ihp+ results

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

2014 PERFORMANCE REPORT

Governments and development agencies have made commitments to increase the effectiveness of development cooperation, most recently in the Busan Partnership agreement. Based on these commitments, partners in the International Health Partnership (IHP+) have highlighted seven aspects of development cooperation where there is room for improvement:

Jointly supporting a single national health strategy through a process of inclusive development and joint assessment

Recording resource inputs on budget and in line with national priorities and ensuring predictability of government and development partner funding

Ensuring that country financial management systems perform well and using those systems

Ensuring that country procurement / supply systems perform well and using those systems

Joint monitoring of process and results, based on one national information and accountability platform including joint annual reviews that define actions and reinforce mutual accountability

Promoting and supporting systematic learning between countries (south-south/ triangular cooperation)

Ensuring strategically planned and well-coordinated technical support

Four of the seven aspects (those highlighted in bold) were assessed in the 2014 IHP+ monitoring round.

Acknowledgements

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Acronyms and Abbreviations

CDC	Centre for Disease Control (USA)
COIA	Commission on Information and Accountability
CPIA	Country Policy and Institutional Assessment (World Bank)
CRF	Country Results Framework
CRS	Creditor Reporting System (OECD/DAC)
CSO	Civil Society Organisation
DAD	Development Assistance Database
DP	Development Partner
DRC	Democratic Republic of Congo
EC	European Commission
EWEC	Every Woman Every Child
FBO	Faith-Based Organisation
GAVI	Global Alliance for Vaccines and Immunisation
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GIZ	German Agency for International Cooperation
GNI	Gross National Income
GPEDC	Global Programme for Effective Development Cooperation
IATI	International Aid Transparency Initiative
IHP+	International Health Partnership
IHP+R	IHP+ Results Consortium
INGO	International Non-Governmental Organisation
KFW	German Development Bank
MAWG	Mutual Accountability Working Group
MDG	Millennium Development Goal
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NGO	Non-Governmental Organisation
OECD/DAC	Development Assistance Committee of the Organisation for Economic Cooperation and Development
PFM	Public Financial Management
UK	United Kingdom
UNAIDS	Joint United Nations Programme on AIDS
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
WHO	World Health Organization

Foreword of the Independent Advisory Group

The International Health Partnership (IHP+) aims to deliver better health outcomes through more effective development cooperation. The fundamental premise under which it operates is that by applying the principles agreed at successive high-level global fora on aid effectiveness (from Paris, through Accra to Busan) and adapting them to the needs of the health sector, development cooperation will help to build sustainable health systems that deliver improved results.

When IHP+ was established in 2007, independent monitoring of what the partnership has achieved was an integral part of the agreement. In this report the IHP+Results Consortium (IHP+R) present the results of the fourth round of monitoring, completed during the course of 2014.

It takes place at a time when 36 middle and low income countries, along with 29 development partners have signed up at global and national level to improve the effectiveness of their cooperation. The fourth round thus includes a greater number of participating agencies and countries. It continues to rely on self-reporting, but all data collection in this, unlike previous rounds, has either been collected and/or validated at country level. Critically, the report also shows trends in selected indicators over the four rounds of monitoring.

Any data collection exercise that seeks to provide an internationally comparable data set inevitably involves compromise: to ensure focus and policy relevance; to limit the demands made on national counterparts and weak administrative systems; to allow for differences in national context and the different approaches to development adopted by different partners; and to find indicators that are both meaningful and measurable. The consortium, working closely with the IHP+ core team, has handled these demands with care and skill. While inevitably there remains some scope for differing interpretation, the report reaches a series of important conclusions.

The duration of IHP+ membership is associated with better country performance, and that performance by governments and their development partners are closely correlated. In other words, development partners are likely to perform better in a more conducive policy environment. It is also apparent that partner countries continue to deliver on their commitments to establish robust health sector strategies, to report on results and to take measures that strengthen mutual accountability. Of continuing concern, however, is that despite efforts to strengthen financial management systems by aid receiving countries, the use of these systems by development partners has fallen significantly.

These findings, which are well documented in the report, prompt one further conclusion that questions one of the basic premises of IHP+, namely that adherence to a set of agreed principles will result in a rapid "step-change" in the effective delivery of aid. Rather, as we review the findings over four successive rounds of monitoring, it seems more realistic to conclude that aid effectiveness is a process that requires persistence, sensitivity to context and sustained effort.

The problems being addressed by IHP+ are complex and subject to changes that take place in both national and international environments. Their resolution depends on the speed of institutional capacity building in countries and the degree to which development partners are prepared to invest trust and tolerate risk; neither of which are subject to quick fixes. We would therefore conclude that IHP+ should not be marked down for failing to transform the health and aid environment in member countries at a stroke. Rather it should be commended for sustained effort and progressively expanding its influence.

This conclusion is borne out by the discussions and recommendations of the Fifth IHP+ Country Health Teams Meeting, held in Siem Reap, Cambodia, in December 2014. Here, participants agreed that, while the IHP+ "seven behaviours" continue to be relevant in a wide variety of situations, improving performance will require sustained action by all partners – by governments; development partners at HQ and country level; CSOs; the private sector and new development actors such as the BRICS. There remains a need to better understand the underlying causes of poor performance, and incentives for change within different organisations. Frank and transparent dialogue is needed to address these longstanding and persistent issues.

The report correctly focuses primarily on the mandate given to the consortium to document progress against agreed deliverables. Particularly in this round to look at changes against four of the seven behaviours associated with effective development cooperation. In addition, however, IHP+ partners should read the report with an eye to the broader policy questions that it raises.

The environment for development policy is evolving rapidly. Aid budgets are under increasing pressure. The geography of poverty is changing, with the majority of the absolute poor now residing in middle-income countries. As a result, increasing attention is being paid to all sources of finance (as opposed to aid in isolation) and a new generation of global development goals will seek to give renewed attention to sustainability and solutions that require solidarity between all countries rich and poor.

The report that follows contains several important insights and raises important questions for the future.

The most fundamental concerns the basic premise that increased aid effectiveness delivers better health outcomes. The idea that it contributes to building institutional capacity and stronger health systems seems secure, but to sustain support for the valuable work of IHP+ there is a need to show a link with results. This may require new and complementary approaches.

Similarly, if it is observed, for example, that development partners consistently fail to use country financial management systems despite evident progress in making them more robust, there is a need to spell out the consequences and to be clear why this matters. This will require more qualitative information from individual countries.

A consistent premise of IHP+ is that greater civil society engagement will enhance accountability. The country case studies in Mali and DRC raise difficult questions in this regard and demonstrate clear differences in perspective on the part of civil society organisations and governments. Overall, the results suggest that progress in achieving meaningful engagement has been less than anticipated. The report would suggest that an in-depth consideration as to the role and purpose of civil society and the mechanisms by which non-state actors more generally should be engaged in the processes of health and development, is now overdue.

On accountability more generally, the report makes valuable suggestions as to options for the future. It points to the choice and trade-offs between strengthening an independent system as opposed to closer integration with the global process designed to monitor the Global Partnership for Effective Development Cooperation (GPEDC). In addition, it will be important to take into account the views of those that advocate greater attention to "independent" as opposed to "mutual" accountability, learning lessons, for example from the Independent External Review Group, established following the report of the Commission on Information and Accountability for Women's and Children's Health.

As a last word, the IHP+R has, through its work over the last eight years, contributed to the development of the largest global database on development cooperation in health. In addition, the core team in WHO and the World Bank that manages IHP+ has accumulated unparalleled experience of the realities of improving aid effectiveness in a complex and fragmented sector. It is vital that this combined experience is widely and more effectively communicated so that it can better inform countries and their partners in development. This report focuses on those agencies and countries that have signed up to IHP+. However, its messages, and the ways of working that it describes, deserve to inform ways of doing business in health and development far more widely.

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Executive Summary

The International Health Partnership (IHP+), launched in 2007, is in its eighth year of operation. Through the partnership and its global and country compacts, 36 developing countries and 29 development partners have signed up to improve the effectiveness of their development cooperation, numbers that have increased steadily over time. Development cooperation effectiveness objectives have evolved following commitments undertaken at the Fourth High Level Forum on Aid Effectiveness in Busan in 2011. The goal of the IHP+ has remained to deliver better health outcomes in low- and middle-income countries by encouraging partners to work together effectively to build sustainable health systems; and by applying the principles adopted in high-level fora on development cooperation to achieve more effective health sector cooperation.

In December 2012, at the 4th IHP+ meeting of country health teams in Nairobi, participants identified seven operational principles of cooperation in the health sector. International development partners should adhere to these principles in order to accelerate progress towards the achievement of health-related MDGs. Recent meetings of global health leaders strongly supported renewed action on these 'seven behaviours'.

Development cooperation effectiveness has been measured through four monitoring rounds since 2007. The fourth round of IHP+ monitoring in 2014 assessed the status of adherence by both countries and development partners to four of the 'seven behaviours'. This performance assessment differed from previous monitoring rounds as data were collected at country level by Ministries of Health (MOHs).[1] This approach was chosen to strengthen the accountability for commitments by health partners at country level. Twenty-four partner countries participated in this monitoring round, five more than in 2012. Thirty-seven development partners provided data, up from 17 in the previous round. Four international NGOs participated for the first time. The final data set included data from 24 MOHs and 213 development partner country offices. This is currently the largest global database on development cooperation in health.

1 The exceptions were data from GAVI and the Global Fund which do not have a permanent presence in countries.

SUMMARY OF RESULTS

Key messages

1. **IHP+ membership is associated with better country performance in relation to development cooperation effectiveness**

2. **Performance by governments and development partners are correlated**

3. **Partner countries continue to deliver on commitments to establish health sector strategies, measure results and strengthen accountability**

Establishing a country results framework	PROGRESS
Engagement of civil society in health policy and planning	STAGNATION
Joint assessment of national strategy including targets and budgets	PROGRESS
Implementation of policies and procedures for mutual accountability	STAGNATION

4. **Development partners increasingly align and continue to participate in accountability processes at country level**

Support for and use of country results framework and proportion of funds monitored using the country results framework	PROGRESS
Support to CSOs for participation in health policy processes	PROGRESS
Participation in mutual assessment of progress in implementing health commitments	STAGNATION

5. **Partner countries improve the financing and to some extent financial management of the health sector**

Proportion of budget allocated to health and level of budget execution	PROGRESS
Predictability of health funding over next 3 years through rolling budget or MTEF	PROGRESS
Public financial management strength according to CPIA	STAGNATION

6. **Performance of development partners on financing and financial management has declined**

Level of health sector support budget execution in 2013	DECLINE
Proportion of support to government registered in national health budget	STAGNATION
Predictability of funding communicated to government for 2015-17	DECLINE
Proportion of support using national financial management procedures	DECLINE

IHP+ membership is associated with better country performance in relation to development cooperation effectiveness

The performance of member countries is correlated with the duration of IHP+ membership. The correlation is stronger for accountability than for financial indicators. There is also a positive correlation between financial performance indicator scores and the level of external funding. These findings may indicate a positive effect of IHP+ partnership on performance, or that countries with more developed external cooperation mechanisms were more likely to have joined the IHP+ early, and were more likely to have received health sector support from international agencies.

Performance by governments and performance by development partners are correlated

The performance scores of governments and development partners in the 24 participating countries are correlated, suggesting that development partners may perform better in countries with a conducive policy environment, and that countries working with effective development partners may have more incentives to improve their policies and systems.

Partner countries continue to deliver on commitments to establish health sector strategies, measure results and strengthen accountability

The 17 countries that participated in previous monitoring rounds were more likely to have a sector results framework in place than the seven countries that participated for the first time. The Ministries of Health reported a high level of participation of civil society organisations (CSOs) in health policy and planning processes, with the exception of participation in budget development and resource allocation where a 50% decrease was recorded since the last monitoring round. Out of the 17 countries that participated in the previous rounds, 16 (94%) now have jointly assessed strategies in place. Two thirds of countries reported that at least four of five mutual accountability processes were in place. All five processes were more frequently reported by the 17 countries that participated in previous rounds of monitoring than by the countries that had joined for the first time.

Development partners increasingly align and continue to participate in accountability processes at country level

The proportion of expenditures by development partners that are aligned with the country results framework ranged from 98% by the World Bank to 34% by UNAIDS. Alignment has increased since the last monitoring round. In most countries, all partners had disbursed some proportion of their funds through a programme that was aligned with the country results framework and had participated in efforts to strengthen the framework. Support for the participation of CSOs in health policy and planning had increased slightly over previous rounds: 63% of the development partners reported providing financial assistance, 56% gave technical assistance, and 37% supported CSOs for advocacy. Financial support for health service delivery by CSOs was excluded from the survey. Only five development partners participated in mutual assessments (for example through a Joint Annual Review) in all countries that had established such assessments. In the fourteen partnerships for which serial data were available, the high level of participation in mutual assessments noted in previous rounds continued unchanged. Participation was lower among those partners who submitted performance data for the first time. This is some indication of a positive trend towards greater participation in mutual assessments.

Partner countries improve the financing and to some extent financial management of the health sector

Since the last monitoring round, partner governments have increased the proportion of national budgets allocated to health from an average of eight to ten percent. Two countries reached the African Abuja target of 15%. The number of countries that reached the target of 90% budget execution increased by 44%. Nineteen of 24 MOHs reported that they had a medium-term expenditure framework (MTEF) or a three-year rolling budget. Data from the World Bank's Country Policy and Institutional Assessment (CPIA) database showed no change in the soundness of the public financial management (PFM) systems since 2005. Twelve countries had a CPIA score greater than or equal to 3.5.

Performance of development partners on financing and financial management has declined

Development partners executed 85% of their 2013 health sector cooperation budget and reached the target of 90% budget execution in about half of the countries for which they submitted reports. The combined target of 90% execution of both the development partner and the national health budget was reached in nine of the 24 participating countries. Based on reported expenditures in 2013 and information from MOHs about forward planning by development partners, IHP+R estimated that MOHs had forward expenditure estimates for about 86% of development funds in the year immediately following the survey, falling to 34% in year three. Almost all development partners reported significant reductions in the percentage of aid on budget compared to previous rounds except Belgium and the Global Fund which reached the target of 85%. Overall the proportion of external funds for health recorded in national budgets was similar to the previous round at 71% and much lower than in the first monitoring round when it was reported at 81%. Among the eight countries with data from previous rounds and relatively sound PFM systems (CPIA score ≥ 3.5) the use of national public systems for the management of international development funds declined to a low of 41% from a level of 65% in the previous round.

Lessons from focus countries on the monitoring process

The pilot approach of focused in-country support to IHP+ performance monitoring in Mali and the DRC generated three main lessons:

- IHP+ performance monitoring was considered a useful input into the health policy dialogue by all national stakeholders. In-country support to the process helped raise the quality and the profile of performance monitoring. The level of assistance required by the MOH for managing the process of performance monitoring varied between countries.
- Communication and discussion of the results of previous performance assessments were limited to technical departments of government and development agencies. There was little public knowledge of the results, including among CSOs working in health. This limited potential policy impact of the performance reports and was described as a 'missed opportunity' for linking development performance monitoring to accountability systems through parliament, media and civil society.
- The transaction costs of IHP+ monitoring were considered to be reasonable, but stakeholders in both countries recommended a greater effort to include development performance indicators in routine data collection systems, in order to increase the reliability of data and to make them accessible on a more regular and timely basis.

Lessons from focus countries on the role of civil society

Civil society organisations have a major input in health service delivery but consider their engagement in health policy and planning to be often symbolic rather than substantive. This was a major difference to the views expressed by Ministries of Health. While development partners reported support to civil society, CSOs felt that most financial support was tied to service delivery and that the role of CSOs in promoting public sector accountability was often neglected. The question on who should represent civil society in health sector policy processes is complex because of multiple and divergent roles and interests. CSOs at the national and international level have until now had relatively little information about and not much involvement in IHP+ performance monitoring.

Conclusions and way forward

The link to the Paris and Busan monitoring processes has been a key feature of IHP+ performance assessments since 2010. Integrating the IHP+ performance assessment into the GPEDC monitoring framework would require a closer coordination in the definition of indicators and data collection methods. Transferring greater ownership of IHP+ monitoring to the Ministries of Health can potentially stimulate the country-level dialogue among partners on concepts and performance, as well as provide space for better validating self-reported data. There remains, however, a strong case for a global aggregation of information on the status and trends in health sector development cooperation. Comparing and publishing data on country and development partner's performance is likely to have contributed to the documented improved performance since 2007, even if change is more pronounced for countries than for development agencies. Furthermore, it seems that some of the persistent institutional obstacles to development partner progress require policy responses that must be made at the headquarters level, and which are likely to be best influenced through global level dialogue and accountability. Integrating the monitoring of development cooperation effectiveness in routine national information systems should be explored further. While such streamlining efforts continue, it is important to allocate sufficient time to future IHP+ monitoring rounds.

The IHP+ also needs to acknowledge that its partnership could reach out more effectively to the growing number of partners at the global level, as well as the many different stakeholders in national health systems. IHP+, as from the start, actively promotes broad participation, including of CSOs at country and global levels, broadened participation in the 2014 IHP+ performance monitoring through the country-based approach (eg. participation of non IHP+ partners and INGO's), and continues to increase its membership (both of countries and development partners). Still there is scope for getting the wider group of partners (including BRICS) and countries involved to ensure more effective development cooperation and accountability. It is similarly important for the policy dialogue on development cooperation effectiveness and accountability to be more inclusive at country level, including other stakeholders such as elected representatives, media and non-health CSOs such as trade unions.

Based on the experience of collecting data for the fourth round of performance monitoring, the consultations with partners in the two focus countries, and a review of global accountability mechanisms for development cooperation, IHP+R has identified a number of possible approaches for monitoring and mutual accountability in IHP+.

- Continue strengthening country-led monitoring and accountability
- Establish stronger peer accountability mechanisms
- Establish stronger links to international social accountability mechanisms
- Integrating development cooperation and results monitoring in health
- Integrate IHP+ performance assessment with the GPEDC monitoring mechanism

These approaches are not mutually exclusive, nor are they recommendations for actions. This is a contribution to further discussion on future approaches for monitoring development cooperation effectiveness and mutual accountability.

The fourth performance monitoring round of the IHP+ has again documented that the partnership has contributed to a greater alignment of the practice of development cooperation in health with principles of development effectiveness. It has also shown the persisting gaps in this process. Closing these gaps will require a continued effort, and maybe a revised or expanded approach. It is the task of IHP+R to analyse progress and document results. It is now up to the IHP+ partners to draw conclusions and initiate action.

The IHP+ website provides access to the main results of the 2014 monitoring[2]. Country and development partner score cards, as well as the global report of the 2014 monitoring round can be downloaded from the same source.

The value of the 2014 monitoring round, having benefited from substantially increased participation of countries and development partners compared to previous rounds, will depend on the use of the results at country and global level. Especially at country level, it is important to include all development partners (those that have participated and those that have not participated) and relevant national stakeholders (including other ministries, media, parliament, health-related CSOs, non-health CSOs, etc.) in the policy dialogue on development cooperation effectiveness, with a view to learn from the monitoring and discuss how to do better. Development partners should also discuss the results at headquarters level in order to further improve their performance as documented in this report.

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2 Weblink: http://www.internationalhealthpartnership.net/en/results-evidence/2014-monitoring-round/

Table 1: Overview of partner country performance

SUMMARY TABLE OF GOVERNMENT PERFORMANCE

Government	1G Is a sector results framework in place?	2G Does government support meaningful participation of Civil Society Organisations?	3Ga Are government funds disbursed predictably?	3Gb Are government resources planned over more than one year?	4G Is there a national health plan in place that has been jointly assessed?	5G Are mutual assessment mechanisms in place?	6G Are country public finance management systems of good quality?
Benin	▶	●	▶	▶	▶	▶	▶
Burkina	▶	▶	●	▶	▶	▶	▶
Burundi	▶	●	▶	▶	▶	▶	▶
Cambodia	▶	●	▶	▶	●	▶	▶
Cameroon	●	▶	●	▶	▶	▶	■
Cape Verde	●	●	▶	▶	●	▶	▶
Cote d'Ivoire	●	●	▶	▶	●	●	▶
DRC	▶	●	●	▶	▶	▶	▶
El Salvador	■	●	▶	■	■	▶	?
Ethiopia	▶	●	▶	▶	▶	▶	▶
Guinea	■	●	●	■	■	■	■
Guinea Bissau	■	●	●	■	●	■	■
Mali	▶	●	●	■	▶	●	▶
Mauritania	●	●	▶	▶	▶	●	■
Mozambique	▶	●	▶	▶	▶	▶	▶
Nepal	▶	●	▶	▶	▶	▶	▶
Niger	▶	▶	●	▶	▶	▶	▶
Nigeria	▶	▶	▶	▶	▶	●	■
Senegal	▶	▶	●	▶	▶	▶	▶
Sierra Leone	▶	▶	▶	▶	▶	●	▶
Sudan	▶	●	?	▶	▶	●	▶
Togo	▶	▶	●	▶	●	▶	■
Uganda	▶	●	?	▶	▶	▶	■
Vietnam	▶	●	▶	■	●	▶	▶

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

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

- ▶ TARGET ACHIEVED
- ● EVIDENCE OF ACTION
- ■ NO EVIDENCE OF ACTION
- ? NO DATA AVAILABLE
- – COUNTRY SYSTEM UNDER DEVELOPMENT

Table 2: Overview of development partner performance

SUMMARY TABLE OF DEVELOPMENT PARTNER PERFORMANCE

Development Partners	1DP Do development partners use the sector results framework?	2DP Do development partners support meaningful engagement of Civil Society Organisations?	3DPa Are development partner funds disbursed predictably?	3DPb Does government have information on development partner expenditure plans for three years ahead?	4DP Is development partner cooperation reported on budget?	5DP Do development partners use mutual assessment mechanisms?	6DP Are development partners using country public finance management systems?
African Development Bank (2)	▶	●	▶	■	▶	●	?
Asian Development Bank (1)	▶	■	▶	▶	●	■	▶
Australia (2)	▶	▶	▶	■	●	●	●
Belgium (Belgium,Flanders, Wallonia) (8)	▶	●	●	●	●	●	●
Canada (4)	▶	●	▶	●	●	●	▶
European Commission (11)	▶	●	●	●	●	▶	▶
France (7)	▶	●	●	●	●	●	●
GAVI Alliance (22)	▶	▶	▶	●	●	●	●
Germany (GIZ & KfW) (7)	▶	●	●	■	●	▶	●
GFATM (24)	●	●	●	●	●	●	●
GOAL (1)	▶	▶	?	●	■	–	–
ILO (1)	–	■	▶	■	■	■	■
Ireland (2)	▶	▶	▶	■	▶	▶	▶
Italy (2)	▶	●	●	●	●	▶	■
Japan (3)	▶	●	▶	●	▶	▶	■
Korea (1)	▶	▶	▶	■	■	▶	■
Luxemburg (3)	▶	▶	▶	●	●	▶	▶
Netherlands (5)	▶	▶	▶	■	●	●	▶
Pathfinder (1)	▶	■	▶	■	■	▶	■
Plan (2)	▶	▶	▶	▶	●	–	–
Portugal (1)	–	▶	▶	■	●	▶	●
Save the Children (2)	▶	▶	●	●	▶	■	▶
Spain (7)	▶	●	●	■	●	●	▶
UNAIDS (8)	▶	▶	▶	■	●	▶	●
UNICEF (16)	▶	●	●	●	●	▶	●
UNDP (1)	▶	▶	●	?	▶	–	–
United Kingdom (5)	▶	▶	▶	■	▶	▶	●
UNFPA (15)	▶	●	▶	●	●	●	●
UN Women (1)	–	▶	▶	■	■	■	■
USAID (Incl. CDC) (5)	▶	●	▶	●	●	●	●
WHO (23)	▶	●	▶	●	●	●	●
World Bank (15)	●	●	●	●	●	●	●
World Food Programme (1)	▶	▶	●	■	■	▶	■

1. Introduction

The International Health Partnership (IHP+), launched in 2007, is in its eighth year of operation. Through the partnership and its global and country compacts, 36 developing countries and 29 development partners have signed up to improve the effectiveness of their development cooperation, numbers that have increased steadily over time. Development effectiveness objectives have evolved following commitments undertaken at the Fourth High Level Forum on Aid Effectiveness in Busan in 2011. Nevertheless, the goal of the IHP+ has remained to deliver better health outcomes in low and middle income countries by: improving the quality, management and efficiency of health aid and domestic health resources, according to Paris principles of aid effectiveness; and by working effectively together to build sustainable health systems.

At the 4th IHP+ meeting of country health teams in Nairobi in December 2012, participants identified seven operational principles of cooperation in the health sector that international development partners should adhere to in order to accelerate progress towards the achievement of the health-related MDGs. Recent meetings of global health leaders strongly supported renewed action on these 'seven behaviours'. The 2014 IHP+ monitoring round assessed the status of adherence to four of the principles.

Table 3: The seven behaviours for effective health sector cooperation

The seven behaviours	Measured in the 2014 IHP+ Monitoring
1. **Agreement on priorities that are reflected in a single national health strategy and underpinning sub-sector strategies, through a process of inclusive development and joint assessment, and a reduction in separate exercises.**	✓
2. **Resource inputs recorded on budget and in line with national priorities**	✓
3. **Financial management systems harmonized and aligned; requisite capacity building done or underway, and country systems strengthened and used.**	✓
4. **Procurement/supply systems harmonized and aligned, parallel systems phased out, country systems strengthened and used with a focus on best value for money. National ownership can include benefiting from global procurement.**	✗
5. **Joint monitoring of process and results is based on one information and accountability platform including joint annual reviews that define actions that are implemented and reinforce mutual accountability.**	✓
6. **Opportunities for systematic learning between countries developed and supported by agencies (south-south/triangular cooperation).**	✗
7. **Provision of strategically planned and well-coordinated technical support.**	✗

The performance of the IHP+ was assessed three times prior to the current monitoring round: at baseline in 2007 and subsequently in 2010 and 2012. The previous performance reports document progress towards more effective cooperation in some areas, more notable among developing country governments than among their international partners. Progress was particularly slow on key financial indicators, including registering the external resources provided to the government sector in the national budgets and improving the predictability of funding.

This fourth performance assessment integrated lessons from earlier monitoring rounds. It followed the established methodology in some areas in order to document trends, but it took a different approach to data collection and refined some of the indicators. It also responded to two key criticisms of earlier rounds: the relatively high transaction costs of monitoring and the lack of validation of self-reported data.

In previous monitoring rounds, developing country governments and their international partners reported separately on progress towards meeting their commitments. In 2014, all data were collated and submitted by the governments of developing countries, including the data from participating development partners. This change aimed at strengthening the accountability at the country level for commitments made through country compacts.

IHP+Results (IHP+R) supported data collection by the Ministries of Health (MOHs) through a helpdesk and through remote technical assistance by an international health systems expert. An alternate approach was piloted in two countries where consultants were engaged locally to support the MOH throughout the entire process, from data collection to the communication of results. To investigate constraints to civil society participation in the IHP+, a global survey of civil society organisation (CSOs) was undertaken, as well as round table and focus group discussions in the two pilot countries.

Finally, IHP+R reviewed the concept and implementation of mutual accountability, a key principle of the IHP+ emanating from the 2005 Paris Declaration on Aid Effectiveness. This is a contribution to further discussion on future approaches for monitoring development effectiveness and mutual accountability.

2. The way performance was monitored in 2014

2.1. OVERALL APPROACH

In December 2012, the participants in the 4th IHP+ country health teams meeting in Nairobi agreed on six issues to be monitored in 2014 (Annex 1, Table 6) and a number of principles that were subsequently incorporated by the IHP+ Mutual Accountability Working Group (MAWG) in the following procedural guidelines:

- Participation in monitoring will continue to be voluntary and rely on self-reported data;
- The decision to participate as well as the process of data collation and the discussion of the findings will be located at country-level under the leadership of the Ministry of Health (MOH);
- Government and development partner performance will be tracked through fewer indicators (seven in 2014 compared to twelve in the 2012 IHP+ monitoring round);
- The monitoring framework will be aligned as much as possible with the framework of the Global Partnership on Effective Development Cooperation (GPEDC);
- The findings will be communicated through scorecards to promote accessibility and discussion; scorecard ratings will be based on transparent targets and criteria.

2.2. METHODS

From May to September 2014, IHP+R collected data through two survey tools, one completed by Ministries of Health (MOHs) and another by the country representatives of development partners and submitted to the MOH. The MOH, through the IHP+ focal point or other MOH staff, provided quality assurance and clarifications for all data with support by an international consultant and a helpdesk provided by IHP+R. The Global Fund and GAVI completed the data tools at their headquarters. They were entered into the database after validation by the MOH. IHP+R did not accept data directly from development partner headquarters or country offices without prior validation by the MOH.

IHP+R also explored the potential to use publicly available data sources such as the OECD/DAC Creditor Reporting System (CRS), the International Aid Transparency Initiative (IATI), country-level aid information management systems (AIMS) and development assistance databases (DADs). Data reported by these systems were, however, of limited usefulness for IHP+ performance monitoring. Only one indicator in the current IHP+ performance framework could be completed by importing from another database, and partial information was available for a second; furthermore the data was only available in a limited number of participating countries, and with concerns about the quality and timeliness of this data.

Participating countries that had participated in previous rounds: Benin, Burkina Faso, Burundi, DRC, El Salvador, Ethiopia, Mali, Mauritania, Mozambique, Nepal, Niger, Nigeria, Senegal, Sierra Leone, Sudan, Togo, Uganda,

New participants: Cambodia, Cameroon, Cape Verde, Côte d'Ivoire, Guinea, Guinea Bissau, Vietnam

As a pilot experience for supporting performance monitoring at country level and to animate a national discussion of mutual accountability in the health sector, IHP+R recruited local consultant teams in Mali and the Democratic Republic of Congo (DRC). Teams were selected by national IHP+ focal points in consultation with development partners. Both teams worked under the direction of the national IHP+ focal point with support of an international consultant.

Twenty-four partner governments participated in the 2014 IHP+ performance monitoring round, five more than in 2012. Seven countries participated for the first time and two previous participants (Djibouti and Rwanda) did not participate in 2014. Thirty-seven development partners[3] provided data at the country level, including four international NGOs. This was a major increase from 17 in 2012. Two participants in previous rounds, Norway[4] and Sweden, did not provide data in 2014.

3 Data were combined for bilateral development partners with more than one aid delivery channel. These we Belgium (Belgian, Flemish and Walloon Governments), Germany (GIZ and KfW) and USA (USAID and CDC).

4 The contributions to multilateral agencies and INGOs by Norway and other countries are reported by those agencies without indicating the origin of funds. As the IHP+R methodology does not allow showing the origin of the funds, Norway's contributions are not reflected in this monitoring report.

Table 4: Monitoring issues and performance indicators

Issues	Government indicators	Development partner indicators
1. Health development cooperation is focused on results that meet developing countries' priorities	An agreed transparent and monitorable country results framework was used to assess progress in the health sector	Proportion of countries in which the country health sector results framework was used
2. Civil society operates in an environment which maximises its engagement in and contribution to development	Civil society was meaningfully engaged in health sector policy processes - including health sector planning, coordination & review mechanisms	The meaningful engagement of civil society in health policy processes was supported, including in health sector planning, coordination and review mechanisms
3. Health development co-operation is more predictable	A. Proportion of health sector funding disbursed against the approved annual budget B. Projected government expenditure on health provided for 3 years	A. Percentage of health sector development cooperation for the government sector disbursed in the year for which it was scheduled B. Estimated proportion of health sector development cooperation covered by indicative forward expenditure and/or implementation plans covering at least three years ahead
4. Health aid is on budget	National Health Sector Plans/Strategy are in place with current targets & budgets that have been jointly assessed.	Percentage of health sector development cooperation scheduled for disbursement that was recorded in the annual budgets approved by the legislatures of developing countries.
5. Mutual accountability among health development cooperation actors is strengthened through inclusive reviews	An inclusive process for mutual assessments of the implementation of health sector commitments exists that meets at least 4 of 5 selected criteria.	Proportion of countries in which DPs participated in mutual assessments of the implementation of commitments in the health sector, including on aid effectiveness.
6. Effective institutions: Developing countries' systems are strengthened and used	Country public financial management systems either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these	Percentage of health development cooperation disbursed for the government sector that used national public financial management systems (in countries where systems were considered to adhere to accepted standards, or that had embarked on a reform)

The final database included data from 24 developing country governments and 213 country offices of development partners. Performance was analysed and reported using grouped data. Some indicators were analysed and reported for all participating countries, but for the analysis of trends, only data from the 17 countries that participated in previous rounds were included. Institutional adherence to development effectiveness commitments among development partners was analysed among the 16 development partners who reported in at least four countries.

A global questionnaire survey of civil society organisations launched by IHP+R was distributed widely through a number of civil society networks. Despite several reminders and extensions, only 34 responses were received, most from just two countries: Uganda and Pakistan. The response rate was too low for a meaningful analysis of the survey results.

2.3. DATA LIMITATIONS

There were important limitations in the collected data. Some were inherited from the monitoring framework of previous rounds, others stemmed from the alignment with the GPEDC monitoring process. A full discussion of the limitations is included as a Methodology Annex to this report (available online).

2.3.1. Limited scope of the reporting framework

The IHP+ may have made progress in areas that were not tracked through the agreed reporting framework. IHP+R made efforts to draw on additional data, such as data on progress towards the MDGs and on health financing, but this has not been the primary focus of this monitoring round.

2.3.2. Methodological challenges with some indicators

The agreed monitoring framework included two new indicators: availability of MTEFs and availability of expenditure plans that cover three years ahead. It also included new approaches to measuring issues that had been previously tracked: use of country results frameworks (CRFs), meaningful participation of civil society, and the availability of mutual accountability mechanisms. Some of these changes introduced challenges for data collection and analysis, for example, using data reported by governments to track development partner performance on the use of CRFs and on recording aid on budget.

For indicator 3DPa on the predictability of funding (which compared funds disbursed with scheduled disbursements), there were some instances where aggregate data (on the front of scorecards) and disaggregated data (on the back of scorecards) appear to be inconsistent. This reflects the method for aggregation used in previous monitoring rounds. For example, with the Global Fund, where aggregate performance is 100% and yet there are seven countries with a score of less than 100%. This is driven on one hand by over-disbursement (in 8 countries) and by weighted aggregates (where the volume of a country programme affects the aggregate performance), which means that countries with large resource envelopes that demonstrate good performance can mask poor performance in countries with small resource envelopes. Furthermore, the data presented in scorecards are capped at 100% which can hide this phenomenon.

2.3.3. Self-reported data

IHP+R made efforts to validate self-reported data by triangulating them with other aid effectiveness analyses, through structured discussions at country level, and through informal peer reviews of scorecards. In practice these approaches were too challenging to implement systematically and meaningfully within the time and resources available.

2.3.4. Limited data from self-selected sources

The number of participants increased since the last IHP+ monitoring round and new development partners joined, some of them providing significant volumes of health sector assistance, such as the governments of Canada, France and the USA. There were, however, still many gaps. Some development partners did not participate in all countries where they have programmes. It cannot be excluded that they only participated in those countries where they had an active collaboration on policy and technical issues with government, introducing a significant reporting bias in their performance score. Furthermore, in the context of the increasing number of development actors globally, the sample captured in the monitoring round was relatively small. It did not include the cooperation with philanthropic foundations and the growing number of South-South partnerships; and only four international NGOs participated in only three of the participating countries.

2.3.5. Availability and reliability of data

IHP+R intended to focus on 'data collation' rather than 'data collection', harvesting data from existing monitoring systems. This was realised only in rare instances. Data for performance monitoring were not readily available and had to be collected and verified in processes that were at times onerous and often raised questions of reliability. In some countries there were major discordances between financial data provided by government and development partners. As indicated, the potential to import data from available international sources was also limited.

2.3.6. Lack of qualitative and interpretive data

The development of the IHP+R monitoring framework was heavily influenced by concerns about the transaction costs of reporting. As a result both development partners and governments were not asked to provide additional information to allow a more nuanced analysis of complex issues that may not be captured by quantitative indicators. Nevertheless, the IHP+R database is currently the largest global database on development cooperation in health; the collected data are the best that are available and, despite limitations, they shed a useful light on performance by IHP+ signatories at country level and to some extent also of other development partners. They should be used to foster a contextualised and nuanced dialogue on health sector cooperation performance at country level.

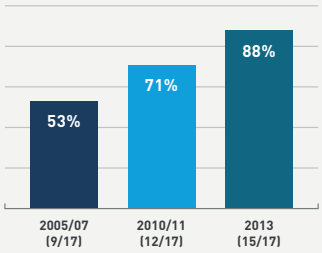
3. The performance of partner countries

3.1. PARTNER COUNTRIES CONTINUE TO DELIVER ON COMMITMENTS TO ESTABLISH HEALTH SECTOR STRATEGIES, MEASURE RESULTS AND STRENGTHEN ACCOUNTABILITY

Data for four indicators were analysed to assess the performance of partner countries on meeting commitments to accountability:

1. The establishment of a comprehensive health sector results framework
2. The engagement of civil society in health policy and planning processes
3. The joint assessment of a national health sector strategy that included targets and budgets
4. The implementation of policies and procedures that foster mutual accountability

Figure 1: Proportion of countries with country results frameworks



Since the start of monitoring IHP+ performance, an increasing number of partner countries have established comprehensive country results frameworks (Figure 1). The 17 countries that had participated in previous monitoring rounds were more likely to have a country results framework in place than the seven countries that participated for the first time.

To monitor the engagement of civil society, Ministries of Health reported on the participation of civil society organisations (CSOs) in five health policy and planning processes: joint annual reviews; sector coordination meetings; thematic or technical working groups; budget development and resource allocation; and the development of a medium term health sector plan. This last process was measured for the first time in this monitoring round.

The government-reported participation of CSOs in health policy and planning processes continued to be as high as reported in 2010/11 with the exception of participation in budget development and resource allocation, where a 50% decrease was recorded. This greatly reduced the total number of countries that met the target for this indicator (Figure 2 for 17 countries that previously reported).

Figure 2: Number of countries with CSO involvement in each of the five health policy processes

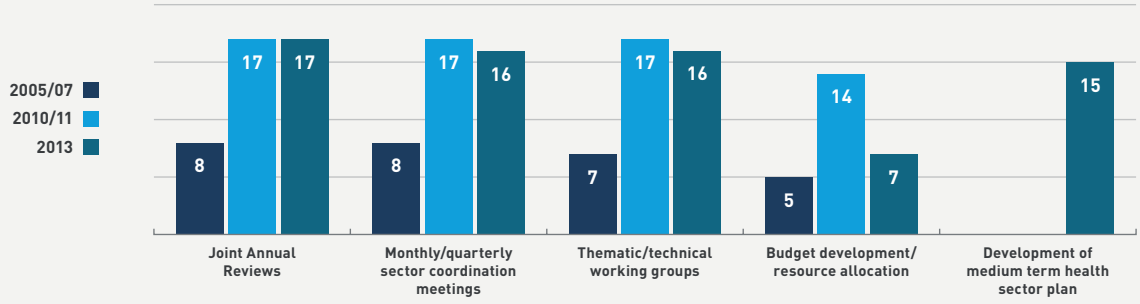
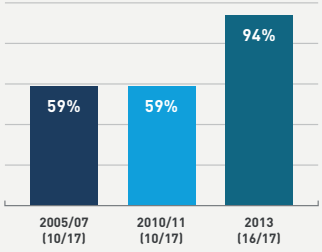


Figure 3: Proportion of countries with jointly assessed national health strategies

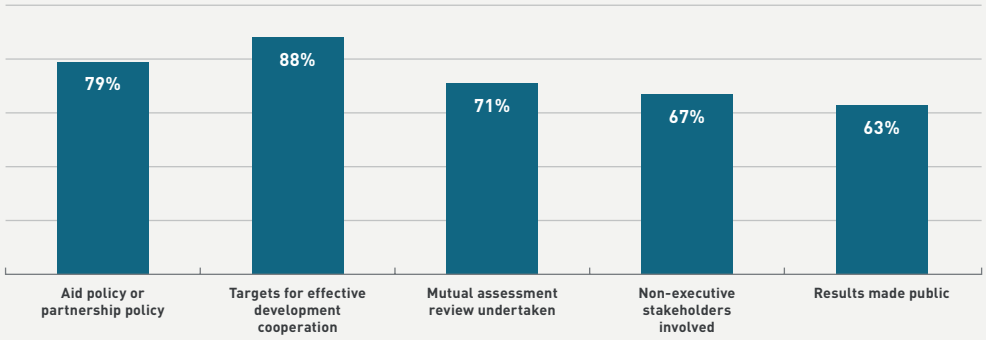


Partner countries continued to report national health strategies and plans that included targets and budgets. Out of the 17 countries that participated in the previous rounds, 16 (94%) now have jointly assessed strategies in place. This is a substantial increase compared to only 10 countries (59%) in 2011. (Figure 3) It should be noted that this might reflect a cumulative effect (as strategic plans are generally for 5-years, and the IHP+ reporting only every 2 to 3 years), as well as an increase from cycle to cycle. Among the newly participating countries, only 1 had a jointly assessed health strategy.

Five national processes were monitored to assess the policy environment for mutual accountability: (i) the existence of an aid or partnership policy, (ii) the inclusion of development effectiveness indicators in the policy, (iii) the joint review of this policy, (iv) the involvement of civil society in the review, and (v) the public communication of the review results.

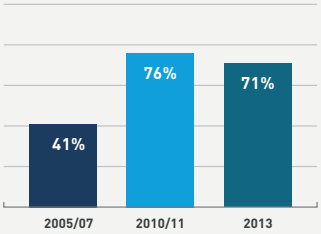
Two thirds of the 24 participating countries reported that at least four of the five mutual accountability processes were in place. The most common process was the establishment of targets for effective development cooperation, the least common was the public communication of results (Figure 4). All five processes were more frequently reported by the 17 countries that participated in previous rounds than by the countries that had joined for the first time.

Figure 4: % of countries that have established mutual accountability processes (N=24)



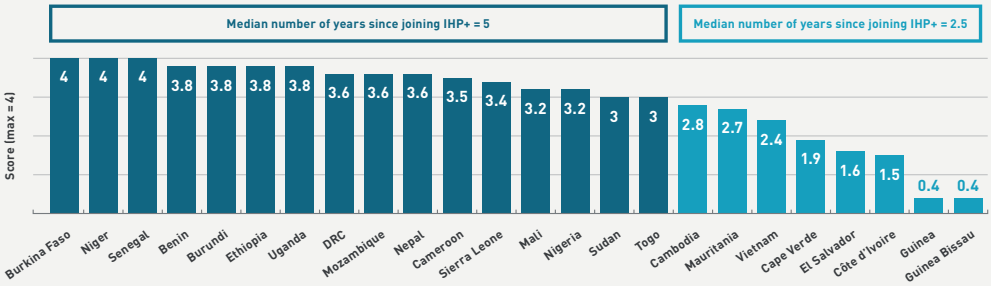
In comparison to 2010/11 the number of countries that met the target criteria of having established at least four processes decreased slightly, however the data are not strictly comparable because more stringent criteria were applied in the 2014 monitoring round (Figure 5).

Figure 5: % of countries with at least 4 mutual accountability processes (N=17)



The average score obtained by the 24 participating countries for the four accountability indicators was 74%. Eight countries had a score below the average. They tended to be newer members of the IHP+ with a median membership history of 2.5 years compared to the other 16 counties who had a median duration of membership of five years (Figure 6).

Figure 6: Aggregate scores of participating countries on 4 accountability indicators



3.2. PARTNER COUNTRIES HAVE IMPROVED THE FINANCING AND TO SOME EXTENT FINANCIAL MANAGEMENT OF THE HEALTH SECTOR

Three indicators were analysed to assess the progress of partner countries on meeting commitments to transparent and predictable health sector financing:

1. The proportion of the national budget allocated to the health sector and the level of execution of the budget
2. The predictability of health sector funding over the next three years through a rolling budget or a medium term expenditure framework (MTEF)
3. The strength of public financial management as assessed by the World Bank's Country Policy and Institutional Assessment (CPIA) scale

Since the 2010/11 monitoring round, partner governments increased the proportion of national budgets allocated to the health sector from an average of eight to ten percent. Two countries (Togo and Burkina Faso) reached the targets for the Abuja commitment for Africa of 15%. Twelve had increased their budget allocation since the last monitoring round while five maintained or decreased it (Figure 7). The average level of budget execution remained virtually unchanged at 71%, but the number of countries that reached the target of 90% budget execution increased by 44% to 13/22 (Figure 8).

Figure 7: Proportion of national budget allocated to health in 2013

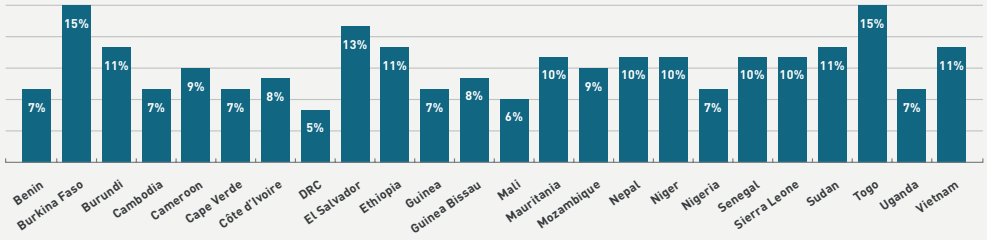
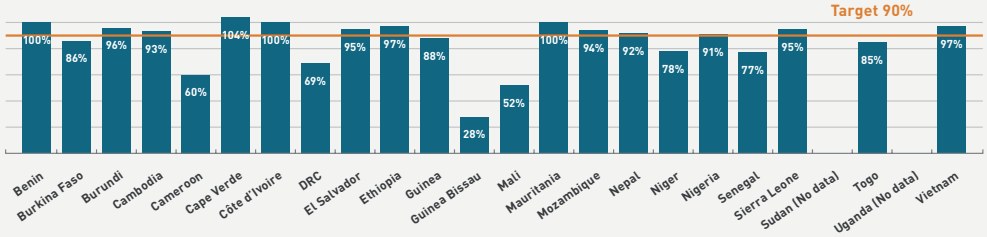


Figure 8: Government health sector budget execution in 2013



A word of caution

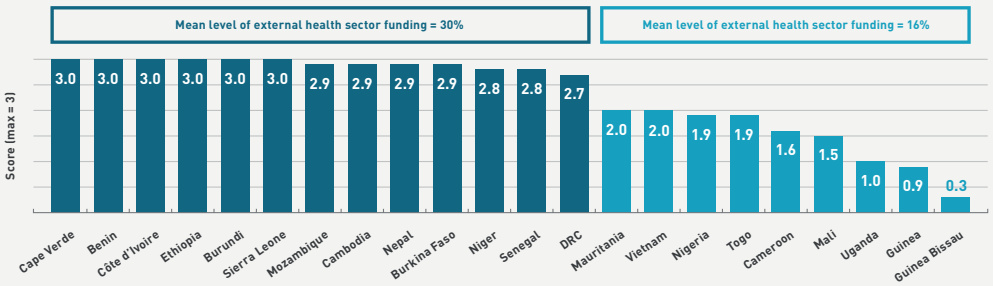
During consultations in the DRC, stakeholders remarked that the budget execution rate reported by the Ministry of Health is overestimated because it includes on-budget partner funds. The execution of the national budget excluding external funds is habitually only in the region of 30% to 35% .

Nineteen of 24 Ministries of Health reported that they had established an MTEF or a three-year rolling budget/plan for the health sector.

Serial CPIA data published by the World Bank for 23 of the 24 participating countries show no change in the soundness of the public financial management systems from an average score of 3.17 in 2005 to 3.26 in 2013. (No CPIA scores are published for El Salvador). In 2013, twelve participating countries were assessed as having sufficiently robust public financial management systems with CPIA score greater than or equal to 3.5.

The overall performance of partner countries on the three financing indicators ranged from 0.3 to three out of three. Nine countries performed below the average of 2.3. While there was some correlation between performance and duration of membership in IHP+, it was weaker than for the accountability indicators. There was, however, a stronger correlation of performance with the level of external funding of the health sector (Figure 9). This may be due to preferences by development partners to support countries with strong national financial management, or countries with high levels of external funding may have incentives to strengthen their systems to manage public finances.[5]

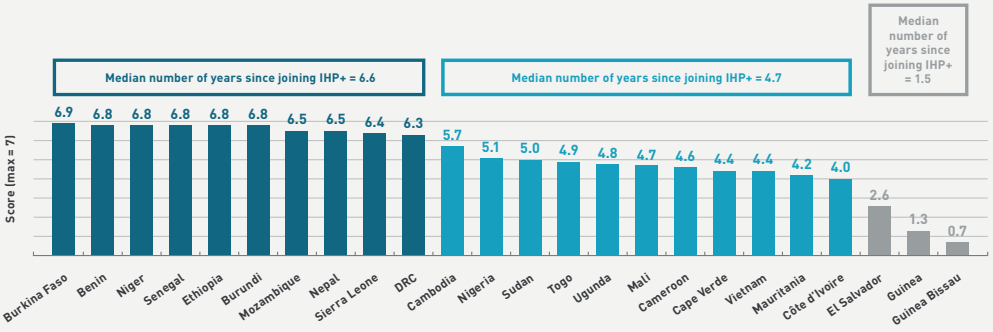
Figure 9: Average scores of participating countries on 3 financing indicators



3.3. PROGRESS TOWARDS DEVELOPMENT COOPERATION COMMITMENTS IS NOT UNIFORMLY SHARED ACROSS COUNTRIES

There was significant variation among the 24 countries in performance on the seven indicators: the largest number of countries (19 or 79%) met the target for having a forward expenditure plan for the health sector; the smallest number of countries (seven or 29%) met the target for engaging civil society in health policy processes.[6]

Figure 10: Average scores of participating countries on 7 indicators



Six countries (Benin, Burkina Faso, Burundi, Ethiopia, Niger and Senegal) performed well across all indicators, while three (Guinea, Guinea-Bissau and El Salvador) performed weakly across all (Figure 10). Possible explanations for poor performance differed from country to country. Guinea-Bissau experienced a coup d'état in 2012 and only joined the IHP+ in 2013, the year for which data were collected.

5 Sudan was excluded from this analysis because the level of external funding was not known, and El Salvador was excluded because the CPIA score was not available

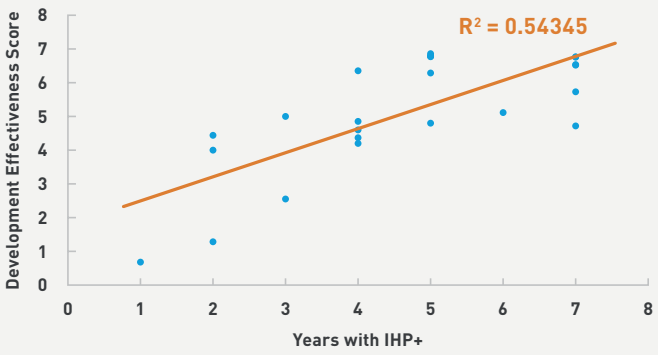
6 Indicators with unknown values were entered as "0" in this analysis. This affects the scores for Cameroon, Cape Verde, Côte d'Ivoire, El Salvador, Mauritania and Sudan for one indicator each.

El Salvador is also a recent IHP+ partner. Its total score is affected by the missing indicator on public financial management, but this does not affect the ranking. The country receives only about one percent of health financing from external sources and development cooperation issues are likely to be of lower priority than in other countries with large health sector aid budgets. Guinea is also a new partner, having joined in 2012, but the low score of 1.3/7 was nevertheless unexpected. IHP+ Results therefore compared its results to the scores of Burkina Faso, a neighbouring country that registered the highest overall score of 6.9/7 among all 24 participants in the monitoring round.

Table 7 in annex 3 shows that these two countries had similar population, economic and health data. However, Burkina Faso had a larger share of external assistance in its health sector financing than Guinea and also recorded faster progress on health indicators. The monitoring results suggest that Burkina Faso had a more enabling national environment for development cooperation than Guinea and that its development partners also showed greater responsiveness and more cooperative behaviours. Burkina Faso joined the IHP+ partnership three years before Guinea, which may have contributed to the difference.

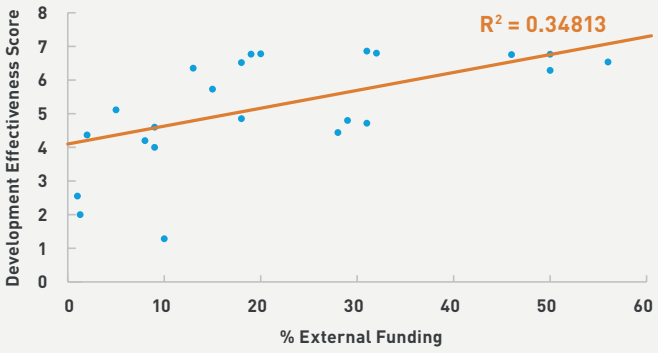
Overall country performance scores were positively correlated with the number of years a country participated in the IHP+ (Figure 11). The correlation was stronger for accountability than for financial indicators.

Figure 11: Country score on 7 development effectiveness indicators by year of IHP+ membership



There was also a positive correlation between overall country performance scores and level of external funding, albeit less strong (Figure 12).

Figure 12: Country score on 7 development effectiveness indicators by % of external health financing



This may indicate either a positive effect of IHP+ partnership on performance, especially on accountability, or that higher performing countries are more likely to join the partnership early and more likely to receive a larger amount of external funding. The correlation has to be interpreted with caution.

4. The performance of development partners

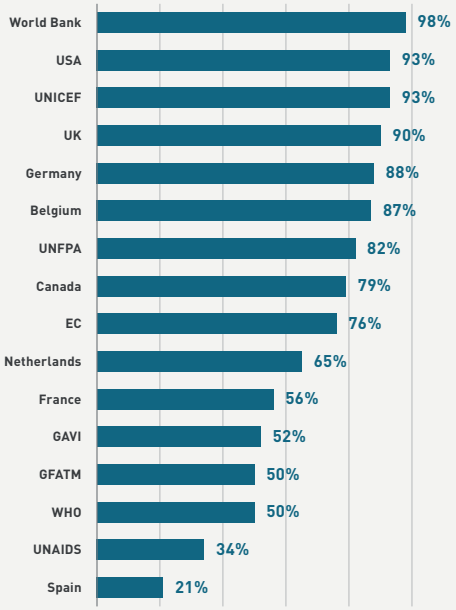
4.1. DEVELOPMENT PARTNERS INCREASINGLY ALIGN AND CONTINUE TO PARTICIPATE IN PROCESSES FOR ACCOUNTABILITY AT THE COUNTRY LEVEL

IHP+R analysed three indicators for the performance of development partners on meeting commitments to accountability:

1. The self-reported support and use of the country results framework and the proportion of development funds disbursed through programmes that are monitored using the country results framework (CRF).
2. The financial, technical and advocacy support provided to civil society organisations for participation in health policy processes.
3. The participation in mutual assessment(s) of progress in implementing health sector commitments, including on development effectiveness

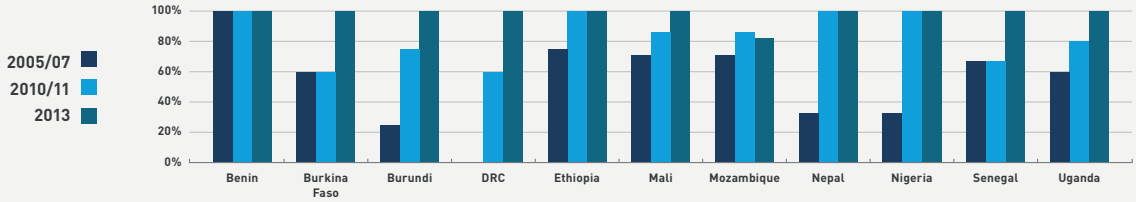
Among the 16 development partners who provided data to the MOHs in at least four countries, the proportion of total reported expenditures in programmes that were aligned with the country results framework ranged from 98% by the World Bank to 34% by UNAIDS. Some partners responsible for a large volume of health sector assistance were only 50% aligned (Figure 13).

Figure 13: Proportion of development funds disbursed through a mechanism aligned with the country results framework



Serial data from countries and development partners that participated in performance monitoring over the last three rounds were only available for eleven countries. They show an increasing alignment of development partners with country results frameworks (Figure 14). In 2013 the development partners in all eleven countries except Mozambique scored 100% on this indicator. This finding has to be interpreted with caution. It does not mean that the programmes of the participating development partners were fully aligned, but rather that all the partners had disbursed a proportion of their development funds through a programme that was aligned, such as a general or sector budget support programme and, in addition, that they participated in at least one of four possible processes to strengthen the country results framework.[7]

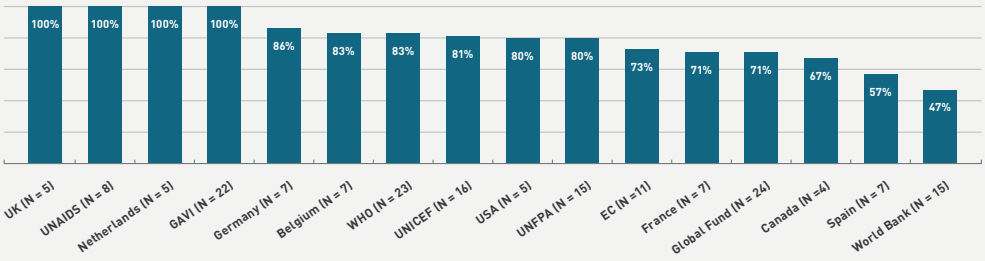
Figure 14: Proportion of development partners in selected countries that are aligned with the CRF



7 (i) use of the CRF for own programme; (ii) programmes aligned with government programming cycles; (iii) participation in country-led health sector M&E; and (iv) adoption of the national M&E system

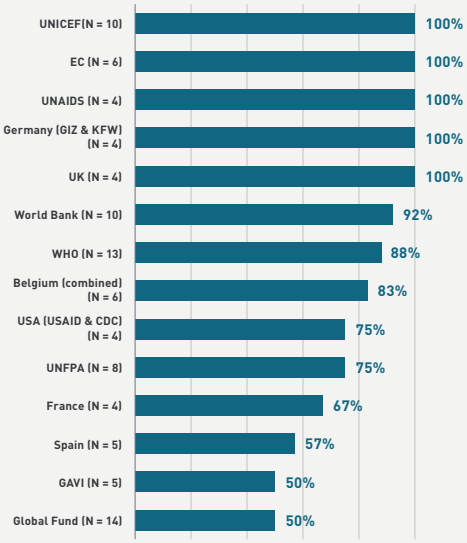
Development partners reported support for the participation of CSOs in health policy and planning in most countries. In about three quarters of all partnerships, development partners provided at least one type of support to enable CSOs to participate in the health policy dialogue (Figure 15). This was a slight increase over previous rounds. Of these 63% reported providing financial assistance to CSOs, 56% provided technical assistance and 37% supported CSO lobbying and advocacy roles. Funding of CSOs for service delivery was excluded from this survey.

Figure 15: % of countries where development partners reported at least one type of CSO support



N = Number of countries in which the development partner participated in the monitoring round

Figure 16: Proportion of countries in which the development partners participated in mutual assessments



N = Countries with mutual assessment processes in which the development partner submitted performance data

About a third of development partners reported that they participated in mutual health sector assessments in all countries that had established such processes. Most development partners supporting more than three countries, participated in mutual assessments in 60-100% of those countries (Figure 16). The multilateral agencies and the global health initiatives that responded in a large number of countries had results ranging from 100% participation (UNICEF) to 50% (GAVI and Global Fund).

While most development partners reported an increase in participation in mutual assessments in the 2011 monitoring round, participation declined by 2014 in all but three countries.

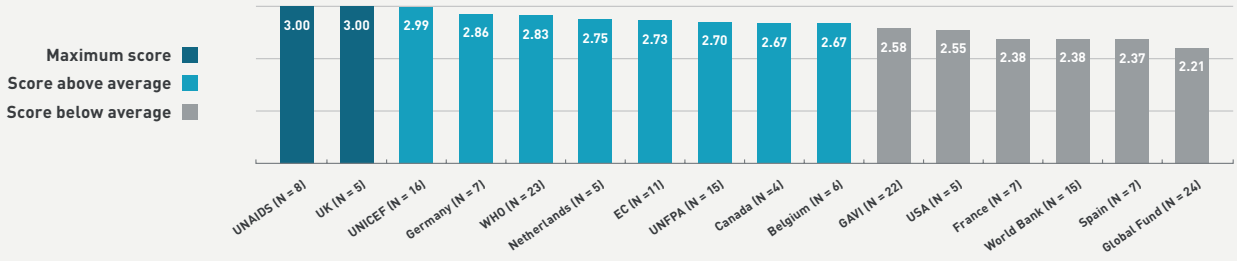
Germany, UK, UNAIDS, UNICEF and the EC reported that they participated in mutual assessments in all countries. By contrast, the global health initiatives (Global Fund and GAVI) found it particularly challenging to participate in these processes.

Findings from countries suggest that while countries have worked hard to put accountability processes in place, there has been less progress among the development partners in taking advantage of those processes to hold both each other and partner governments to account. For example, in Burkina Faso, Cape Verde, Nepal and Togo, governments reported that they had established a full complement of accountability processes but only 40-50 % of development partners reported participating in them.

In the small number of partnerships (between countries and development partners) for which data from past monitoring rounds were available, there was a high level of participation in accountability processes, as noted in 2010/11 (but increased compared to the 2007 monitoring round). Participation was, however, lower for those who joined for the first time. This is some indication of a positive trend towards greater and continued participation in accountability processes, the longer the partnership lasts.

Drawing conclusions about the overall performance of development partner institutions on accountability is problematic because of the selected reporting of each partner in a limited number of countries and the criteria for meeting the targets on the three accountability indicators which were set low. Among the 16 development partners who submitted data in at least four countries, the average score was 2.67/3. Two partners achieved a full score of 3/3, while six scored below average (Figure 17).

Figure 17: Scores of development partners on 3 accountability indicators



4.2. PERFORMANCE OF DEVELOPMENT PARTNERS ON FINANCING AND FINANCIAL MANAGEMENT IS WEAKER

Data for four indicators were analysed to assess the performance of development partners on meeting commitments for providing transparent and predictable financial assistance that meets the priorities of national health systems:

1. The level of execution of the resources allocated to the health sector in 2013
2. The proportion of support to the government sector that is registered in the national health sector budget
3. The predictability of funding communicated to government for the three years from 2015 to 2017
4. The proportion of financial support to the government sector that used national budget execution, financial reporting and/or auditing procedures

In the 24 countries sampled, the 90% budget execution target for development partners was reached in 12 countries (Figure 18), just one less than the 13 countries where budget execution by government met the target (Figure 8). The combined target of 90% budget execution of both the government and the development partner budgets was reached in nine countries (Figure 19).

Figure 18: Development partner health sector budget execution in 2013

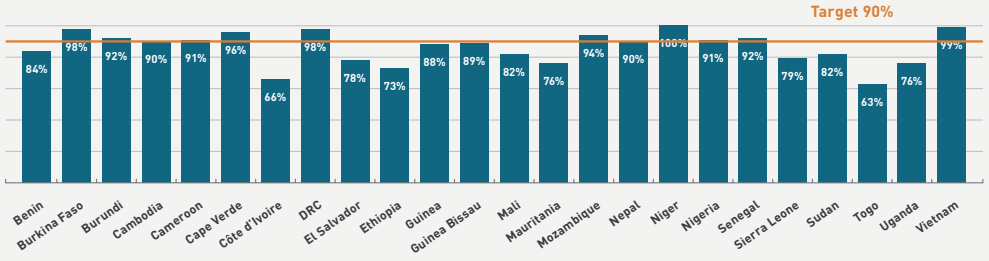
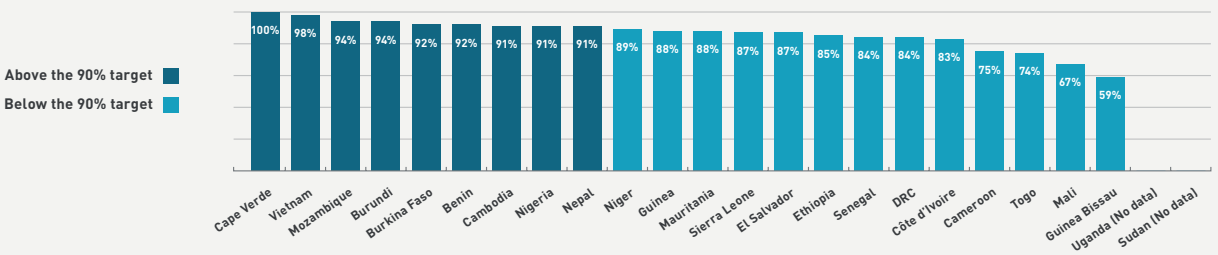


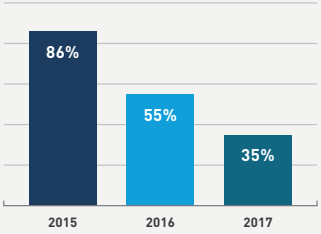
Figure 19: Combined government/development partner health sector budget execution in 2013



When comparing results with the 2010/11 performance report for the 17 countries that participated in both rounds, the aggregate rate of development partner budget execution fell from 99% to 85%. However this is to a large extent due to the fact that there were major unscheduled disbursements in 2010, primarily by the Global Fund. The 2010/11 budget execution rates in many countries were therefore well above 100%.

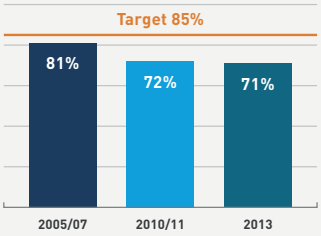
Predictability of development partner funding is essential for forward planning. Based on development partner expenditures in 2013 and reports from MOHs about available information for the three years following the survey, IHP+R estimated how well partner governments were informed in 2014 about the estimated spending of development partners over the next three years, from 2015 to 2017. While an estimated 86% of expenditure was predictable for 2015, for 2017 it was only 35% (Figure 20).

Figure 20: Development partner forward expenditure estimates available to MOH



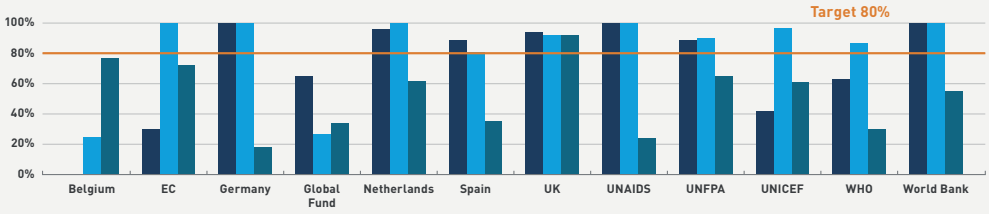
There were significant differences in the information provided by Ministries of Health and by development partners on the amount of development funds reported on budget. Data derived from both sources could therefore not be merged and the indicator was calculated using only self-reported data by development partners. The proportion of development funds recorded in the national budgets in 2013 was 71%, similar to the proportion reported in 2010/11 (72%). It had declined significantly from the level of 81% recorded in 2005/07 (Figure 21). This finding, however, is sensitive to data provided by a few partners with large resource envelopes.

Figure 21: % of total aid on budget



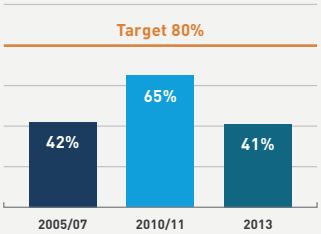
Among the development partners for whom serial data from past monitoring rounds were available, only the UK reached the target of 85% of support to the government sector reported in the national budget. Almost all reported significant reductions in the percentage of aid on budget compared to previous rounds except Belgium and the Global Fund (Figure 22).

Figure 22: % of aid on budget by development partner



While there was no decline in the financial management systems of partner countries, they were only used to manage 43% of development partner funds in the 12 countries with CPIA scores > 3.5. Of these, for eight countries with serial data, the use of national public financial systems by development partners dropped to a low 41% in 2013, from 65% in 2010/11 and 42% in 2005/07 (Figure 23)[8].

Figure 23: % of partner funds using national PFM system



8 It is important to note that DP data in those countries with PFM CPIA scores of less than 3.5 were not counted. Whilst this is consistent with previous IHP+R reporting, it discounts instances where DPs are using the PFM system in spite of relative weakness of the PFM system. This for example applies to Germany in Nepal, the World Bank and Belgium in Uganda where the PFM systems have a CPIA score of less than 3.5 but where these DPs have still reported that they use the PFM system. We cannot generalise about the effect of this methodological approach – in some cases it may reduce the aggregate DP performance on use of PFM systems, in others it may improve the aggregate DP performance. For more details see the IHP+R 2014 methodology annex (available online).

Aggregate performance data mask substantial variation among development partners (Figure 24). Some development partners, for example the EC, Netherlands and Spain, consistently used at least two of the three national financial management procedures. Many others, including some of the largest contributors such as the Global Fund and USAID, used national systems for less than 20% of their contributions.

Figure 24: % of development partners using PFM procedures in countries with CPIA≥3.5

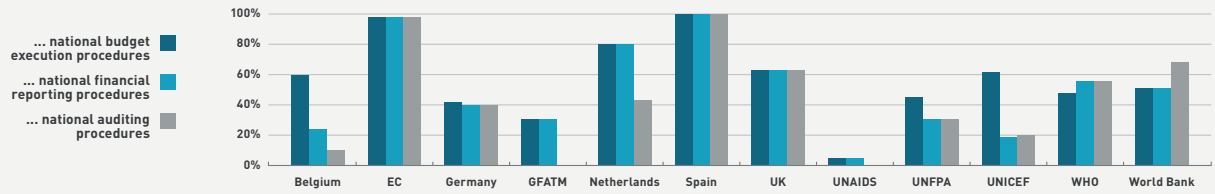
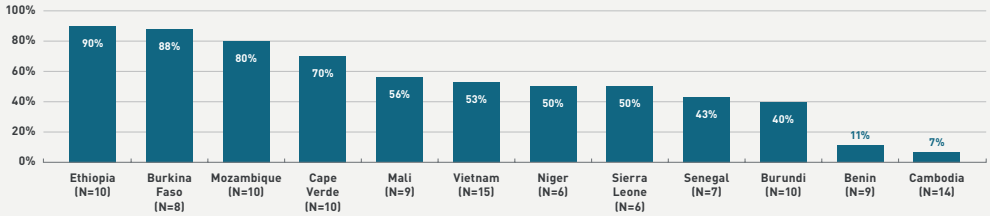


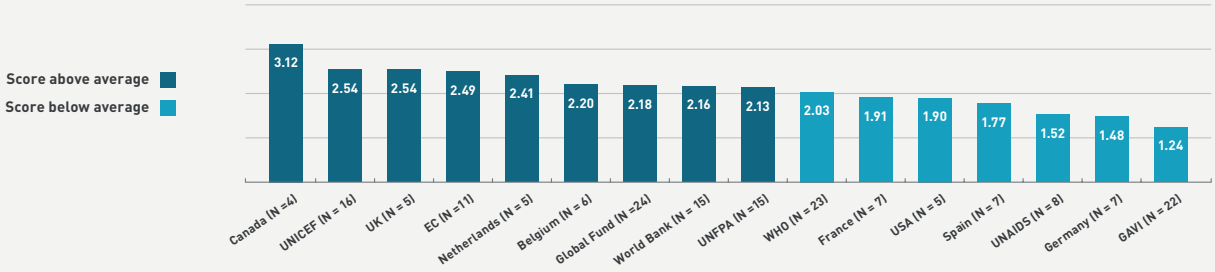
Figure 25: % of partners using PFM procedures in countries with CPIA≥3.5



N = number of development partners who participated in each country

Overall, the performance of development partners in meeting the commitments on financial cooperation has been at best static and less convincing than the performance on the commitments to accountability processes. Out of a total possible score of four, only Canada came close to the target of 3.43. The average score of the 16 partners who participated in at least four countries was 2.1, and seven development partners scored below the average. Among these is USAID which is a more recent member of IHP+, but it also includes the WHO, Germany, France, Spain and GAVI who are among the original signatories of the Global Compact (Figure 26).

Figure 26: Scores of development partners on 4 financial cooperation indicators

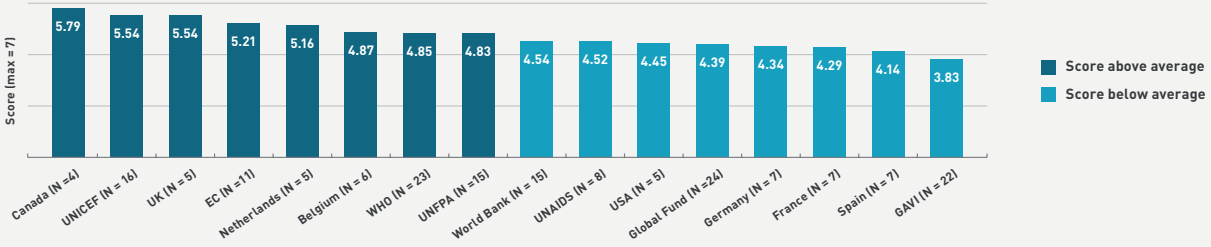


4.3. THE OVERALL PERFORMANCE OF DEVELOPMENT PARTNERS ON MEETING THEIR COMMITMENTS TO EFFECTIVE COOPERATION IS LOWER THAN THAT OF PARTNER COUNTRIES, BUT AT THE COUNTRY LEVEL THE SCORES OBTAINED BY BOTH PARTNERS ARE CORRELATED

As in previous rounds, most development partners did not submit data in all their programme countries. For some this was because they did not have a health sector programme in all countries. The exceptions were the Global Fund, GAVI and the WHO which reported in almost all participating countries.

The 16 development partners who participated in at least four countries achieved a mean score of 4.8 out of seven. (Figure 27) This was lower than the mean score of 5.1 achieved by the partner countries, although for some indicators the development partners faced considerably lower barriers to achieving the targets than countries (for instance, for the engagement of civil society and for participation in processes for mutual accountability). None of the development partners reached the target of 6.34. Canada came closest albeit with data reported for only four countries.

Figure 27: Overall score of development partners on 7 indicators



There are many reasons why development partners may fail to reach targets on meeting commitments for development cooperation. They may operate primarily in countries where it is more difficult to meet commitments, or where the conditions for mutual accountability and financial effectiveness do not exist. They may have governance bodies that do not prioritise or incentivise development effectiveness. There was no pattern according to whether the partners were bilateral or multilateral agencies: UNICEF performed well, UNFPA less so; Canada and the UK outperformed Spain and France.

One of the findings of the performance review, however, is worth keeping in mind. At the country level the scores obtained by partner countries and development partners are correlated (Figure 28). The message is plausible: development partners are more likely to perform better in countries with a conducive policy environment. Likewise, countries working with effective development partners have more incentives to improve their policies and systems. As in any partnership, the outcome is largely determined by the interaction between both.

Figure 28: Correlation between the scores of partners at country level

5. Lessons from Mali and the Democratic Republic of Congo on IHP+ monitoring

For the 2014 IHP+ performance monitoring round, IHP+R contracted local consultants in Mali and the DRC to pilot the approach of providing intensive, focused national support to country-based monitoring. The purpose of this exercise was to animate a national discussion of mutual accountability in the health sector, to prepare case studies of mutual accountability in two countries, and to further explore the role of civil society in health policy processes. IHP+R organised group discussions with representatives of civil society and interviewed government and development partner stakeholders.

5.1. MUTUAL ACCOUNTABILITY MECHANISMS AND PROCESSES

5.1.1. Mutual accountability mechanisms exist in both countries but functioned better in Mali than in the DRC

In Mali, mechanisms established under the country compact were sufficiently mature to conduct performance reviews with minimal external support. Stakeholders however acknowledged that in practice, reviews focused on the performance of government and there was little monitoring of the performance of development partners. In the DRC the structures were barely functioning and, because of limited leadership by the MOH, sector policy dialogue was driven by the development partners. Few partners participated in the monitoring effort led by the MOH. This suggests that country-based performance monitoring led by the MOH requires different levels of support depending on the capacity and leadership strength of the MOH.

5.1.2. MOHs and development partners in both countries rated IHP+ performance monitoring as a useful input into their development cooperation dialogue

Country-level and country-centred data collection introduced in this monitoring round created opportunities to stimulate the development effectiveness dialogue between governments and development partners. In Mali and the DRC, IHP+ performance monitoring injected new dynamism into the national dialogue on development cooperation in health and helped identify some of the areas that required more attention. These included the engagement of civil society in the health policy dialogue and the sharing of financial information between MOHs and development partners.

The consultations in both countries also revealed that the results of IHP+ performance monitoring were only discussed among technical staff and lacked policy traction. This was described as a 'missed opportunity' for linking development performance monitoring to accountability systems through parliament, media and civil society.

5.1.3. Integration of development performance monitoring in routine monitoring systems

In Mali, most of the data required for the IHP+ performance evaluation were readily available and there were few instances of discordance between financial data provided by government and development partners. In the DRC, on the other hand, the coordination structures and the information flow were considerably less functional. The collection of accurate and reliable data could not have been achieved without the support of national technical assistance.

The partners in Mali considered that the transaction costs of IHP+ performance monitoring were reasonable while in the DRC they were much higher. In both countries, stakeholders recommended a greater effort to integrate development cooperation indicators into routine monitoring systems.

5.2. ROLE OF CIVIL SOCIETY

5.2.1. Civil society disagree with government and development partners on the quality of their inclusion in health policy dialogue

In both countries, the consultations revealed major differences of views between MOHs, civil society organisations and development partners on the degree of inclusion of civil society in health policy processes. Civil society representatives felt that their inclusion was symbolic rather than substantive and that financial support from development partners was mainly tied to service delivery, while activities such as advocacy, networking and participation in policy processes were underfunded. They also received insufficient or late information from government and little financial support for building capacity to engage in the national health policy dialogue.

5.2.2. Civil society organisations have multiple and potentially conflicting roles

Civil society organisations and groups include diverse types of CSOs and some combine multiple roles in the health sector which may conflict: as beneficiaries (eg patient groups); as advocates (eg health activist groups); as implementers (eg professional groups, private sector, NGO and FBO health services); and as financiers (eg health mutual funds). Organisations included in health policy processes were most commonly in the categories of 'advocates' or 'implementers' with a considerable overlap between these two functions. This generates tensions with MOHs with whom they sometimes compete for international funds to deliver health services. In the DRC, a civil society coordinating office had been created with the support of some development partners to represent civil society in the national health dialogue. However, with time this structure evolved into an organisation that delivered services funded by international partners. It entered into competition with its own constituents. Some larger NGOs therefore no longer recognise it as an institution that represents their views and interests in the health policy dialogue.

The question of who represents civil society in the national health policy dialogue was discussed intensely among stakeholders in both Mali and the DRC. CSOs expressed the view that financing by development partners for service delivery may increase their role in the national health sector, but it also risked creating a dependency that may weaken their effectiveness as advocates and monitors of accountability. The consultations in both countries underlined the importance of providing support to civil society organisations that is not linked to service delivery, but that allows organisations to network among each other and to develop common advocacy and policy positions.

Involving civil society in accountability

In Mali, the Ministry of Economy and Finance organises training sessions for civil society organisations on the subject of accountability. The Ministry's secretariat for donor harmonisation communicates closely with a civil society group on budget monitoring, and provides information on national budget planning and execution. This information is also posted on-line and accessible to the public.

6. Conclusions and way forward

6.1. WHAT HAVE WE LEARNED

Table 5: Key messages of the fourth round of IHP+ performance monitoring

Key messages	
1. IHP+ membership is associated with better country performance in relation to development cooperation effectiveness	
2. Performance by governments and development partners are correlated	
3. Partner countries continue to deliver on commitments to establish health sector strategies, measure results and strengthen accountability	
Establishing a country results framework	PROGRESS
Engagement of civil society in health policy and planning	STAGNATION
Joint assessment of national strategy including targets and budgets	PROGRESS
Implementation of policies and procedures for mutual accountability	STAGNATION
4. Development partners increasingly align and continue to participate in accountability processes at country level	
Support for and use of country results framework and proportion of funds monitored using the country results framework	PROGRESS
Support to CSOs for participation in health policy processes	PROGRESS
Participation in mutual assessment of progress in implementing health commitments	STAGNATION
5. Partner countries improve the financing and to some extent financial management of the health sector	
Proportion of budget allocated to health and level of budget execution	PROGRESS
Predictability of health funding over next 3 years through rolling budget or MTEF	PROGRESS
Public financial management strength according to CPIA	STAGNATION
6. Performance of development partners on financing and financial management has declined	
Level of health sector support budget execution in 2013	DECLINE
Proportion of support to government registered in national health budget	STAGNATION
Predictability of funding communicated to government for 2015-17	DECLINE
Proportion of support using national financial management procedures	DECLINE

6.1.1. Development effectiveness

The fourth performance monitoring round documented an overall improvement of performance by partner countries. Both mutual accountability and financing indicators improved in the majority of countries, although many countries continue to have weak financial management systems. Overall performance scores were positively correlated with the number of years since countries joined the IHP+, as well as with the level of external funding of the health sector, a proxy indicator for the intensity of the partnership network in the country.

Almost all development partners improved their performance on mutual accountability indicators, and some on indicators for the alignment of financial assistance with national systems. But overall, the indicators for effective financial cooperation by development partners documented a decline. The performance of development partners was correlated with the performance of partner countries. This underlines the fact that the performance of a partnership depends on the behaviours and quality of interaction between all partners.

6.1.2. The country-based approach

Consultations in the two focus countries strongly supported the country-based approach. It injected new dynamism in the national dialogue on development cooperation in health and helped identify areas that required more attention, for instance the engagement of civil society in the health policy dialogue, and the sharing of financial information between Ministries of Health and their development partners. It also widened participation to non IHP+ signatories and INGOs.

The experience of the monitoring round also suggests that this approach requires a differentiated level of support depending on the capacity and leadership strength of the MOH. While in some countries this approach can be implemented by the Ministry of Health without significant external support, other countries require extensive technical assistance. As the experience in the DRC suggests, this assistance is most effective when it is provided within the country by a national consultant or organisation.

The country-based approach to performance monitoring also highlighted the need to improve routine monitoring of health sector cooperation. The intention of IHP+R to prioritise the harvesting of data from existing data bases was only realised in rare instances. Most of the time, reliable data were not available and had to be assembled by the Ministries and development partners through onerous processes of data collection and validation. In both focus countries, stakeholders strongly recommended that development performance monitoring data should be integrated in routine national information systems.

6.1.3. Civil society engagement

The participation of civil society in the national partnership for health continues to be an issue that elicits major discussions. The consultations in the two focus countries underlined that there are different perceptions among governments, development partners and civil society organisations about effective engagement of civil society. The question of who should represent civil society in the national health dialogue is largely unresolved and hampers effective CSO participation. Limited participation in the health policy and development effectiveness dialogue at country level may explain that knowledge and interest in the IHP+ among health-focused NGOs at the country level is at best limited. This was also confirmed by the very low response rate to a survey launched by IHP+R via a large number of international civil society networks. IHP+ has taken a number of steps to promote the participation of CSOs in policy and planning processes, including inter alia through including CSOs in IHP+ governance structures and providing country-level grants to support CSO capacity (through the Health Policy Action Fund). However, there remain unresolved questions on the difficult issue of whether the CSO participation is meaningful, and a strategic and adequate resourced approach is required.

6.1.4. Mutual accountability

Accountability among IHP+ partners for the effectiveness of cooperation in health depends on mutuality. Implementation has to overcome two main difficulties: first, the relationship between international partners in development cooperation is highly asymmetrical; and second, there is no institutional mechanism to enforce accountability among partners. Asymmetrical relationships reflect major structural power differentials among stakeholders in health sector development that risk undermining the implementation of mutual accountability processes. Providers of development assistance have powerful financial instruments to hold recipients to account. The instruments of recipient governments to hold their partners to account are, however, limited. Governments can also impose legal and financial sanctions on civil society actors while the ability of civil society to hold governments to account is highly variable. Although the processes and tools adopted by the IHP+ may have mitigated some of the effects of the asymmetry among partners, it has not overcome them.

IHP+R reviewed examples of international accountability mechanisms from which IHP+ might draw inspiration on how to move forward. A summary of possible approaches for strengthening mutual accountability is presented in section 6.2.3.

6.2. THE WAY FORWARD

6.2.1. Global monitoring of development effectiveness

The link to the Paris and Busan / Global Partnership (GPEDC) monitoring processes has been a key feature of IHP+ performance assessments. In line with the GPEDC, the IHP+ 2014 monitoring was explicitly located at country-level, and intended to collate existing data, rather than collect new data as a means of reducing transaction costs. This approach resulted in greater ownership and increased participation, compared with IHP+ monitoring in 2012, but it did not generate the anticipated reduction of transaction costs because data were not routinely available in existing databases and so had to be collected at source.

Ultimately the value of integrating or merging IHP+ and GPEDC monitoring frameworks for the health sector rests in its ability to reduce the transaction costs; these reductions are expected to derive from shortcutting the process of developing a monitoring framework for development effectiveness and from the potential to coordinate the process of health sector data collation and analysis – ie for the GPEDC process to include the collation of sector-disaggregated data. Whilst there were clear reductions in transaction costs from adapting the GPEDC monitoring framework for the IHP+, there was no coordination on the process of data collation and analysis and at the same time there were methodological limitations with the GPEDC indicators which created challenges for IHP+ analysis but can be addressed. To justify continued alignment, a closer coordination between the IHP+ and the GPEDC will be required in the definition of indicators and data collection methods prior to the next round of GPEDC monitoring.

The fourth IHP+ monitoring round underlined the benefits of locating the process at country-level, including increased ownership by the Ministries of Health and greater emphasis on stimulating a country-level dialogue among partners on concepts and performance. It appears that a country-focused process comes with a risk of increased transaction costs, but this could be mitigated by incorporating a minimum set of development effectiveness indicators in the sector performance framework and/or country-led mutual performance assessment processes, as is being done in Mozambique. The experience in Mali and the DRC suggests that different countries require different levels of support. Some will require more resources than were allocated to the country level in 2014. Given the overall challenges described in the 2014 performance report, there remains, however, a strong case for a global aggregation of information on the status and trends in health sector development cooperation, in order to keep promoting necessary changes in institutional behaviour and foster the global debate

on development effectiveness. Comparing and publishing data on country and development partner's performance is likely to have contributed to the documented improved performance since 2007, even if change is more pronounced for countries than for development agencies. Furthermore, it seems that some of the persistent obstacles to development partner progress require policy responses that must be made at the headquarter level, and which are likely to be best influenced through global level dialogue and accountability.

6.2.2. The challenges for IHP+ in a changing environment

The global environment of international cooperation in the health sector is changing. With the end of the UN millennium development agenda in 2015, a new global cooperation framework is emerging that places more emphasis on sustainability and systems than on the specified health challenges of the millennium development goals. Allied to this trend is an increasing emphasis on accountability for development results. The IHP+ could have much to offer to these global changes if it manages to position itself strategically. It has extensive experience in supporting country-based and country-led accountability mechanisms, a strong focus on supporting national health plans and budgets, and an implicit strategy of investing in health systems to deliver a range of health outcomes.

To be effective in this role, the IHP+ signatories will need to be realistic about what they have failed to achieve so far. Development partners are delivering more assistance, but not necessarily more effectively and efficiently. IHP+ should continue to explore ways for development partners to be accountable for their commitments.

The IHP+ also needs to acknowledge that its partnership could reach out more effectively to the growing number of partners at the global level, as well as the many different stakeholders in national health systems. IHP+, as from the start, has actively promoted broad participation, including of CSOs at country and global levels, broadened participation in the 2014 IHP+ performance monitoring through the country-based approach (eg. participation of non IHP+ partners and INGO's), and continues to increase its membership (both of countries and development partners). Still there is scope for getting the wider group of partners (including BRICS) and countries involved in ensuring development cooperation to be more effective and to be accountable for this; as well as for the policy dialogue on development effectiveness and accountability to be more inclusive at country level, including other stakeholders such as elected representatives, media and non-health CSOs such as trade unions. The participation of four international NGOs and of development partners that are not signatories of IHP+ such as South-Korea in the fourth monitoring round is however an encouraging development, as well as the participation of China at the 2014 country health team meeting.

6.2.3. Approaches for strengthening future monitoring and mutual accountability

Based on the experience of collecting data for the fourth round of performance monitoring, the consultations with partners in the two focus countries, and a review of global accountability mechanisms for development cooperation, IHP+R has identified a number of possible approaches to strengthen mutual accountability. These are not mutually exclusive, nor are they recommendations for actions. They should be further analysed and discussed to guide the IHP+ through the next stage of positioning itself in the international architecture of partnerships for effective development. Transaction costs of different approaches vary and need to be considered when developing future monitoring strategies. The different approaches listed below are explained in detail in a separate IHP+R paper on mutual accountability[9].

9 The IHP+R Mutual Accountability Options Paper is available at http://www.internationalhealthpartnership.net/en/results-evidence/2014-monitoring-round

Continue strengthening country-led monitoring and accountability

Continue the unfinished business of holding IHP+ signatories to account for their commitments in the global and national compacts. Central to taking this forward would be further development of the country-based performance monitoring.

Establish stronger peer accountability mechanisms

Establish separate linkages between different peer groups of development partners and governments (including Ministries of Health, Ministries of Finance and Planning, parliaments and local government) respectively. This could be established at sub-regional, regional or cross-regional level.

Establish stronger links to international social accountability mechanisms

Inclusion of civil society is already one of the principles pursued by the IHP+. The IHP+ could expand this relationship by seeking partnerships and alliances with civil society advocacy organisations (health and non-health) that have shown considerable effectiveness in holding development partners and governments to account.

Integrate development cooperation and results monitoring in health

With the introduction of a new UN development agenda, a new set of development goals will be defined, providing an opportunity for IHP+ to refocus its accountability framework on results rather than (mainly on) processes of cooperation.

Integrate IHP+ performance assessment with the GPEDC monitoring mechanism

The GPEDC monitoring mechanism is new and has only conducted one round of monitoring in a limited number of countries. But the approach of greater integration offers the potential to achieve economies of scale and mutual reinforcement of messages.

It may be that a combination of approaches will deliver the greatest improvement in accountability for improved development cooperation. Current thinking around how to mitigate asymmetries and lack of enforceability proposes 'a triangular, multi-layered accountability architecture that includes three main components: North-South [mutual accountability], South-South [peer review] and non-governmental'[10]. A multi-layered architecture with strong domestic counterparts – particularly parliaments and civil society – should be supplemented by regional peer review processes and global, independent reports.

For these approaches actually to change development partner behaviour, the IHP+ has to find ways to enhance the leverage it has over organisational decision making. One priority is for IHP+ signatories to generate and allocate sufficient political capital to their issues. Political attention was paid to aid effectiveness in the health sector at the start of the IHP+ in 2007 but since then has waned. Recently, political interest has again revived. Political leadership will also encourage CSOs to become more interested in these issues, thereby creating a virtuous circle of organisations making and holding to commitments to improve their development behaviour. Crucial for gaining political commitment to development effectiveness is providing the evidence that it leads to better health outcomes. This is an area where IHP+ may need to invest some further efforts.

10 Ocampo, JA and N Gomez Arteaga (2014) Accountable and effective development cooperation in a post-2015 era. Background Study 3: Accountability for Development Cooperation. Preparing for the 2014 Development Cooperation Forum DCF Germany High-Level Symposium, p.2.

6.2.4. Conclusion

The fourth performance monitoring round of the IHP+ has again documented a greater alignment of the practice of development cooperation in health with principles of development effectiveness, while indicating the persisting gaps in this cooperation. Closing these gaps will require a continued effort, and maybe a revised or expanded approach towards making development cooperation more effective and accountable. It is the task of IHP+R to analyse progress and document results. It is now up to the IHP+ partners to draw conclusions and initiate action.

The IHP+ website provides access to the main results of the 2014 monitoring[11]. Country and development partner score cards as well as this report of the 2014 monitoring round can be downloaded from the same source.

The value of the 2014 monitoring round, having benefited from substantially increased participation of countries and development partners compared to previous rounds, will depend on the use of the results at country and global level. Especially at country level, it would be important to include all development partners (those that have participated and those that have not participated) and relevant national stakeholders (including other ministries, media, parliament, health-related CSOs, non-health CSOs such as trade unions, etc.) in the policy dialogue on development effectiveness, with a view to learn from the monitoring and discuss how to do better. Development partners should also discuss the monitoring results at headquarters level in order to further improve their performance as documented in this report.

11 Weblink: http://www.internationalhealthpartnership.net/en/results-evidence/2014-monitoring-round

Annexes

ANNEX 1. IHP+ RESULTS STANDARD PERFORMANCE MEASURES

IHP+ signatories worked through the IHP+ Mutual Accountability Working Group (MAWG) to advise on specific indicators to track six issues listed in the table below. The indicators in the table form the basis of the 2014 round of IHP+ monitoring and come from the GPEDC or the last round of IHP+ monitoring. Detailed information on each indicator is provided in the Annex of the 2014 IHP+ Monitoring Guide for Participants.

Table 6: Seven indicators for monitoring Government performance and seven for DPs performance

		Government indicators		Development Partner (DP) indicators	
#	Issue	Indicator	Source	Indicator	Source
1	**Health development cooperation is focused on results.**	An agreed transparent and monitorable country results framework* to assess health sector progress exists.	Gov	Proportion of countries in which the country health sector results framework is used.	Gov
2	**Civil Society engagement.**	Evidence that Civil Society is meaningfully represented in health sector policy processes - including Health Sector planning, coordination & review mechanisms.	Gov	Evidence of support for Civil Society to be meaningfully represented in health sector policy processes - including health sector planning, coordination and review mechanisms.	DP
3a	**Health development cooperation is more predictable.**	Proportion of health sector funding disbursed against the approved annual budget.	Gov	Percentage of health sector aid for the government sector disbursed in the year for which it was scheduled.	DP
3b		Projected government expenditure on health provided for 3 years.	Gov	Estimated proportion of health sector aid covered by indicative forward expenditure and/or implementation plans covering at least three years ahead.	Gov
4	**Health aid is on budget.**	National Health Sector Plans/ Strategy in place with current targets & budgets that have been jointly assessed.	Gov	% of health sector aid scheduled for disbursement that is recorded in the annual budgets approved by the legislatures of developing countries.	Gov & DP
5	**Mutual accountability is strengthened.**	An inclusive mutual assessment of progress in implementing agreed health sector commitments exists and meets at least 4 of the 5 proposed criteria.	Gov	Proportion of countries where mutual assessments have been made of progress implementing commitments in the health sector, including on aid effectiveness.	DP
6	**Developing countries' PFM systems are strengthened and used.**	Country public financial management systems either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	World Bank CPIA data	Amount of health sector aid disbursed for the government sector that uses national public financial management systems in countries where systems are generally considered to adhere to broadly accepted good practices, or to have a reform system in place	DP

*Amended from IHP+R indicator which used Performance Assessment Framework instead of results framework.

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

ANNEX 2. GLOSSARY OF KEY TERMS

Aid effectiveness	Aid effectiveness is the effectiveness of development aid in achieving economic or human development (or development targets).
Approved annual budget for the health sector	Is the annual budget as it was originally approved by the legislature. In order to support discipline and credibility of the budget preparation process, subsequent revisions to the original annual budget — even when approved by the legislature — should not be recorded here. This is because it is the credibility of the original, approved budget that is important to measure and because revisions to the annual budget in many cases are retroactive.
Busan Partnership Agreement	The Busan Partnership agreement sets out principles, commitments and actions that offer a foundation for effective co-operation in support of international development. The Busan Partnership agreement is a consensus that a wide range of governments and organisations have expressed their support for. It offers a framework for continued dialogue and efforts to enhance the effectiveness of development co-operation (OECD).
Capacity Development	The processes whereby people, organisations and society as a whole unleash, strengthen, create, adapt and maintain capacity over time.
Country Policy and Institutional Assessment (CPIA)	The Country Policy and Institutional Assessment (CPIA) assess the quality of a country's present policy and institutional framework. "Quality" refers to how conducive that framework is to fostering poverty reduction, sustainable growth, and the effective use of development assistance. (World Bank)
Development Partner	Includes bilateral and multilateral donors, eg country aid agencies, and international organisations; trust funds, foundations and international NGOs
General Budget Support	General budget support is a sub-category of direct budget support. In the case of general budget support, the dialogue between donors and partner governments focuses on overall policy and budget priorities (OECD 2006).
Global Partnership for Effective Development Co-operation	The Global Partnership for Effective Development Co-operation (GPEDC) was established as a direct result of the Busan Partnership agreement. The Global Partnership will help ensure accountability for implementation of Busan commitments at the political level.
Health Aid reported on national health sector budget	This should include all health sector aid recorded in the annual budget as grants, revenue or loans.
Health sector coordination mechanism	Multi-stakeholder body that meets regularly (usually monthly or quarterly) to provide the main forum for dialogue on health sector policy and planning.
Health sector aid	ODA contributed to the health sector. ODA includes all transactions defined in OECD/DAC statistical directives paragraph 35, including official transactions that are administered with the promotion of economic development and welfare of developing countries as its main objective; and are concessional in character and convey a grant element of at least 25%.
IHP+	A global partnership that puts the Paris, Accra and Busan principles on Aid Effectiveness into practice, with the aim of improving health services and health outcomes, particularly for the poor and vulnerable.
IHP+ GlobalCompact	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.
Joint Annual Review	A Joint Annual review of the health sector (JAR) is a process that can be part of monitoring and planning the implementation of the health sector strategic plan. The JAR helps to identify whether the plan is on track and the strategies are adequate to achieve the intended results. The term 'Joint' refers to a range of stakeholders interested in health sector performance and participating in the review.
Medium Term Expenditure Framework (MTEF)	A set of broad principles for sound budgeting that are implemented in different ways in different institutional settings. An approach that links expenditure allocations to government policy priorities using a medium-term (i.e. three to five year time horizon) budget planning and preparation process
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)
Mutual Assessment Reviews	Mutual assessment reviews are exercises that engage at national level both country authorities and DPs at senior level in a review of mutual performance. These reviews should be conducted through inclusive dialogue involving a broad range of government ministries (including line ministries and relevant departments, at central and local level), DPs bilateral, multilateral and global initiatives) as well as non-executive stakeholders, including parliamentarians, private sector and civil society organisations. These assessments are undertaken on a regular basis and might be supplemented through independent/impartial reviews. The comprehensive results of such assessments should be made publicly available in a timely manner through appropriate means to ensure transparency. These reviews can be part of joint annual reviews (JAR) or be separate reviews of mutual performance (eg review of country compact performance).
Overseas Development Assistance	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)
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). A synonym used in this report is Country Results Framework.
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. (UNDG)
Public financial management systems (PFM)	The public financial management system (PFM) is the country system to manage financial resources. It includes four components, the first three of which are focused on PFM (the fourth is not assessed in 2014 IHP+ monitoring): a) national budget execution procedures; b) national financial reporting procedures; c) national auditing procedures; and d) national procurement procedures. Legislative frameworks normally provide for specific types of financial reports and audit reports to be produced as well as periodicity of such reporting. The use of national financial reporting and/or auditing means that donors (in principle) do not impose additional requirements on governments for financial reporting and/or auditing.

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 and GPEDC indicators.

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

ANNEX 3. COMPARISON OF PERFORMANCE IN BURKINA FASO AND GUINEA

Table 7: Guinea and Burkina Faso – a comparison of performance

	Guinea	Burkina Faso
Population 2013	11.7 million	16.9 million
GNI per capita (Atlas method)	$460 (2012)	$670 (2012)
U-5 Mortality (% decrease since 2005)	101 (26%)	98 (38%)
Per capita Health Expenditure	$32	$38
Domestic / External Health Expenditure	90% / 10%	69% / 31%
Year of joining IHP+	2012	2009
Summary of financing issues	Public financial management weak (CPIA = 3); budget execution 88%; no forward expenditure plan	Public financial management strong (CPIA = 5); budget execution 86%; forward expenditure plan exists
Summary of accountability issues	No CRF; no partnership policy; no joint evaluations; civil society participates only in coordination meetings and thematic groups	CRF in place; partnership policy in place; all partnership cooperation mechanisms in place, including full participation of civil society
Development partner behaviours	8 partners reported; 7/8 positive scores for work with CSOs; 13% positive financial scores for cooperation with government	9 partners reported; 9/9 positive scores for work with CSOs; 59% positive financial scores for cooperation with government

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