strengthen the national PFM system were in place.

National procurement and supply management systems were used by some development partners in two-thirds of the countries. About half of the government respondents considered that these systems did not receive sufficient support.

Sector plans for technical assistance were largely absent, but sub-sector plans existed in some countries. Health ministries were not consistently involved in the development of the terms of reference for, or the selection of, technical assistance. South-south cooperation was overall modest.

Development partners: In the countries with robust PFM systems, about half of development cooperation funds for the government sector were disbursed using national budget execution procedures. Sufficient support to strengthen national public financial management systems was available in half of the countries. Use of national PFM systems by development partners increased compared to 2014 but was at the same level as in 2012.

Although development partners confirmed that support to strengthen national procurement and supply management systems was provided in all countries, only 42 percent of development partners used the systems at least for some procurement.

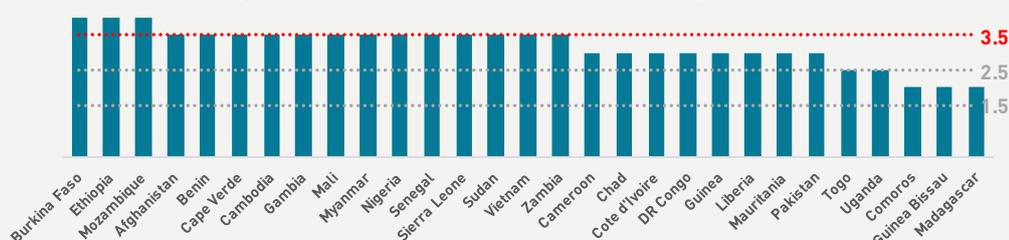
Almost all development partners reported that they provided technical assistance as agreed with national authorities or in line with sector or sub-sector strategies. They stated that in almost all cases the recipient institutions were involved in developing the terms of reference, and in 85 percent of cases in the selection of technical assistants. These reports were at variance with the reports from governments. The majority of development partners reported that they provided some form of support for south-south or regional cooperation.

3.3.1. National public financial management (PFM) systems (EDC indicator 3)

Performance of governments

For the assessment of national PFM systems, data for the participating countries were transcribed from the World Bank database of country policy and institutional assessments (CPIA) of the quality of budgetary and financial management. (Figure 17) The statistic is a compound index, rating the quality of PFM systems on a scale of one (low) to six (high). A score of 3.5 or higher implies that the systems are reasonably robust. In 2014, the PFM systems in 16/29 countries¹⁵ were assessed at this level. The average score of the 29 countries had been relatively unchanged since 2010 as well as the list of countries with scores of at least 3.5.

Figure 17. World Bank CPIA scores for public financial management 2014



Source: <http://data.worldbank.org/data-catalog/CPIA> (accessed 17/02/2016)

Programmes to strengthen PFM systems were in place in 28 of the 29 countries that responded to this question. Implementation constraints were mentioned by seven respondents, four of them from countries with scores below the 3.5 threshold. Constraints included insufficient resources or technical capacity, limited political will, and insufficient support by development partners.

Performance of development partners

National public financial management systems were used primarily by development partners contributing to pooled funds and sector support, as well as for World Bank loans. In 17 countries, at least one development partner used the public system for budget execution, and in 12 countries also for auditing. In the 16 countries with reasonably robust public financial management systems approximately 53 percent of development cooperation funds for the government sector were disbursed using national budget execution procedures. When the analysis was restricted to the 18 development partners who participated in four or more countries, the aggregate performance was 55 percent, but still short of the target of 80 percent.^{16,17}(Figure 18) Weak systems, weak governance, political instability and lack of trust were cited by respondents as reasons for not using the systems.

15. The CPIA score for El Salvador is not provided in the database

16. Aggregate performance was calculated as the sum of funds disbursed using the PFM system divided by the sum of all disbursements to government.

17. The low score of the World Bank is due to the fact that a large grant to Nigeria was not registered on-budget because Nigeria does not have a budgeting mechanism that allows the posting of international resources

Figure 18. Disbursements to government using national budget execution procedures (%)*



* N = number of countries for which data for disbursements and for use of the PFM system were reported. Only development partners who participated in four or more countries are included.

More than half of all development partner respondents (53%) considered that sufficient support was available to strengthen national PFM systems, although this ranged from none in Madagascar to all in Sierra Leone. Respondents offered few suggestions for systems strengthening.

In the global review of development partner policies, procedures and practices, seven of 14 ODA agency representatives confirmed that strengthening national PFM systems was an explicit objective of their health sector support programmes. Five agencies do so occasionally, and only the representatives of GAVI and the Italian MAECI stated that their agency is never involved in this type of support. Using national PFM systems is a default option for nine of the 14 agencies, it is used inconsistently by four of them, and not a default option for DFID.

3.3.2. National procurement and supply management (PSM) systems (EDC indicator 4)

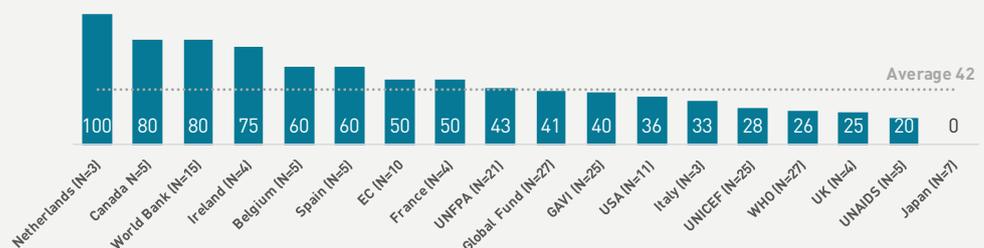
Performance of governments

Almost all governments (27/29) reported that the country had a government-led procurement and supply management system, and many of them reported that an annual health sector procurement plan was prepared. In three countries, the plan only covered national procurement, excluding regional or global procurement. There was almost uniform agreement (27/29) that national procurement and supply management systems needed to be strengthened. Half of the government respondents considered current support from development partners for this task to be insufficient.

Performance of development partners

Responses by development partners about the use of national procurement and supply management systems were, in all cases, qualified. Most development partners stated that they used several procurement systems depending on the type of programme, implementing partner and volume of procurement. Several stated that they used the national system only for national procurement, small volume procurement or for procurement that was financed with sector budget support or through a pool-funded programme administered jointly with government. In some instances, commodities were procured using agency-specific systems, but then channelled into the national supply chain, for instance through the central pharmacy. On average, 42 percent of respondents stated that they used the national PSM system for at least some procurement.¹⁸ (Figure 19)

Figure 19. DP use of national PSM systems for at least some procurement (%)*



* N = number of countries for which DPs provided a response. Only development partners who participated in four or more countries are included.

Respondents in all 30 countries, and overall half of all respondents, considered that sufficient support to strengthen national PSM systems was provided. This contrasts with statements by the governments of half of the countries that development partner support for strengthening PSM systems was insufficient.

18. The average is not weighted by volume and therefore does not reflect the percentage of goods procured with the national PSM system

In the global review of development partner policies, procedures and practices, only five of the 14 ODA agency representatives stated that strengthening national procurement systems was an explicit objective of their agency's health sector cooperation programme. Only four stated that their agency used national procurement systems for all their goods and services, and six that national PSM systems were used for some procurements.

3.3.3. Coordinated technical assistance and south-south cooperation (EDC indicator 6)

Performance of governments

Six of the 29 governments that responded to the questions about technical assistance stated that the government had a technical assistance plan for the health sector. In one case this was a comprehensive plan developed by the ministry of finance with a process of annual determination of sector needs. Two health ministries reported that they were in the process of developing a plan. Generally, except in one country, the plans only covered the public sector. Only one respondent stated that international development partners always adhered to the plan.

Many more governments reported sub-sector or programme-specific technical assistance plans, for instance for the implementation of programmes funded by the Global Fund. The preferred option for improving the coordination of technical assistance in health for most government respondents was a sector technical assistance plan as part of the jointly developed health sector strategy.

Government respondents in 23 of 29 countries reported that the health ministry participated in the development of the terms of reference and in the selection of staff for technical assistance mobilised by development partners. This involvement may only be partial according to one respondent, or it may be systematic and include several government ministries according to the responses from another country. Technical assistants in the public sector usually report to government, although this was reported not to be the case in five countries, and other countries noted that reporting to government was not a consistent practice. Half of the responding governments stated that they had mechanisms to monitor the performance of international technical assistants, although these were not always considered to be adequate or systematically applied.

Most respondents provided some examples of technical cooperation with other low- or middle-income countries, either bilaterally or within a regional institutional framework. The terminology of south-south cooperation to describe these activities, or triangular cooperation when they also involve financing by a traditional OECD development partner, was not always well understood. Regional institutions were mentioned often as well as countries with emerging economies such as India, Brazil and South Africa. One government respondent, for instance, reported a technical cooperation agreement with Cuba and progress in the development of technical assistance projects with Algeria, Egypt and South Africa. Overall, eight respondents felt that the health sector in their country benefitted greatly from south-south cooperation, nine felt that it benefitted most of the time, and three sometimes.

Performance of development partners

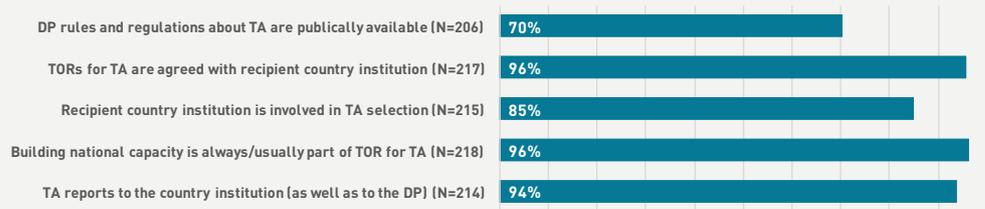
Of the 33 participating development partners that completed the qualitative questionnaire, 28 stated that they provided technical assistance to the public sector and 22 did so in all countries in which they submitted a response. Some development partners responded that they did not provide technical assistance because their funds were channelled to implementing partners or pooled funds.

The question of whether technical assistance was provided under a national technical assistance plan was not uniformly understood. Most development partners responded affirmatively, but only six of the 30 ministries of health reported that such a plan existed. The development partners instead referred to the fact that their agency's technical assistance was agreed with sector authorities or was in line with sector or sub-sector strategies. The requirements for technical assistance are presented with varying levels of detail in some of these strategies.

There was almost unanimous agreement that international technical assistance to the public sector should be well coordinated. According to a majority of development partners, this could be achieved by developing a national technical assistance plan for health. The need for such a plan was, however, queried by several respondents who expressed their preference for more focused coordinated planning of technical assistance at the sub-sector or programme level.

In response to specific questions about their organisation's practices in providing technical assistance in the health sector, respondents signalled agreement with five statements of practice with the frequency shown in Figure 20.

Figure 20. DP technical assistance practice *



*N = number of DP respondents who answered the questions out of 255 submitted qualitative questionnaires

In the global review of development partner policies, procedures and practices only three ODA agency representatives stated that their agency had an explicit policy demanding that technical assistance by their agency had to be provided under a sector-wide technical assistance framework developed jointly by governments and development partners. An additional ten of the 14 agencies confirmed that they involved governments in developing terms of reference and in selecting technical assistants.

Questions about south-south, regional and triangular cooperation were not understood in the same way by all respondents. When technical assistance from one developing country to another is supported by a development partner it becomes by definition triangular cooperation. The distinction between regional and south-south cooperation is more fluid, whereby south-south cooperation refers more directly to bilateral arrangements of technical and programme assistance among two or more developing countries, while regional cooperation is more likely to be framed within a formal regional network or institution. The overlap is large and both can co-exist between two countries.

Respondents of the 18 development partners who participated in four or more countries, affirmed to 79 percent that they provided some form of support for south-south or regional cooperation. Most of them mentioned support to a regional institution or a cross-border initiative involving two or more countries. Others mentioned the funding of learning visits among countries. While these activities may contribute to exchanges of knowledge between developing countries, it is not entirely clear how many of them should be categorised as triangular cooperation, i.e. mutual technical and programme assistance among developing countries supported by a traditional development partner.

3.3.4. Trends in meeting commitments to establish, strengthen and use country systems

Data on the use of procurement and supply management systems, as well as on coordinated management of technical assistance were collected for the first time in 2016. Information on trends is therefore not available. Data to calculate trends on the use of public financial management systems for the budget execution of development cooperation funds disbursed to government were limited. Only seven of the 14 countries that participated in all three rounds had a CPIA score of at least 3.5, indicating a financial management system that was sufficiently robust. Trends in the use of the national PFM system for budget execution of funds disbursed by the 14 development partners to the government sector are presented in Figure 21. The rates are calculated from relatively few reports provided by the 14 development partners in seven countries (42 in 2016, 46 in 2014, 55 in 2012) and are therefore not very stable, but they suggest that performance has not changed over the past six years.

Figure 21. Trend in DP use of national PFM systems for disbursements to government sector*



3.3.5. Constraints and opportunities

Constraints

Governments stated that the main constraints for strengthening public financial management included insufficient resources or technical capacity, limited political will, and insufficient support from development partners.

Government respondents stated that development partners did not use the national procurement and supply management systems because of slow and cumbersome procurement procedures, inefficient or unreliable systems, or simply that the partners had their own systems and preferred to use them because they had more confidence in their efficiency, especially for large volumes and emergency procurement.

Alignment of technical assistance provided by development partners with government needs and priorities was considered much weaker by governments than by development partners. Development partners only adhered fully to the technical assistance framework in one of the six countries where such a framework existed; in six out of 29 countries the government was not involved in developing terms of reference or selecting staff for technical assistance; in five out of 28 countries the technical assistance staff did not report to government; and mechanisms to monitor the performance of technical assistance staff only existed in half of the countries.

The expansion of south-south cooperation in health was limited by low financial support, insufficient capitalisation of lessons learnt, insufficient knowledge about possibilities and experience in other countries. In many countries, the negotiations and agreements for south-south cooperation were within the remit of the ministries of foreign affairs or international cooperation, and the scope for health ministries to participate in these negotiations was limited.

Development partners did not use public financial management systems for budget execution, financial reporting and/or auditing when they considered that national systems were not sufficiently reliable, when agency regulations did not allow the use of national systems for project-type investments, or when they disbursed most of their funds to implementing partners outside government. In a few countries, political instability, corruption, misuse of funds or non-transparent budget allocations were cited as the main bottlenecks.

Constraints to using national procurement systems cited by development partners included the perception that the systems were inefficient or did not meet standards of quality and transparency. Several development partners mentioned preference to procure through harmonised or established international third-party procurement systems, and some had mandatory requirements or strong preferences for the use of agency-specific systems. Efforts for strengthening PSM systems were generally rated much higher by development partners than by governments.

Twelve of 18 development partners did not engage in triangular cooperation (i.e. did not support south-south cooperation) because they stated that they had no mandate, that this was not a priority of the ministry of health, or that this type of support did not fit within the framework of cooperation agreed with the country.

Opportunities

Governments: For both the national PFM and PSM systems, governments see the main opportunities in increased capacity development and systems' strengthening initiatives by development partners. Responses in some countries documented a tension between the expressed need by governments for more investment in strengthening systems and the view by development partners that sufficient support was provided.

The coordination of international technical assistance, according to many government respondents, could be improved by making better use of existing sector coordination fora and by agreeing on the needs for technical assistance on the basis of the national health strategy. Regional institutions provided the main opportunities for increasing south-south cooperation, and the role of WHO was mentioned most frequently in this context.

Development partners acknowledged that there was scope to strengthen public financial management in some countries, including support to increase planning and financial management capacity at central and decentralised levels. Opportunities mentioned to increase the use of national PFM systems included increased use of national or global pooled funds, joint financing agreements and trust funds, as well as channelling funds through global initiatives that use national PFM systems. The launch of national health sector plans was seen by some development partners as an opportunity to structure their support through joint or multi-donor sector agreements or multi-donor projects with financial management integrated in the national PFM system. Many development partners confirmed their willingness to increase the use of these systems.

Financing, reporting and auditing procedures that were harmonised among development partners were cited frequently. UN agencies pointed to the UN's Harmonised Approach to Cash Transfers (HACT) and the United Nations Development Assistance Frameworks (UNDAF). The Global Fund cited the cooperation with UNDP as principal grant recipient in several countries, while GAVI mentioned collaboration with UNICEF in the vaccine sector. Bilateral development partners accepted shared or delegated financial management to varying degrees for their contributions to pooled funds at country level, for instance in Afghanistan, Cambodia and Myanmar.

Many development partners confirmed their willingness to use national procurement and supply management systems. They stated that efforts to strengthen these systems were in place in many countries. The launch of a new health sector strategy was an opportunity to review the needs for strengthening PSM systems and plan for increased use of the systems by all partners.

Suggestions on how to improve coordination of technical assistance included working with governments to better outline key areas of technical assistance needs at the sector or sub-sector level and sharing them with all partners. Other suggestions included annual reassessments and updates of technical assistance needs and regular joint evaluations of technical assistance performance, especially focusing on outcomes in terms of increased national capacity. Some respondents also suggested that information sharing among development partners could be improved to avoid duplication.

Development partners offered many suggestions on how south-south and triangular cooperation could be employed more effectively. These included the joint development of plans for south-south cooperation between governments and development partners, including a joint selection of potential southern partner countries that have the necessary experience and technical resources that could be mobilised to address specific health sector issues. Regional institutions, regional networks, regional pools of experts, as well as regional and international conferences were also mentioned as mechanisms through which south-south technical assistance could be defined and developed.

3.4. CREATE AN ENABLING ENVIRONMENT FOR PARTICIPATION OF CIVIL SOCIETY AND THE PRIVATE SECTOR

Governments: Governments reported that civil society organisations participated in the development, implementation and monitoring of health policies in almost all countries, but many government respondents recognised that the quality of participation could be improved and broadened. Participation of the private sector in the health policy dialogue was acknowledged in 19 countries, but often considered insufficient or not representative.

Development partners: Eighty percent of development partners reported institutional mechanisms to involve civil society organisations in programme development and oversight. Two-thirds supported some CSOs financially, technically or with training. Overlap with their own programmatic and geographic interests was more important than national inclusiveness. Two-thirds of development partners stated that CSOs received support for networking, advocacy and participation in national policy. Support to CSOs may have weakened since 2014, but was still above the level in 2012.

Seventy percent of development partners confirmed that their agency included private sector organisations in stakeholder consultations and other participatory structures for their programme. Among them, 70 percent promoted the participation of private sector actors in the national health dialogue and about half stated that their agency provided financial or technical support to strengthen the role of the private sector in health.

Civil society organisations: Only one-third of CSOs considered that freedom of association, assembly and expression were effectively recognised in national policies, laws and regulations of their country (two-thirds acknowledged that there was partial recognition), 39 percent stated that their organisation could access resources without restrictions. Almost all felt that the legal and regulatory environment was enabling, albeit only partially for some of them.

More than half of the CSOs were part of a network, coalition or other mechanism to facilitate their participation in health policy dialogue. It was considered moderately or relatively effective by most.

Although 28/30 governments stated that CSOs were consulted, only 35 percent of CSOs fully agreed that they were consulted in major health policy or programme decisions while another third acknowledged some level of consultation. Access to information about these decisions was only partial for most of them and, for two-thirds of CSOs, it was deemed to be too late to ensure meaningful participation. Lack of a representative CSO coalition or network constrained the ability for greater participation in some countries.

Although 80 percent of development partners reported that they had institutional mechanisms to involve CSOs in programme development and oversight and 70 percent reported that they used them, CSOs reported that few, if any, development partners involved them in the development of cooperation programmes.

Private sector stakeholders: Involvement of the private sector in health sector policy development was absent or limited to ad hoc selective consultations in all participating countries. In most countries, the private sector lacked a representative body or umbrella organisation that could formally represent the sector or provide a platform for dialogue with government.

While the legal frameworks in most countries permit private practice in health, they are often not comprehensive or sufficiently strong to ensure quality of care in the private sector.

Technical and financial support for the private sector by government and development partners was very limited or absent.

3.4.1. Civil society engagement (EDC indicator 7)

Performance of governments

According to government respondents, civil society organisations participated in the development, implementation and monitoring of health policies in 28 of the 30 countries although the degree of involvement varied. Participation was described as limited or just starting in two countries. In another, the Country Coordinating Mechanism was referred to as the main structure for participation, while in another, a national network affiliated to Transparency International that produces annual health sector reports was mentioned. Mechanisms for CSOs to provide feedback on public health policy were described in 23 countries, including regular meetings or workshops, joint annual sector reviews, 360 degree evaluations or a dedicated internet site. Respondents in two of these countries acknowledged that these mechanisms were not well defined.

In 18 of the 30 countries the government provided financial resources to civil society organisations; 25 respondents mentioned training support and 19 technical assistance. Other government support to CSOs included participation in study tours, workshops, meetings and conferences, as well as provision of materials for training and information technology.

Performance of development partners

Eighty percent of development partners stated that they had institutional mechanisms to involve civil society organisations in programme development and oversight, 66 percent provided financial resources to CSOs, 55 percent technical assistance, and 54 percent training. Among the 18 development partners who reported in four or more countries, nine stated that they involved CSOs in programme development and oversight in at least 80 percent of programme countries, and eight provided at least one type of CSO support in at least 80 percent of those countries. This is shown in Table 5.

Table 5. Development partners with more than 80 % performance in support to CSOs

	Involvement in programming	Support		
		Financial	Technical assistance	Training
Belgium		✓		
Canada	✓	✓		✓
EC	✓	✓		
Global Fund	✓	✓	✓	
Spain	✓			
UK		✓		
UNAIDS	✓	✓	✓	✓
UNFPA	✓	✓	✓	✓
UNICEF	✓			
USA	✓		✓	✓
WHO	✓			

The types of activities in which civil society organisations were involved included programme scoping and design missions, programme steering committees, and monitoring and evaluation activities. In addition, national mechanisms for the involvement of CSOs in health sector policy and programmes were mentioned. These had different structures and levels of inclusiveness from country to country.

On the question of inclusiveness of CSOs in health sector cooperation, the development partners referred primarily to national responsibilities. For their own programming, overlap with programmatic and geographic interests was more important than national inclusiveness. As stated by one respondent: "It is the state that confers a place for participation to civil society and not the international community".

There is, nevertheless scope for development partners to enhance the voice of CSOs in national governance and decision-making bodies, for instance through the approach pursued by the Global Fund to strengthening the role and capacity of the Country Coordinating Mechanisms in which CSO participation is a mandatory requirement for grant eligibility. Two-thirds (66%) of all development partner respondents stated that CSOs received support for participation in national decision-making. However, in response to an open question about the type of support, only ten percent provided answers that could be allocated to this objective, including support for participation in national policy fora, support for networking among CSOs, support for advocacy activities, and support for watchdog activities. It is, of course, possible that this type of support to CSOs is provided through other development partner sector programmes.

Development partner responses to the question about the feedback they provided to civil society organisations were analogous to their responses to questions about CSO inclusion in programme development and oversight. Some mentioned project-specific feedback mechanisms, but most referred to mechanisms and structures established at national level that differed from country to country. Thirty percent of respondents stated that through these mechanisms, no feedback, insufficient feedback or inconsistent feedback was provided to CSOs.

In the global review of development partner policies, procedures and practices, 13 of the 14 agency representatives (with the exception of the World Bank) confirmed that they supported the participation of CSOs in health sector policy processes. According to the World Bank informants, this was under the sole responsibility of governments. Only seven of the 14 agency representatives stated that their agency had specific procedures to engage civil society in the identification, formulation and implementation of their agency's health sector support programme.

3.4.2. Private sector engagement (EDC indicator 8)

Performance of governments

The private sector was reported to participate in the health policy dialogue in 19 of the 30 countries, although in seven of these, participation was described as very limited. Governments in all 19 of these countries stated that there were feedback mechanisms to take the views of the private sector into account, but only 16 acknowledged that they provided sufficient and timely information for private sector participation. Only six of 29 respondents stated that private sector health services were fully captured in the national health information system; the information was partially captured in 15 countries, and in six countries not at all.

Performance of development partners

Seventy percent of development partner respondents confirmed that their agency included private sector organisations in stakeholder consultations and other participatory structures for their programme; 49 percent stated that their agency provided financial or technical support to strengthen the role of the private sector in health, and 70 percent promoted the participation of private sector actors in the national health dialogue. Among the 18 development partners who reported in four or more countries, six included the private sector in stakeholder consultations in at least 80 percent of their country programmes and six promoted the participation of the private sector in the national health dialogue, but only three provided financial or technical support to the private sector in 80 percent of their country programmes. This is shown in Table 6.

Table 6: Development partners with more than 80 % performance in private sector support

	Involvement in stakeholder consultations	Promotion of participation in health policy dialogue	Financial and/or technical assistance
Belgium	✓	✓	✓
Canada	✓		
France		✓	
Global Fund	✓		
Japan		✓	
UK	✓		✓
UNAIDS	✓		
USA	✓		✓
WHO		✓	
World Bank		✓	

In the global review of development partner policies, procedures and practices, seven ODA agency representatives stated that their agency had a keen interest and a track record in strengthening the health sector regulatory framework in countries of cooperation. Eight agencies confirmed that their policies and strategies included explicit statements about promoting the involvement of the private sector in health sector development, and 11 actively promoted the involvement of the private sector in the health policy dialogue.

In the global review of development partner policies, procedures and practices, seven ODA agency representatives stated that their agency had a keen interest and a track record in strengthening the health sector regulatory framework in countries of cooperation. Eight agencies confirmed that their policies and strategies included explicit statements about promoting the involvement of the private sector in health sector development, and 11 actively promoted the involvement of the private sector in the health policy dialogue.

The responses suggest that while most development partners advocate for the participation of the private sector in health sector reviews and policy fora, or promote the establishment of public-private partnerships, far fewer provide direct financial or technical support.

3.4.3. Views of civil society organisations

Almost one in five (18%) of the CSOs that responded to the on-line survey (overall response rate 43 percent) did not answer the questions about their operating environment. Although they were assured confidentiality, this may indicate reluctance to express views that could be perceived as being critical of government in a questionnaire that was circulated under the authority of the ministry of health. Almost all that responded considered that freedoms of association, assembly and expression were recognised in their country, however two-thirds of them stated that this recognition was only partial, and 16 percent confirmed that certain groups were prevented from participating in health policy processes because of gender, ethnicity, religion, sexual orientation or other reasons for exclusion.

More than half of the CSOs worked in a network, coalition or other mechanism to facilitate their participation in health policy dialogue, but their assessment of the effectiveness of these mechanisms was qualified. Only one in five respondents considered it to be very effective. Most CSOs (85%) assessed their management capacity as at least acceptable. The capacity for policy dialogue achieved the lowest score with only 71 percent being at least at an acceptable level.

Most of the respondents (78%) reported to their ministry of health, however only about one-third fully agreed that they were consulted by government on major health policy or programme decisions. Access to information about these decisions was only partial for the majority, and in two-thirds of instances it was judged to be too late to ensure meaningful participation. Occasional training support by government was confirmed by at least one CSO in 25 countries, occasional technical assistance in 28 countries and occasional financial support in 23 which closely reflected the reports from governments. Many CSOs, however, reported that government support was rare or not provided at all, indicating that this support was not highly inclusive.

CSOs reported that few, if any, development partners involved them in the development of cooperation programmes. They also reported that support for participation in health policy fora was provided at best occasionally and for about half of them rarely or never. Based on the analysis of the development partner responses, a much higher level of CSO participation in programme development was expected, because two-thirds among them reported that they had institutional mechanisms to involve CSOs in programme development and oversight. The responses from CSOs suggest that these mechanisms are selective, similar to development partner support to CSOs which for about half of the organisations was rarely or never provided.

Overall, the responses by CSOs to the on-line survey did not contradict the responses from government and from the development partners, but they point to a problem of inclusion. In practical terms, this can only be addressed through building strong representative national coalitions and networks among CSOs working in health.

In addition to the civil society survey, 229 civil society representatives participated in focus group discussions in 27 countries.¹⁹ The purpose of these discussions was to contextualise the information provided by the survey in order to enrich the analysis of cooperation at country level. The outcomes of the discussions were reflected in the CSO consultation reports provided to the ministries of health, and in the country assessment reports provided to all partners. The issues raised by CSOs were highly country specific but, overall, confirmed the findings of the survey analysis.

3.4.4. Views of private sector stakeholders

Focus group discussions with representatives of private sector organisations were organised in 24 countries. Difficulties in organising these groups included a lack of interest by government and by private sector organisations. Most participants were representatives of professional associations, followed by private medical care providers. Most themes raised by the focus groups were highly country specific. Nevertheless, there were some common themes.

¹⁹ In Sudan, a focus group discussion took place with CSOs working in health as part of the GPEDC process and was therefore not repeated. In Cameroon and Madagascar, it proved difficult to bring together CSOs

Involvement of the private sector in health sector policy development was absent or limited to ad hoc selective consultations in all participating countries. Ministries of health engage with the private sector by inviting selected representatives to specific coordination fora such as technical working groups or joint health sector reviews, sometimes in an individual capacity rather than as representatives of organisations. In most countries, there was no representative body or umbrella organisation that could formally represent the sector in interaction with the ministry of health. Some countries have set up, or are in the process of setting up, a dedicated platform for dialogue with the private sector. These platforms as well as existing CCMs may become an entry point for more meaningful engagement.

While the legal frameworks in most countries permit private practice in health, they are often not comprehensive or sufficiently strong to assure quality of care in the private sector. Accreditation systems are absent in several countries. The health information systems in most countries capture private sector activities only partially or not at all, and reporting is generally poor. Accountability systems for the private sector were generally viewed as being insufficient.

Figure 22. Trend in DP support of civil society organisations



3.4.5. Trends in meeting commitments to create an enabling environment for civil society organisation and private sector participation

Data were collected in all three monitoring rounds about development partner support of civil society organisations. The questions about the type of support were slightly different between the fourth and the fifth monitoring rounds. When responses for any type of support are aggregated among the 14 development partners in the 14 countries with serial data, there is a suggestion that support to CSOs may have weakened since the last time this indicator was assessed in 2014, but it was still above the level assessed in 2012. (Figure 22)

3.4.6. Constraints and opportunities

Constraints

Almost all constraints mentioned by **governments** for greater involvement of civil society and private sector organisations in the health policy dialogue referred to the diversity and large numbers of actors, and the absence or weakness of representative platforms or coalitions. The competition of the private sector with public sector service providers, especially for human resources, was also mentioned by some.

Development partners felt constrained in their ability to work with civil society organisations if these were not trusted and respected by their governments. For some development partners, increased engagement with CSOs would require that their governance and accountability mechanisms be strengthened and become more transparent. Constraints for engaging with the private sector also included a lack of commitment and trust of the private sector by governments, as well as weak legal and regulatory frameworks for private health service providers. Many development partners mentioned that the private sector lacked legitimate representative bodies, had weak governance, high and non-transparent cost structures.

The selectivity of support by and engagement with governments and development partners were also the main constraints raised by representatives of **civil society and private sector organisations**. The civil society survey indicated that some organisations felt excluded, and private sector representatives stated in discussions that their participation was ad hoc and not systematic.

Opportunities

Governments suggested that the engagement with civil society could be strengthened by supporting the establishment of a CSO platform, creation of a CSO liaison office in the ministry of health (where it did not already exist), broadening the scope of CSOs invited to participate in health partner fora, and encouraging the participation of community-based organisations in district-level coordination. The Global Fund model was cited by several respondents as an experience on which to build. One respondent suggested that CSOs should be involved in the development of country compacts and become signatories to the compact, thereby also integrating them in the mutual accountability framework.

For the private sector, government respondents suggested the establishment of public-private partnerships, the appointment of a body to represent private sector interests in health policy, and the integration of private sector health facilities in the national health information system. Support provided by the World Bank in setting up a private sector platform for dialogue with government was mentioned in several countries.

Development partners mostly referred to increased integration of CSOs in existing coordination fora or processes. This would also require the strengthening of CSOs and especially of representative networks. The Global Fund model of requiring CSO participation in the country coordinating mechanisms as a condition for grant approval, and of monitoring the participation was cited by several respondents as an experience on which to build.

Opportunities for engagement with the private sector also referred to existing health partnership fora and mechanisms as well as engagement with private sector representative bodies and interest groups such as professional associations, private health sector alliances, and business coalitions on HIV; or with large service, extractive, agricultural or manufacturing companies that are maintaining their own health service and health insurance schemes. Some development partners mentioned project-type support for public-private partnerships, social marketing programmes or start-up support for health industries such as pharmaceutical production; working with other ministries and entities outside the health sector such as the ministry of labour or the chambers of commerce; contracting private sector companies for project implementation; and up-stream financing of the production of essential health commodities such as vaccines or medicines for malaria.

Interests in investing in regulatory framework of the private sector were signalled in the policy review of UNICEF (for child health issues) and GIZ which pointed to a track record in supporting the development of regulatory frameworks in partner countries. Several ODA agencies have explicit statements on promoting private sector involvement in their policy and strategy documents. Some agencies (e.g. DFAT and JICA) indicated that collaboration with the private sectors focused primarily on creating international opportunities for the domestic private sector.

3.5. THE INTERFACE OF DEVELOPMENT COOPERATION AND HUMANITARIAN ASSISTANCE IN HEALTH

Finding: In crisis situations, a major proportion of international health sector assistance may be provided through humanitarian assistance channels. Development partner staff working in the cooperation sector at country level are not always fully informed about the volume of disbursements under this modality, and ministries of health are rarely informed. Humanitarian assistance has its own principles and systems of coordination, but there is a need among development partners to develop a consensus about the interface between development cooperation and humanitarian assistance in health, and about the application of EDC principles. Humanitarian assistance funds are largely provided outside the country-level EDC framework.

In some countries, a considerable amount of financial assistance to the health sector is disbursed through humanitarian aid channels. According to the OECD CRS database, eight of the 30 countries participating in the fifth IHP+ monitoring round received high levels of humanitarian assistance in 2014. For data collection in these countries, questions about disbursements for the health sector through humanitarian aid were included in the questionnaires to development partners.²⁰ Information about health financing through the UN-coordinated humanitarian aid strategic response plan was collected in a separate questionnaire to be completed by the health cluster coordinator at the WHO Country Office. These were answered in Afghanistan and the DRC, the only two among the eight countries that had such a plan in 2014. The plans were 55 percent financed in Afghanistan and 23 percent financed in the DRC. A strategic response plan for Chad was launched in February 2015.

Based on information provided by development partners, aggregate health sector disbursements through humanitarian channels to the eight countries in the selected fiscal year made up 38 percent of total disbursements for health through all channels, ranging from zero in Guinea to 76 per cent in Liberia, and from zero for several development partners to 58 percent for the USA. The disbursements and percentages are under-estimated because information on humanitarian aid disbursements for health was not always available to the development partner missions at country level, or because humanitarian aid disbursements by some development partners were not differentiated by sector. Figure 23 shows the disbursements for health through development cooperation and humanitarian assistance channels reported by participating development partners.

Figure 23. Disbursements for development cooperation and humanitarian assistance in health*



Only in the DRC was the Ministry of Health aware of the budget and disbursements for health through humanitarian aid channels. The Ministry of Health in Chad stated that it was partially informed. In the remaining six countries, the ministries stated that they were not informed or they did not answer the question.

20. Afghanistan, Chad, DR Congo, Guinea, Guinea Bissau, Liberia, Mauritania and Sierra Leone

4. Policy and practice of effective development cooperation in health

The global review of development partner policies, procedures and practices in relation to EDC behaviours identified issues of structure and political economy that were raised by representatives of development assistance agencies and that potentially constrain, facilitate or demand a review of commitments to EDC under specific circumstances. These will require further discussion among IHP+ partners.

To better understand the factors that promote or constrain health sector development partners to adhere to EDC principles, a cross-sectional study of policies and practices of 14 development partner agencies was conducted and published in a separate report. The agencies participating in the study are listed in Table 7. Information was collected through a review of published documents, publicly accessible databases, key informant interviews with senior agency programme and policy staff, and a self-administered multiple choice questionnaire about policy and practice related to EDC.

Table 7: Development partner agencies participating in the review of EDC policy and practice

Agency	Country	Agency	Country
DFAT	Australia	MOFA, MOHLW, JICA	Japan
GAC	Canada	SIDA	Sweden
European Commission		DFID	UK
GAVI		UNFPA	
BMZ	Germany	UNICEF	
Global Fund		World Bank	
MAECI	Italy	WHO	

USAID participated in a group interview but declined full participation in the review

Although scores in terms of agency adherence to EDC principles in health sector cooperation were calculated in this study and published in a separate report, they are not comparable to the results of IHP+ country-level monitoring and cannot be triangulated. However, a content analysis of the interviews and document reviews revealed several issues raised by development agencies that affect their ability to adhere to EDC commitments.

- Perceptions of risk and risk tolerance:** When development partners, in line with their commitments to EDC, channel public funds of their agency or government into budgets or activities that are administered by the public financial management system of a partner country, or that are used to procure and manage goods by national institutions, they are potentially taking fiduciary and programmatic risks by delegating management control. Strengthening and using local and national systems and institutions is a core principle of effective development cooperation. But when these systems and institutions do not meet the standards of effectiveness, efficiency and management control that are demanded by those who finance development cooperation, development partners have to decide on the level of risk they are willing to accept. The assumption is that their own systems are more robust and efficient, which is not always the case. Furthermore, there is a trade-off because having multiple parallel systems is an important cause of inefficiency, even if each of these systems are individually highly efficient.
- Decentralisation and devolution of authority:** Some agencies that have a record of solid policy support for EDC principles and practices mentioned in interviews that the decision of the modalities for implementation of their programme was, to varying degrees, devolved to their decentralised missions. Several interviewees mentioned that the adherence to EDC principles and the implementation of EDC practices was the primary responsibility of their country offices. In practice, it is difficult to see how the mutual accountability and participatory mechanisms that characterise good EDC practice can be managed without delegating authority to the level where dialogue among health sector partners takes place. Decentralisation is therefore a potential facilitator for EDC adherence, but it raises an issue of capacity, which is discussed under the next bullet.
- Capacity of development partners at country level:** When development partner agencies devolve the authority for implementation of EDC principles to country level, the demands on decentralised staff are increased, potentially in multiple sectors. Some development partners have dealt with this by delegating sector leadership at country level to other development partners and by reducing the number of sector focus countries. This does, however, require a high level of trust among partners.

- **Domestic agendas and restructuring ODA at national level:** Bilateral ODA is an instrument of foreign policy and of domestic policy. Recent developments related to national political agendas have a potential impact on the implementation of EDC practices. These include the merger of international trade and international development departments in some countries, as well as expanding the mandate and the budget for ODA programming to other departments of government, or engaging domestic private for-profit agencies. These new partners may have no commitment to nor any institutional interest in EDC principles. This change in the ODA architecture in development partner countries can potentially weaken the commitments to achieve EDC.
- **Demand to generate and document attributable results:** Several interviewees mentioned the tension between an increased focus on results and the objective of strengthening national systems. They mentioned increasing pressure to generate and document results in a relatively short timeframe, creating a bias towards short-term outcomes at the expense of effective support of development objectives of partner countries. The increasing demand to demonstrate value for money also requires the estimation of attributable changes that can then be related to the financial investment. Demands to measure attribution undermine the EDC principle of mutual accountability.
- **Multilateral funding and earmarked contributions:** Although multilateral agencies are signatories to the global IHP+ compact and committed to EDC principles, many of them are highly dependent on grants that are earmarked for specified activities, countries or regions. According to reports by several agencies, they frequently have to meet requirements for attribution to the funding agency, thereby limiting their ability to fully apply EDC principles in their cooperation with countries.
- **Increased focus on fragile states and use of humanitarian assistance channels:** Several development partners have a declared intention of a greater focus of development cooperation with fragile states. The principles of cooperation with fragile states as endorsed by the 4th High Level Forum on Aid Effectiveness in 2011 are not substantially different from the EDC principles but may require more flexibility in their application. Most fragile states have weak national institutions and systems, which can undermine the principle of using country-managed systems. In situations where the domestic legitimacy of government is weak, or where two or more parallel government structures exist, many development partners opt to provide support through humanitarian assistance. Principles of humanitarian aid are outlined in the Agenda for Humanity at the 2016 Humanitarian Aid Summit in Istanbul.²¹ It includes a recommendation to 'tailor international support based on a clear assessment of complementarity with national and local efforts, and avoid investing in parallel international coordination and response mechanisms.' While this is in line with EDC principles, it has yet to be translated into a commitment by all partners, as well as into a definition of practices in the health sector and an accountability framework.
- **Development cooperation with middle-income countries:** The practices for EDC in health were developed and agreed primarily in the context of cooperation with low-income countries where international funding represents a significant proportion of health financing. In countries where international partners contribute only a very small proportion of public health expenditures, some EDC mechanisms may be less appropriate or perceived as unwarranted foreign interference in domestic policy. Some development partner agencies reported that they are working on defining modalities of cooperation with middle-income countries. These initiatives have not yet been reviewed by IHP+ partners and may lead to some adjustments of agreed EDC practices for collaboration with these countries.
- **Changes in the global political economy of ODA and EDC:** Several interviewees noted that ODA is coming under increasing public scrutiny, including an increasing prominence of voices questioning the investments of public funds in development cooperation. Governments are sensitive to these changes in public opinion, and while it may or may not lead to a reduction in the ODA budget, it may lead to a redefinition of objectives that are more easily communicated than adherence to EDC principles. As per OECD guideline, most DAC members report expenditures on programmes for refugees in their own countries under the ODA envelope (varying between zero percent in Japan to 34 percent of net ODA in Sweden in 2015).²² The combined allocation of ODA funds for domestic refugee programmes among DAC member countries increased from 2.7 percent in 2010 to 9.1 percent in 2015. In addition, there is a global shift of attention and resources towards the goal of universal health coverage (UHC). While EDC is primarily about aid modalities, UHC offers a more comprehensive agenda focusing on national health systems. This could potentially re-enforce EDC principles of strengthening and using national systems, but care should be taken to maintain a focus on EDC while moving the UHC agenda forward.

21. One humanity: shared responsibility: Report of the Secretary-General for the World Humanitarian Summit. UNGA February 2016

22. OECD, DAC secretariat, ODA reporting of in-donor country refugee costs, April 2016

5. Summary of findings

Table 8: Performance on IHP+ indicators in the 5th monitoring round

Legend	Progress (at least 3% increase over 2014 monitoring round)	Stagnation (within +/- 3% of results in the 2014 round)	Decline (at least 3% decrease from 2014 monitoring round)	Not comparable with 2014 monitoring round	Not applicable
	Government		Development Partners		
Health sector strategies and mutual accountability					
Proportion of countries with a national health sector strategy in place and proportion of development partners that align their programmes with national priorities	100%	100%			
Proportion of countries with a comprehensive monitoring and evaluation framework in place and proportion of development partners that exclusively use the national monitoring framework	80%	47%			
Mutual accountability mechanisms are in place and used by development partners	80%	73%			
Health sector financing commitments					
Proportion of government health sector budget execution and proportion of development partner health sector support budget execution	86%	71%			
Proportion of governments that have a 3-year rolling budget or MTEF in place and proportion of development partners of which the government has information about their next 3 years forward looking expenditure plans	66%	35%+			
Proportion of countries where the contributions of development partners are (at least partly) reflected in the national budget and proportion of development partner support to government registered in national health budget	77%	53%			
Use of national management systems					
Proportion of countries where the public financial management system adheres to good practices (CPIA) and the proportion of support using national financial management procedures (development partners)	55%	53%			
Proportion of countries with sufficient development partner support for strengthening public financial management system	NA	50%*			
Proportion of countries with a government-led plan for procurement and supply systems and proportion of development partners that use national procurement and supply systems at least for some procurement	93%	41%			
Proportion of countries with sufficient development partner support for strengthening public procurement and supply systems	NA	100%*			
Proportion of countries with an agreed national technical assistance (TA) plan and the proportion of development partners that provide TA in accordance with this plan	21%	Not assessed			
Recipient institutions are involved in developing the terms of reference and in the selection of TA	79% ⁺	96% / 85%*			
The proportion of countries where the ministry of health benefits from south-south or triangular cooperation (SSC or TrC) and the proportion of development partners that supports this type of cooperation	67%**	79%#			
Support for engagement of CSO and private sector in health policy dialogue					
Proportion of countries where CSOs participate in health policy dialogue and proportion of development partners that have institutional mechanisms to involve CSOs in programme development and oversight; and use them	93%	80% / 70%			
Proportion of governments that have feedback mechanisms in place to CSOs	77%	NA			
Proportion of governments and development partners that provide either financial resources, training or technical support to CSOs	83%	66%			
Proportion of countries where the private sector participates in health policy dialogue and proportion of development partners that provide support for private sector participation in national health policy dialogue	63%	70%			
Proportion of development partners that provide financial or technical support to the private sector	NA	49%			
Proportion of governments that have feedback mechanisms in place to the private sector	63%	NA			
Proportion of development partners that include private sector organisations in stakeholder consultations and other participatory structures for their programme	NA	70%			

+ As reported by government

* As reported by development partners

** 20/30 countries reported they either benefit greatly, most of the time or sometimes from SSC or triangular cooperation

Not all development partners had the same understanding of SSC or triangular cooperation

5.1. EFFECTIVE DEVELOPMENT COOPERATION PROGRESS

The 2016 performance monitoring round documented mixed progress towards effective development cooperation in the health sector. The trends over three rounds in the performance of partner countries and development partners are largely stagnant with some improvements and some deterioration in aggregate performance.

Commitment 1: Establish strong health sector strategies that are jointly assessed and strengthen accountability

Findings

Partner alignment with health sector strategies, and participation in joint strategy assessments and joint sector reviews have strengthened but need to be matched by increased reliance of development partners on national performance monitoring frameworks and systems. Mutual accountability mechanisms are not sufficiently inclusive and conditions for meaningful participation by civil society and private sector organisations are often not met.

Governments and development partners continue to deliver on their commitments to establish national health sector strategies and assess them jointly. Development partners participate in annual health sector reviews and thereby share the accountability for performance.

Most development partners align the performance monitoring frameworks for the projects and programmes they support with the indicators and targets of national performance monitoring frameworks. However, only half of them use national monitoring data, and most of them require the monitoring of additional indicators. They are more likely to rely on national systems when they have been involved in the development of the national health strategy, including the performance monitoring and evaluation strategy. Monitoring performance at the sub-sector level continues to be important for about three-quarters of partner governments and for half of development partners. Overall, the findings are in line with the results of GPEDC 2016 monitoring round.

Commitment 2: Improve the financing, predictability and financial management of the health sector

Findings

The predictability of health sector financing has not improved. The level of execution of development partner budgets for public sector support has declined, and information about three-year forward looking expenditure estimates remains at a low level. On-budget registration of development partner funds is stagnant.

Government expenditures for health as a proportion of total government expenditures have continued to decrease over the last three monitoring rounds. Governments in 16 of the 30 countries executed at least 90 percent of their health sector budget, while development partners only reached the 90 percent target for the execution of their budget for the government sector in 11 countries.

Two-thirds of the countries have a medium-term expenditure framework or three-year rolling budget estimate in place and three-quarters of them are informed about two-year forward-looking expenditure plans by development partners. However, only one-third have information for the next three years. Overall, the data suggest that financing and predictability of the health sector is stagnant.

The target of recording at least 85 percent of their health sector support to government on the national budget was reached by only six of 14 development partners. In aggregate, the proportion of development partner funds recorded on budget (53%) has not changed since the 2014 monitoring round. Findings on annual and medium-term predictability are in line with GPEDC 2016 findings, but with lower health sector scores for medium-term predictability.

Commitment 3: Establish, strengthen and use country systems

Findings

Development partners make better use of national public financial management systems than in 2014, although not better than in 2012. Only half of them use national procurement systems. Most development partners provide technical assistance in agreement with recipient institutions. Few governments have sector-wide technical assistance plans and fewer development partners use them.

Almost all participating countries received international support to strengthen their public financial management systems. In slightly more than half of the countries, the systems were assessed as reasonably robust (CPIA score $\geq 3.5/6$). In these countries, more than half of development partner contributions to the government sector were disbursed using national budget execution procedures. Most participating countries have national procurement and supply management (PSM) systems, but only 42 percent of development partner respondents stated that they used the national PSM system for at least some procurement.²³

Almost all development partners reported that they cooperated with national institutions in defining the support for technical assistance, although governments rated their participation somewhat lower. Sector-wide technical assistance plans were only reported by six governments; in only one country did the development partners confirm that they used this plan for all sector technical assistance support. Technical assistance plans were more frequently developed and used at the sub-sector or programme level, and this was a preferred option for some development partners. Health sector support through south-south or triangular cooperation was reported by two-thirds of participating governments, and development partner support for these modalities was strong.

Overall, the use of national PFM systems for the execution of development partner budgets increased since 2014 but there was no improvement on the situation reported in the 2012 monitoring round. The use of national PSM systems, national sector technical assistance plans and support to south-south cooperation were not monitored in previous rounds. The finding of higher use of public financial management systems and low use of national procurement systems is in line with GPEDC 2016 findings.

Commitment 4: Create an enabling environment for civil society organisations and private sector participation in the health sector

Findings

Governments and development partners continue to provide support for CSOs to engage, but this support is not inclusive of all actors. Engagement with and support for the private sector is reported by many governments and development partners, but it is acknowledged to be weak as also confirmed by private sector representatives. Lack of, or weakness of nationally representative bodies for both CSOs and the private sector are identified as major constraints to stronger engagement. In the majority of countries, private sector health services are not captured in the national health information system.

The majority of participating governments and development partners reported that they involve CSOs in programme decisions and in health policy dialogue and provide support to CSOs, with government more likely to provide training and development partners more likely to provide financial support. However, some governments stated that the involvement of CSOs in the health policy dialogue was limited. Specific support to CSOs for networking, advocacy and watchdog activities were together only mentioned in 10 per cent of development partner responses.

CSOs that participated in the survey and focus group discussions presented a somewhat different picture of the situation. In their view, CSO involvement in national health policy dialogue and development partner programming was selective and not meaningful because most of the time they were invited to participate after decisions had been made. More of them received financial, training and technical assistance support from development partners than from government, and survey responses indicated that this support was rather selective.

The involvement of the private sector in health policy dialogue was acknowledged by two-thirds of participating governments, and support to the private sector by a similar proportion of development partners. However, engagement with and support of the private sector was acknowledged to be weak by many respondents. This was confirmed in focus group discussions with private sector representatives. Several development partners suggested that stronger engagement by ministries of health with the private sector would enhance their ability to provide support. For CSOs, and even more so for the private sector, the lack or the weakness of nationally representative bodies was seen as a major constraint to more effective engagement with government.

Compared to previous monitoring rounds, self-reported development partner support to CSOs was weaker than in 2014 but stronger than in 2012, although the questions on which these findings are based differed and responses are not strictly comparable. Private sector engagement was not assessed in previous monitoring rounds. In line with these findings, GPEDC 2016 findings also confirm that creating an enabling environment for civil society requires further effort and that there is willingness and scope to strengthen cooperation and partnership between the public and private sectors.

23. The survey did not distinguish between procurement and supply management, but some DPs provided differentiated information about the use of national procurement and national supply management systems

Additional findings: Humanitarian assistance for health

In the review of the policies and the political economy of EDC adherence by development partner agencies that was conducted in parallel to the fifth monitoring round, several key informants mentioned the shift of ODA funds from development cooperation to humanitarian assistance and its effect on adherence to EDC principles. Information collected in six countries with high volumes of humanitarian assistance confirmed that ministries of health were poorly informed about health sector assistance provided through humanitarian channels, even though the volume of this assistance may be substantial and even outweigh financial support for development cooperation. Humanitarian assistance is often managed by agency departments at headquarters level working across sectors, and country-based development partner staff may often only be partially informed. In this situation, EDC principles such as strategic alignment, joint decision-making and mutual accountability in the health sector are challenged.

Development partners' review

The global review of development partner policies, procedures and practices confirmed an overall strong commitment by international development agencies to the EDC principles, but it also provided insight into the political economies at institutional, national and global levels that may limit their implementation. The review also highlighted issues that require further examination by the UHP2030 partners, especially for the cooperation with middle-income countries and fragile states.

5.2. LESSONS LEARNT FROM A COUNTRY-BASED, MORE QUALITATIVE AND MORE INCLUSIVE MONITORING APPROACH

Broadening the scope of data collection, in particular collecting more qualitative information, allowed for better contextualisation and more informed interpretation of statistics and trends. This resulted in a more meaningful analysis of the main findings for discussion at national level. However, there is need to limit the scope of collecting qualitative information to ensure good quality data.

Participation of civil society and private sector in focus group discussion varied by country, to some extent reflecting how much they were already involved in the health sector dialogue. Providing the opportunity for them to share their views may have contributed somewhat to increased participation in future policy dialogue in some countries. Twelve of the 15 country action plans that were developed provide actions on how to improve or maintain participation of civil society and the private sector. It also helped to cross-check some of the information provided by other partners. Representativeness of participating civil society and especially private sector organisations was an issue in many countries, unless coordinating bodies or umbrella organisations existed.

Engaging skilled national experts who were familiar with government and sector stakeholders to support the ministries of health in collecting, validating and analysing the information was a key factor of success in most countries. In some countries, however, it reduced the ownership and leadership of the assessment process by the government.

Discussions of findings and development of action plans added value to the IHP+ monitoring process (see annex 3 for a more detailed discussion). Discussions of findings were held in 24 of 30 countries at the time of producing the global report.²⁴ Discussions of findings can increase awareness of EDC practices amongst stakeholders and can increase ownership by the ministry of health. It helps to generate dialogue and develop consensus on EDC practices, especially in countries where monitoring of EDC practices is not institutionalised or discussed at JARs or in other sector fora. Discussions can also promote dialogue between government and civil society and private sector organisations. The development of action plans helped focus the discussions on issues identified by the monitoring process and on priority actions. It is too early to assess how agreed action plans will be implemented, but in some countries, the national discussion resulted in a decision to institutionalise EDC monitoring.

The effectiveness and efficiency of the discussion of findings meetings may be increased if findings are shared and data are validated beforehand. This would allow the meetings to focus on discussion of the implications of the findings. The added value of the discussion of findings and action plan depends to a considerable extent on the commitment of government, especially on leadership and ownership at the highest level by the ministry of health, and of the development partners. The use of existing fora or mechanisms that include all relevant stakeholders, such as health partner groups, for the discussion of findings may increase the likelihood that plans and decisions will be followed up. In a number of countries, time allocated for the discussion of findings and the development of an action plan was too limited to be sufficiently meaningful.

24. As of 2nd May 2017, Burkina Faso, Cape Verde, Mozambique, Gambia, Liberia and Myanmar have not held a formal discussion of findings but the results were shared with participants in the monitoring process and they were asked to share their feedback.

In several countries, participation by development partners in the discussion of findings was limited, suggesting some fatigue with or less interest in global monitoring exercises, including GPEDC and IHP+. Similarly, participation by civil society and private sector representatives was generally limited, especially in countries where participation in policy dialogue is weak or absent. The absence of a CSO or private sector platform for dialogue with government was cited as one of the main reasons for low participation. In most discussions, GPEDC focal points were absent as well as the ministries of finance in many countries.

Future monitoring rounds, if still planned, should reduce duration and complexity of data collection and validation (see annex 2 how data collection can be addressed), while providing sufficient time for analysis and discussion. Before engaging in such a process, IHP+ should ensure that countries (government and development partners) are fully committed to monitoring their commitments. While a strong government lead is essential for successful monitoring, a strong development partner lead is helpful in fragile states with limited government capacity or in countries with a change of government. A well-attended informative kick-off meeting is another success factor for a more effective in-country process. Such a meeting could be supported by the sector lead or WHO. Finally, in countries where health sector governance is decentralised, monitoring should involve the decentralised levels.

Development partners' review

In addition to the country-based assessment of performance of 33 development partners, 14 ODA agencies and government departments volunteered to participate in an in-depth review of policies, strategies and procedures on EDC. This assessment allowed contextualising the implementation of EDC practices at country level with the agencies' policies and procedures. Triangulating information from different sources (reviews of policy and strategy documents, key informant interviews, self-assessment and country-based monitoring results) deepened the analysis of opportunities and constraints towards more effective development cooperation in health. The assessment across the 14 agencies confirmed an overall strong commitment to EDC principles, but it also provided insight into the political economies at institutional, national and global levels that may constrain their implementation. The study raised several issues that require further examination and that could inform the approach and scope of future monitoring rounds.

The methodology of the global review of development partner policies, procedures and practices will need to be reviewed if it is to be repeated in another monitoring round. Scoring of development partner performance based on a self-assessment of a limited number of questions is challenging. The main added value of the review was the identification of a set of issues constraining or promoting EDC compliance. The usefulness of the review as a new approach or tool to hold development partners to account for their agreed global commitments is questionable. The limitation of the methodology is further discussed in annex 2.

6. The way forward

To achieve progress in effective development cooperation in the health sector, partner governments and development partners should enhance their efforts to meet the commitments of the IHP+ global compact. To achieve this, governments and development partners should implement actions to overcome the constraints and bottlenecks identified in the 5th monitoring round. Furthermore, IHP+ partners should continue to review the framework of EDC practices and the monitoring framework to adapt them to the evolving context of international cooperation in the health sector in order to ensure that they retain their relevance and maintain the efficiency of the monitoring exercises.

6.1. RECOMMENDATIONS FOR GOVERNMENT PARTNERS

1. Continue to enhance the quality, rigour and inclusiveness of joint assessments of national strategies (JANS) and of joint annual sector reviews (JARS) to make them more useful and acceptable for planning and priority setting for all health sector partners
2. Continue to strengthen the national health sector performance monitoring frameworks and the quality, timeliness and use of data collected by the national health information management (HMIS) systems, including the links to national civil registration and vital statistics (CRVS) systems. Consider engaging with the Health Data Collaborative to strengthen country information platforms and the capacity to collect, analyse and use reliable health data
3. Strengthen the process of preparing forward expenditure estimates by establishing or maintaining three-year rolling budgets
4. Review and revise budgeting procedures and regulations to allow the systematic registration of development partner support for the public sector in the national health sector budget
5. Ensure that strengthening the public financial management (PFM) systems remain a priority of the finance and of the health ministries and engage with development partners to ensure their financial and technical support for this effort
6. Ensure that strengthening national procurement and supply management (PSM) systems remain a priority of the implementation of the national health strategy and engage with development partners to ensure their financial and technical support for this effort
7. Identify the needs and the task descriptions for technical assistance to build capacity in the health sector and in priority sub-sectors as part of multi-year sector and sub-sector strategies, and update them regularly in consultation with health sector partners during annual sector reviews
8. Use the regular reviews of technical assistance requirements and the engagement with regional institutions to explore opportunities for south-south collaboration (SSC), and present proposals for financial support of SSC to international financing partners
9. Involve civil society organisations consistently in JANS, JARs, technical working groups (TWGs) and other health policy and programme decision-making processes at national and decentralised level, and facilitate their meaningful participation by providing financial and technical support as well as timely information of plans and events. Consider involving other relevant stakeholders such as members of Parliament.
10. Mobilise the experience and the cooperation frameworks established by the governing bodies of global initiatives such as the CCMs (Global Fund) and ICCs (GAVI) as well as of other oversight bodies established by development partners to increase the inclusiveness of health sector-wide joint cooperation frameworks and processes
11. Invite representatives of the private sector, including professional associations, health worker unions, health insurance schemes, manufacturers of health commodities and networks of health service providers to participate in the national health policy dialogue. Support the establishment of a private sector platform or representative body for dialogue with government

6.2. RECOMMENDATIONS FOR DEVELOPMENT PARTNERS

12. Continue to support and engage in JANS, JARs and equivalent processes and increase the use of these processes for setting priorities and monitoring the performance of the health sector support provided by your agencies; decrease the use of separate agency-specific strategy assessments and sector reviews
13. Continue to support countries developing and strengthening health sector performance frameworks, including data collection and registration systems such as HMIS and CRVS. Consider engaging with the Health Data Collaborative to strengthen country information systems and build country capacity to collect, analyse and use reliable health data. Increase your reliance on national health information and evaluation data
14. Adopt and implement a policy of providing three-year rolling expenditure estimates for your cooperation programmes to health and finance ministries of partner countries
15. Adopt a policy to require that your agency's budgeted support to the public sector is registered in the national health sector budget. On-budget registration of cooperation funds, where national procedures permit, does not take much effort and is a quick win to increase transparency, and avoid financing gaps and duplications of investments in national health sector development
16. Adopt a policy of making the use of national PFM systems the default option for support to the public sector in health in countries with sufficiently robust systems. Meanwhile maintain the strengthening of national PFM systems as a priority for country support in health and other sectors. Consider delegated cooperation with development partners that have a strong track record in supporting the strengthening of national PFM systems
17. Adopt a policy of making the use of national PSM systems the default option for services, infrastructure, health commodities and medicines procured with the support of your agency in countries with sufficiently robust systems. Meanwhile maintain the strengthening of procurement and supply management a priority for country support in health. Consider delegated cooperation with development partners that have a strong track record in supporting the strengthening of national PSM systems
18. Support ministries of health in developing sector or sub-sector capacity building and technical assistance frameworks in coordination with all health sector partners, and collaborate with the other partners in filling the priority needs for technical assistance identified in these plans
19. Support ministries of health in jointly developing plans for south-south cooperation including a joint selection of potential southern partner countries that have the necessary experience and technical resources that could be mobilised to address specific health sector issues
20. Advocate with government for the meaningful participation of civil society organisations and other relevant stakeholders such as committees of parliament in JANS, JARs and other mutual accountability processes at sector and sub-sector level. Provide financial and technical support to CSOs to increase their capacity for meaningful participation in national health policy
21. Advocate with government for the meaningful participation of the national private sector in health policy and programme development and monitoring. Support national efforts to strengthen the national regulatory framework for private sector health service providers and to extend the coverage of the HMIS to include private sector health services
22. Ensure that all domestic governmental and private institutions that are delivering programmes under the national ODA envelope are aware of the national commitments to EDC and apply the associated practices

6.3. RECOMMENDATIONS TO THE UHC2030 PARTNERSHIP GROUP

23. Review the framework of EDC practices for health sector cooperation with middle-income countries and emerging economies. Consider the modalities of cooperation with these countries currently being drafted by the European Community and bilateral ODA agencies. Adapt the IHP+ monitoring framework accordingly
24. Identify the flexibility that may be required in the application of EDC principles in the health sector cooperation with fragile states, depending on the types and causes of fragility and incorporate these considerations in the terms of reference of future country-level UHC2030 monitoring rounds
25. Review the framework of EDC practices and its application to health sector support through humanitarian aid channels in line with the Call to Action of the 2016 World Humanitarian Summit. Identify the areas of overlapping principles for effective development cooperation and effective humanitarian aid in the health sector and adapt the UHC2030 monitoring framework to make it fit for comprehensive monitoring of health sector support through all international and national channels
26. Continue and improve the coordination of monitoring efforts between UHC2030 and GPEDC, especially when reviewing and refining the monitoring tools in order to increase the possibilities of cross-referencing and triangulation of data. Improve the links between the GPEDC and UHC2030 monitoring efforts at country level which until now has been very weak in most countries
27. Ensure the continued commitment of development partners to hold all UHC2030 partners accountable to the commitments made in the global and country compacts and to monitor the implementation of these commitments. Recommend that country compacts contain targets for all stakeholder groups including civil society organisations and private sector. Among some development partners, the engagement in EDC monitoring appears to have decreased in comparison to previous monitoring rounds
28. Jointly review the issues identified by the global review of development partner policies, procedures and practices to identify constraints for the adherence to EDC practices in health sector cooperation and develop actions to overcome these constraints
29. Continue to conduct any future monitoring of IHP+/UHC2030 performance at the country level under the leadership of the national ministry of health. Include the support from UHC2030 for a country process of discussing the findings and developing an action plan to overcome constraints and bottlenecks. Incorporate lessons from the current pilot to integrate IHP+ monitoring in national health sector performance monitoring frameworks to gradually reduce the effort and transaction costs of applying an additional global IHP+ monitoring framework
30. Review the monitoring tools and indicators applied in the 5th monitoring round and apply lessons learnt from the fifth monitoring round in any future monitoring exercise. Questions in the qualitative data collection tool for which no consistent or useful answers were received should be deleted, the two data collection tools for quantitative and qualitative data could be combined, the questions about the use of national procurement and supply management systems should be separated into their two components, and the questions about national performance monitoring systems and about technical assistance should be reviewed to assure a better fit of the associated practices with the commitments under which they are categorised

In response to the health-related sustainable development goals (SDGs) adopted in 2015, the IHP+ steering committee and IHP+ signatories agreed to expand the scope of the IHP+ to include coordination of health systems strengthening (HSS) towards the achievement of universal health coverage (UHC), and to broaden the base of the partnership to respond to the health-related SDGs. The new 'International Health Partnership for UHC 2030', created in September 2016, will continue to work on improving effective development cooperation in countries receiving external assistance, but will broaden its scope to also focus on HSS and domestic spending in all countries and promoting accountability and advocacy for UHC as well as knowledge-sharing. One challenge for UHC2030 will be to maintain the interests of governments and development partners in effective development cooperation. Holding governments and development partners accountable for their commitments and assessing effectiveness of development cooperation should continue and can best be done within a framework that captures all financial resources, including domestic financing, and that links resource inputs and health system strengthening with the overall goal of reaching the health-related SDGs. Taking the new global aid architecture and the overall goal of universal health coverage into account, the content and the application of the EDC framework should be revisited and updated as necessary.

Annexes

ANNEX 1. IHP+ RESULTS STANDARD PERFORMANCE MEASURES

IHP+ signatories worked through the IHP+ Mutual Accountability Working Group (MAWG) to advise on specific indicators to track the issues that are a priority for IHP+ members. The indicators in Table 9 form the basis of the 2016 round of IHP+ monitoring and come from the GPEDC or the last round of IHP+ monitoring. Detailed information on each indicator is provided in the 2016 Monitoring Round Guide for Participants.

Eight indicators for monitoring government performance and eight for DPs performance

Table 9: Monitoring issues and performance indicators²⁵

Issue	Government indicators	Source	Development Partner indicators	Source	Method
Partners support a single national health strategy	National Health Sector Plan/ Strategy in place with current targets & budgets that have been jointly assessed	G	Extent to which JANS (or equivalent) are used in programming decisions, and to which programmes are aligned with national priorities	DP	Qualitative survey
Health development co-operation is more predictable	Proportion of health sector funding disbursed against the approved annual budget	G	Percentage of health sector aid for the government sector disbursed in the fiscal year for which it was scheduled	DP	Quantitative data collection tool (MS Excel) & qualitative survey
	Projected government expenditure on health provided for 3 years.	G	Extent to which governments are aware of 3-year expenditure plans provided by DPs	G/DP	
Health aid is on budget	Health sector resources reflected in the national budget include contributions of individual development partners	G	% of health sector aid scheduled for disbursement that is recorded in the annual budgets approved by the legislatures of developing countries	G/DP	
Developing countries' Public Financial Management (PFM) systems are strengthened and used	Country PFM systems either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these	World Bank CPIA data	Amount of health sector aid disbursed for the government sector that uses national PFM systems in countries where systems are generally considered to adhere to broadly accepted good practices, or to have a reform system in place	DP	Quantitative data collection tool (MS Excel) & qualitative survey
Developing countries' procurement systems are strengthened and used	Extent to which a government-led plan for procurement and supply management systems exists that is supported by development partners	G	Extent to which procurement and supply management systems are harmonised and aligned; and national systems are used or strengthened	DP	Qualitative survey
Mutual accountability is strengthened	Extent to which an inclusive mutual assessment of progress in implementing agreed health sector commitments exists	G	Extent to which mutual assessments have been made of commitments in the health sector, including on aid effectiveness	DP	Qualitative survey
Technical support is coordinated and south-south/triangular cooperation supports learning	Extent to which an agreed national TA plan exists, informed by the national health strategy, on which all DPs are basing their support.	G	Extent to which technical assistance is provided in accordance with an agreed national TA plan	DP	Qualitative survey
	Extent to which the MOH is benefitting from SSC and/or TrC		Extent to which developing partners are supporting south-south and triangular cooperation		
Civil society engagement	Evidence that civil society operates within an environment that maximises its engagement in and contribution to health sector development			G, DP, CSO	Qualitative survey using GPEDC methodology
Private sector engagement	Evidence that private sector has the space to participate in the development and implementation of effective, efficient and equitable health policies			G, DP, PS	Qualitative survey using GPEDC methodology

*The indicator on private sector engagement was added for the first time, based on the IHP+R proposal

G Data to be provided by Government representatives

DP Data to be provided by Development Partners either at country- or Headquarters level (DP chooses which)

CSO Data to be provided by CSO representatives

PS Data to be provided by private sector representatives

25. With the following exceptions: indicator 1DP and 2Gc are new; indicator 2DPb has been modified and indicator 8 has been added by IHP+R in consultation with IHP+

ANNEX 2: METHODOLOGY AND LIMITATIONS

A. Methods

1. Participants and data sources

The performance of governments and development partners in the 30 partner countries (six more than in 2014) that participated in the 2016 monitoring round was assessed on the basis of two questionnaires that collected qualitative and quantitative information about the status of the health sector strategy, health sector financing, public management and engagement of civil society and private sector stakeholders in a chosen fiscal year within the period of 2014 to 2015. The qualitative questionnaire explored constraints and opportunities for more effective cooperation in the health sector. The participating countries are listed in Table 2 (section 2.2.1).

In total, 35 development partners submitted 253 responses providing quantitative and/or qualitative data on cooperation in partner countries (compared to 33 development partners providing 209 responses in 2014). Among them, 18 provided data in four or more countries. The analysis of development partner performance was primarily limited to these 18 partners. Separate responses by ODA agencies from the same country were aggregated. This applied to the USA (USAID and CDC), Belgium (Flanders and BTC), and France (AFD and the Embassy of France in Togo), and Germany (KfW and GIZ). The 17 development partners who submitted data on financial cooperation in less than four countries included nine bilateral partners, four foundations and four multilateral partners. A list of participating development partners is provided in Table 3 (section 2.2.1).

The questionnaires were completed by the ministries of health and the development partners, either during an interview or through self-reporting with on-site support by a local health specialist mobilised by IHP+R, and in some instances also with support from other government ministries. The performance assessment, based on self-reported information, was validated by each respondent and by the partner ministry of health.

Data from civil society and the private sector were collected in 29 countries. Sudan was excluded because of recent data collection among CSOs by GPEDC with a focus on the health sector. In the 29 countries, 995 organisations were invited by email and 431 responses were received. In each country, lists of CSOs that were known for their activities in the health sector were compiled based on CSO databases maintained by the ministries of health as well as membership lists of national CSO networks and coalitions with the objective to obtain as broad a sample of organised civil society voices as possible and feasible, aiming to collect responses from at least 15 organisations in each country. The objective was reached in 14/29 countries, but the number of overall responses (431) was close to the expected total of 435. The following types of organisations were invited to participate:

- National non-governmental and faith-based organisations that deliver health services or that are involved in health sector advocacy or in monitoring national health policies and programmes. These include national membership organisations, civil society watchdog groups and chapters of regional and international civil society organisations (e.g. MSF, Oxfam, etc.) or federations that are constituted in the country as independent legal entities with a national governance structure
- National federations or network organisations representing community-based organisations or NGOs working in health, including umbrella organisations for groups with special health service needs
- National academic institutions that operate as policy think-tanks, as independent research organisations, or as providers of services in the health sector.

Focus group discussions were organised with representatives of 229 civil society organisations in 27 countries.²⁶ All surveyed CSOs were invited, however generally only those with presence in the capital cities participated as no funds for travel and accommodation were available. The number of participating organisations in each country is presented in Table 10.

Focus group discussions were also organised with private sector organisations in 24 countries with a total attendance of 176 representatives.²⁷ Private sector organisations were identified by the national expert in collaboration with the national IHP+ focal point. The following types of organisations were invited to participate:

- Health workers' trade unions and professional associations
- Public health associations or other thematic associations of health professionals
- Organised private interest groups or organisations representing, for instance, the health insurance, private hospitals, private clinics / health centres or pharmaceutical industry

26. Consultations with CSOs working in health were recently conducted by GPEDC in Sudan and were therefore not repeated. In Madagascar and Cameroon, focus group discussions with CSOs could not be organised for different reasons.

27. Private sector consultations could not be organised in Cameroon, El Salvador, Guinea, Mozambique, Myanmar and Sierra Leone for different reasons.

Table 10. Survey responses and focus group participation of CSOs

	Online survey	FGD
Afghanistan	11	13
Benin	5	10
Burkina Faso	23	11
Cape Verde	15	10
Cambodia	18	7
Cameroon	13	-
Chad	11	4
Comoros	13	7
Cote d'Ivoire	34	8
DR Congo	18	12
El Salvador	6	8
Ethiopia	6	5
Gambia	20	5
Guinea	13	8
Guinea Bissau	15	12
Liberia	15	6
Madagascar	9	-
Mali	15	21
Mauritania	15	14
Mozambique	6	9
Myanmar	15	6
Nigeria	18	18
Pakistan	9	20
Senegal	14	5
Sierra Leone	15	3
Sudan	-	-
Togo	12	13
Uganda	14	7
Vietnam	17	3
Zambia	10	4

Additional data on policies and practices of international development agencies were collected through a review of published documents, publicly accessible databases, key informant interviews with senior agency programme and policy staff, and a self-administered multiple choice questionnaire about policy and practice related to EDC. Interviews were held with senior staff of 14 international development agencies between December 2016 and March 2017. The participating agencies are listed in Table 2 of the DP Review synthesis report.

As in 2014, IHP+R also analysed data from publicly available sources such as the OECD/DAC Creditor Reporting System (CRS), the WHO National Health Accounts (NHA), the International Aid Transparency Initiative (IATI), the GPEDC monitoring data, country-level aid information management systems (AIMS) and development assistance databases (DADs). Apart from the CRS and NHA for financial data, and the GPEDC monitoring data for selected indicators in one country, these systems were of limited use for IHP+ performance monitoring. However, all data sources except AIMS and DADS were used in the in-depth review of development partner policies and practices.

2. Scope of the reporting framework

The 2016 monitoring round used a broader reporting framework, covering all seven behaviours (or eight practices) compared to 4 behaviours in 2014. The eight EDC practices, translated into 9 issues and 11 specific indicators for both government and development partners. They are listed in Table 4 (section 2.2.2).

While in 2014, there was only one quantitative data collection tool, in 2016, two tools (one quantitative and one qualitative) was completed by governments and development partners. Furthermore, the views of civil society and the private sector were collected and analysed for the first time. These measures addressed the critique of a too limited scope of the reporting framework in previous rounds.

The agreed monitoring framework included eight new indicators, all of which were obtained through the qualitative survey.²⁸ In some instances development partners only completed the quantitative survey tools and their performance could therefore not be calculated for these indicators. It also included new approaches to measuring issues that had been previously tracked: support to the national health strategy, meaningful participation of civil society, the availability of mutual accountability mechanisms and the availability of expenditure plans that cover three years ahead. These changes were introduced to facilitate data collection and analysis, while making sure it was still possible to compare the results with previous monitoring rounds.

The qualitative tools were developed in close collaboration with the IHP+ Core Team and based as much as possible on questions from the 2016 GPEDC monitoring round. For example, the questions for the CSOs and private sector participants were taken from the GPEDC monitoring tools in order to increase the ability to cross-reference findings from the two monitoring mechanisms. In Sudan, one of two countries where GPEDC integrated the health sector as a pilot sector, it was decided to use the GPEDC data for civil society with a view not to duplicate efforts. However, data were not health sector specific and not used in the analysis.

Collecting qualitative information helped to triangulate and better understand some of the quantitative data received, hence improving the quality of analysis. Participants, however, had to respond to many more detailed questions and several respondents felt that the surveys were too long and detailed.

3. Data analysis and validation

Data collected at country level and validated by the ministry of health were analysed by the IHP+R helpdesk and translated into tables and spreadsheet matrices to facilitate the development of a country report by the national and international expert. The helpdesk also prepared a visual aid presenting a summary of the results and a PowerPoint presentation to facilitate the national discussion of the findings.

Discussion meetings of country-level results were organised by ministries of health in 24 countries and provided another level of validation. In 18 of these countries civil society organisations participated in the validation meetings. Private sector participated in 14 of those meetings. While this process provided an additional level of validation, it should be kept in mind that all data were self-reported and not the output of independent assessments.

Of the 24 participating countries that organised a meeting to discuss the findings of the monitoring, 15 developed an action plan addressing all or a selection of EDC practices.

For the 2016 performance report, average rates of quantitative indicators are calculated as the average of the execution rates in each country or for each development partner. For the aggregate rate of financial indicators (funds disbursed predictably, aid on budget and use of PFM systems), all reported expenditures for development partners are summed and divided by the sum of all budgets. Only budgets and expenditures to the government sector are included in these calculations. For the qualitative indicators, results were calculated as an average.

4. Analysis of trends across monitoring rounds

Thirty-five countries participated at least once in the five rounds of IHP+ performance monitoring since 2009. The number of participating countries increased gradually from nine in 2009 to 30 in 2016. The methodology of data collection also evolved gradually. While the assessment in 2009 was conducted in the format of an external evaluation, the approach became increasingly more country-centred and participative, and it increasingly included the collection of qualitative information to understand constraints and opportunities for change.

Lessons learnt from preceding monitoring rounds helped to refine the definitions of indicators and the management of data. Although this process continued until the fifth round in 2016, the quantitative data collected since the third round in 2012 are sufficiently comparable to allow an analysis of trends for some indicators among the 14 countries that participated in all three monitoring rounds since 2012. These countries are underlined in Table 4. In 2016, qualitative data were collected systematically for the first time since 2009, and no trends can therefore be analysed.

28. Four for governments and four for DPs (use of procurement and supply systems; use of national TA systems; support to south-south cooperation; private sector engagement)

5. Global review of development partner policies, procedures and practices

For the review, 15 development partner agencies were selected. Selection criteria included: membership in IHP+, participation in at least one IHP+ monitoring round, proportional mix of multi- and bilateral agencies reflecting IHP+ membership, volume of Official Development Assistance and relative allocation to the health sector, and prominence of profile in international health. Participation was voluntary. Agencies in France and the Netherlands declined participation. USAID declined to participate fully, but provided information in a group interview with senior staff that was used for some of the analyses in the synthesis report. The participating agencies are listed in Table 2 of the DP Review synthesis report.

A separate report of the outcome of the review has been prepared. Data collection for this review included:

- A desk review of cooperation policies, strategies, evaluations and analyses related to international cooperation, effective development cooperation practices, and health sector cooperation for each country or agency
- Key informant Interviews with senior staff at headquarters and field level of development partner agencies
- Extraction of data from global development assistance databases and reviews
- A questionnaire survey completed by staff at the agencies' headquarters and collated by the agencies' IHP+ focal point

Information obtained was triangulated with preliminary data of the 5th IHP+ country-level monitoring round. Agency-specific reports were prepared and validated by each participating agency.

B. Data limitations

As in previous monitoring rounds there were important limitations in the collected data. Some were inherited from the monitoring framework used in previous rounds, some were due to the extended set of EDC practices being monitored and to the new qualitative data framework, others stemmed from the alignment with the GPEDC monitoring process, especially for the indicators used for civil society and private sector engagement.

1. Methodological challenges

The participating countries differ greatly in terms of the proportion of international funding of total health expenditure ranging from 2 percent in El Salvador to 49 percent in Mozambique.²⁹ The importance given to effective development cooperation, both by government and development partners is likely to be higher in more aid-dependent countries. Furthermore, not all health sector partners present in each country participated in the monitoring round (see Figure 1). Statistics such as the proportion of on-budget health sector support, for instance, only refer to the disbursements of the participating partners and do not reflect the total international health sector support.

The number of participants increased, both in terms of the participating countries and development partners. However, as participation is voluntary, development partners can also choose in which countries they participate. Also, as shown in Figure 1, in some countries only few development partners participated, limiting the potential impact of the monitoring exercise in that country. A participation bias by development partners towards countries with better EDC indicator performance cannot be excluded.

The main weakness of the methodology, as already noted in previous IHP+ and GPEDC monitoring rounds, is the reliance on self-reported data rather than independent assessments. To counter this, triangulation of self-reported data was done through different approaches, including validation of all reported data by the ministries of health, validation of all data by the national and international experts as well as by the helpdesk, comparing information received from different sources including published reports and publicly available databases, validation of the country visual aid and country report by participating stakeholders, and national discussions of the main findings. Within the time and resources constraints of the monitoring exercise it was a challenge to implement all approaches concisely and systematically in all countries.

2. Availability and reliability of data

In some participating countries the state functions in the health sector are highly devolved. Sub-national governments develop their own health sector strategies, have full autonomy over sectoral budget allocation and manage their own cooperation agreements with development partners, civil society and the private sector. Except for one case of a provincial government in Pakistan, only national or federal ministries of health participated in the performance assessment. It therefore does not provide a complete picture of the status of cooperation in countries with highly decentralised health sector governance.

The limited number of participating civil society and private sector organisations in some countries raises a question on representativeness of data collected among these partners. However, the main findings were discussed and validated in the subsequent national discussion in most countries.

In several countries, a considerable proportion of health sector support was disbursed through humanitarian aid channels. Information on humanitarian aid disbursements for health was collected from development partners in eight countries.³⁰ However only limited data were provided which were not used for the calculation of the indicators for effective development cooperation.

29. 2014 estimates of the WHO Global Health Expenditure Database

30. Afghanistan, Chad, DRC, Guinea, Guinea Bissau, Liberia, Mauritania and Sierra Leone. These countries were selected because the volume of humanitarian aid for health (as recorded by publicly available databases) represented 10% or more of the public health expenditure.

3. Interpretation challenges and data analysis

IHP+R developed a detailed guide explaining the key terms and definitions used in both questionnaires, and contracted national experts to conduct interviews with governments and development partners to ensure a common understanding of the survey questions. In a number of countries, however, the questionnaires for development partners were self-administered, primarily because of limited availability of staff for interviews. There were some obvious differences of understanding of certain questions across development partners which made analysis more difficult. The indicator 'recorded on budget' remains subject to misinterpretation by the respondents (both government and development partners), making the indicator difficult to interpret. The indicator on 'use of procurement and supply management systems' should be disaggregated to separate procurement from supply management in future monitoring. The indicator on 'forward looking expenditure' is time sensitive and the response depends on the timing within a programme cycle when the information is collected.

A number of development partner respondents did not know whether their contribution was registered in the budget or administered with the national PFM system. When no responses were provided the data entries were removed from the aggregate calculations. In some instances this may give a distorted performance result.

4. Challenges with the DP policy and practices review

The global review of development partner policies, procedures and practices was carried out before final analysis of the 2016 country-level monitoring data. This limited the possibilities of more focused discussions with each participating agency on the main findings, bottlenecks and opportunities as reported by their country-based representatives, and thereby to contextualise the documented or reported development partner policies. The self-assessment questionnaires completed by each agency risk over or underscoring agency-specific performance. Scores based on self-assessment should be interpreted with caution.

Suggestions for future reviews include:

- **Sequence the process.** Start the in-depth development partner review once the country-based IHP+ monitoring round is almost finalised; i.e. when all development partner results are available and validated. Discuss the monitoring round results with all key experts involved in the review, prior to interviews and document search.
- **Consider a differentiated approach:** (i) An in-depth analysis including interviews with a limited number of development partner agencies (up to 5); and (ii) organise a review through a structured email communication for all other development partners who are member of IHP+.
- **For the in-depth analysis** (of up to 5 development partners) the approach of the review in 2016/17 could again be used with the following suggestions:
 - » Simplify the wording of the analytic framework and the related generic questions (the division in political, strategic, operational, opportunities/constraints can be maintained).
 - » Before the actual interviews, ensure that the lead expert is clear on agency-specific issues to be discussed. Share the key issues with the interviewees before the interview.
 - » The interviews should primarily focus on (i) contradictions between agency specific EDC policies and practices, and (ii) clear, practical opportunities for enhanced EDC adherence.
 - » Jointly conduct the self-assessment, during one interview with one or more agency representative.
- For the **structured email communication**:
 - » Develop a three-page summary for each development partner with (i) key results from the monitoring round (including the development partner's performance against average performance by EDC practice); (ii) a summary of agency specific results of MOPAN and other reviews and databases; and (iii) a short list of questions that are specific to the development partner agency.
 - » Together with this summary, send a uniform, semi-quantitative, self-assessment questionnaire, with clear instructions (same as the one mentioned above).
 - » Schedule one additional email interaction to discuss the completed self-assessment.
 - » Instead of producing lengthy development partner or agency-specific reports, a fact sheet for each development partner complementary to the visual aids prepared for country-based IHP+ monitoring could be envisaged.

ANNEX 3: LESSONS LEARNT FROM DISCUSSIONS OF FINDINGS AND ACTION PLANS AT COUNTRY LEVEL

This section highlights the main outcomes and lessons from the discussion of findings and development of action plans phase of the IHP+ 2016 monitoring process, based on 24 of 30 countries that have so far held a meeting to discuss the findings.³¹ This was the first time that an IHP+ monitoring round included a discussion of findings and development of an action plan in the process and it is, therefore, important to reflect on whether these additional activities added value.

Meetings to present and discuss the findings of the 2016 IHP+ monitoring round were organised in 24 of the 30 countries. In about half of these countries, a specific meeting for this purpose was arranged with the participation of all stakeholders; in the remainder, the presentation and discussion was included in the agenda of an existing forum, most often a health partners' meeting. In most cases, the meeting was chaired by the ministry of health and the findings were presented by the IHP+ Results national expert. Action plans have been developed or are in development in 15 of the 24 countries (63%). At this point it is too early to assess the extent to which the action plans have been implemented or have resulted in changes in EDC practices.

Although there were differences across participating countries, some common issues emerged. The main achievements and challenges are summarised below. The main achievements and challenges are summarised below.

1. Achievements

Discussion of findings can increase awareness about EDC practices. In some countries, the discussion helped raise awareness of EDC practices and commitments among stakeholders who are less familiar with these.

In the Comoros, a high-level forum chaired by the Vice-President was organised to discuss the findings, including four ministries and representatives from 11 development partners and embassies. It led to a detailed action plan, including actions to be more inclusive ensuring wider participation by development partners, civil society and private sector.

Discussion of findings can increase ownership of EDC issues by ministries of health. In some countries, the meetings with stakeholders provided an opportunity for the ministry of health to take or to reconfirm leadership in the dialogue between partners on effective development cooperation. This was reflected by ministries leading the discussions and developing the action plans.

In El Salvador, during the stakeholders meeting and under the leadership of the Unit of External Cooperation of the Ministry of Health, the need for a coordination mechanism at the highest political level was identified by strengthening the ministry's Interagency Board for Harmonisation and Guidance of International Cooperation. The Board was created during the IHP+ monitoring round for the coordination of multilateral and bilateral agencies and international NGOs, in order to facilitate timely provision of information on support and investments, resulting in greater effectiveness and efficiency of international cooperation, improved monitoring and stronger mutual accountability.

Discussion of findings helps to generate dialogue and develop consensus on EDC practices. In almost all countries, the discussion of findings was reported to have been productive and meaningful. It provided a forum for different stakeholders to come together to discuss EDC practices, to hear the, often different, perspectives of other stakeholders, and to reach consensus on areas that require improvement. Although the issues and actions discussed varied between countries, common themes included the need to improve sector coordination, joint assessment and sharing of information; strengthen mutual accountability; identify measures to support increased use of national financial, procurement and monitoring and evaluation systems; develop an overarching technical assistance plan; and strengthen government engagement with civil society and the private sector.

EDC practice	Discussion points
Health strategy	<ul style="list-style-type: none"> Need for development partners to align with the national health sector plan (Chad) Need for systematic sector monitoring (Guinea Bissau) Need to integrate development partner activities into the consolidated annual work plan of the Ministry of Health and integrate joint review into partnership agreements (Cameroon)
Predictable on-budget financing	<ul style="list-style-type: none"> Lack of information from development partners about financial commitments to inform planning (DRC, Mali, Senegal) Need for greater development partner transparency (Chad, Nigeria) Need to improve the predictability of financing (Cote D'Ivoire) Need to simplify and clarify the government's budget planning process (Comoros)
Public Finance Management (PFM) systems	<ul style="list-style-type: none"> How to improve PFM systems (Vietnam) Need to strengthen government systems if development partners are to use them (Chad, Nigeria) Low use by development partners of national PFM systems (Cote D'Ivoire, Senegal)
Procurement systems	<ul style="list-style-type: none"> Low use by development partners of national procurement systems (Cote D'Ivoire, Mali, Senegal) Need to strengthen government systems (Nigeria)
Mutual accountability	<ul style="list-style-type: none"> Need for greater mutual accountability (Mali, Senegal) Need to improve engagement between government and development partners (Nigeria, Pakistan)
Technical support	<ul style="list-style-type: none"> Need for government to develop a national technical assistance plan (Nigeria) Integrate technical assistance into existing planning frameworks and align development partner support (Cameroon)
Civil society engagement	<ul style="list-style-type: none"> Need for CSOs to be accountable as health service providers (Mali) Improve government coordination of and engagement with CSOs (Chad, Guinea Bissau, Pakistan) Need to operationalise existing framework for cooperation between government and CSOs (Chad) Need for better government oversight of CSOs (DRC) Need to increase CSO involvement in national health processes (Cote D'Ivoire, El Salvador) and for mechanisms to monitor this (Vietnam)
Private sector engagement	<ul style="list-style-type: none"> Need for private sector to be accountable as health service providers (Mali) Need to operationalise framework for cooperation between government and private sector (Chad) Need to increase private sector involvement in national health processes (Cote D'Ivoire, Vietnam)

31. As of 2nd May 2017, Cape Verde, Burkina Faso, Mozambique, Gambia, Liberia and Myanmar have not held a formal discussion of findings but the results were shared with participants in the monitoring process and they were asked to share their feedback. Reasons include the MOH does not have time, capacity or interest (Cape Verde, Mozambique) and/or it is not the right moment in the country to conduct this type of exercise (Myanmar, Gambia). There are plans for a discussion in Burkina Faso and Liberia.

In [Senegal](#), the Minister of Health has formally requested institutionalisation of IHP+. The Ministry of Health is also currently strengthening the national health accounts and designing, with the support of development partners, a health financing strategy. One outcome in Togo was the decision to engage in institutionalisation of IHP+ monitoring. In Nigeria, one of the actions agreed was to present the results to a special meeting of the Development Partners' Group and the Health Partners Consultative Committee, as well as to develop a brief for the Federal Minister of Health to enable him take an appropriate decision on presenting the results at the National Council on Health and other high-level policy fora.

Discussions can promote dialogue between government and civil society and private sector organisations. In some of the countries, the discussion was reported to have promoted dialogue between government, civil society and private sector organisations, in some cases for the first time.

In [Cote D'Ivoire](#), the discussions provided a rare opportunity for all parties, including civil society and the private sector, to sit together. In [Guinea Bissau](#), the discussion stimulated debate about civil society and private sector engagement and has helped to give government ownership of the results.

There is value in including the development of action plans in the process and providing a template. The development of action plans helped focus the discussions on issues identified by the monitoring process and priority actions. For the most part, the action plans that were developed addressed gaps and weaknesses in all eight EDC practices, identified actions and responsibility for actions, and included timelines and mechanisms or indicators to monitor implementation progress, although not all allocated the responsibilities for monitoring progress.

In [Ethiopia](#), where the Ministry of Health provided strong leadership, the action plan includes clear commitments, e.g. to consolidate the joint assessment of the national plan and minimise separate assessments by development partners. A Joint Core Coordinating Committee was established to lead the monitoring process, which includes government, development partner, CSO and private sector representation. It will follow up on the implementation of the action plan and could also play a role in ensuring the future sustainability of EDC monitoring. In Vietnam, the Ministry of Health incorporated the IHP+ monitoring process and discussion of findings into the quarterly meetings of the existing Health Partnership Group, which includes ministry departments, development partners, CSOs and the private sector, as well as some provinces. The Health Partnership Group will monitor progress in implementing the action plan. In Cameroon, the discussion of findings meeting recommended strengthening the capacity of the mechanism charged with oversight of the health sector strategy to enable it to provide a platform for coordination of IHP+ monitoring.

2. Challenges

Lack of government commitment and capacity. In the countries where discussion of findings did not take place this was, in most cases, due to lack of ministry of health commitment or capacity, or the wider political context, e.g. elections and changes of government, staff changes within the ministry of health. A key challenge, particularly where government capacity was weak, was the lack of formal recognition and support within ministries for the IHP+ focal point role.

Participation of development partners was relatively limited. This was consistent with the limited interest and involvement of development partners in the monitoring process in some participating countries. Feedback suggests that limited involvement reflected fatigue with multiple monitoring processes, the complexity of some of the IHP+ monitoring tools and the lengthy timeframe of the process.

The extent to which civil society organisations participated varied. CSOs participated in the discussion of findings in 18 of the 24 countries (75%). In most of the other countries, the discussion only involved government and development partners. In the countries where CSOs were invited, their participation was generally quite low, ranging from between one and six organisations. Factors influencing CSO participation in the discussion meeting included the forum used for the meeting, the relationship between government and civil society, and the existence of a CSO platform.

Private sector participation was limited. There was private sector participation in the discussion of findings in 14 of the 24 countries (58%). The number of private sector organisations attending was generally low, i.e. mostly only one or two organisations. As with CSOs, factors influencing private sector participation in the discussion of findings included the meeting forum chosen and the relationship and extent of engagement between government and private sector organisations. In many countries, the lack of a platform that brings private sector organisations together was reported to be a key barrier to engagement with government.

There was little or no involvement of GPEDC focal points or finance ministries in discussions of findings or action planning. This is consistent with the limited involvement of GPEDC focal points in the overall IHP+ monitoring process in many of the participating countries.

There was insufficient time for discussion and development of action plans. The amount of time allocated to discuss the findings and develop an action plan ranged from less than one hour to one day but in most countries was less than half a day. Consequently, in most countries, inadequate time was available to develop a comprehensive plan. In some countries, the meeting identified action points or decisions but no plan was developed, in others, actions identified were generic and unspecific or plans were incomplete, and in others, initial action plans were drafted to be further developed and shared with stakeholders after the meeting.

ANNEX 4: RESULTS OF CIVIL SOCIETY AND PRIVATE SECTOR SURVEYS AND FOCUS GROUP DISCUSSIONS

1. Results of the civil society survey and consultations, and triangulation with responses by governments and development partner

Finding

Only one-third of CSOs considered that freedom of association, assembly and expression were effectively recognised in national policies, laws and regulations of their country (two-thirds acknowledged that there was partial recognition), 39 percent stated that their organisation could access resources without restrictions. Almost all felt that the legal and regulatory environment was enabling, albeit only partially for some of them.

More than half of the CSOs were part of a network, coalition or other mechanism to facilitate their participation in health policy dialogue, considered moderately or relatively effective by most.

Only one-third of CSOs fully agreed that they were fully consulted in major health policy or programme decisions while another third acknowledged some level of consultation. Access to information about these decisions was only partial for most of them and, for two-thirds of CSOs, it was deemed to be too late to ensure meaningful participation.

Few, if any, development partners involved CSOs in the development of cooperation programmes.

For the on-line survey of civil society organisations, 995 organisations in 29 countries³² were invited to participate and 431 responses were received for an overall response rate of 43 percent. The number of organisations invited to participate ranged from 15 in Togo to 66 in Uganda. The number of responses ranged from five in Benin to 36 in Cote D'Ivoire, and the response rate from 6/40 (15%) in Ethiopia to 19/20 (95%) in the DRC.

Responses to the survey were country and context specific, and the analysis of aggregated responses cannot differentiate between the different country environments in which CSOs work or between national policies and practices concerning CSO involvement in health policy and programmes. The analysis is not weighted by the number of responses from each country, which introduces a potential bias. It does, nevertheless, provide an overview of how CSOs perceive their participation and role in the health sector, and how this compares with the information provided by ministries of health and development partners.

CSO survey respondent types and organisational environment

Survey questions	Response	
Type of organisation (as per self-identification) (N=431)	85%	Non-governmental organisation (NGO)
	7%	Community-based organisation (CBO)
	4%	Academic institution
	3%	Faith-based organisation (FBO)
Are the freedoms of association, assembly and expression for CSOs recognised in policy, law and regulation of the country? (N=355)	33%	Yes, effectively
	65%	Yes, partially
	5%	No
Is the legal and regulatory environment in the country enabling for your organisation formation, registration and operation? (N=355)	52%	Yes, effectively
	43%	Yes, partially
	5%	No
Does the legal and regulatory environment facilitate access to resources for your organisation? (N=355)	39%	Yes, without restriction
	47%	Yes, with some restrictions
	15%	No
Are certain groups prevented from participating in health policy processes based on gender, ethnicity, religion, sexual orientation, etc.? (N=355)	84%	No
	16%	Yes

Almost one in five (18%) of the participating CSOs did not answer the questions about their operating environment. Although they were assured confidentiality, this may indicate reluctance to express views that could be perceived as being critical of government in a questionnaire that was circulated under the authority of the ministry of health. Nevertheless, only one-third of the CSOs that responded considered that freedoms of association, assembly and expression were effectively recognised in national policies, laws and regulations of the country, with two thirds acknowledging that there was partial recognition. Slightly more than one-third stated that their organisation could access resources without restrictions, and only about half felt that the legal and regulatory environment was enabling without any restrictions, while half of them stated that some restrictions applied.

Government respondents were not asked about the institutional environment of the organised civil society sector, but in some countries development partners mentioned that suspicion or lack of respect for CSOs by the government constrained their ability to work with civil society.

32. No CSO consultation was conducted in Sudan because of a recent GPEDC CSO consultation focused on health

Self-assessed capacity of surveyed CSOs

Survey questions	Response
Does your organisation participate in a CSO-initiated process or network to facilitate representation of CSOs in the national health policy dialogue? (N=383)	57% Yes
	34% No
	9% Don't know
How effective is this mechanism? (N=216)	18% Very effective
	66% Moderately / relatively effective
	14% Slightly effective
	2% Not effective
What is your organisation's capacity to engage in <u>policy dialogue</u> ? (N=356)	29% Full capacity
	42% Acceptable capacity
	25% Partial / limited capacity
	4% No capacity
What is your organisation's capacity to do <u>advocacy</u> ? (N=357)	38% Full capacity
	37% Acceptable capacity
	23% Partial / limited capacity
	2% No capacity
What is your organisation's <u>management and administrative</u> capacity? (N=360)	54% Full capacity
	31% Acceptable capacity
	14% Partial / limited capacity
	1% No capacity

Among those CSOs that responded, more than half (220/383) stated that they worked in a network, coalition or other mechanism to facilitate their participation in health policy dialogue. Most considered this mechanism to be only moderately or relatively effective. This assessment did not vary much among countries for which there were sufficient responses to calculate meaningful proportions. Most CSOs (85%) assessed their management capacity as at least acceptable. The capacity for policy dialogue achieved the lowest score with only 71 percent being at least at an acceptable level.

The self-assessments of the CSO respondents provided, to some extent, a confirmation of the responses by development partners. Strengthening CSO capacity, and especially the capacity of networks, was mentioned frequently by development partners as a necessary step to increase civil society participation. Although two-thirds of development partners were of the view that CSOs received support for networking, advocacy and participation in national policy fora, only about ten percent stated that they provided such support (11/162 for participation in policy, 6/162 for networking and coalition-building, and 4/162 for advocacy activities).

CSO partnerships with ministries of health

Survey questions	Response
Does your organisation report to the ministry of health or other government department (N=383)	78% Yes
	20% No
	2% Don't know
Are CSOs consulted by government in the design, implementation or monitoring of health policies or programmes? (N=405)	35% Totally agree
	28% Partially agree
	8% Partially disagree
	19% Totally disagree
	10% Don't know
Do CSOs have timely access to government information about major national health policy initiatives? (N=405)	6% Full access
	31% Acceptable access
	57% Partial / limited access
	6% No access
When do CSOs have this access to information about major national health policy initiatives? (N=382)	8% Early during planning
	25% In time to participate in decisions
	66% Too late to participate in decisions
Does the government provide <u>financial</u> resources to facilitate CSO participation in multi-partner health policy processes? (N=394)	3% frequently
	15% occasionally
	43% rarely / very rarely
	39% never
Does the government provide <u>training</u> to facilitate CSO participation in multi-partner health policy processes? (N=391)	5% frequently
	18% occasionally
	55% rarely / very rarely
	22% never
Does the government provide <u>technical assistance</u> to facilitate CSO participation in multi-partner health policy processes? (N=391)	26% frequently
	24% occasionally
	44% rarely / very rarely
	5% never

CSOs reported that few, if any, development partners involved them in the development of cooperation programmes. They also reported that support for participation in health policy fora was provided at best occasionally and for about half of them rarely or never. Based on the analysis of the development partner responses, a much higher level of CSO participation in programme development was expected, because 181/227 reported that they had institutional mechanisms to involve CSOs in programme development and oversight. The responses from CSOs suggest that these mechanisms are selective, similar to development partner support to CSOs which for about half of the organisations is rarely or never provided.

Overall, the responses by CSOs to the on-line survey did not contradict the responses from government and from the development partners, but they indicated that inclusivity is an issue which, in practical terms, can only be addressed through building strong representative national coalitions and networks among CSOs working in health. In the country-specific analyses of responses the levels of disagreements between CSO, government and development partner assessments varied. This was presented in the country reports discussed by governments and partners.

In addition to the civil society survey, 229 civil society representatives participated in focus group discussions in 27 countries.³³ The purpose of these discussions was to contextualise the information provided by the survey in order to enrich the analysis of cooperation at country level. The outcomes of the discussions were reflected in the CSO consultation reports provided to the ministries of health, and in the country assessment report provided to all partners. The issues raised by CSOs were highly country specific but, overall, confirmed the findings of the survey.

2. Results of focus group discussions with private sector organisations

Finding

Involvement of the private sector in health sector policy development is absent or limited to ad hoc selective consultations in all participating countries. Few countries have a dedicated ministry of health directorate, department or unit that deals with the private sector and, in most countries, the private sector lacks a representative body or umbrella organisation that can formally represent the sector or provide a platform for dialogue with government.

The legal frameworks in most countries permit private practice in health, but several focus groups mentioned the weak capacity of ministries of health to work with the private sector, and weak capacity to manage and enforce systems for accreditation and assurance of service quality.

Technical and financial support for the private sector by government and development partners is very limited or absent.

Focus group discussions with representatives of private sector organisations were organised in 24 countries with a total participation of 176 ranging from two in Afghanistan to 18 in Senegal. They included professional associations (34%), private medical care providers (27%), medical/professional councils (10%), health worker unions (7%) as well as representatives of chambers of commerce, health insurance companies, the pharmaceutical industry, laboratories and pharmacies. As in the focus group discussions with CSOs, the themes raised in the discussions with the private sector were highly country specific. Nevertheless, there were some common themes:

- Involvement of the private sector in health sector policy development was absent or limited to ad hoc selective consultations in all participating countries. Ministries of health in 19/30 countries reported processes for private sector participation, with 7/19 acknowledging that these processes were very limited. Focus group participants stated that these processes were poorly promoted and attended, highly selective and not perceived as true partnerships.
- Few countries had a dedicated directorate, department or unit in the ministry of health dealing with the private sector. More often ministries engage with the private sector by inviting selected representatives to specific coordination fora such as technical working groups or joint health sector reviews, and sometimes in an individual capacity rather than as representatives of organisations.
- In most countries, there was no representative body or umbrella organisation that could formally represent the sector in interaction with the ministry of health. Some countries have set up, or are in the process of setting up, a dedicated platform for dialogue with the private sector. These platforms as well as existing CCMs may become an entry point for more meaningful engagement with the private sector.
- The legal frameworks in most countries permit private practice in health, but several focus groups mentioned the weak capacity of ministries of health to work with the private sector, and weak capacity to manage and enforce systems for accreditation and assurance of service quality. The health information systems in most countries capture private sector activities only partially or not at all, and reporting is generally poor. Accountability systems for the private sector were generally viewed as being insufficient.
- According to focus group participants, technical and financial support for the private sector by government and development partners was very limited or absent, although almost half of all development partners (106/218) stated that their agency provided financial or technical support to strengthen the role of the private sector in health.
- Opportunities for stronger engagement of the private sector mentioned by focus group participants echoed suggestions by government and development partners. They included the creation of a private sector platform for dialogue with the public sector, the development and adoption of a public-private partnership strategy by the ministry of health and the creation of a PPP technical working group, membership of the private-for-profit sector in the country coordinating mechanisms for Global Fund grants, and the participation of private sector organisations in joint health sector reviews.

33. In Sudan, a focus group discussion took place with CSOs working in health as part of the GPEDC process and was therefore not repeated. In Cameroon and Madagascar, it proved difficult to bring together CSOs

ANNEX 5. GLOSSARY OF KEY TERMS

Aid effectiveness	Aid effectiveness is the effectiveness of development aid in achieving economic or human development (or development targets).
Approved annual budget for the health sector	Is the annual budget as it was originally approved by the legislature. In order to support discipline and credibility of the budget preparation process, subsequent revisions to the original annual budget — even when approved by the legislature — should not be recorded here. This is because it is the credibility of the original, approved budget that is important to measure and because revisions to the annual budget in many cases are retroactive.
Busan Partnership Agreement	The Busan Partnership agreement sets out principles, commitments and actions that offer a foundation for effective co-operation in support of international development. The Busan Partnership agreement is a consensus that a wide range of governments and organisations have expressed their support for. It offers a framework for continued dialogue and efforts to enhance the effectiveness of development co-operation (OECD).
Capacity Development	The processes whereby people, organisations and society as a whole unleash, strengthen, create, adapt and maintain capacity over time.
Civil Society Organisation (CSO)	Includes national non-governmental and faith-based organisations that deliver health services or that are involved in health sector advocacy or in monitoring national health policies and programmes; national federations or network organisations representing community-based organisations or NGOs working in health, including umbrella organisations for groups with special health service needs; and national academic institutions that operate as policy think-tanks, independent research organisations, or providers of services in the health sector.
Country Policy and Institutional Assessment (CPIA)	The Country Policy and Institutional Assessment (CPIA) assess the quality of a country's present policy and institutional framework. "Quality" refers to how conducive that framework is to fostering poverty reduction, sustainable growth, and the effective use of development assistance. (World Bank)
Development Partner	Includes bilateral and multilateral donors, e.g. country aid agencies, and international organisations; trust funds, foundations and international NGOs
General Budget Support	General budget support is a sub-category of direct budget support. In the case of general budget support, the dialogue between donors and partner governments focuses on overall policy and budget priorities (OECD 2006).
Global Partnership for Effective Development Co-operation	The Global Partnership for Effective Development Co-operation (GPEDC) was established as a direct result of the Busan Partnership agreement. The Global Partnership will help ensure accountability for implementation of Busan commitments at the political level.
Health Aid reported on national health sector budget	Includes all health sector aid recorded in the annual budget as grants, revenue or loans.
Health sector coordination mechanism	Multi-stakeholder body that meets regularly (usually monthly or quarterly) to provide the main forum for dialogue on health sector policy and planning.
Health sector aid	ODA contributed to the health sector. ODA includes all transactions defined in OECD/DAC statistical directives paragraph 35, including official transactions that are administered with the promotion of economic development and welfare of developing countries as its main objective; and are concessional in character and convey a grant element of at least 25%.
Humanitarian Aid for Health	Humanitarian Aid for Health is an intervention to help people who are victims of a natural disaster or conflict meet their basic health needs and rights. The financial or material aid is earmarked to be used by the health sector and can consist of direct assistance, indirect assistance or infrastructure support. Humanitarian assistance must be provided in accordance with the basic humanitarian principles of humanity, impartiality and neutrality, as stated in General Assembly Resolution 46/182.
IHP+	A global partnership that puts the Paris, Accra and Busan principles on Aid Effectiveness into practice, with the aim of improving health services and health outcomes, particularly for the poor and vulnerable.
IHP+ Global Compact	The IHP+ is open to all countries and partners willing to sign up to the commitments of the Global Compact. IHP+ Global Compact defines commitments following Paris principles on national ownership, alignment with national systems, harmonisation between agencies, managing for results and mutual accountability.

Joint Assessments of National Strategies (JANS)	<p>Joint assessment is a shared approach to assessing the strengths and weaknesses of a national strategy. IHP+ partners have developed a process for the Joint Assessment of National Strategies (JANS) with the intention that a JANS assessment is accepted by multiple stakeholders, and can be used as the basis for technical and financial support. In this definition, a plan has been jointly assessed if the JANS process, or a similar joint assessment, has been completed.</p>
Joint Annual Review (JAR)	<p>A Joint Annual Review of the health sector (JAR) is a process that can be part of monitoring and planning the implementation of the health sector strategic plan. The JAR helps to identify whether the plan is on track and the strategies are adequate to achieve the intended results. The term 'joint' refers to a range of stakeholders interested in health sector performance and participating in the review.</p>
Medium Term Expenditure Framework (MTEF)	<p>A set of broad principles for sound budgeting that are implemented in different ways in different institutional settings. An approach that links expenditure allocations to government policy priorities using a medium-term (i.e. three to five-year time horizon) budget planning and preparation process.</p>
Mutual Accountability	<p>Two or more parties have shared development goals, in which each has legitimate claims the other is responsible for fulfilling and where each may be required to explain how they have discharged their responsibilities, and be sanctioned if they fail to deliver. (DFID)</p>
Mutual Assessment Reviews	<p>Mutual assessment reviews are exercises that engage at national level both country authorities and DPs at senior level in a review of mutual performance. These reviews should be conducted through inclusive dialogue involving a broad range of government ministries (including line ministries and relevant departments, at central and local level), DPs (bilateral, multilateral and global initiatives) as well as non-executive stakeholders, including parliamentarians, private sector and civil society organisation. These assessments are undertaken on a regular basis and might be supplemented through independent/impartial reviews. The comprehensive results of such assessments should be made publicly available in a timely manner through appropriate means to ensure transparency. These reviews can be part of joint annual reviews (JAR) or be separate reviews of mutual performance (e.g. review of country compact performance).</p>
Official Development Assistance	<p>Grants and concessional loans for development and welfare purposes from the government sector of a donor country to a developing country or multilateral agency active in development. ODA includes the costs to the donor of project or programme aid, technical cooperation, debt forgiveness, food and emergency aid, and associated administration costs. (OECD/DAC)</p>
Paris Declaration	<p>The Paris Declaration, endorsed on 2nd March 2005, is an international agreement to which over 100 Ministers, Heads of Agencies and other Senior Officials adhered and committed their countries and organisations to continue to increase efforts in harmonisation, alignment and managing aid for results with a set of monitorable actions and indicators. (OECD)</p>
Performance Assessment Framework	<p>The basis of a government's policy to make information about the quality and performance of health care services available to the public and partners. National Performance Assessment Frameworks should be comprehensive (i.e. cover all areas of health sector performance). A synonym used in this report is Country Results Framework.</p>
Pooled funding mechanism	<p>A funding mechanism which receives contributions from more than one donor which are then pooled and disbursed upon instructions from the Fund's decision-making structure. (UNDG)</p>
Private sector stakeholders	<p>Includes health workers' trade unions and professional associations; public health associations or other thematic associations of health professionals; and organised private interest groups or organisations representing, for instance, the health insurance, private hospitals, private clinics / health centres or pharmaceutical industry in the country.</p>
Public financial management systems (PFM)	<p>The public financial management system (PFM) system is the country system to manage financial resources. It includes three components focused on PFM: a) national budget execution procedures; b) national financial reporting procedures; and c) national auditing procedures. Legislative frameworks normally provide for specific types of financial reports and audit reports to be produced as well as periodicity of such reporting. The use of national financial reporting and/or auditing means that donors (in principle) do not impose additional requirements on governments for financial reporting and/or auditing.</p>
Public procurement	<p>Procurement is defined as the overall process of acquiring goods, works and services including functions from the identification of needs, solicitation and selection of sources, preparation and award of contract, and all phases of contract administration through to the end of a contract. Public procurement is procurement falling under the jurisdiction of a government or other public sector organisation including all entities that use public funds.</p>

Sector Budget Support	Sector budget support is a sub-category of direct budget support. Sector budget support means that dialogue between donors and partner governments focuses on sector-specific concerns rather than on overall policy and budget priorities (OECD 2006). Some development partners (e.g. EC) do no longer distinguish between direct and sector budget support.
South-South Cooperation (SSC)	South-South Cooperation (SSC) refers to a partnership in which two or more South countries pursue their individual and/or shared national or institutional capacity development objectives. The common factor is that all arrangements should be country-led and based on exchanges of knowledge, skills or technical know-how through collective actions and inclusive partnerships, involving governments, civil society, academia or the private sector, for the individual or mutual benefit of the countries involved.
Standard Performance Measures (SPMs)	Indicators developed and agreed by the IHP+ Working Group on Mutual Accountability. SPM were designed to track the implementation of development partners' and country governments' commitments as set out in the IHP+ Global Compact. They are based as closely as possible on the Paris Declaration and GPEDC indicators.
Triangular Cooperation (TrC)	Triangular Cooperation (TrC) refers to an SSC partnership as defined above that is assisted by a development partner of one of the OECD-DAC member countries, an emerging economy, a multilateral agency, international foundation, or international NGO. The assistance may be in the form of financial, technical or administrative support.

Note: Complementary operational definitions can be found in the Annexes to the IHP+R guidelines, available on line.



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