

The International Health Partnership: delivering the health MDGs

Concept Note

Summary

As part of a broader Global Campaign for the Health Millennium Development Goals, this paper proposes a new agreement between developing countries and international partners to accelerate action to scale up coverage and use of health services, and deliver improved outcomes against the health related MDGs. The initiative will focus on the overall efficiency of resources going into the health sector, providing a clear sense of how resources are allocated, the results of these investments and the critical funding gaps for health.

Global and country level compacts will set out a process of mutual responsibility and accountability for the development and implementation of national health plans. Development Partners will better coordinate external support to help develop and implement comprehensive national health plans, provide aid in ways that strengthen health systems¹ and, where possible, provide more long term, flexible support through national systems. Partner countries will invest further in their own health systems, address policy constraints to progress, strengthen planning and accountability mechanisms to make them more inclusive and transparent, and better link external support to improvements in health outcomes. Civil society and other stakeholders will play an important role in the design, implementation and review of the IHP at global and country levels and in holding all parties to account. The performance of all parties will be subject to a joint high level review at country and global levels. The proposed model will be further developed and tested by a first wave of countries supported by international partners.

1. Preamble

Better health lies at the centre of the Millennium Development Goals (MDGs). Yet at the mid point to 2015 many countries are seriously off track in their efforts to realize the health related goals including more recent commitments to achieve universal access to prevention, treatment, care and support for HIV/AIDS and universal access to reproductive health.

External resources for health have more than doubled since 2000 and many countries have increased domestic resources. Whilst there is still a long way to go in meeting overall financing gaps for health, this increased investment has produced significant results, including higher levels of vaccine coverage and more people receiving effective treatment against AIDS, TB and malaria. However, there has been far less progress in many other areas, notably maternal and child health and in some aspects of reproductive health, further donor support is required to strengthen programmes.

¹The WHO definition is: Health systems consist of all organisations, people and actions whose primary purpose is to promote, restore or maintain health.. This includes efforts to influence determinants of health as well as more direct health-improving activities. It is more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behaviour change programmes; vector control campaigns; health insurance organizations. It also includes intersectoral action by the health staff. Health systems have six essential 'building blocks': health services, health workforce, health information systems, medical products and technologies; health financing; and leadership and governance.

Much of the recent increased investment has targeted specific diseases or interventions such as vaccination. There is consensus that making further progress and sustaining recent health gains will require more and better integrated investment in underlying systems that make health services work. This includes addressing key systemic constraints including human resources for health, basic health infrastructure, procurement and distribution of reliable supplies of essential medicines and health commodities, and sustainable health financing and risk-pooling mechanisms in-country, as well as management and measurement systems covering both state and non-state sectors. It will also require new approaches to resource allocation at every level that lead to improved health outcomes.

The limited reach of much health investment is compounded by the complexity of the aid architecture. This is reflected both globally and in countries where multiple health partnerships, global funds, bilateral and multilateral agencies provide support through multiple funding streams that are often planned and managed separately from national systems. Country governments and international partners have worked to address this by, among other things, supporting the development of single health or AIDS plans and by improving accountability and governance mechanisms. However, much more could be done. As highlighted in the recent health strategies of the World Bank, WHO, the African Union (AU) and the UK Department for International Development (DFID), this combination of a fragmented approach and poor coordination has reduced the effectiveness of health support.

Partner countries send a number of clear messages in relation to health aid.

- Delivering sustainable results requires **strengthening the systems** that make health services work such as production, training, and retention of health workers, yet this is difficult given current modes of external financing;
- They need **greater levels of flexible and predictable financing** for health if they are to budget for long term costs;
- They face **high transaction costs** in dealing with multiple international partners who often operate outside of national planning and budgeting processes and compete for scarce resources, particularly trained staff;
- Whilst recognising the benefits of targeted investments, they want to see **greater coordination and integration** of international support;
- They are suspicious of new donor initiatives over which they have little influence and have limited faith in their international partner's performance in delivering on their commitments.
- Efforts to strengthen national health systems need to be country driven.

International partners also send a number of clear messages.

- There is a need for partner countries to demonstrate high level political commitment by increasing and sustaining domestic investment in health and to deal effectively with policy, implementation and governance obstacles to progress;
- There is **little confidence in the quality of many national health plans**, which may be divorced from meaningful budgets, which may not address difficult issues such as gender, sexual and reproductive health and rights of vulnerable groups such as adolescents, and often exclude the non-state sector (which often delivers the majority of health services in countries);

- There is concern over limited **capacity to implement the health plan**, and inadequate engagement of supporting sectors such as water, education and transportation;
- There is little confidence in the **accountability mechanisms** to citizens and other stakeholders;
- They need to see their support better translated into **improved health outcomes**. This is vital in maintaining the case for aid to their taxpayers.

2. A new International Health Partnership: delivering the health MDGs

There is broad agreement on the need to rationalise the health architecture and change the way donors work together with partner countries. This paper proposes a new approach, the *International Health Partnership (IHP)*, based on a compact of mutual accountability.

The purpose of the IHP is to accelerate action to scale up coverage and use of health services (whether through public, private or non-governmental channels) and deliver improved outcomes against the health related MDGs and universal access commitments. It does not create new institutions or funding streams

Partner countries will increase their own resources for health, change policies and practices that are obstacles to efficient use of these resources, will strive to create sustainable financing structures at national level, strengthen planning and accountability mechanisms to make them more inclusive and transparent, and better demonstrate improvements in health outcomes.

International Partners will better coordinate external support around priorities set out in comprehensive, government owned national health plans, provide aid in ways that strengthen health systems and, where possible, provide financial and technical resources in a more long term, predictable and flexible manner, coordinated under the national plan and with a greater proportion through national systems.

Civil society will play an important role in planning and implementation and in holding all parties to account.

All partners, at all stages of the process, will be accountable for performance and results and will be subject to a mutual reporting and accountability process.

A number of principles underlie the Partnership. It will be country-driven and tailored to reflect country needs, plans and systems; institutionally light to avoid further complicating the global health architecture and adding to the administrative burden for countries; fully aligned with countries' national development frameworks; innovative in exploring new ways to link finance to results, particularly in relation to AIDS, TB, malaria and maternal, newborn and child health; and supportive of efforts to strengthen health systems.

The Partnership will not establish a new international health fund. It will place national strategies and sector wide implementation at the centre of funding decisions by all partners and will help identify and address systemic bottlenecks to delivery of health services and access for the poor. By removing barriers to efficient flow of funds, it will be expected to facilitate more efficient and effective use of existing finance and in turn release new funds. It recognises that the total funding available

for health is inadequate in many countries, seeks to provide compelling evidence for this in as many specific cases as possible, and endorses wider efforts to increase funding for health.

The Partnership is an integral part of the *Global Campaign for the Health MDGs*, which recognises the need for urgent and collective action to address the off-track MDGs at the half way point to 2015 and includes a range of new and ongoing efforts such as the Norwegian efforts to accelerate progress on maternal and child health, the G8 Providing for Health initiative that supports development of countries' health financing systems, the World Bank's efforts to test results-based financing and others.

The partnership also builds upon a number of past and ongoing efforts to increase external support for health, improve harmonisation and alignment of that support and achieve results². It will draw lessons from the UNAIDS-led work to rationalise the architecture around AIDS, reflected in the 'Three Ones' framework and the Global Task Team. It aims to complement initiatives to support health systems including the Health Metrics Network Framework and the Global Health Workforce Alliance.

Through improving coordination in support of country health plans, the Partnership will put into practice the Paris Declaration on Aid Effectiveness in the health sector. Working in the Partnership at global and country levels will strengthen collaboration between the UN, the global funds in health, the World Bank and IMF.

The individual country compacts promoted through the initiative will be defined locally and will be influenced by:

- Respect for national planning, political, and budgeting cycles;
- The existing bottlenecks inhibiting progress;
- Opportunities to learn from emerging experience;
- Organisational willingness to innovate and incentives in place to do so;
- The presence of a strong results measurement framework with indicators that can be monitored.

The detail of the initiative will be determined locally in keeping with the principle of country ownership. Partners at country level will work together in coming months to identify specific challenges where they can collectively make most difference to health sector performance. The initiative may support action in the following areas:

a) Making country health plans more inclusive, ambitious and robust

The scope and quality of health plans is varied. The lack of transparent budgets linked to health outputs and the limitations of accountability frameworks are major bottlenecks to providing performance based resources to support such plans.

The initiative builds on a number of processes in place at the country level to better harmonise and align donor support and strengthen performance measurement. The WHO, the World Bank and other partners will work collaboratively with stakeholders

² Including the Monterrey Consensus (2002), the Paris Declaration on Aid Effectiveness (2005), the High Level Forum on the Health MDGs, DAC/OECD work on using health as a tracer sector, One UN approach of the High Level Panel for System Wide Coherence, UNAIDS GTT process, the 2007 G8 commitments on health, the recent efforts of the Global Health Leaders (H8), The Paris Conference on Social Health Protection, country level aid harmonization frameworks and the European Commission work on harmonisation and alignment and MDG contracting model. It builds upon efforts to strengthen health sector performance in Africa, notably the Africa Health Strategy 2007-2015 and the ongoing Harmonization for Health Initiative in Africa.

in countries to assist in the development of robust national health plans and budgets in countries where these do not exist, fill gaps identified in existing plans and support the development of the next national health plan when appropriate. This process needs to be aligned with the overall development framework, work through existing in-country coordination mechanisms, such as partnership groups or Sector Wide Approaches (SWAs), and enable engagement of national stakeholders.

The health plans will need to respond to country context, priorities and constraints. Critical areas and principles that are likely to be reflected include:

- Target the MDGs particularly MDGs 4, 5 and 6
- Improve access for the poor and under-served groups.
- Identify sustainable financing mechanisms for the sector, tailored to the needs of the national health system and the country as a whole, as the basis for accessible and pro-poor health systems. This will include development of sound risk-pooling approaches relevant to the country context.
- Address the health workforce constraints including how workers will be trained, employed, motivated and retained.
- Address the supporting systems and capacity building required for the health system to function, in areas such as forecasting, procurement and logistics of health commodities and medicines; financial management; regulation, governance and accountability; and systems for measuring results.
- Incorporate priority disease programs (such as immunization, TB, Malaria and relevant components of multi sector “universal access HIV/AIDS plans) into national health plans and wider health system strengthening.
- Cover the whole health system – public and private sectors
- Identify costs and funding sources.
- Link indicators of performance to expected funding levels.

These plans would then serve as the foci for coordinating donor and country action. The country partners could review how resources already committed for targeted interventions could be more effectively used to support the wider system, without losing their specific outcome focus.

b) Shared appraisal of country health plans

The Partnership aims to streamline the process of appraisal and support to health plans. There is a need to build on existing processes of joint appraisal and encourage a collective commitment to support the national plan. Reaching consensus is valid, no matter how international partners provide their assistance. While this joint appraisal process exists in many settings, it needs to agree on a more robust results and indicator based framework in order to encourage more partners to accept a common assessment rather than requiring their own individual processes. Agencies unable to participate in these appraisals should make every effort to align their own review process to the common approach. In some cases, this may require a change in agency policy and procedures.

c) Coordinating support and making funding more flexible

Once all partners have confirmed collective support for the health plan, they would agree with the government how to finance the overall, medium-term funding envelope and review how any critical financing gaps can be met. Through a division of labour they will provide needed technical assistance. Once the financing envelope has been agreed it will be jointly allocated among the partners. This allocation process is critical and will be developed among stakeholders at the country level in

coming months. The respective contributions of each funder can then be considered through the existing institutional channels. The outcome will be a financing plan agreed with the government that details the financial contributions of government, other domestic financing mechanisms, donors, international agencies, and others.

Resources will be provided through government budgets and through non-government channels. Appropriate policies for, and linkages to, private financing will need to be considered. Wherever possible and appropriate, an increasing share and amount of resources should be provided through the national budget and managed through national systems. This will provide governments with confidence to fund core recurrent costs, such as salaries, drugs, and the services they subsidise or commission from private and NGO providers. It will also promote greater fiscal sustainability. Financing should continue to allow for a multiplicity of health system actors - both public and private - according to competency and results.

New resources that are made available later in the planning cycle should always be included in the national plan, and their impact on the wider health system assessed. This should help to reinforce the principle that there should not be a requirement for new project proposals and separate reporting mechanisms.

In future, increasing levels of external support are likely to be linked to performance³. This will require transparent lines of management and accountability linked to benchmark indicators of progress. There is need to ensure that such efforts are complementary and that there is clarity in advance on how non-performance will be managed.

d) Implementation and mutual accountability

Support for implementation of health plans will depend on country needs and capacities. The Partnership will encourage coordination of efforts in capacity building and technical assistance to maximise its effectiveness and avoid duplication. Development partners will also avoid procedures or programmes that undermine other priorities within the health system. They will work to ensure that support targeted to specific diseases or populations are mutually reinforcing with measures to strengthen health systems. Meanwhile country partners in the Partnership are committed to strengthening the governance and management of the health sector, in order to deliver results.

Under host government leadership, all parties will be collectively responsible for delivery of the national priorities as outlined in health plans and delivering the financial and technical resources agreed. They will review progress, at least annually, with key stakeholders including the Ministry of Finance, Ministry of Health, other key Ministries affecting health related MDG outcomes, parliamentarians, civil society, donors, international agencies and the private sector. The indicators for measuring progress will be agreed at country level as part of the health sector plan and annual budgets. This mutual accountability process will be reflected in a country compact or the memorandum of understanding between partners.

³ For example World Bank/Gates results based funding, European Commission work on harmonisation and alignment and MDG Contracting. GFATM and GAVI already work in this way.

Performance of country-level partnerships will also be independently assessed through a report generated by independent monitoring.⁴ At the end of the first phase (after 18-24 months) the members of the Partnership would meet at a senior level in one of the first wave countries. This high level process would: a) hold all partners to account for their performance against agreed principles and benchmarks relative to their agreed roles and responsibilities; b) coordinate the response to emerging systemic issues; c) help mobilise new funding for plans as needed and d) monitor progress towards the health MDGs and other internationally agreed goals such as universal access to AIDS services. Progress will also be reviewed in the Third High Level Forum on Aid Effectiveness in Accra in September 2008, which has already identified health as a tracer sector.

3. What will success look like?

All partners work to achieve national health objectives as laid out in robust national plans that include the contributions of public, private and civil society providers. All stakeholders share a collective commitment to assist the host country to implement the plan effectively and meet measurable indicators to address bottlenecks to progress and to deal with emerging issues. All external support is provided in ways that strengthen health systems and facilitate the delivery of a coordinated package of basic services that respond to all major health challenges and achieve results. More resources are provided as long term, flexible aid with a greater proportion delivered through national systems. There is a clear and inclusive monitoring mechanism that is able to demonstrate progress in improving health outputs/outcomes on an annual basis; other international agencies are encouraged to rely on joint appraisal and reporting systems rather than requiring their own separate arrangements. Countries increasingly share lessons and learn from each others' experience.

4. Next steps

The concept has broad support among a number of bilateral partners including the UK, Norway, Netherlands, Germany, France, and others and multilateral agencies including the WHO, UNAIDS, UNICEF, UNFPA, the World Bank, the Global Fund to fight AIDS, TB and Malaria and the GAVI Alliance. Other multilateral agencies including the IMF, ILO, African Development Bank and European Commission are being invited to join the Partnership. Other bilaterals are also encouraged to join the Partnership.

A number of partner countries have indicated interest in further developing and testing this initiative (including Ethiopia, Kenya, Zambia, Mozambique, Burundi, Mali, Nepal, and Cambodia). These countries have well established coordination mechanisms to build on. Additional countries will also be welcome to join the Partnership and work with their development partners in country to identify how it will be taken forward. Future expansion will need to address the particular challenges of working with fragile states and aid orphans.

The Partnership will be launched in London on 5th September 2007 and in New York on 26 September. At the London launch the initial set of partners will commit to a high level compact setting out the commitments of the partners. Other countries and

⁴ For example a consortium of national and regional research/knowledge centres guided by a high-level panel of international experts.

development agencies that want to join the Partnership will be expected to sign the IHP Compact as a sign of their commitment.

The WHO, other UN agencies active in health and the World Bank will support the coordination of the Partnership. This will include defining the governance arrangements, facilitating country level work, encouraging harmonisation of agency procedures or policies, and designing and initiating the monitoring process for the initiative and the global level accountability. It is envisaged that this will be an integral part of the agencies work and not require a separate secretariat.

There will be a subsequent design phase in the first wave countries, building on existing plans and processes. This will identify local challenges for early action and build them into existing planning, coordination and reporting mechanisms. The proposed changes will be set out as clear commitments within a country specific compact or within the existing mechanism for partner commitments such as the health sector memorandum of understanding.

In parallel, the headquarters level of agencies will identify the implications of the country level commitments. This may involve changes in policy or procedures, development of guidance and monitoring of implementation.

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