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PROGRESS IN THE INTERNATIONAL HEALTH PARTNERSHIP & RELATED INITIATIVES (IHP+)

2012 ANNUAL PERFORMANCE REPORT

ACKNOWLEDGEMENTS

This 2012 Annual Performance Report and the ongoing work of IHP+Results comes from the collective efforts of individual researchers and project team members from: the IHP+Results Country Representatives, the IHP+Results Consortium, the IHP+Results Advisory Group, the IHP+ Core Team and survey respondents, and the representatives of agencies and governments.

A core team led by Tim Shorten, prepared this report and the accompanying scorecards. Many thanks to Martin Taylor and Louisiana Lush as lead authors of the report, as well as to Dr Shaun Conway, Nicole Neumeister, Mialy Dermish, Alice Schmidt, Adi Eyal and Etienne Kruger.

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ACRONYMS AND ABBREVIATIONS

AfDB	African Development Bank
CPIA	Country Policy and Institutional Assessment
CSO	Civil Society Organisation
DFID	UK Department for International Development
DP	Development Partners
DRC	Democratic Republic of Congo
EC	European Commission
GAVI	The GAVI Alliance
GBS	General Budget Support
GFATM	The Global Fund to Fight AIDS, TB and Malaria
HMIS	Health Management Information System
HMN	Health Metrics Network
HRH	Human Resources for Health
IHP+	International Health Partnership and related initiatives
JANS	Joint Assessments of National Strategies
MDGs	Millennium Development Goals
MoH	Ministry of Health
OECD	Organisation for Economic Co-operation and Development
OECD/DAC	The Development Assistance Committee
PAF	Performance Assessment Framework (PAF)
PBAs	Programme Based Approaches
PFM	Public Financial Management
PIUs	Project Implementation Units
SBS	Sector Budget Support
SPMs	Standard Performance Measures
SuRG	IHP+ Scaling Up Reference Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	The United Nations Children's Fund
WB	World Bank
WHO	World Health Organization
WHS	World Health Statistics

CONTENTS

IHP+RESULTS INDEPENDENT ADVISORY GROUP FOREWORD

The International Health Partnership and related initiatives (IHP+) act on the commitments made by Development Partners and countries under the Paris Declaration on Aid Effectiveness, including enhanced transparency and mutual accountability. Under the IHP+, the IHP+Results group leads monitoring of efforts to operationalise those commitments. As members of the Independent Advisory Group to IHP+Results, we comment on the current IHP+ monitoring report, using our comments and reflections on earlier annual reports with focus on the report's methodology, scope and relevance.

IHP+Results has focused on documenting practices toward meeting the commitments in the IHP+ by country and Development Partner signatories. Our comments on this third annual report of IHP+Results address questions salient not only to IHP+ but also to the intentions of the Paris Declaration and the 2011 Busan Partnership Agreement:

- Is the monitoring process sufficient?
- What can be said about the actual performance of IHP+ signatories?
- How can the findings from this report be put into use, and what further data are needed?

Comments on IHP+Results methodology

In previous commentaries, we observed various methodological constraints that IHP+Results attempted to address. The most important methodological improvement took place in the second annual report published in 2011, with the introduction of standardised indicators, many of which were drawn from the Paris Declaration. Other methodological issues could not be addressed at that time, and those methodological limitations remain. Most important among these are (1) the absence of a verification mechanism for self-reported data from signatories that do report, and (2) high rates of non-compliance with reporting commitments from many signatories, both Development Partners and countries. Other issues include a limited number of indicators, insufficient qualitative information to describe actual changes in aid practices, and inadequate capturing of the roles and actual engagement of civil society in all aspects of development cooperation for health. We highlight these concerns in order to guide future revisions to the monitoring process.

Notwithstanding these limitations, the current monitoring process makes an important contribution specifically to the IHP+ and further serves as a stimulus for improving development aid effectiveness in general. We commend the rise in participation by signatories in this third review compared to the previous two years. We further note that in many cases signatories recorded their own underperformance against targets, providing some indication of integrity in the self-reported data. The quality of data interpretation has been enhanced by IHP+Results drawing on additional sources and indicators to triangulate some of its findings, such as examining outpatient services utilization as a proxy for health system strengthening.

The IHP+Results process has raised additional, deeper questions that were not addressed when the Paris Declaration indicators were first developed. Four questions in particular, which cannot be answered with the data to date but are important for assessing and understanding changes in aid delivery and their impact, are as follows:

- How can Development Partners and countries track or demonstrate whether multi-year funding commitments are fulfilled; e.g., was a commitment made in 2009 actually delivered in 2010, 2011 and 2012?
- How do improvements in the predictability of funding improve the consistency and predictability of policy, given tendency for aid to be influenced by transient fashions?
- Is the progress towards enhanced country ownership – as suggested by the data – real and sustainable?
- And finally, does improved aid effectiveness correlate with better health outcomes?

The IHP+Results group is examining factors that might lead to more effective delivery of aid. That analysis is not ready for this report, and may require another monitoring round before conclusions can be reached. Nevertheless, the very fact that evidence is being assembled to answer questions such as these represents an important step forward for the international health community.

Thus, despite some short-comings, the methodology and outputs from the IHP+Results process remain important tools for assessing aid effectiveness. Their continued use by the IHP+ SURG and Secretariat is essential for evidence-based discussions and planning to improve aid effectiveness. Importantly, they represent efforts to improve transparency and mutual accountability amongst the many, diverse actors operating in a health sector which remains too fragmented and incoherent.

Comments on the findings

During the four years of IHP+Results, more countries have signed up to the IHP+, and more signatories are contributing data to the IHP+Results monitoring process – both of which are strong signals of confidence in the IHP+ and in IHP+Results. On the other hand, some signatories remain silent, or have even exempted themselves from the monitoring process, perhaps reflecting a diminished commitment to the actual work of improving aid effectiveness while attempting to convey the impression of participation.

Four high-level findings clearly stand out:

- Important progress has been made toward country ownership of development assistance, as reflected in the design of national health plans, performance frameworks and country compacts and the incorporation of those tools into dialogues and joint assessments with Development Partners;
- Aid delivery to five countries that initially signed the IHP+ appears to be more effective in certain ways;
- Evidence remains scanty or poor, regarding both the extent and nature of civil society engagement; and
- Development Partners as a whole have to date not realized the "step change" in aid effectiveness that was anticipated when IHP+ was launched. Only three of 12 targets have been met, and two of those were already achieved by 2009, prior to the reporting process.

Based on these and other findings from the current report, IHP+ has produced a few clear deliverables while other areas show little to no change and require substantial improvement. The most important change recorded, progress toward country ownership and leadership, must not be taken lightly because that is an essential step toward more effective development cooperation. Although overall progress has been uneven or disappointing, particularly with respect to civil society engagement and the step-change in aid practices by Development Partners, the IHP+ deserves substantial credit for catalyzing enhanced country leadership. As a facilitator of discussions, the IHP+ secretariat has brokered changes in development practice that very likely would not have occurred had the IHP+ not been formulated and implemented.

In this foreword, we have highlighted both positive and negative developments with respect to the original goals of the IHP+. Now it is essential that the various IHP+ bodies (secretariat, SURG and northern/southern civil society representatives) review and discuss the IHP+Results findings and recommendations so as to define action needed. Equally important, Development Partners and countries may use the trends identified in the report and the IHP+Results scorecards in their own Joint Assessments of National Health Strategies and other policies and procedures regarding development cooperation for health.

In the near-term, there are clear steps to be taken:

1. In their forthcoming meetings, countries and Development Partners should provide interpretive information to elaborate the data in the main report and in the scorecards, and should plan for additional qualitative measures in future reporting rounds.
2. The SURG executive should provide a management response to the results, findings and conclusions of this report to inform the December 2012 meetings of the partner countries.

Looking to the future, we urge the following:

- Creation of country-based M&E mechanisms, that continue to use standardised indicators and add data, including qualitative data, to enrich future reporting;
- Deeper analysis of results;
- Global and country level data dissemination in ways that support advocacy and encourage continued improvements in development cooperation and achievements;
- Active engagement of civil society in analysis of the data, drafting of findings and creation of the scorecards; and
- Use of information to support changes in policies and practice and to hold countries and Development Partners to account for their results.

IHP+Results in relation to the architecture and effectiveness of aid

With three monitoring rounds for IHP+ completed and the conclusions of the Fourth High Level Forum on Aid Effectiveness at Busan, it is timely to reflect on the value added by the IHP+Results. Their "light touch monitoring" with low transaction costs, has initiated a global longitudinal dataset on a significant dimension of development cooperation for health. As noted earlier, the methodology needs further refinement while maintaining reasonable comparability to earlier data.

Attention needs to be given to strengthening country capacity to conduct routine monitoring, local dissemination of findings, engagement of civil society, and use of the findings for advocacy, within and outside the IHP+ framework. These steps are necessary in order to translate the political commitments of the IHP+, its predecessor agreements and the Busan Partnership Agreement into the 'step change' intended by the Paris Declaration, as opposed to the incremental steps so far seen.

Much has changed in the global economic environment since the IHP+ was launched in 2007. Development assistance has stagnated or been slashed in many cases. Reductions in the largest sources, such as the Global Fund's Round 11 and PEPFAR, among others, have often led to the precipitate hand-over of donor projects to governments. Given these trends, we see an urgent need for the following:

- Enhanced effectiveness of development cooperation for health, with stronger mechanisms to demonstrate long-term results, engage civil society and use evidence in decision-making and practice;
- Inclusion of measures of policy coherence in relation to development effectiveness and public health, particularly regarding international practices in trade, tariffs, intellectual property rights, services, loan conditionalities and capital movement.

Conclusion

This present report is a unique and valuable contribution to systematic assessment of development effectiveness in health. The findings must not be ignored, and the monitoring process must be strengthened to build on the existing evidence in order to enhance aid effectiveness even as the total volume of development assistance may decline. While this report demonstrates some successes, in future, it is essential to secure consistent data collection from all partners, to include more contextual interpretation, and to include civil society proactively in all aspects of the IHP+.

Finally, we note that the IHP+ secretariat has a funded workplan through 2013. While the evidence shows only modest progress toward the IHP+ goals, we believe that the long-anticipated "step change" is possible. Given the prevailing macroeconomic environment, the time is now for making necessary changes. The secretariat should use the findings and recommendations of this report to modify its workplan and to assist countries and Development Partners to make further and faster progress toward effective development cooperation.

Independent Advisory Group members: *Prof Ronald Labonté; Prof Gill Walt; Dr David McCoy; Dr Ravi M Ram; Prof David Sanders; Prof Adrienne Germain; Dr Lola Dare; Mr Tobias Luppe.*[1]

[1] The Independent Advisory Group provides independent advice to IHP+Results on its work to monitor and evaluate the implementation of the IHP+. Membership of the Advisory Group is on an individual basis – members are not representing the organisations for which they work. For more information about the Advisory Group membership, see www.ihpresults.net

EXECUTIVE SUMMARY

The International Health Partnership (IHP+) was launched in 2007 with a commitment to "work effectively together with renewed urgency to build sustainable health systems and improve health outcomes in low and middle-income countries" and to do this in a "well-coordinated" way. It set out to achieve this through a five-point work plan.[2] Five years on, and with the completion of a third round of independent monitoring, it is timely to ask whether this promise is being delivered on.

This Performance Report presents findings for the third annual cycle of IHP+Results[3] performance reporting and monitoring. It is accompanied by scorecards which show the progress Development Partners and Partner Countries have made since the launch of the IHP+. Evidence for this report was self-reported by 36 out of 56 IHP+ signatories on a voluntary basis drawing on data from 2011 (and in some cases from 2010). The report has two objectives: 1) to update IHP+ members and other stakeholders on the results of the survey undertaken in 2012; and 2) to use this evidence to contribute to the wider debate on aid effectiveness in the health sector.

Results

There has been progress on some aid effectiveness indicators: Partner Country governments strengthened leadership and aid governance and they strengthened country financial management systems, and some increased financing for health. Development Partners are supporting country leadership and they are providing better coordinated support. Five countries that signed the IHP+ in 2007 appear to have received more effective aid.

There has been less progress on other aid effectiveness indicators: Government spending on health decreased in some countries. In 2011, Development Partners delivered more predictable Health Aid, but missed the target for the proportion of this external funding recorded on national budgets. Development Partners did not increase the proportion of aid delivered through country systems.

Discussion and conclusions

IHP+Results findings suggest that there has been some progress but there is still much to do to improve Health Aid effectiveness: progress could be quicker and there is no room for complacency.

Development Partners (and, to a lesser extent, Partner Countries) have made improvements to Health Aid effectiveness that fall short of the 'step change' promised in the Paris Declaration and the IHP+ Global Compact commitments. Development Partners met only 3 of 12 targets they committed to (which represents static performance compared with progress reported in IHP+Results 2010 performance report).[4] They made less than expected progress on key indicators that measure actual aid delivery: multi-year aid commitments, aid that is recorded on country budgets, and aid that uses country systems. At the same time, Partner Countries made less than expected progress on improving health budget allocations and disbursements. On current performance Development Partners will not perform well in delivering more effective aid to the health sector against key Busan indicators.[5]

Mutual accountability is an under-used tool to drive improvements in Health Aid effectiveness.

The IHP+ missed an opportunity to pioneer mutual accountability by not having a structured discussion on the findings of the IHP+Results 2010 report. With a few exceptions, country-level Mutual Accountability processes did not make use of IHP+Results findings to inform discussions about improving aid effectiveness. Development Partners have not systematically and routinely used IHP+Results 2010 findings to drive internal reviews to improve aid effectiveness. Civil society has been insufficiently engaged in accountability processes, and has not been provided with sufficient information to fulfil its anticipated role.

The IHP+Results performance monitoring and reporting process suggests that monitoring is useful but there are still gaps that need to be better understood.

Each round of monitoring provides stronger evidence and explanatory power. The current indicators drawn from the Paris Declaration have been useful, but do not cover all elements of aid effectiveness and new indicators need to be agreed – particularly for measuring how well Development Partners use country Procurement Systems. Partner Countries and Development Partners still report high transaction costs of monitoring, which points to insufficient ownership of the process. It is difficult to draw general conclusions from the small number of Partner Countries and Development Partners involved in the surveys, the high number of caveats, and the limitations of the existing indicator framework. More contextual information is required in future monitoring to make better sense of the findings.

IHP+ signatories and the IHP+ Core Team have devoted most of their resources to improving leadership and country frameworks for managing Health Aid so this has been where most progress has been made. In many Partner Countries the challenge is shifting to improving aid delivery by Development Partners. That too will require significant effort and resources.

The 2012/13 IHP+ workplan[6] is beginning to address some of these issues that focus on the delivery of Health Aid although this is not yet adequate. IHP+Results 2012 findings suggest that the greatest need is for countries to strengthen Public Financial Management and Procurement systems and Development Partners to channel aid through these systems, to deliver more predictable Health Aid that is recorded on national budgets.

Recommendations are provided to IHP+ signatories (Partner Countries and Development Partners), as well as to the IHP+ Executive and Core Teams, to speed up their progress on implementing the IHP+ commitments. This calls for much more concerted efforts to drive aid effectiveness through mutual accountability, using stronger country-led reporting and performance monitoring processes. A summary of these recommendations follows.

[2] More inclusive national health planning and joint assessment (JANS) processes; More unified support to national plans through Country Compacts; One monitoring and evaluation platform to track strategy implementation; Greater mutual accountability; and Improved civil society engagement.

[3] IHP+Results is an independent consortium of research and advocacy organizations, led by Re-Action, working in partnership with the London School of Hygiene and Tropical Medicine, and Oxfam GB. Oxfam's role is to advise on links between IHP+Results and civil society; Oxfam has not been directly involved in producing this report. LSHTM's role during 2012 monitoring has been to advise on aspects of IHP+Results methodology. LSHTM has not been directly involved in producing this report.

[4] In 2010, IHP+Results also reported that 3 Development Partner commitments had been met – the same 3 as reported in 2012.

[5] Busan Indicators include Paris/IHP+Results indicators of: (i) proportion of aid disbursed within the fiscal year within it was scheduled, (ii) % aid scheduled for disbursement that is recorded in the annual budgets and approved by the legislature of developing countries, (iii) use of country PFM and procurement systems. OECD Working Party on Aid Effectiveness. (2012). Proposed indicators, targets and process for global monitoring of the Busan Partnership for Effective Development Co-operation. OECD

[6] www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/About_IHP_/ihp_phase_iii_workplan_EN%5B1%5D.pdf

Recommendations

1. **Faster progress is needed to deliver more effective Health Aid, if this is to contribute to improving health outcomes.** Partner Countries should continue to increase leadership, increase National Health Budgets and strengthen their management systems. Development Partners should intensify their efforts to deliver more effective Health Aid. The IHP+ should increase its advocacy and support for more effective Health Aid to be delivered.

2. **Better mutual accountability is required to drive improvements in Health Aid effectiveness.** IHP+ signatories should write explicit targets to address areas of slowest progress (as reported here) into Country Compacts; these should be reviewed in country Mutual Accountability processes. They should also use the IHP+Results data and tools to support Mutual Accountability processes at the country level so that problems with Health Aid delivery and management can be identified and corrective actions agreed between partners. And they should hold a global Mutual Accountability process in 2012 using the IHP+Results data, and agree an agenda for action to improve the effectiveness of Health Aid in 2013. The IHP+ Executive Team should address an area of slowest progress (as reported here) each month, reviewing data and exploring options to take collective action to make progress.

3. **Stakeholders should take ownership of future monitoring of Health Aid effectiveness, which should use improved indicators that measure what they need to know.** Countries should take the lead to drive and own future performance monitoring and reporting processes, and integrate these within existing joint annual reviews of the health sector. Development Partners should routinely monitor and publish data on their performance against standard aid effectiveness indicators; and integrate IHP+ indicators into their routine internal performance monitoring. IHP+ signatories collectively and with the core team should continue monitoring Health Aid effectiveness, as anticipated in the IHP+ workplan for 2012-13;[7] more IHP+ signatories should participate, and more years of comparable data should be collected. They should also revise and update the indicator set of performance measures; more qualitative and contextual information from Partner Countries and Development Partners should be included in future monitoring to enable better understanding of the factors and circumstances supporting or limiting progress.

[7] IHP+ Phase III workplan and budget 2012-13

1. INTRODUCTION

The past 20 years have seen an unprecedented rise in development assistance for health (DAH), from $5bn in 1990 to $28bn in 2011[8]. Development assistance for health doubled between 2001 and 2008. The rate of increase has subsequently declined. Over the same period there has been a parallel rise in interest in the effectiveness of aid. The Paris Declaration, endorsed in 2005 by countries, donors and multilaterals, was a landmark international agreement to put countries in the driving seat of their development, to improve the quality of aid and its impact on development. The international community recommitted to the principles[9] in Accra in 2008 and Busan in 2011.

In 2007 the International Health Partnership (IHP+) was launched, pioneering the application of these principles to the health sector. The IHP+ aimed to deliver better health outcomes by: improving the quality, management and efficiency of health aid and domestic health resources, according to Paris principles of aid effectiveness commitments; and by supporting countries to build health systems that are sustainable and able to deliver results. At the heart of the IHP+ was the notion of mutual accountability: that Partner Countries and Development Partners would work together so that countries with improved aid management systems would receive more predictable aid through these systems. It also implied a promise of increased financing for health.

The IHP+ has grown to include 31 countries and 25 development partners, including multilateral organisations, bilateral donors and global health initiatives. It has five areas of work:

- More inclusive national health planning and joint assessment (JANS) processes
- More unified support to national plans through country compacts
- One monitoring and evaluation platform to track strategy implementation
- Greater mutual accountability
- Improved civil society engagement

The IHP+ core team, based at WHO and the World Bank, has catalysed and facilitated processes, and supported the development of tools where necessary.

There have been two significant changes in the global context since the IHP+ was launched: Firstly the global economic crisis led to some donors allocating less to their international aid budgets and increased the need to demonstrate health outcome results; Secondly, the 2011 Busan High Level Forum on Aid Effectiveness reflected this results focus in four revised key principles:[10]

- *Ownership of development priorities by developing countries.*
- *Focus on results.*
- *Inclusive development partnerships.*
- *Transparency and accountability to each other.*

[8] Institute for Health Metrics and Evaluation. (2010). Financing Global Health 2010. University of Washington.

[9] Five Paris principles are: ownership (developing countries set strategies for poverty reduction, improve their institutions and tackle corruption); alignment (development partners align behind these objectives and use local systems); harmonisation (development partners coordinate, simplify procedures and share information to avoid duplication); results (developing countries and donors shift focus to development results and results get measured); mutual accountability (donors and partners are accountable for development results)

[10] http://www.oecd.org/dataoecd/54/15/49650173.pdf

This IHP+Results 2012 performance report is the third that the IHP+Results consortium has produced (the last in three cycles of approved monitoring). The 2010 IHP+Results performance report was well received and helped to establish confidence that the agreed reporting framework can produce credible findings. This 2012 report draws on 2011 data – allowing two more years, since IHP+Results 2010 performance report, for progress to have been made in implementing the commitments in the IHP+ Global Compact. There are 6 years of data to draw on (2005-11), from 36 IHP+ signatories (up from 25 in 2010) leading to over 6,000 data points as the basis for analysis and conclusion. More than half of the IHP+ signatories voluntarily participated in the IHP+Results 2012 survey. Together these factors allow IHP+Results to take a broad ranging perspective on the implementation of the IHP+ commitments and of the progress of the IHP+ initiative itself.

The report is aimed principally at IHP+ signatories – officials and politicians with responsibility for managing and delivering Health Aid.[11] The report has two objectives:

1) It provides up-to-date data on the implementation of aid effectiveness commitments in the health sector by IHP+ signatories, including notable changes or trends since 2005-07. Accompanying scorecards provide a one-page graphical presentation of the progress of each participating IHP+ signatory. They use a traffic light guide with three ratings. These should be read in conjunction with more detailed data available online to get a more rounded assessment of performance disaggregated by indicator, Partner Country and Development Partner. The report also examines the progress on delivering more effective Health Aid to 5 of the Partner Countries that first signed the IHP+ in 2007.

2) It uses this evidence to reflect on what the IHP+ has achieved to inform a wider debate on health sector aid effectiveness. This offers conclusions and recommendations for Partner Countries, Development Partners, the IHP+ and the international community seeking to improve health outcomes by improving the effectiveness and efficiency of how existing resources are used.

[11] IHP+Results has also produced an 'Advocacy guide' aimed at a broader audience, and with the intention of enabling stronger civil society engagement with the content and process of aid effectiveness monitoring.

2. HOW THIS PERFORMANCE REVIEW WAS CONDUCTED

In July 2011 IHP+ signatories agreed that the methodology for IHP+Results 2012 survey should be consistent with the 2010 monitoring process, with minor modifications to strengthen the credibility of the findings and to minimise transaction costs.[12]

Evidence for this report was collected from a sub-set of 36 IHP+ signatories[13] that chose to participate (11 more than in 2010). Each agency provided data for a set of Standard Performance Measures (12 for DPs and 10 for country governments). These measures are based on the Paris Declaration indicators, applied to the health sector. A structured survey tool[14] was completed by the representatives of Partner Country governments and Development Partners over the period February to April 2012. The overall Development Partner response rate was 75%. IHP+Results clarified data gaps and issues, analysed the findings, and calculated the performance scorecards using transparent criteria.[15] Additional details, including disaggregated ratings, have been made available online with the release of this report.

Critical assumptions and qualifiers

The IHP+ Mutual Accountability Working Group (MAWG) agreed that some changes needed to be made to the IHP+Results framework in order to strengthen the approach and address limitations noted in the IHP+Results 2010 performance report. However, a number of limitations remain, largely because the MAWG agreed that the reporting framework should not be subject to substantive change so that comparisons could be made between performance reported over time.

The key limitations of this framework are:

- *Limited scope of reporting framework.* It seems likely that the IHP+ has made progress in areas that are not tracked through the agreed reporting framework used by IHP+Results. We have made efforts to draw on additional data, but this has not been the primary focus of our efforts.
- *Self-reported data.* There has been limited opportunity for triangulation of the data provided to IHP+Results by participating IHP+ signatories. Some triangulation efforts have been considered – including comparison with other aid effectiveness analyses, structured discussions at country level and an informal peer review of Development Partner scorecards. In practice these have proved challenging to systematically and meaningfully execute within the time and resources available.
- *Limited data set.* Whilst the number of participants has increased there are still some notable omissions, including the Bill & Melinda Gates Foundation. And whilst they are not IHP+ signatories, the lack of data on US Government performance means that the country data sets represent a picture of IHP+ signatories performance, not overall Development Partner performance. The number of participants does not allow for rigorous statistical analysis. There is also a relatively small time series, albeit growing; this points to the importance of continued monitoring using at least some of the indicators used by IHP+Results.
- *Lack of qualitative and interpretive data provided by participating signatories.* The development and agreement of IHP+Results monitoring framework has been heavily influenced by concerns about the transaction costs of reporting. As a result both DPs and Partner Country governments were not asked to provide mandatory qualitative data. This limits IHP+Results' ability to fully understand points of complexity and nuance, and to explore how and why results have been achieved.

[12] See Annex A for more detail on the methodology.
[13] 19 IHP+ country governments: Benin, Burkina Faso, Burundi, Djibouti, DRC, Ethiopia, El Salvador, Mali, Mauritania, Mozambique, Nepal, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Sudan, Togo and Uganda. 17 Development Partners: AusAID, AfDB, Belgium, EC, GAVI, Germany, the Global Fund, Netherlands, Norway, Spain, Sweden, UK, UNAIDS, UNFPA, UNICEF, WHO and World Bank.
[14] The survey tool was available in English, French and Spanish both in MS Excel format and as an online tool (which was a new development in the 2012 monitoring process): www.ihpresults.net
[15] Criteria for rating can be found at www.ihpresults.net

- *Weaknesses in specific indicators.* In particular, the indicators for the strength of country systems and DP use of these systems are not as specific and sensitive as necessary to form strong conclusions. As a result, firm conclusions on the use of national Procurement Systems are hard to draw.
- *Availability of data.* For some indicators response rates were quite low, which has further affected the statistical significance of some of the analysis.
- Measuring the proportion of aid flows through country Procurement Systems is complicated by two factors: firstly, many governments and development partners use global procurement mechanisms (e.g. UNICEF for vaccines) to reduce cost, and this is counted as aid for procurement that does not use country systems. Secondly Development Partners do not always know what values of general or sector budget support is used for health sector procurement.

The IHP+Results framework does though provide the basis for credible findings and robust conclusions and recommendations that should form the basis of discussions on how to improve the effectiveness of future aid. Suggestions on how the monitoring framework could be adapted and strengthened are included in the recommendations section.

Participants in IHP+Results Reporting and Monitoring process

Development Partners	Country Partners
The African Development Bank (AfDB)	Benin
AusAID	Burkina Faso
Belgium	Burundi
The European Commission	Djibouti
The GAVI Alliance	DRC
Germany	El Salvador
The Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria	Ethiopia
The Netherlands	Mali
Norway	Mauritania
Spain	Mozambique
Sweden	Nepal
The United Kingdom	Niger
UNAIDS	Nigeria
UNFPA	Rwanda
UNICEF	Senegal
The World Health Organization (WHO)	Sierra Leone
The World Bank	Sudan
	Togo
	Uganda

Those participants highlighted in green have also participated in IHP+Results 2010 Reporting and Monitoring process

3. KEY FINDINGS FROM THE 2012 IHP+RESULTS SURVEY

3.1 Are countries leading the development of health sector plans and policy frameworks and are Development Partners following this lead?

Key indicators that IHP+Results uses to measure country leadership, Development Partner support for leadership and the existence of a framework for managing health aid are:

The existence of National Health Plans (and related strategies).

The existence of a Country Compact that outlines how the Partner Country government, Development Partners and civil society will improve the delivery and management of domestic and external resources for health.

The proportion of capacity building support to improve the skills of individuals and institutions in the health system that is coordinated between Development Partners.

The proportion of development assistance for health that is provided in the form of programme-based approaches (PBAs) to Health Aid. A PBA is *'based on the principles of co-ordinated support for a locally owned programme of development'* (See glossary for full definition).

Whether countries have a Mutual Accountability process, and whether Development Partners participate in this. In a *Mutual Accountability process*, government, Development Partners and civil society hold each other to account for implementing their commitments to deliver and improve Health Aid.

The proportion of development assistance for health recorded on the country budget. *Health Aid recorded on country budgets* supports ownership and enables aid to be better integrated into national planning.

Whether governments engage civil society in the key national processes of planning, monitoring and accountability, and whether Development Partners support civil society. *Civil society* contributes to health policies, planning and holding partners accountable.

Headline findings for leadership and aid management frameworks

18 12 12

The majority of Partner Countries exercised leadership and ownership. Of the 19 surveyed 18 had national health plans, 12 had compacts, and 12 countries had both (Table 1)

11

11 out of 19 Partner Countries had national health plans which included targets, a budget, and had been through a joint assessment process (Table 1)

Headline findings for Development Partners supporting country leadership and ownership with aid on budget and coordinated capacity building

77%

77% of Development Partners with country representation signed up to support a Compact when they existed.[16]

Development Partners exceeded the targets for providing coordinated capacity development (90% of aid in 2011, no change since baseline) (Figure 3) and through funding using programme-based approaches (81% of aid in 2011, no change since baseline) (Figure 5).

Development Partners did not meet the target for recording aid on budget (Figure 1). The proportion of Health Aid reported on the recipient country health budget was 59% in 2011. The proportion was 68% when excluding Development Partners that did not report sufficient data.[17] There was no overall trend since baseline years.

85%

8 of 17 Development Partners met the target of 85% of their aid recorded on budget in 2011 (AfDB, AusAID, EC, Netherlands, Norway, Germany, Sweden and World Bank) (Figure 2).

Mozambique (95%) and Nepal (87%) received the most aid recorded on their country budget in 2011.

13/19

13 of 19 Partner Countries had a process of Mutual Assessment of health sector performance including of aid effectiveness (Table 2). 69% of Development Partners participated in country Mutual Assessments when they occurred.

Headline findings for civil society engagement in national planning, monitoring and accountability

14

In 14 of the 19 Partner Countries surveyed civil society was involved in four key aspects of the national planning, budgeting and review process (Table 4).

All Development Partners that reported on this Standard Performance Measure provided support to civil society, but not necessarily in every country (Table 5).

Development Partners mostly supported civil society with financial support, and with advocacy and lobbying to include them in national planning processes.

There was no clear pattern to the types of civil society organisation that development partners supported and countries where they engaged with them.

Civil society has been actively engaged in preparing advocacy materials for this 2012 IHP+ Results report.

NOTE: In countries where part of the policy framework (compact, national plan, mutual accountability mechanism) does not exist, Development Partner compliance with that policy was not possible and therefore not rated.

[16] This does not include GAVI and the Global Fund which do not have country representation. GAVI and the Global Fund provide letters of support to some compacts.
[17] GAVI, Global Fund, and UNAIDS.

The following Tables and Figures provide detail for the summary findings presented in section 3.1 above.

Table 1: Government performance in putting in place country Compacts and national health sector plans and strategies

	Standard Performance Measure	Benin	Burkina Faso	Burundi	DRC	Djibouti	El Salvador	Ethiopia	Mali	Mauritania	Mozambique	Nepal	Niger	Nigeria	Rwanda	Senegal	Sierra Leone	Sudan	Togo	Uganda
1G	IHP+ Compact or equivalent mutual agreement in place	✓	→	✓	✓	!	!	✓	✓	→	✓	✓	✓	✓	✓	→	✓	!	→	✓
2Ga	National Health Sector Plans/Strategy in place with current targets & budgets	✓	→	✓	✓	!	→	✓	✓	→	✓	✓	✓	✓	✓	→	→	→	→	✓

Figure 1: Aggregate proportion of partner support reported on national budgets (2DPa)

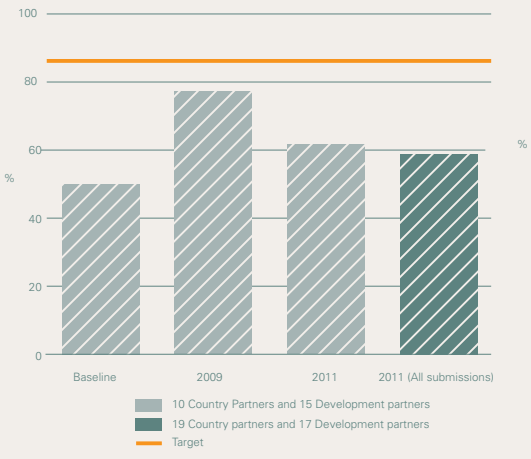


Figure 2: Proportion of partner support reported on national budgets (2DPa)

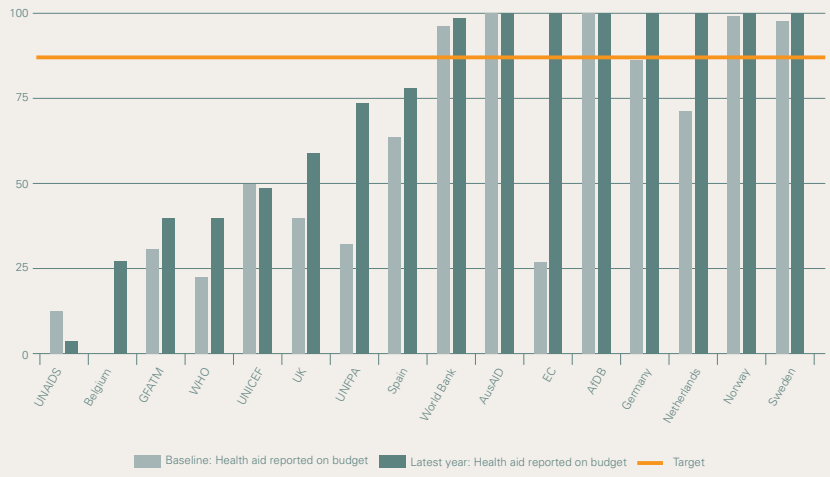


Figure 3: Aggregate proportion of partner support for capacity-development provided through coordinated programmes in line with national strategies (2DPb)

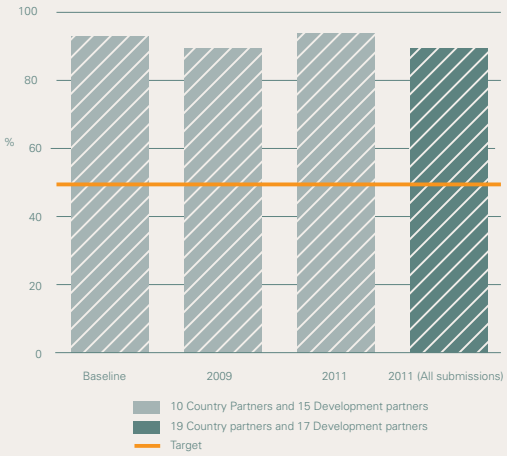


Figure 4: Proportion of partner support for capacity development that is coordinated and in line with national strategies (2DPb)

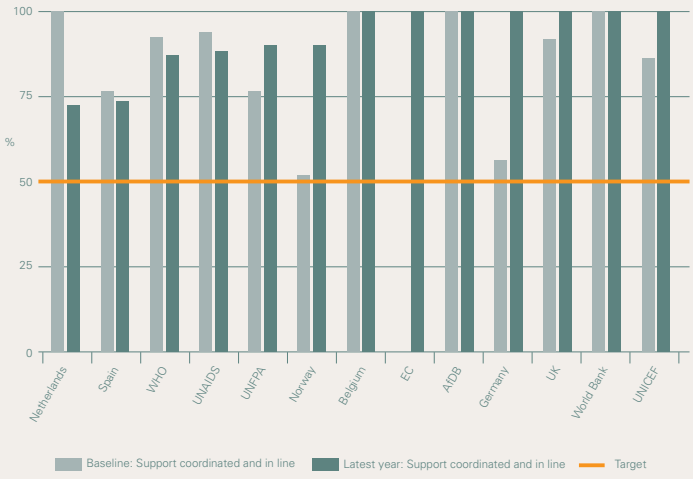


Figure 5: Aggregate proportion of partner support provided as programme based approaches (2DPc)

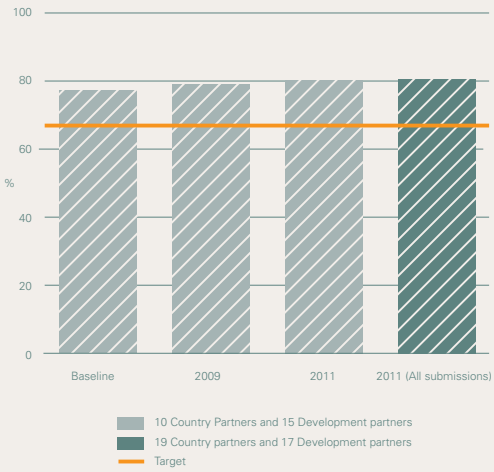


Figure 6: Proportion of partner support provided as programme based approaches (2DPc)

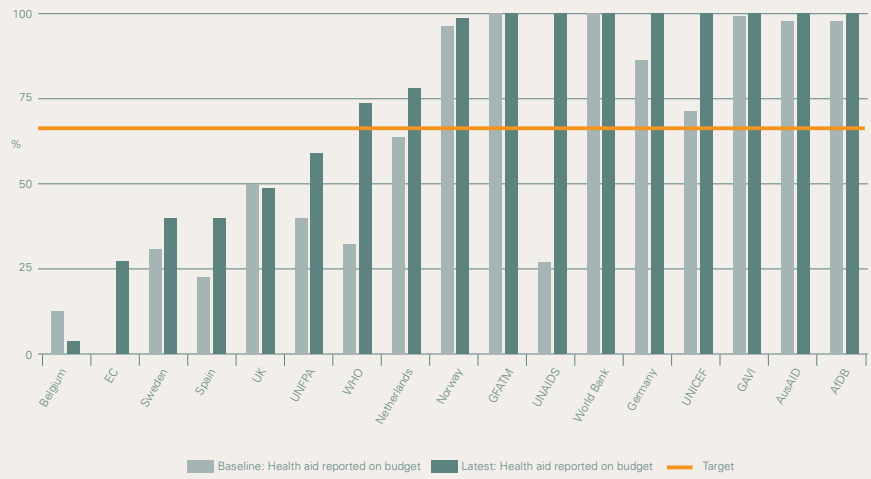


Table 2: Government performance in establishing mutual assessments

	Standard Performance Measure	Benin	Burkina Faso	Burundi	DRC	Djibouti	El Salvador	Ethiopia	Mali	Mauritania	Mozambique	Nepal	Niger	Nigeria	Rwanda	Senegal	Sierra Leone	Sudan	Togo	Uganda
7G	Mutual Assessments, such as Joint Annual Health Sector Reviews, have been made of progress implementing commitments in the health sector, including on aid effectiveness	✓	!	!	✓	!	✓	✓	✓	!	✓	✓	✓	✓	!	✓	✓	→	✓	✓

Table 3: Partner performance in participation in mutual assessments

	Standard Performance Measure	AfDB	AusAID	Belgium	EC	GAVI	GFATM	Germany	Netherlands	Norway	Spain	Sweden	UK	UNAIDS	UNFPA	UNICEF	WHO	World Bank
7DP	Proportion of countries where mutual assessments have been made of progress implementing commitments in the health sector, including on aid effectiveness	!	✓	✓	→	→	?	✓	→	→	→	→	✓	✓	→	→	✓	→

Table 4: Government performance in supporting the meaningful engagement of Civil Society at key stages of health policy and planning processes

	Standard Performance Measure	Benin	Burkina Faso	Burundi	DRC	Djibouti	El Salvador	Ethiopia	Mali	Mauritania	Mozambique	Nepal	Niger	Nigeria	Rwanda	Senegal	Sierra Leone	Sudan	Togo	Uganda
8G	Evidence that Civil Society is meaningfully represented in health sector policy processes – including Health Sector planning, coordination & review mechanisms	✓	✓	✓	✓	!	→	→	✓	→	→	✓	✓	✓	✓	✓	✓	✓	✓	✓

Table 5: Partner performance in supporting the meaningful engagement of Civil Society Organisations in health policy and planning processes.

	Standard Performance Measure	AfDB	AusAID	Belgium	EC	GAVI	GFATM	Germany	Netherlands	Norway	Spain	Sweden	UK	UNAIDS	UNFPA	UNICEF	WHO	World Bank
8DP	Evidence of support for Civil Society to be meaningfully represented in health sector policy processes - including health sector planning, coordination and review mechanisms	→	✓	✓	✓	→	?	✓	→	✓	✓	→	→	✓	→	→	✓	✓

NOTE: Disaggregated data for Development Partners can be found at www.ihpresults.net

3.2 Is there more money for health and are funding sources becoming more predictable?

Key indicators that IHP+Results used to measure the volume and predictability of government and Development Partner financing for health are:

The proportion of national budgets allocated to health. Governments provide substantial public financing for the health sector from their own budgets.[18] In Abuja in 2001, African heads of state committed to allocate 15% of annual government budgets to health, although the commitment is now more focused on increasing funding for health than on reaching this specific target.[19]

The proportion of national health budget that was actually disbursed in the calendar year. For governments to achieve their health sector plans, they need to be able to fully expend their available health sector budgets.

The proportion of development assistance for health that was made as long-term commitments, and the proportion of scheduled development assistance for health that was delivered in the scheduled year. Governments need long-term commitments and predictable disbursements from Development Partners to confidently fund health sector plans that make investments over the longer-term, for instance to employ and pay the salaries of more health workers. Both under and over-disbursement from Development Partners can compromise the government's ability to plan and effectively use funding.

Headline findings on governments' own expenditure on health

Government allocations to health increased in more than half the countries that reported on this indicator. Three countries (Burkina Faso, El Salvador and Rwanda) allocated 15% of government budget to health, and nine increased the proportion of their budget on health (Figure 7).[20]

10 Of the 19 surveyed, 10 countries met the target to reduce the gap between allocation and disbursement of country health budget.

7 7 of 19 countries had both increased the health budget and increased disbursement of the budget (Burkina Faso, Burundi, Djibouti, El Salvador, Mali, Mauritania and Sierra Leone).

Headline findings on predictability of Development Partner financing for health:

The predictability of health aid improved, but not to the extent anticipated in the Paris and IHP+ targets.

Development Partners provided 76% of Health Aid through multi-year commitments in 2011 (Figure 8), below the 90% target. This proportion was 88% in 2011 when excluding Development Partners that cannot make three-year commitments).[21]

10 10 of 17 Development Partners met the target for making multi-year commitments.

103% Development Partners delivered more health aid (103%) than had been scheduled in 2011, exceeding the target of 71% (Figure11).

[18] External aid and out of pocket expenditures are the other important sources of health financing.
[19] African Union ministers of finance, planning and economic affairs, and the U.N. Economic Commission for Africa, held on 28 - 29 March agreed to "increase resources for health financing and strengthen dialogue and partnership with ministries of health to ensure better understanding of health needs, budgeting and planning requirements and improved use of resources for strengthening health system."
http://www.who.int/pmnch/media/press_materials/pr/2011/20110414_pmnch_pr_africanhealthfinancing.pdf
[20] IHP+Results findings differ from World Health Statistics. There are some similar findings. There is a need to harmonise reporting on these indicators.
http://www.who.int/gho/publications/world_health_statistics/EN_WHS2012_Full.pdf
[21] WHO, UNAIDS, Global Fund and UNFPA funding cycles do not allow commitments of more than 2 years.

The following Tables and Figures provide detail for the summary findings presented in section 3.2 above.

Figure 7: Proportion of national budget allocated to health (3G)

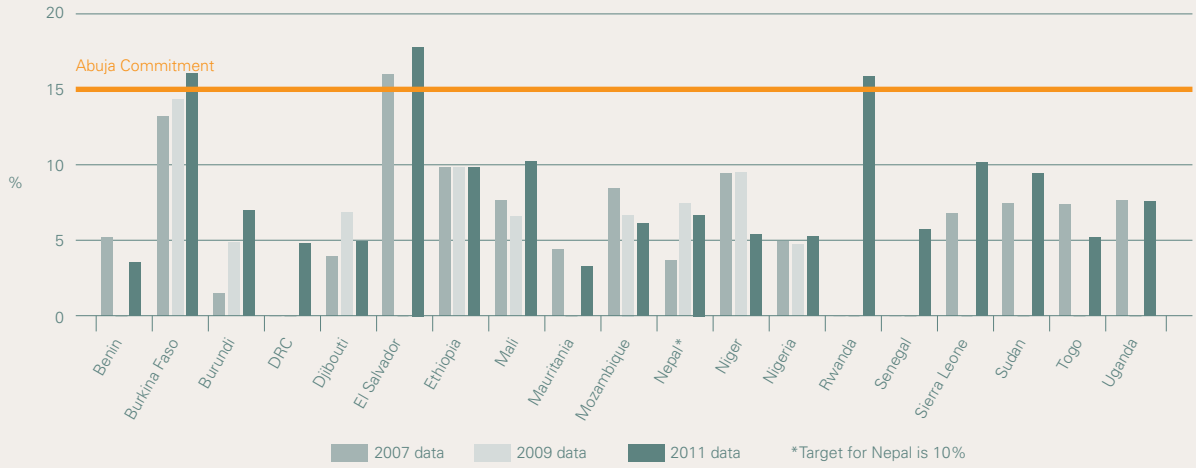


Figure 8: Aggregate proportion of partner support provided through multi-year commitments (3DP)

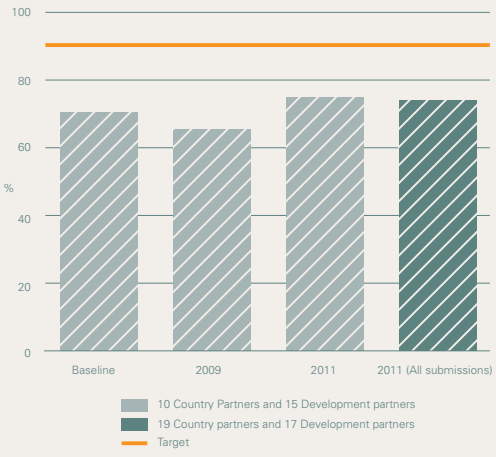


Figure 9: Proportion of partner aid provided through multi-year commitments (3DP)

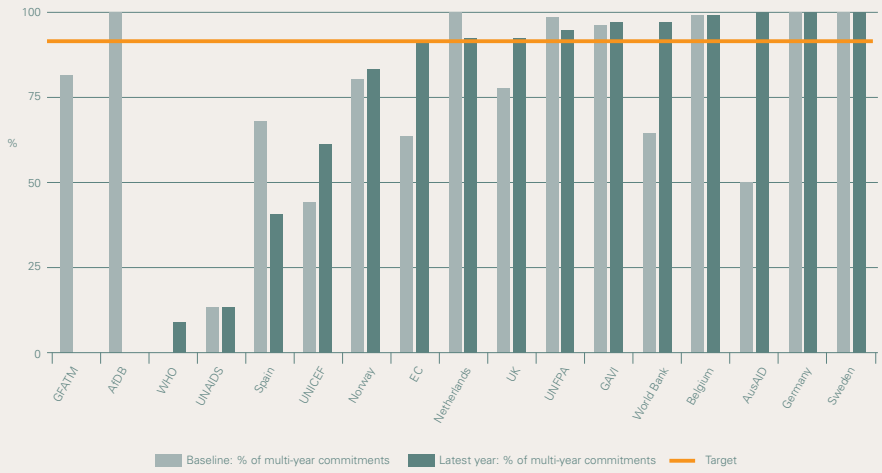


Figure 10: Disbursement of government health budgets (4G)

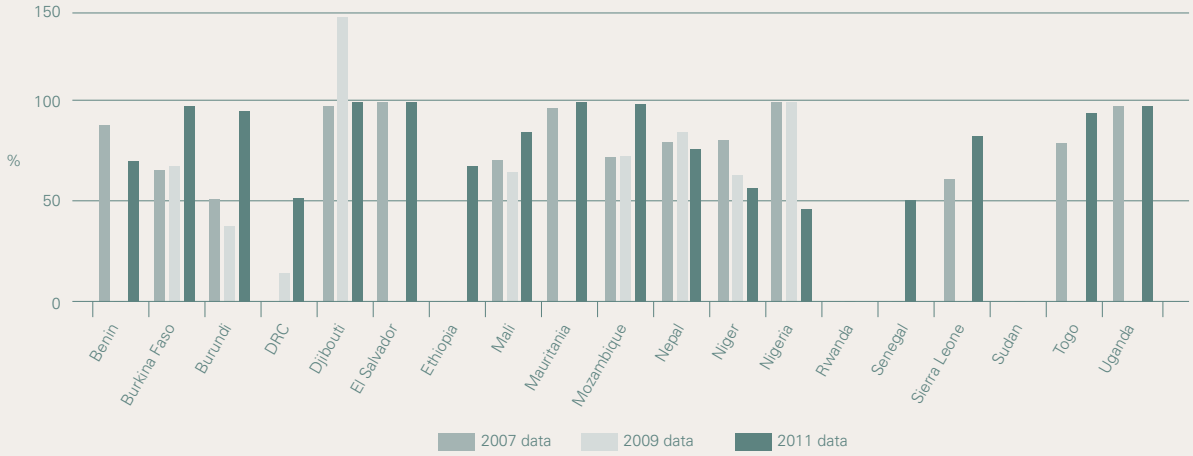


Figure 11: Aggregate proportion of partner health aid disbursed within the year for which it was scheduled (4DP)

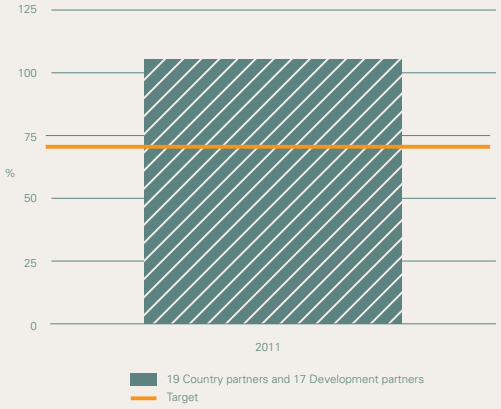
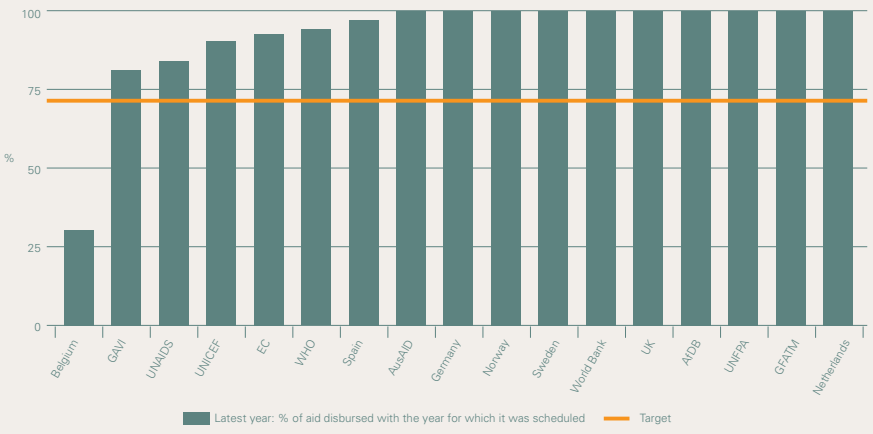


Figure 12: Proportion of health sector aid disbursed within the year for which it was scheduled (4DP)



3.3 Are country financial management and procurement systems becoming more robust and are Development Partners making better use of these systems?

Key indicators that IHP+Results used to measure the strength of country financial management and procurement systems, and whether Development Partners are using these systems to channel their Health Aid include:

World Bank assessments of the strength of Public Financial Management Systems, and OECD DAC assessment of country Procurement systems. Countries need *strong Public Financial Management Systems and strong Procurement Systems* to ensure health financing is used to achieve health outcomes.

The proportion of Development Partner aid that was channelled through country Public Financial Management and Procurement systems.[22] Development Partners can contribute to strengthening country systems by *channelling their health aid to government through country systems.*

The number of Parallel Implementation Units (PIUs) supported by Development Partners. A *PIU is a unit separate from government management systems that Development Partners set up* to manage their Health Aid. Development Partners have committed to reduce the number of PIUs.

Headline findings on the strength of country public financial management and procurement systems.

13/19 Partner Country systems have improved. In 2011, 13[23] of 19 countries achieved the target of having at least one measure of improvement on the World Bank PFM/CPIA scale since the last round of reporting, or a score equal to or greater than 3.5 on this measurement scale.

10 In 2011, 10 of 17 countries had public financial management systems which were good enough for development partners to use them (scored 3.5 or above).

Very few data were available to measure the strength of country procurement systems (see box 1 below). Only 5 of 19 countries (Niger, Rwanda, Senegal, Sierra Leone and Uganda) underwent Procurement Systems assessments in 2011. All scored 'level B', the second highest of four possible ratings.

Headline findings on Development Partners channelling health financing through country Public Financial Management and Procurement systems:

Development Partner use of country systems had not met the agreed targets. The proportion of Health Aid using Public Financial Management Systems was 58% in 2011, far short of the 80% target (Figure 13). In the 5 countries for which IHP+Results has trend data the proportion was 54% in baseline year and 71% in 2011.

Aggregates can mask the variations in these measures between agencies and countries. For instance, in 2011 the World Bank, UK, EC, Netherlands and Norway achieved the target of 80% of aid when aggregated across those 10 countries that were judged to have sufficiently strong Public Financial Management Systems (Figure 14).

5 In 5 countries (Ethiopia, Mali, Mozambique, Rwanda and Senegal) where PFM systems were considered to be adequate, half of Development Partners were using PFM systems. In 3 countries (Benin, Burkina Faso and Niger) where PFM systems were considered to be adequate, less than half of Development Partners were using these PFM systems.

The overall proportion of Health Aid for procurement that used the country system was 32% in 2011. In the 10 countries for which IHP+Results has trend data the proportion was 60% in the baseline year and only 24% in 2011 (Figure 15) although this is likely to be an underestimate (see box 1 below).

The target to reduce the number of Parallel Implementation Units by two thirds was not met – although the overall number of Parallel Implementation Units did fall (from 64 to 39) between the baseline year and 2011[24] (39% reduction) (Figure 17).

[22] IHP+Results measured development partner use of country PFM systems only in countries which scored a CPIA score of at least 3.5. IHP+Results measured development partner use of country procurement systems only in countries which scored a 'B' or above in the OECD procurement assessments.
[23] The 13 countries are Benin, Burkina Faso, Burundi, Ethiopia, Mali, Mauritania, Mozambique, Niger, Nigeria, Senegal, Sierra Leone, Togo and Uganda. There was no assessment for El Salvador.
[24] Ensuring that only the same development partners and same countries were counted in both baseline and latest year data.

The following Tables and Figures provide detail for the summary findings presented in section 3.3 above.

Table 6: Country CPIA scores[25] (Source: IDA Resource allocation Index)

	CPIA score			
Country	2005	2009	2010	Change (since 2005)
Benin	4	3.5	3.5	-0.5
Burkina Faso	4	4.5	4.5	+0.5
Burundi	2.5	3	3	+0.5
DRC	2.5	2.5	2.5	0
Djibouti	3	3	3	0
El Salvador	-	-	-	-
Ethiopia	3.5	3.5	3.5	0
Mali	4	3.5	3.5	-0.5
Mauritania	2	3	3	+1
Mozambique	3.5	4	4	0.5
Nepal	3.5	3	2.5	-1
Niger	3.5	3.5	3.5	0
Nigeria	3	3	3	0
Rwanda	3.5	4	4	+0.5
Senegal	3.5	3	3.5	0
Sierra Leone	3.5	3.5	3.5	0
Sudan	2.5	2	2	-0.5
Togo	2	2.5	3	+1
Uganda	4	4	3.5	-0.5

Figure 13: Aggregate partner use of country public financial management systems (5DPb)

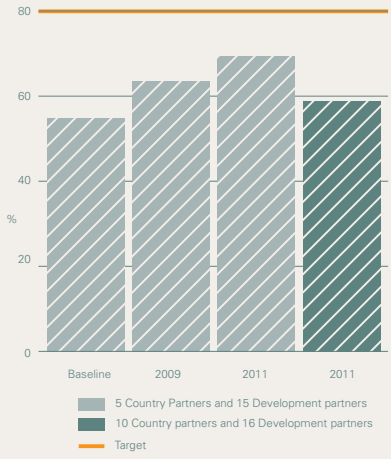
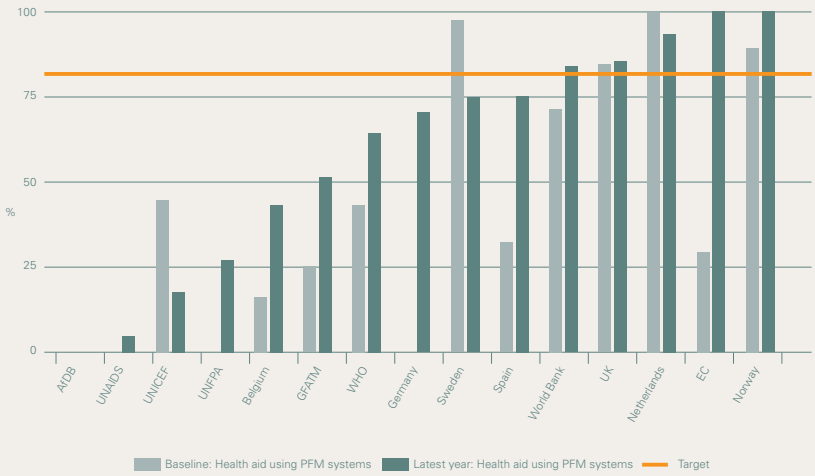


Figure 14: Proportion of partner health aid using country Public Financial Management Systems (5DPb)



[25] Source: World Bank CPIA assessments: http://web.worldbank.org/WBSITE/EXTERNAL/EXTABOUTUS/IDA/0,,contentMDK:23229417~pagePK:51236175~piPK:437394~theSitePK:73154,00.html 2011 data IRAI data was not available at the time that data collection commenced in February 2012.

Figure 15: Aggregate proportion of partner health aid using country Procurement Systems (5DPa)

Figure 16: Proportion of partner health aid using country Procurement Systems (5DPa)

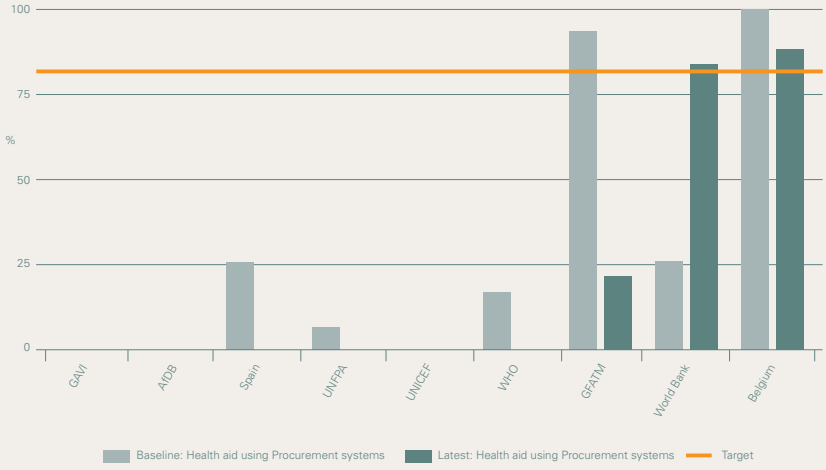
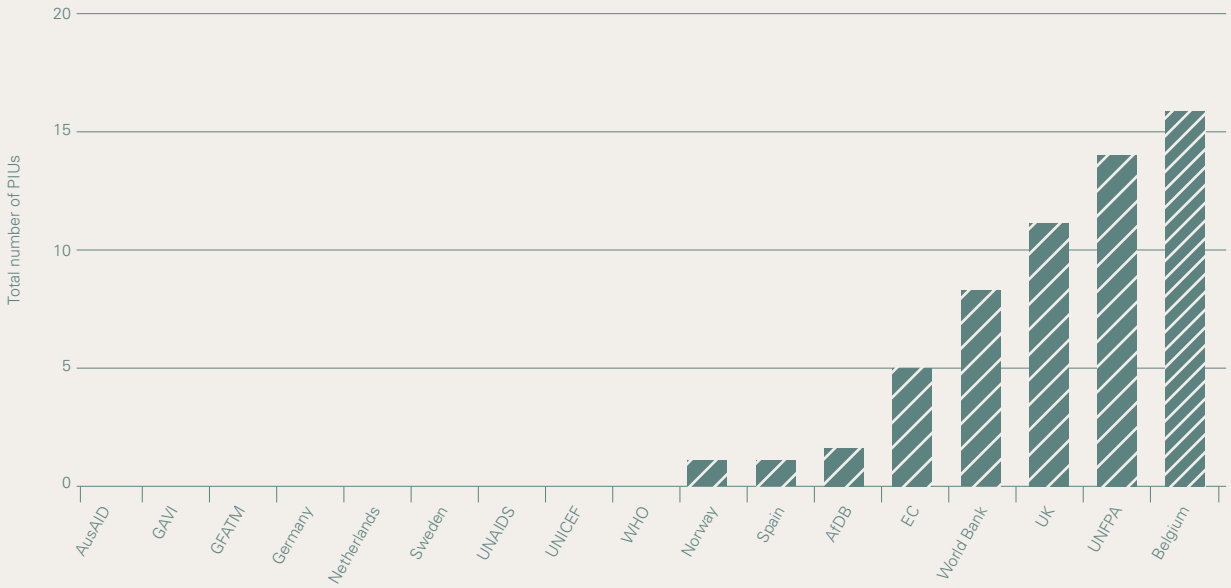


Figure 17: Aggregate number of parallel Project Implementation Units (PIU)s by development partner (5DPc)



3.4 Is health sector performance being jointly monitored and are health results improving?

Key indicators IHP+Results has used to measure whether health sector performance is being jointly monitored and whether health results are improving:

Whether Partner Countries have a single Performance Assessment Framework and whether Development Partners use that framework. Governments use a *single Performance Assessment Framework* to measure the contributions of all Development Partners to improving health systems and outcomes, thereby reducing duplication.

Whether countries have a plan for Human Resources for Health (HRH) and funding for health workers has increased. IHP+ aimed to contribute to stronger health systems including increased *planning and financing for health workers,* and their increased availability in the health system.

Utilisation of outpatient services by the general population. This could indicate that health systems are stronger and being used.

Headline findings on shared use of a single Performance Assessment Framework:

There is evidence of improvement in the ways in which health sector results are being monitored through country Performance Assessment Frameworks. 13 of 19 countries reported having a results framework in place (Table 7).

67%

Development Partners reported that they were using these frameworks as the primary basis to assess the progress resulting from their health aid in 67% of instances where countries reported that they had such a framework in place (Table 8).[26]

There is insufficient evidence of whether health information systems are stronger. Governments appeared to have a better overview of joint progress in their health sectors. But there was no discernible trend to imply that countries were incurring fewer transaction costs in their reporting to multiple donors.

Headline findings on the strength of health systems:

There was positive progress on human resource planning for the health sector. In 2011, 12 of 19 countries (Table 9)[27] reported that they had a high quality HRH plan that was integrated into the National Health Plan (up from 3 in the previous year). However, the data available suggest that there had been very modest gains, if any, in the levels of investment being made into human resources (Figure 20) – even in those countries that had managed to integrate a Human Resources Plan (and budget) into their National Health Plans (and budgets).

Data on availability of health workers were inconclusive, but suggest that 10 of the 13 countries that we have baseline data for did have more health workers in 2011 (Figure 19).[28]

The experience of IHP+Results is that impact on health systems strengthening is difficult to track in practice through global monitoring processes (Figure 18).

There was no discernible trend in levels of financing for human resources.

8

There was no discernible trend in outpatient utilisation, but a number of countries (8 of 19) were showing generally positive trends.

[26] IHP+Results does not have data on any additional reports that DPs require from countries.
[27] In addition to Burundi, Mali and Mozambique last year, Benin, Ethiopia, Nepal, Rwanda, Senegal and Uganda have achieved this now, with Djibouti and Nigeria making progress.
[28] Data for health workers is not fully consistent with that in World Health Statistics, possibly because of the different years that data is collected from.

The following Tables and Figures provide detail for the summary findings presented in section 3.4 above.

Table 7: Government performance in putting in place transparent and monitorable performance assessment frameworks

	Standard Performance Measure	Benin	Burkina Faso	Burundi	DRC	Djibouti	El Salvador	Ethiopia	Mali	Mauritania	Mozambique	Nepal	Niger	Nigeria	Rwanda	Senegal	Sierra Leone	Sudan	Togo	Uganda
6G	An agreed transparent and monitorable performance assessment framework is being used to assess progress in the health sector	✓	✓	✓	✓	!	→	✓	✓	→	✓	✓	✓	✓	✓	✓	→	!	→	✓

Table 8: Development Partner use of national transparent and monitorable performance assessment frameworks as the primary basis to assess progress

	Standard Performance Measure	AfDB	AusAID	Belgium	EC	GAVI	GFATM	Germany	Netherlands	Norway	Spain	Sweden	UK	UNAIDS	UNFPA	UNICEF	WHO	World Bank
6DP	Partner uses the single national performance assesment framework, where they exist, as the primary basis to asses progress (of support to health sector)	→	✓	→	→	✓	?	✓	✓	→	→	→	→	✓	→	→	✓	→

Table 9: Government performance in putting in place Human Resources for Health plans that are integrated with the national health plan

	Standard Performance Measure	Benin	Burkina Faso	Burundi	DRC	Djibouti	El Salvador	Ethiopia	Mali	Mauritania	Mozambique	Nepal	Niger	Nigeria	Rwanda	Senegal	Sierra Leone	Sudan	Togo	Uganda
2Gb	Costed and evidence based HRH plan in place that is integrated with the national health plan	✓	→	✓	✓	!	✓	✓	✓	→	✓	→	✓	✓	✓	✓	!	→	→	✓

Figure 18: Outpatient Department visits per 10,000 population

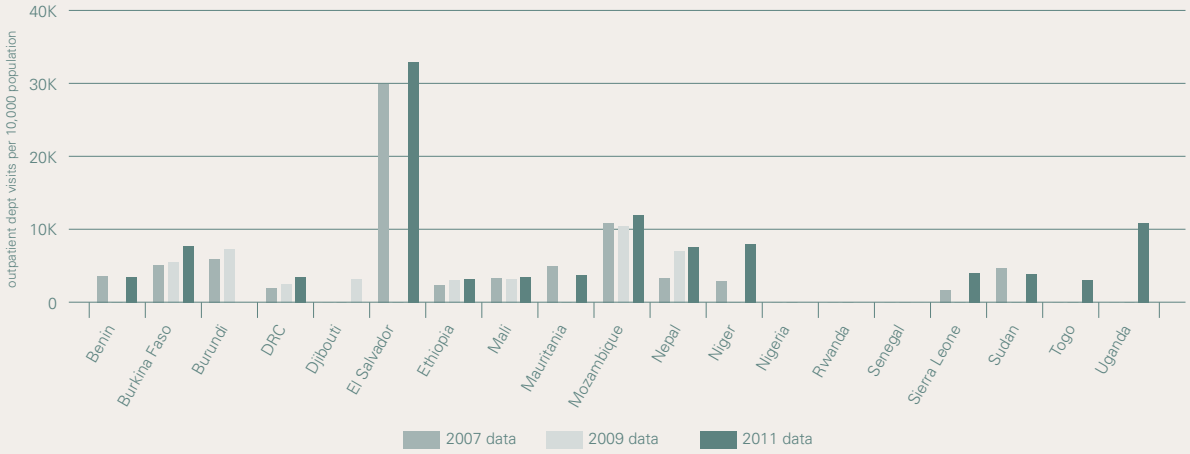


Figure 19: Skilled medical personnel per 10,000 population

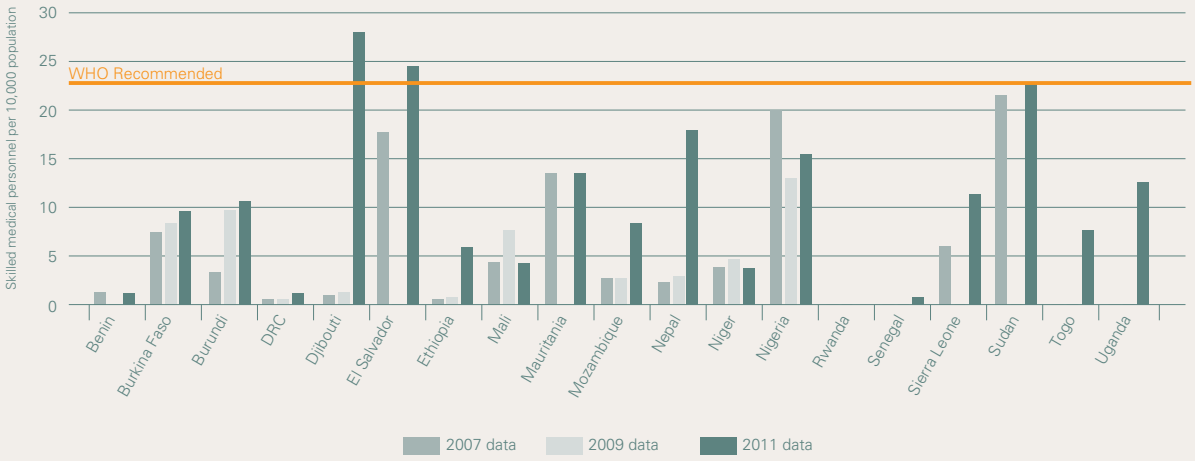
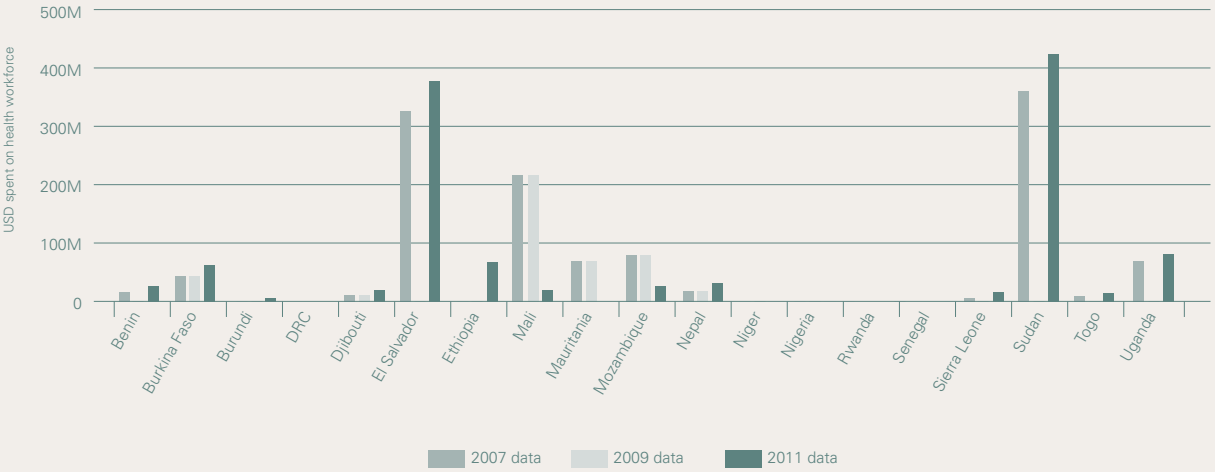


Figure 20: Amount (USD$) spent on Human Resources for Health



NB: Some of the findings presented here are surprising and may need further verification. IHP+Results used the latest data available in order to have the most recent sense of progress; alternative sources of data are more reliable but several years older that the data presented here.

3.5 Have Development Partners made more progress in the 5 of the Partner Countries that have participated in the IHP+ longest?

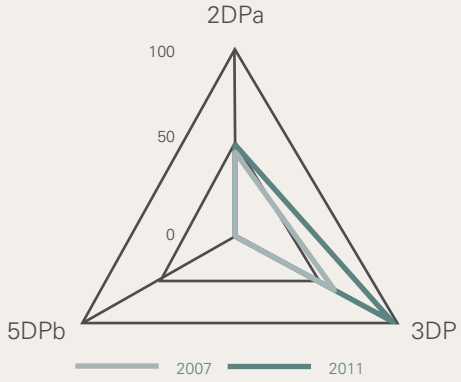
5 countries (Burundi, Nepal, Ethiopia, Mali, Mozambique) joined the IHP+ as signatories to the Global Compact in 2007 and have had the longest period over which to demonstrate changes in how their Development Partners deliver aid to the health sector.

All of these five countries had a national health plan in place and had put in place the other three frameworks for managing health aid (a Country Compact, a single Performance Assessment Framework and a Mutual Accountability Process). In 2011, Burundi had all except a Mutual Accountability Process (although one was reported in 2009).

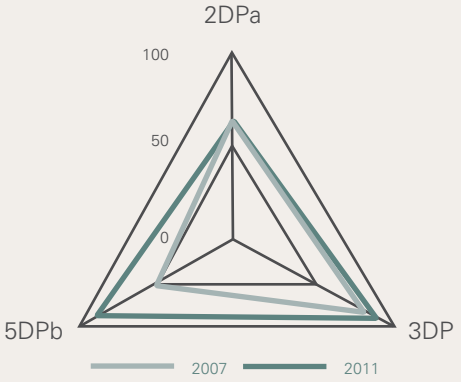
The star charts below (Figure 21) show how Development Partner performance on 3 key indicators - 2DPa: aid on budget, 3DP: multi-year commitments, 5DPb: use of national Public Financial Management systems - has changed between baseline (2005/7) and latest year (2010/11).

Figure 21: Aggregate Development Partner performance on 3 key indicators (2DPa – aid on budget; 3DP – multi year commitments; 5DPb – use of national Public Financial Management Systems) in 5 early signatories to the IHP+ Global Compact.

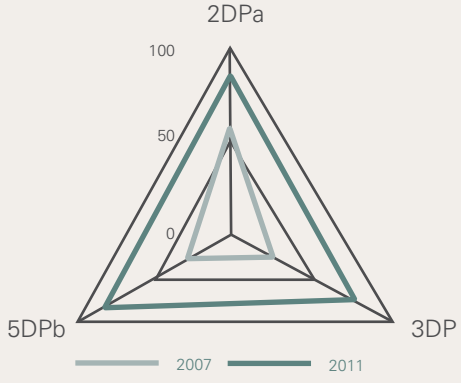
Burundi



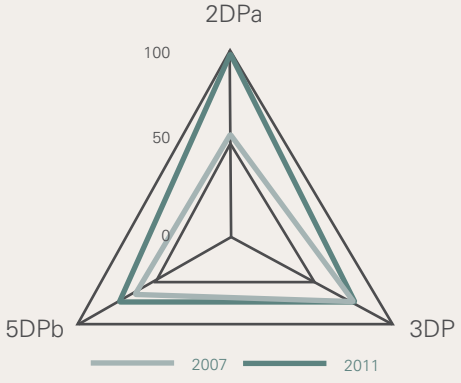
Ethiopia



Mali



Mozambique



Nepal

Based on this sample size and strength of the data available, it has not been possible to draw any firm conclusions that associate changes within these countries with their participation in the IHP+. However, all 5 countries did have more external aid recorded on their national budgets by 2011, compared with 2009. In 3 of these countries (Nepal, Mali and Mozambique), the target levels for this measure had been met. There was a mixed picture on the extent of multi-year commitments by donors in all 5 countries, but there was a trend towards increased levels of predictability (disbursement of promised aid in the years that this was scheduled for) in 4 countries. 2 countries showed the unexpected trend of having significantly more aid delivered during the 2011 period than had been planned for. These findings cannot be attributed as overall progress of the IHP+, but could be interpreted as improvement that could demonstrate the potential to achieve further gains.

Further analysis to identify other areas of correlation between results and participation in the IHP+ is tenuous, due to the lack of data points from which to draw valid conclusions. Future research, with more qualitative data, should ask whether the countries that implement measures to improve the management of health aid actually benefit from receiving more aid through country systems, that is recorded on budget, and that is delivered when it was scheduled.

4. DISCUSSION: WHAT THE LATEST FINDINGS TELL US ABOUT THE EFFECTIVENESS OF HEALTH AID IN COUNTRIES THAT HAVE JOINED THE IHP+

Summary table of Partner Country Performance

Table 10: Overview of country government performance

	Standard Performance Measure	Benin	Burkina Faso	Burundi	DRC	Djibouti	El Salvador	Ethiopia	Mali	Mauritania	Mozambique	Nepal	Niger	Nigeria	Rwanda	Senegal	Sierra Leone	Sudan	Togo	Uganda
1G	IHP+ Compact or equivalent mutual agreement in place	✓	→	✓	✓	!	!	✓	✓	→	✓	✓	✓	✓	✓	→	✓	!	→	✓
2Ga1	National Health Sector Plans/ Strategy in place with current targets & budgets	✓	→	✓	✓	!	→	✓	✓	→	✓	✓	✓	✓	✓	→	→	→	→	✓
2Ga2	National Health Sector Plans/ Strategy in place with current targets & budgets that have been jointly assessed	✓	→	✓	✓	!	→	✓	✓	→	✓	✓	✓	✓	✓	→	→	→	→	✓
2Gb	Costed and evidence based HRH plan in place that is integrated with the national health plan	✓	→	✓	✓	!	✓	✓	✓	→	✓	→	✓	✓	✓	✓	!	→	→	✓
3G	Proportion of public funding allocated to Health	!	✓	→	?	→	✓	→	→	→	!	→	!	→	✓	?	→	→	!	!
4G	Proportion of health sector funding disbursed against the approved annual budget	!	✓	✓	?	✓	✓	?	✓	✓	✓	!	!	!	?	?	✓	?	✓	✓
5Ga	Country public financial management systems for the health sector either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these	✓	✓	✓	!	!	?	✓	✓	✓	✓	!	✓	!	✓	✓	✓	!	✓	✓
5Gb	Country procurement systems either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	?	?	?	?	?	?	?	?	?	?	?	?	?	?	?	?	?	?	?
6G	An agreed transparent and monitorable performance assessment framework is being used to assess progress in the health sector	✓	✓	✓	✓	!	→	✓	✓	→	✓	✓	✓	✓	✓	✓	→	!	→	✓
7G	Mutual Assessments, such as Joint Annual Health Sector Reviews, have been made of progress implementing commitments in the health sector, including on aid effectiveness	?	!	!	✓	!	✓	✓	✓	!	✓	✓	✓	✓	!	✓	✓	→	✓	✓
8G	Evidence that Civil Society is meaningfully represented in health sector policy processes – including Health Sector planning, coordination & review mechanisms	✓	✓	✓	✓	!	→	→	✓	→	→	✓	✓	✓	✓	✓	✓	✓	✓	✓

Summary table of Development Partner Performance

Table 11: Overview of Development partner performance

	Standard Performance Measure	AfDB	AusAID	Belgium	EC	GAVI	GFATM	Germany	Netherlands	Norway	Spain	Sweden	UK	UNAIDS	UNFPA	UNICEF	WHO	World Bank
1DP	Proportion of IHP+ countries in which the partner has signed commitment to (or documented support for) the IHP+ Country Compact or equivalent agreement	!	✓	✓	✓	→	→	✓	✓	→	✓	→	✓	→	→	→	✓	✓
2DPa	Percent of aid flows to the health sector that is reported on national health sector budgets	✓	✓	→	✓	?	→	✓	✓	✓	→	✓	→	!	✓	!	→	✓
2DPb	Percent of current capacity-development support provided through coordinated programmes consistent with national plans/strategies for the health sector	✓	?	✓	✓	–	–	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓
2DPc	Percent of health sector aid provided as programme-based approaches	✓	✓	→	→	✓	✓	✓	✓	✓	→	!	→	✓	✓	✓	✓	✓
3DP	Percent of health sector aid provided through multi-year commitments	!	✓	✓	✓	✓	?	✓	✓	→	!	✓	✓	!	✓	→	→	✓
4DP	Percent of health sector aid disbursements released according to agreed schedules in annual or multi-year frameworks	✓	✓	?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
5DPa	Percent of health sector aid that uses country procurement systems	!	–	✓	–	!	?	?	–	–	!	–	?	–	!	!	!	✓
5DPb	Percent of health sector aid that uses public financial management systems	!	–	→	✓	?	✓	✓	✓	✓	✓	!	✓	→	→	!	✓	✓
5DPc	Number of parallel Project Implementation Units (PIUs) per country	!	✓	!	→	✓	✓	✓	✓	!	✓	✓	→	✓	→	✓	✓	→
6DP	Proportion of countries in which agreed, transparent and monitorable performance assessment frameworks are being used to assess progress in the health sector	→	✓	→	→	✓	?	✓	✓	→	→	→	→	✓	→	→	✓	→
7DP	Proportion of countries where mutual assessments have been made of progress implementing commitments in the health sector, including on aid effectiveness	!	✓	✓	→	→	?	✓	→	→	→	→	✓	✓	→	→	✓	→
8DP	Evidence of support for Civil Society to be meaningfully represented in health sector policy processes - including health sector planning, coordination and review mechanisms	→	✓	✓	✓	→	?	✓	→	✓	✓	→	→	✓	→	→	✓	✓

✓ Target achieved → Progress made towards achieving target ! No progress or regression ? Data not provided – Measure not applicable

4.2. Discussion

In this section we interpret the headline findings and discuss issues that have been identified through reflecting on the following key questions:

- Has there been progress? If so, does this progress meet the expectations committed to in the IHP+ Global Compact and Paris Declaration? Are IHP+Results findings consistent with the findings from the most recent OECD monitoring?
- What has contributed to progress? How did the IHP+ signatories and Core Team contribute? What else might have contributed to progress or lack of progress?
- Has IHP+ aid effectiveness made a difference to health systems and health outcomes?

In the IHP+ Global Compact Partner Countries agreed to exercise leadership, increase their resources for health and strengthen their country systems. Development Partners agreed to support their leadership and provide more effective health aid.

Partner Country governments have exercised leadership and with Development Partners have improved the arrangements for managing health aid...

IHP+Results findings suggest that eight countries, including many early IHP+ signatories, have made good progress in implementing four key frameworks to improve effective management of aid.[29] Compared with OECD Paris monitoring of non-sector specific aid[30] countries reporting data to IHP+Results have made marginally better progress overall in putting in place National Health Plans and Mutual Accountability Mechanisms. IHP+ signatories and the IHP+ Core Team likely contributed to this by allocating considerable resources to improving the country environment for health aid, by supporting processes and developing tools. However, the picture on progress is incomplete due to lack of data on the strength or quality of these plans or processes. Countries are continuing to sign up to the IHP+, indicating a willingness to take action to improve management of Health Aid and perhaps a sense that the process and outcome of developing Compacts are valuable for providing structure for a dialogue with partners. In some cases, this is accelerating dialogue (e.g. in Sierra Leone and Nigeria).[31] The majority of countries have included civil society at critical steps in the process and approximately one third of Country Compacts are now signed by Civil Society Organisations.

... but domestic and external health financing was only marginally more predictable...

There is no clear pattern of progress in how countries' allocate and disburse funding for health. Development Partners did not make more multi-year commitments, although far exceeded the target for delivering financing in the scheduled year. This is much better performance than OECD Paris reporting found for development aid predictability[32] overall. But we should ask how far this can be called progress. It is positive that Development Partners did not reduce Health Aid delivered, but it is concerning that this could have been at the expense of delivering it when scheduled in a predictable fashion, which could be more useful for countries because predictability supports better long-term planning. Over-funding may be less of a concern than under-funding, but it does not encourage long-term planning. IHP+Results did not collect data that can give evidence for why progress has or has not occurred. It is likely that the predictability of Development Partner Health Aid is subject to many political and other institutional pressures. Predictable funding has not been a major focus of the IHP+, although this is included in many IHP+ Country Compacts.

[29] The frameworks are a national health plan, a compact, a results framework and a mutual accountability process. The eight countries are Mali, Mozambique, Niger, Uganda, Ethiopia, Nepal, DRC and Nigeria.
[30] OECD. (2011). Aid Effectiveness 2005–10: Progress in implementing the Paris Declaration. OECD Publishing.
[31] Taylor, M. (2010). Developing a compact / partnership agreement – is it worth the efforts?. IHP+.
[32] OECD. (2011). Aid Effectiveness 2005–10: Progress in implementing the Paris Declaration. OECD Publishing.

Although Partner Country governments have improved their PFM and Procurement systems, Development Partners have not increased their use of these systems.

IHP+Results findings on country systems and on recording aid on budget are consistent with OECD Paris monitoring. These are difficult issues and progress might be as fast as could be expected given the pace of change in Development Partner bureaucracies. However, it is clear that Development Partners have fallen far short of their targets and of the expectations that they created. IHP+Results has limited data on why progress has not been greater and was not mandated to monitor health systems performance.[33] The IHP+ Core Team has not focused strongly on country systems. These are clearly issues of aid management on which Development Partners have not sufficiently improved their performance, and the IHP+ Core Team has recently started to support work on simplifying and harmonising financial management assessments[34] and to harmonise the quality assurance of products procured within countries using donor funds.[35] It could take some time before these efforts result in better use of country systems, but in the short term they could reduce some of the transaction costs to countries. It is also possible that progress has been greater than IHP+Results findings suggest, as there are limitations with existing measures of the use of procurement and PFM systems (see box 1 below).

Box 1: Measuring the use of country procurement systems

Measures of country Procurement Systems and Development Partner use of these systems are challenging in the following ways:

- Data on the strength of country procurement systems (using the OECD methodology) are not widely available. This has restricted the scope of IHP+Results analysis: it is not reasonable to expect DPs to use weak country systems, and we could not make any assumptions about systems strength where data were not available. Only 5 countries were included in our analysis on DP use of country Procurement Systems.
- It is not possible to specify the amounts of funds that are spent on procurement for those DPs that provide sector-specific and General Budget Support, even though they know that 100% of these funds use the county system. This means that the reported use of country systems is likely to be an underestimate.
- Decisions by Partner Country governments to use global procurement mechanisms to achieve lower prices and value for money reflect as bad performance on Development Partner scorecards. The interpretation of what funds can be counted as using country systems is quite narrow (based on guidance from OECD).

An alternative measure that allows the nuance of this complex, important area needs to be developed for future IHP+ monitoring.

...it is encouraging that Development Partners provided better aid in five of the first countries that joined the IHP+ in 2007. The promise of the IHP+ appears at least partially achievable.

Development Partners improved the proportion of aid recorded on budget and delivered predictably and provided support through country systems in 5 of the first countries that signed the IHP+ in 2007. Ethiopia, Nepal, Mali, Mozambique and Burundi received generally more effective Health Aid, although this was not for all the key performance measures in each country. Additional qualitative information would be required to show what contributed to this improved aid effectiveness, as well as to understand whether these results are recognised by the countries.

[33] Devillé, L., & Taylor, M. (2011). Options for the Future Strategic Directions of the International Health Partnership+: The findings of a consultation with stakeholders. IHP+.
[34] http://www.internationalhealthpartnership.net/en/tools/financial-management-assessment/
[35] http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/AssuringtheQualityofEssentialMedicines.pdf

Overall, Development Partners have performed well on coordination, but more meaningful measures of progress are needed.

Development Partners exceeded targets on providing aid through programme-based approaches and through coordinated support for capacity building in both 2011 and in the baseline year. OECD Paris monitoring data showed that Development Partners met the target for coordinated capacity support, but fell far short of the PBA target.[36] IHP+Results findings suggest that both of these indicators are problematic because they are open to wide interpretation and inconsistent reporting. Neither measure tracks issues that IHP+ and its Core Team have focused on.

Although the anticipated step change in aid effectiveness has not been achieved...

There are no overwhelming trends, no large improvements, nor declines in performance, but a mixed bag with some incremental improvements on some measures. This is probably to be expected given the diversity of Partner Countries and Development Partners involved. This could be viewed optimistically – progress is probably as much as could be expected for large bureaucracies addressing complex issues of how they do business. On the other hand, Development Partners have fallen far short of the commitments that they made to improve aid effectiveness. A step change improvement has not been achieved. There are signs and anecdotal reports from countries that the IHP+ does add value and is making a difference. Unfortunately, IHP+Results self-reported data are not sufficient to validate this or to provide conclusive evidence for change.

...IHP+Results reporting can be used to promote accountability and the finding that this is not yet happening is a missed opportunity to drive aid effectiveness...

IHP+Results findings suggest that the areas of least progress are largely political. The IHP+ is based on a principle that addressing political issues requires effective mutual accountability. Whilst evidence is limited on how significant increased mutual accountability can be in driving better performance (at least from data submitted to IHP+Results), mutual accountability has been a central principle and unique added value proposition of the IHP+ from the outset. There are few examples of systematic discussion of IHP+Results findings as the basis for accountability. The high level attention on the implementation of the recommendations made by the Commission on Information and Accountability for Women and Children's Health 2010 provides an opportunity for increased accountability within the health sector. It will be important for the IHP+ to support coordination of accountability mechanisms in the health sector and avoid a proliferation of these mechanisms.

... so opportunities must be seized to improve mutual accountability.

Partner Country governments and civil society perspectives are becoming more prominent at the international level, for instance through the strength of their participation in the World Health Assembly IHP+ events in 2011 and 2012, as well as the Country Health Sector Team meeting in Brussels at the end of 2010. There are also some, albeit limited, examples of where countries have used the IHP+Results findings and processes to inform their discussions on aid effectiveness (see box 2 overleaf).

[36] OECD. (2011). Aid Effectiveness 2005–10: Progress in implementing the Paris Declaration. OECD Publishing.

Box 2: Country efforts to incorporate aid effectiveness measures into national M&E frameworks

There are some emerging examples of how the IHP+Results measures and data can be useful in contributing to aid effectiveness discussions, both at country and international levels.

- In Mozambique, government and Development Partners requested a presentation of findings from IHP+Results 2010 performance report in the biannual review (July 2011). Subsequently, Development Partners decided to report 7 indicators from the IHP+Results framework into their preparation for the Joint Annual Review (ACA XI) in March 2012. This exercise included both IHP+ signatories and partners that have not signed the IHP+ Global Compact.
- In Nigeria, parliamentarians received a briefing on the IHP+Results scorecards at a Senate hearing on aid effectiveness in May 2011. A commitment to focus on results and accountability was agreed by the Senate appropriation committee.
- A number of Development Partners (including WHO, UNAIDS, AusAID, Spain, Germany, UNICEF) have reported anecdotally that the monitoring exercise, as well as the scorecards, have been useful in stimulating learning and debate about their performance.

Further examples of how aid effectiveness monitoring is being taken forward in Uganda, Nigeria, Ethiopia and Mali can be found at www.ihpresults.net

Increasing participation in IHP+Results suggests that monitoring is valued by IHP+ signatories...

Participation in the IHP+Results 2012 survey was higher than in 2011. This suggests that there is interest in the process and the findings. Every additional year of findings and every additional participating IHP+ signatory increases the usefulness of the data to show progress and trends. This is one of the only sectoral exercises in monitoring aid effectiveness and it highlights how aid effectiveness issues need to be addressed at the sectoral level.

...but improved performance measures are needed to measure and track specific important issues...

IHP+Results findings suggest that future monitoring should consider some alternative indicators and sources of data. This report reflects that progress is happening in some areas that are not picked up in the existing agreed monitoring framework. This framework is limited and so is its utility for learning how to adapt future strategies that can make aid more effective. This needs more qualitative data and some different indicators.

IHP+Results believes that the scorecard approach piloted over the past 3 years has potential to catalyse valuable discussions amongst partners and with civil society where there is a commitment to open dialogue and collective action to make aid more effective.

Box 3: Improving future aid effectiveness monitoring and reporting in the health sector

- Four indicators would benefit from additional qualitative data and assessments that require more data collection than can be achieved through a simple survey tool: 2Ga – the existence of a national plan, 1G – the existence of a National Compact, 6G – the existence of a National Results Framework, and 7G – the existence of a national Mutual Accountability process. There are some instances where government reports on these indicators do not match Development Partner reports on corresponding indicators (1DP, 6DP and 7DP), which suggests that differences in interpretation exist. Assessment at the country level will enable more qualitative data and contextual information on these frameworks and processes to be incorporated. A simple checklist could be developed for each indicator of 'good quality criteria' which could be used both for quality monitoring and as a good practice checklist for countries and development partners.
- Measurement of government engagement with civil society and Development Partner support for civil society could not be triangulated. IHP+Results does not have a measure of the 'quality' or 'meaningfulness' of civil society engagement. An appropriate measure should be developed for this.
- The measures of Development Partner coordination of capacity building (2DPb) and of delivering aid as programme-based approaches (2DPc) should be revised. Both are trying to measure worthwhile issues, but the measures are not easy to understand as the criteria used can easily be applied in an inconsistent manner. Both were met at baseline and in 2011, suggesting there is little value in monitoring them further and neither will be in the Busan indicator framework. Country governments should be consulted to identify the precise aid effectiveness issues that must be tracked and to develop better measures of this.
- There needs to be an agreed, workable definition of when a Development Partner is 'active' in the health sector in a country, and therefore required to report its assistance. In 2011 the definition was based on whether a Development Partner provided ODA for health in any of the participating 19 countries. This has the benefit of being globally consistent. However Norway argued that while according to their OECD returns they are active, in fact in many countries they have no presence and are only active because they fund NGOs, UN, or through general budget support, and thus should not be expected to participate in health coordination.

5. CONCLUSIONS

Conclusion 1: It is possible for countries and Development Partners to strengthen leadership and improve the environment for managing Health Aid.

18/19

Of the 19 Partner Countries surveyed, 18 have exercised stronger leadership by putting in place stronger National Health Plans. Partner Countries have improved the arrangements for managing Health Aid: 12 have Country Compacts, 13 have results frameworks and 13 conduct Mutual Accountability processes.

Development Partners have supported Partner Countries to implement the frameworks for managing their Health Aid.

Countries continue to sign up to IHP+ and to use this to engage Development Partners in a dialogue about improving Health Aid effectiveness. Countries report that they value these processes.

Partner Countries and Development Partners are engaging civil society more in health planning and monitoring processes, but little is known about the quality of this engagement.

13

13 of 19 countries met the target to strengthen their country Public Financial Management systems.

Conclusion 2: Development Partners are able to improve their Health Aid effectiveness.

Development Partners have delivered more effective health aid in 5 of the countries that joined IHP+ in 2007. It takes time for these changes to come into effect.

Development Partners coordinated more of their capacity building support and provided more aid in the form of Programme-Based Approaches in 2011 than they did in the baseline year.

Conclusion 3: Improvements to Development Partners (and to a lesser extent Partner Countries) performance on delivery and use of Health Aid falls short of the 'step change' promise at the IHP+ and the Paris Declaration commitments

3/12

Development Partners met 3 of the 12 targets they committed to.
Two of these were already met in the baseline year.

Development Partners have failed to achieve the 2010 targets that were agreed for key indicators that measure aid delivery: aid that is recorded on country budgets and aid that uses country systems.

On current performance, Development Partners will not meet the Busan targets that have been renewed from the Paris framework for delivering more effective aid (in the health sector). It is not possible to conclude what impacts this lack of progress might have on achieving the health MDGs.

12

Partner Countries have failed to achieve the 2010 targets that were agreed for improving health budget allocations and disbursements. 12 of 19 countries increased their health budget as a proportion of national budget, but only 3 met the target. 10 countries increased the disbursement of their health budget.

Conclusion 4: Mutual accountability has not been put into practice and this continues to be a missed opportunity to drive aid effectiveness.

Partners in the IHP+ missed an opportunity to pioneer mutual accountability when they failed to have a structured discussion on the findings of the IHP+Results 2010 report. Discussions focused more on the process of monitoring than on the implications of the findings.

With a few exceptions, country-level Mutual Accountability processes have not made optimal use of the IHP+Results findings (that are based on their own reports) to drive improvements.

Development Partners have not used the IHP+Results 2010 findings to conduct internal reviews that could identify ways to improve their aid effectiveness.

Conclusion 5: IHP+ signatories and the IHP+ Core Team have concentrated their efforts on promoting leadership and country frameworks for managing Health Aid. The challenge is now to improve actual aid delivery.

The priority focus of IHP+ and IHP+ Core Team work has been on: leadership, improving National Health Plans through the JANS process[37] and putting in place the frameworks for managing Health Aid.

The IHP+ 2012/13 workplan is beginning to address some of the gaps in the actual delivery of Health Aid.

Conclusion 6: Monitoring aid effectiveness in the health sector is valuable, but must be improved for Partner Countries and Development Partners to see the full value and potential of this.

IHP+Results is an IHP+ intervention that has enabled IHP+ signatories to report on and track their progress. Monitoring Paris indicators in the health sector provides IHP+ signatories with data on their performance against their aid commitments to health.

Each round of monitoring provides more data for analysis. Although more than 6,000 data points were collected in this round of reporting and monitoring, this exercise can't produce conclusions that can be generalised.

The Paris/Busan indicators are useful for the health sector but need to be supplemented with specific indicators that measure aid effectiveness in the health sector and to understand why this is working or not.

Partner Countries and Development Partners continue to mention the high transaction costs of monitoring. If IHP+ signatories were systematically implementing and monitoring their Paris and IHP+ commitments they would have data on IHP+Results indicators routinely available, and the transaction costs would be lower.

[37] Walford, 2010

6. RECOMMENDATIONS

1. Faster progress must be made to deliver more effective Health Aid that can contribute to health outcomes.

Countries should continue to increase leadership, increase health budgets and strengthen their systems.

1.1 All countries should continue to strengthen their country Public Financial Management Systems to meet the new Busan target.

1.2 Those countries that have not yet improved the arrangements for managing Health Aid should work with Development Partners to put in place a National Health Plan, a Country Compact, a Results Framework and a Mutual Accountability Process.

Development partners should intensify efforts to deliver more effective Health Aid.

1.3 Development Partners should ensure their aid is recorded on budget to meet the new Busan target.

1.4 Development Partners should deliver more predictable aid to meet the new Busan target.

1.5 Development Partners should channel more aid through national systems to meet the new Busan target.

IHP+ should increase support for delivery of more effective aid.

1.6 IHP+ signatories and the Core Team should catalyse, facilitate and, if necessary, establish tools or processes for Development Partners to put more aid on budget, make aid more predictable, and channel aid through country systems. This goes beyond the focus on procurement harmonisation and financial management assessment harmonisation in the current IHP+ workplan, which are useful first steps. The emphasis must be on actual delivery and the use of systems.[38]

1.7 The IHP+ needs to evolve from promoting tools for managing the aid environment, to support the use of these tools in practice and to hold countries and Development Partners to account.

2. Mutual accountability mechanisms must be used to drive improvements in Health Aid effectiveness.

IHP+ signatories should:

2.1 Include explicit targets that address the areas of slowest progress (as reported here) in Country Compacts or annual country workplans. These should be reviewed in country Mutual Accountability processes. All partners should provide transparent information on their commitments and report on their performance to civil society.

2.2 IHP+Results data and tools (including standardised performance measures and scorecards) should be used by partners to support Mutual Accountability processes at the country level so that problems with Health Aid delivery and management can be identified, and corrective actions agreed between partners.

2.3 A global Mutual Accountability process should be held in 2012 using the IHP+Results data to agree a revitalised agenda for action to improve the effectiveness of Health Aid in 2013.

IHP+ Executive Team should

2.4 Address an area of slowest progress (as reported here) each month, reviewing data and exploring options to take collective action to accelerate progress.

[38] IHP+ Phase III workplan and budget 2012-13

3. Future monitoring of Health Aid effectiveness should be owned by stakeholders and use improved indicators that measure what they need to know

Countries should:

3.1 Take the lead to drive and own future monitoring, and integrate this within existing joint annual reviews of the health sector.

Development Partners should:

3.2 Routinely monitor and publish their performance on agreed aid effectiveness indicators.

3.3 Integrate IHP+ indicators into their routine internal performance monitoring.

IHP+ Signatories collectively and with the core team should:

3.4 Continue monitoring Health Aid effectiveness, as anticipated in the IHP+ workplan for 2012-13.[39] More IHP+ signatories should be enrolled to participate, and more years of comparable data should be collected.

3.5 Revise and update the indicator set. These should continue to include current Paris/Busan indicators that focus on delivery of improved aid. It could include the development of new indicators: for example, for measuring the strength of country Public Financial Management and Procurement systems in the health sector, and the use by Development Partners of the country systems.[40] Qualitative assessment of Compacts, Results Frameworks and Mutual Accountability processes should be considered.

3.6 Include more qualitative and contextual information from countries and Development Partners in future monitoring to enable better understanding of the factors that support or limit progress.

[39] IHP+ Phase III workplan and budget 2012-13

[40] It is important to note that this does not refer to the standard health system terrain of health financing, human resources etc. but it refers to the delivery of aid into financial management and procurement systems in the health sector that can make efficient use of that aid. What differences are the investments into strengthening health systems making to the health of target populations?

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.
Capacity Development	The process whereby people, organisations and society as a whole unleash, strengthen, create, adapt and maintain capacity over time.
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)
Country Procurement Systems	Donors use national procurement procedures when the funds they provide for the implementation of projects and programmes are managed according to the national procurement procedures as they were established in the general legislation and implemented by government. The use of national procurement procedures means that donors do not make additional, or special, requirements on governments for the procurement of works, goods and services.
Development Partner	Includes bilateral and multilateral donors, e.g. country aid agencies, and international organisations.
4-point scale used to assess performance in the procurement sector	The OCED has outlined a procedure to produce an indicative picture of the quality of procurement systems, based on a 4-point scale. Detailed information can be found on the OECD website.
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).
Health Aid reported on national health sector budget	This should include all health sector aid recorded in the annual budget as grants, revenue or loans.
Human Resources for Health (HRH) plan	Human Resources for Health (HRH) plans should address the key constraints that need to be addressed to achieve agreed objectives on HRH. A HRH plan includes three main elements: it is costed, evidence-based and comprehensive.
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%.
IHP+	A global partnership that puts the Paris and Accra principles on Aid Effectiveness into practice, with the aim of improving health services and health outcomes, particularly for the poor and vulnerable.
IHP+ Country 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, harmonization between agencies, managing for results and mutual accountability.

Joint Assessments of National Strategies (JANS)	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 (please provide details in the "Answers and additional information column of the survey tool).
Mutual Accountability	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)
National performance assessment frameworks	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).
ODA	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)
Parallel Project Implementation Unit (PIU)	When providing development assistance in a country, some donors establish Project Implementation Units (They are also commonly referred to as project management units, project management consultants, project management offices, project co-ordination offices etc.). These are designed to support the implementation and administration of projects or programmes.
Paris Declaration	The Paris Declaration, endorsed on 2 March 2005, is an international agreement to which over one hundred 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)
Performance assessment framework	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).
Pooled funding mechanism	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 by an Administrative Agent (or Fund Manager) to a number of recipients. Sometimes known as a Multi Donor Trust Fund. Taken from http://www.undg.org/index.cfm?P=152
Programme based approaches (PBAs)	PBAs are a way of engaging in development co-operation based on the principles of coordinated support for a locally owned programme of development, such as a national development strategy, a sector programme, a thematic programme or a programme of a specific organisation.
Public financial management systems (PFM)	Legislative frameworks normally provide for specific types of financial reports to be produced as well as periodicity of such reporting. The use of national financial reporting means that donors do not impose additional requirements on governments for financial reporting.
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).
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 indicators.
Technical cooperation (also referred to as technical assistance)	Is the provision of know-how in the form of personnel, training, research and associated costs. Technical co-operation includes both free standing technical co-operation and technical co-operation that is embedded in investment programmes (or included in programme-based approaches).

IHP+ RESULTS STANDARD PERFORMANCE MEASURES (SPMs)*

IHP+ Governments		IHP+ Development Partners		
Standard Performance Measures	Target	Standard Performance Measures	Target	Link to Paris Target
1G: IHP+ Compact or equivalent mutual agreement in place.	An IHP+ Compact or equivalent mutual agreement is in place.	1DP: Proportion of IHP+ countries in which the partner has signed commitment to (or documented support for) the IHP+ Country Compact, or equivalent agreement.	100% of IHP+ countries where the signatory operates have support for/commitment to the IHP+ compact (or equivalent) mutually agreed and documented.	
2Ga: National Health Sector Plans/Strategy in place with current targets & budgets that have been jointly assessed.	A National Health Sector Plan/Strategy is in place with current targets & budgets that have been jointly assessed.	2DPa: Percent of aid flows to the health sector that is reported on national health sector budgets.	Halve the proportion of aid flows to the health sector not reported on government's budget(s) (with ≥ 85% reported on budget).	PD3 Aid flows are aligned on national priorities
2Gb: Costed and evidence-based HRH plan in place that is integrated with the national health plan.	A costed, comprehensive national HRH plan (integrated with the health plan) is being implemented or developed.	2DPb: Percent of current capacity-development support provided through coordinated programmes consistent with national plans/strategies for the health sector.	50% or more of capacity development support to each IHP+ country in which the signatory operates are based on national health sector plans/ strategies	PD4 Strengthen capacity by co-ordinated support
		2DPc: Percent of health sector aid provided as programme based approaches.	66% of health sector aid flows are provided in the context of programme based approaches	PD9 Use of common arrangements or procedures
3G: Proportion of public funding allocated to health.	15% (or an equivalent published target) of the national budget is allocated to health.	3DP: Percent of health sector aid provided through multi-year commitments.	90% (or an equivalent published target) of health sector funding provided through multi-year commitments (min. 3 years).	
4G: Proportion of health sector funding disbursed against the approved annual budget.	Halve the proportion of health sector funding not disbursed against the approved annual budget.	4DP: Percent of health sector aid disbursements released according to agreed schedules in annual or multi-year frameworks.	71% of health sector aid disbursed within the fiscal year for which it was scheduled.	PD7 Aid is more predictable
5Ga: Country public financial management either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	Improvement of at least one measure (ie 0.5 points) on the PFM/CPIA scale of performance.	5DPb: Percent of health sector aid that uses public financial management systems.	Reduce by one-third the aid not using public financial management systems (with ≥ 80% using country systems).	PD5a Use of country public financial management (PFM) systems
5Gb: Country procurement systems either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	Improvement of at least one measure on the four-point scale used to assess performance for this sector.	5DPa: Percent of health sector aid that uses country procurement systems.	Reduce by one-third the aid not using procurement systems (with ≥ 80% using country systems).	PD5b Use of country procurement systems
		5DPc: Number of parallel Project Implementation Units (PIUs) per country.	Reduce by two-thirds the stock of parallel project implementation units (PIUs).	
6G: An agreed transparent and monitorable performance assessment framework is being used to assess progress in the health sector.	A transparent and monitorable performance assessment framework is in place to assess progress in the health sector.	6DP: Proportion of countries in which agreed, transparent and monitorable performance assessment frameworks are being used to assess progress in the health sector.	Single national performance assessment frameworks are used, where they exist, as the primary basis to assess progress in all countries where the signatory operates.	PD11 Results-oriented frameworks
7G: Mutual assessments, such as joint annual health sector reviews, have been made of progress implementing commitments in the health sector, including on aid effectiveness.	Mutual assessments (such as a joint annual health sector review) are being made of progress implementing commitments in the health sector, including on aid effectiveness.	7DP: Proportion of countries where mutual assessments have been made of progress implementing commitments in the health sector, including on aid effectiveness.	Annual mutual assessment of progress in implementing health sector commitments & agreements (such as the IHP+ country compact and on aid effectiveness in the health sector) is being made in all the countries where the signatory operates.	PD12 Mutual accountability
8G: Evidence that civil society is actively represented in health sector policy processes - including health sector planning, coordination & review mechanisms.	At least 10% of seats in the country's health sector coordination mechanisms are allocated to civil society representatives.	8DP: Evidence of support for Civil Society to be actively represented in health sector policy processes - including health sector planning, coordination & review mechanisms.	All signatories can provide some evidence of supporting active civil society engagement.	

* AGREED BY IHP+ SIGNATORIES

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