International Health Partnership and Related Initiatives (IHP+)

IHP+ Core Team Report
April 2009 – May 2010

Questions or comments, please contact:

Nicole Klingen
IHP+ Core Team
The World Bank, Washington D.C.
niklingen@worldbank.org
Tel: +1 202 458 7413

Phyllida Travis
IHP+ Core Team
World Health Organization, Geneva
travisp@who.int
Tel: +41 22 791 2566

www.internationalhealthpartnership.net
Background

IHP+ was created in September 2007. This report covers progress made since March 2009. While it is based on the Phase II work plan and recommendations from the Ministerial Review and other IHP+ reviews in 2008 / 2009, it also takes into account the changing environment in which IHP+ functions, and reflects on implications of these changes for the partnership's operations.

Globally, there have been a number of important developments over the last year. Many donor countries have committed to maintain development aid as a percentage of GNI. The realisation of new funds for health through innovative international financing instruments is only just beginning. There are shifts in aid policies of some major donors, most notably the US Government with its Global Health Initiative, which signals much greater engagement with other partners and a stronger health systems focus. The Global Fund has a number of reforms under way to simplify its grant architecture. There are discussions between World Bank, GAVI and Global Fund with WHO facilitation about a 'health system funding platform', with an increasing focus on what this would mean in practice at country level. The profile of MDGs 4 and 5 is being raised. The 2010 MDG Summit provides a platform for reflecting on progress, and for renewed commitments from development partners to achieve the MDGs.

Snapshot of IHP+ achievements in 2009/10

- **IHP+ is becoming more inclusive.** 12 new signatories to the Global Compact since April 2009 make a total of 47 signatories.
- **Joint assessment** of national strategies tool (JANS) was endorsed by IHP+ signatories. Joint assessment of national health strategies in preparation in **around 6 countries in 2010**. Improved access to information on country health planning cycles, through a database on IHP+ website.
- **Civil society engagement** in national health planning processes is getting more attention; most countries have some CSO participation; ways to make this more effective are needed.
- Individual examples of progress towards **common monitoring and evaluation** systems exist; the common monitoring and evaluation framework is being made operational in five IHP+ countries.
- **First update on progress against Global Compact commitments** will be delivered at the 2010 World Health Assembly by the IHP+Results Consortium. At a review by partners in February, the approach was considered innovative but onerous. It is being simplified through consultation with an inter-agency working group on mutual accountability. A clear message already being received from developing countries, however, is that development partner behaviour change is frustratingly slow.
- **IHP+ products are increasingly seen as public goods** - the tools and frameworks can be used freely by any country or partner. The 'Joint Assessment of National strategies' tool, and the Common M&E framework, are two examples. The **Unified Costing Model**, to help cost national health plans, is being developed by an inter-agency group and scheduled to be ready by end 2010. A number of non-IHP+ countries have already begun to apply these tools.
- New, **more representative IHP+ management** arrangements have been introduced and communications improved, including standard presentations, revised materials and website.
New IHP+ partners

There has been a substantial rise in the number of partners, summarised in figure 1. There are now 47
signatories of which 22 are low-income countries. This is positive, as it makes IHP+ a more inclusive
forum.

<table>
<thead>
<tr>
<th></th>
<th>September 2007</th>
<th>May 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-income countries</td>
<td>8</td>
<td>22</td>
</tr>
<tr>
<td>Bilateral donors</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>International...</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>27</td>
<td>47</td>
</tr>
</tbody>
</table>

It is also positive that many new signatories are from the more fragile states, or countries with weaker
traditions of partner coordination. Common expectations on joining IHP+ are that the country will be better
positioned to access new international health funds; it will give added leverage in negotiations with
development partners to support the national health strategy, and will raise the profile of mutual
accountability - not least through easier access to global discussions on implementing the aid
effectiveness agenda.

Main areas of work in 2009/10: progress, challenges, next steps

IHP+ was created to help accelerate progress towards the health MDGs. The phase II work plan stated
clearly that IHP+ work is based on the following principles:

- Keep a focus on health results;
- Build on what already exists, in national health policies, systems and coordination mechanisms;
- Enhance country-led health development, by getting more stakeholders to unite around one
strategy;
- Reduce transaction costs from multiple initiatives, by changing ways of working of different partners;
- Longer term, more predictable financing;
- Promote mutual accountability.

This translates into five lines of work in 2009/11:

1. Support **national planning** processes;
2. **Joint assessment** of national health strategies and plans;
3. Country **compact** development;
4. Moving towards **one results monitoring framework**;
5. Promote **mutual accountability** by monitoring progress against compact commitments.
1 Support for national planning processes

Partners need to have confidence in the national health strategies they are being asked to support. There are also strong arguments that more inclusive processes of strategy development result in better strategies that are more likely to be implemented. In 2010, many countries will be reformulating their national health and HIV/AIDS strategies. Globally, out of 157 countries known to have national health plans, a third will end in 2010. Of the 21 IHP+ countries, over half have health strategies / plans ending in 2010 or 2011.

Figure 2: IHP+ countries developing new national health plans in 2010 /11

Burkina Faso, Burundi
Democratic Republic of Congo, Djibouti, Ethiopia,
Madagascar, Kenya, Nepal, Niger, Nigeria,
Uganda, Vietnam, Zambia.

Progress

- **Increased support to national planning processes.** A number of development agencies are increasing support to sector planning processes. There is a need to ensure plans do not become ends in themselves but actually get implemented. There is also a need to provide timely and effective responses to requests for technical support. This can be done in many different ways - independently and/or in collaboration with other agencies. One example of regional inter-agency collaboration is the support that has been provided by the HHA agencies to the national health planning process in Nigeria over the last year. In addition, a discussion paper on increasing effective technical assistance will be tabled through IHP+. To help development agencies know when and where a new national health strategy is being developed, a global Country Planning Cycle Database has been put up on the IHP+ website, and is being regularly updated.

- **Partner coordination and more ‘joined up’ policy dialogue.** IHP+ has from its start encouraged the notion of multi stakeholder 'country health teams' to improve coordination and support for national health strategies. In practice, it is not uncommon to find multiple health coordination bodies at country level for different purposes. For example, in addition to a general health sector coordination body there may be a GAVI Inter -agency Coordination Committee and a Global Fund Country Coordinating Mechanism. A review in eight IHP+ countries in early 2009 found that where general health sector coordination bodies exist, they commonly involve Ministries of Health and development partners, but less often involve non state service providers or civil society groups, even where these are major providers of health services.

In the last year, several actions have been taken to improve civil society engagement in health policy and planning processes. In the IHP+ joint assessment of national strategies tool (JANS), one attribute that is assessed is the inclusiveness of national strategy development and endorsement processes. As a result, engagement of civil society in national planning and performance review processes is

---

1 [http://www.internationalhealthpartnership.net/en/news/display/country_planning_cycle_database](http://www.internationalhealthpartnership.net/en/news/display/country_planning_cycle_database)

2 Harmonization for Health in Africa: regional offices of African Development Bank; UNFPA; UNAIDS;UNICEF; World Bank; WHO
getting more attention. How much, how ‘meaningful’ and how accountable that engagement is will be part of the analysis of experience with JANS. Second, Oxfam GB won the contract to manage a country small grants programme to promote civil society engagement in policy dialogue and health system performance monitoring. The call for proposals went out in mid March 2010 to civil society organizations in all IHP+ partner countries.

- **Incorporating an equity perspective into policy dialogue.** Analyses of the equity focus of national health plans have been completed in Ethiopia, Zambia, and are planned in Nepal and Vietnam.

- **IHP+ and related initiatives.** Questions are frequently asked about how IHP+ works with related initiatives such as the Health Metrics Network (HMN), Providing for Health (P4H) and the Global Health Workforce Alliance (GHWA). Since many IHP+ partners are also partners in these other initiatives, the approach has been to encourage these partners to engage at country level - finding ways they can coordinate support for national planning and implementation processes.

## 2 Joint assessment of national strategies (JANS)

Joint assessment is a shared approach to assessing the strengths and weaknesses of a national strategy that is accepted by multiple stakeholders and can be used as the basis for technical and financial support. The presumed benefits are enhanced quality of national strategies and greater partner confidence in those strategies, thereby securing more predictable and better aligned funding.

**Progress**

An IHP+ inter-agency working group developed a draft tool and guidelines for joint assessment during 2008/9. In July 2009 these were reviewed by IHP+ partners, and there was broad agreement that they were ‘good enough’ and that there should be a move without delay to undertake joint assessment with a few interested countries. This was considered the best way to improve the tool and develop practical joint assessment processes.

Eight countries have confirmed their intention to organise a joint assessment, or are seriously considering doing so, in 2010/11: Ethiopia, Nepal, Rwanda, Uganda, Zambia, Vietnam, and also two non IHP+ countries, Ghana and Tajikistan. It quickly became clear that there was a need for brief scoping missions to clarify the purpose and possible process with individual countries, and these have taken place in Rwanda, Nepal, Ethiopia, Uganda, and Vietnam. They have involved meeting all local development partners. These missions by the IHP+ Core Team (World Bank and WHO), have also - in Nepal and Ethiopia - involved HQ staff from other agencies including GAVI and Global Fund, as the JANS is expected be the basis for decisions on new funding under the Health Systems Funding Platform. Short mission reports are available on the IHP+ website.

Nepal and Zambia are the two countries that have so far used the tool in greatest depth, but in somewhat different ways: in Nepal, it has been used both as a strategy development and strategy appraisal tool, and in Zambia primarily as a strategy development tool. While the shapes that country joint assessments are taking are varied, all are based on the same principles: it will be country demand driven; country led; build

---

3 See later section of this report, for additional information on the health system funding platform
on existing processes; include an independent element and engage civil society and other relevant stakeholders.

Figure 3: Two contrasting approaches to joint assessment

In Nepal, there was an immediate opportunity, following the scoping mission in January 2010, to widen participation in the already scheduled joint appraisal by major funding partners (AusAID, DFID, and World Bank) of the new National Health Sector Programme II (NHSP-II), using the JANS tool. An analysis of strengths and weaknesses of the first complete draft of the programme involved many development partners. NGOs, who had been actively involved in plan development, made a separate analysis. The exercise is seen as opportunistic but more inclusive than before, even if still imperfect. The assessment has been used to inform the next iteration of NHSP-II. The GAVI Board has recently decided that it will use the national plan as the basis for its Health System Strengthening (HSS) funding for Nepal.

A more developmental use in Zambia: In Zambia, the government asked partners to support the process of developing the new National Health Strategic Plan 2011-2015. A first national health strategic planning meeting was held in January, involving over 100 MOH staff and partners. A review of the old strategy and a new situation analysis used the JANS tool. The situation analysis itself was structured using the health system building blocks and four Primary Health Care reforms. A road map for the NHSP II process up to May 2010 was agreed.

Lessons learned

- The multi-agency endorsement of the JANS tool at global level gives it significant legitimacy at country level.
- Scoping missions can be a useful way to clarify expectations, build confidence and agree a concrete roadmap.
- Civil society engagement is getting more attention, but ways to make it more effective are needed.
- The emphasis on an ‘independent element’ to a joint assessment is sometimes questioned at country level, but accepted as positive if it raises awareness of important but over-looked issues, is done collaboratively, and helps to bring more partners on board.

The tool, guidelines, a FAQ sheet, terms of reference for scoping missions, and a framework for documenting lessons learned are all on the IHP+ website. They are all ‘public goods’, in that they can be used by any interested parties, not just IHP+ signatories.

3 Comacts

A country compact is a set of negotiated commitments by signatories on how they will support a single national health strategy. It provides a framework for improving aid effectiveness and for increasing aid for health, by addressing problems such as fragmentation, volatility, high transaction costs and the need for greater mutual accountability.

IHP+ encourages partners to build on existing agreements - for example MOUs or Codes of Conduct in countries with health SWAPs (sector-wide approaches). It encourages them to make commitments more

---

4 The world health report 2008: primary health care now more than ever
5 http://www.internationalhealthpartnership.net/en/about/j_1253621551
explicit if needed, and to have specific indicators to monitor their implementation. Ethiopia, Nepal, Mali and Mozambique negotiated and signed IHP+ compacts in 2008 / early 2009. In Zambia, an addendum to the existing Memorandum of Understanding between MOH and development partners was prepared in 2009, though signing has been delayed because of a political crisis. While these documents are not legally binding, real negotiated commitments require compromise between different positions, and by enshrining them in signed documents there is a greater chance that they are adhered to.

**Progress**

A recent review of IHP+ country compacts or similar agreements between Governments and development partners is summarised in Figure 4. It is worth noting that seven countries are planning to revise their MOUs or develop first time country compacts during 2010.

**Figure 4: Status of compacts or their equivalent in 21 IHP+ countries**

- **Twelve** countries had some form of existing MOU between MOH and development partners when they joined IHP+. Six did not. For three, the situation is unclear from information available to the Core Team.
- **Five** intend to develop an MOU/Compact for the first time in 2010 (Benin, Burkina Faso, Burundi, Niger, Nigeria).
- **Five** countries have prepared IHP+ compacts. 4 have been signed. Kenya has reviewed its Code of Conduct against Compact guidance, and MOH and partners have agreed the Code of Conduct is a satisfactory equivalent for now.
- **Two** countries (DR Congo, Uganda) are revising MOUs this year in tandem with formulation of their new plan.

A recurring question is, what difference do compacts make? They are certainly not magic bullets but there are examples where they have proved useful. In Ethiopia, the new Compact has more explicit commitments than those in previous MOUs which are therefore easier to monitor. It has also been used to remind all partners - not just IHP+ signatories - of their commitments to the Paris Declaration and the Accra Agenda for Action, and to bring some new partners on board. In Mali, the compact development process, based on the health sector plan, is felt to have strengthened policy dialogue between government and partners, and resulted in more clarity on the commitments of stakeholders regarding their respective roles and expected changes in behaviour. To date, the picture is less positive in Nepal, where fewer agencies signed the IHP+ Compact than the 2007 Statement of Intent by partners to support health sector development, and the Compact was therefore seen as relevant only to a sub-set of agencies. However, a recent review of the Compact commitments served as a reminder that it contained useful indicators which could be used to hold different parties to account.

**Lessons learned**

- There remains a need to stress that Country Compacts must build on existing agreements, not duplicate them.
- Many compacts / revised MOUs are planned for 2010, because many countries are developing new national health strategies, and see a compact as the natural complement to that strategy.
- Compacts are rarely signed by non state actors: in only two agreements reviewed (Mali and Kenya), have any NGOs and CSOs signed or written letters of support. This looks likely to change with new MOUs.
• Active monitoring is key to mutual accountability, but relatively few compacts / MOUs seem to have explicit indicators for tracking progress: Ethiopia, Kenya and Nepal are three that do.

• Most countries have signed the Paris Declaration and Accra Action Agenda, so IHP+ principles and tools are relevant to all stakeholders at country level, irrespective of whether or not they are IHP+ signatories.

• Compacts are living documents, and new signatories can be added. Ireland signed the Ethiopia Compact, and Spain the Mali Compact, in the last year.

4 One framework for monitoring health system strengthening and results

Currently there is no complete overview of progress towards one results monitoring framework across all IHP+ countries, though there are individual examples. In Nepal, the recent joint assessment exercise found that the single results framework for monitoring NHSP-II, agreed by MOH and partners, was sound - though a good plan for strengthening M&E capacity and quality control was needed. Experience from elsewhere also suggests that in efforts to move towards a more unified approach to monitoring, much emphasis goes on indicator selection, with less attention to improving capacity to monitor progress and use the information produced. Overall, this work needs more attention from all partners.

Since IHP+ began it has been supporting efforts to address these issues. A framework for monitoring performance and evaluation of the scale-up for better health – the IHP+ Common Evaluation Framework - was developed during 2008, in collaboration with country and development partners. The framework provides the basis for the monitoring and evaluation of joint efforts to strengthen health systems, and underpins efforts by the development agencies most active in health (known as the H86) to monitor progress towards the health-related Millennium Development Goals.

Progress
To make these efforts operational at country level, the country health systems surveillance or 'CHeSS' approach has been further developed during 2009. This increasingly forms the basis for working with countries by different initiatives and agencies - the Catalytic Initiative to save a million lives; GAVI's evaluation work; monitoring and evaluation in the context of the health systems funding platform of World Bank, Global Fund and GAVI; the Doris Duke PHC initiative. It has also been discussed in the context of the US government's Global Health Initiative. CHeSS focuses on working together to strengthen country M&E systems, including data quality assessment, and using national systems to report to the global level, rather than the other way around. Countries have identified improved analytical capacity as a priority.

• Country health monitoring and evaluation systems in the context of annual health sector reviews have been assessed in four IHP+ countries - Burkina Faso, Ethiopia, Kenya, Zambia, as well as in China, Armenia and Georgia, using this framework.

• A comprehensive review to inform the new health planning framework and health sector strategic plan is being conducted in Kenya, and is planned for Zambia and Burkina Faso. The CHeSS framework is also being used in non-IHP+ countries - in China, it was used to develop indicators and measurement strategies for the monitoring and evaluation of the 2009-2011 health sector reform.

---

6 the Bill and Melinda Gates Foundation, GAVI, GFATM, UNAIDS, UNFPA, UNICEF, World Bank, WHO
Multi-country workshops are planned involving global partners (WHO, Global Fund, GAVI, World Bank, Rockefeller Foundation, MEASURE Evaluation/USAID), academic institutions (Africa Population Health Research Centre, Johns Hopkins University, University of Basel and others) and NGOs. The first, in April 2010 in Nairobi, brought together partners from Ethiopia, Kenya, Malawi, Rwanda, Tanzania, Uganda, and Zambia, to strengthen the analytical component of annual health sector reviews, to more effectively communicate the results, and enhance capacity to use global estimation methods with appropriate country adaptations. At least three more are planned for 2010-2011, involving over 25 countries.

A web-based community portal has been developed as a platform for partners to share information on efforts to support countries in strengthening the availability, quality and use of health information for decision making processes, and provide easy access to instruments and tools.

**Figure 5: Kenya: using the framework to structure the review of its National Health Policy**

An inter-Ministerial working group is guiding the review and development of a new, comprehensive National Health Policy for the health sector that will guide strategic investments in line with supporting Vision 2030. The working group started with a critical assessment of the situation and trends during the Kenya National Health Policy Framework 1994-2010. The IHP+/CHeSS framework was used to guide this participatory process which included two analysis workshops and was based on the contributions of many Kenyan institutions. High level policy makers fully participated in the second analysis workshop. A draft report will be published early April and will inform the qualitative review phase and subsequently the new framework and plan formulation.

**Lessons learned**

- There is a need to make better connections between the joint assessment of national strategies, and efforts such as CHeSS to improve the availability, quality and use of data for decision making.
- More attention is needed to improving countries’ M&E capacity, not just on agreeing a common framework and specific indicators.

**5 Promoting mutual accountability**

The commitment to mutual accountability is one of the most important tenets of IHP+. All signatories to the IHP+ Global Compact explicitly commit to be held to account, through an independent mechanism. The challenge has been to put it into practice, as efforts to monitor other agreements have shown.

**Extracts from the IHP+ Global Compact**

| "We collectively commit to be held to account in implementing this compact." |
| "We call for an independent evidence-based assessment of results at country level and of the performance of each of us individually as well as collectively." |

There are few examples of governments or development partners undertaking critical reviews of country partnership mechanisms - Kenya has developed a partnership dashboard, and Ethiopia has monitored progress against compact commitments.

---

7 IHP+ Global Compact: http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_global_compact_EN.pdf
To create greater momentum for mutual accountability and comply with the Global Compact, IHP+ contracted an independent North-South consortium of civil society organizations and researchers known as 'IHP+ Results', through competitive tender in late 2008. Its brief is to develop the monitoring approach, and implement it annually over three years.

Progress in developing a monitoring approach
The first year, 2009, is best described as a learning year for IHP+ signatories and the consortium alike. It has become clear that the 2009 exercise has been tough and at times frustrating for all concerned. In February 2010, the consortium presented its first draft report to the IHP+ SuRG. Central to the approach is the use of agency score cards and country report cards. Draft scorecards had been developed for seven out of 31 development partners, as had draft report cards for the first nine signatory countries.

At the SuRG, IHP+ partners reaffirmed that mutual accountability is important and there is a need for a common approach to monitoring commitments, provided it reflects national needs and builds on existing processes. Two IHP+ countries are known to have their own tool - Kenya and Ethiopia. Others such as Burundi do not, and see this work as filling a gap. Most saw scorecards as an innovative and powerful way to present information, albeit needing simplification. Everyone agreed that in 2010 a more systematic, less onerous process is needed, with more partners involved.

A small, time limited working group with global and country experts is reviewing proposals from IHP+ Results on how to do their second round of monitoring, and will make recommendations to the IHP+ Executive Team. The focus will be on country level monitoring with enhanced links to other relevant processes such as the OECD/DAC survey on aid effectiveness.

Opportunities to review progress: IHP+ Meetings in 2009/10
There have been, or will be, a number of opportunities to bring government actors, development partners and civil society together for frank discussion of progress against commitments in 2009/2010.

IHP+ held a high level Ministerial Review in February 2009. The Taskforce on Innovative Financing report recommended expansion of the IHP+ ministerial review beyond IHP+ signatories to include all forty-nine low income countries in a 'Health and Development Forum'. With a very crowded international agenda in 2010, and also the high costs of such meetings, the most likely date for such a major event is early 2011. At a more technical level, the Second IHP+ Country Teams Meeting in June 2009 included representatives from thirteen African countries. Its key messages have influenced IHP+ directions over the last year.

- There is progress on the aid effectiveness agenda but it is quite slow, and the window of opportunity is limited.
- IHP+ needs to 'close the gap' by focusing more on what is happening on the ground, and to get more specific both on the understanding of the causes of slow or no change, and on how best to address them.
- Despite its principles, IHP+ supported activities in-country have not always built on existing country processes and aid coordination mechanisms.

---

8 Working Group: Tim Martineau (UNAIDS, chair); Edward Addai (Global Fund); Longin Gashubije (MOH Burundi); Ini Huijts (WHO); Monique Kamphuis (Netherlands); Nina Otto (KfW, Germany); Bjorg Sandkjaer (GAVI); Finn Schleimann (World Bank); Roman Tesfaye (FMOH Ethiopia); Desmond Whyms (DFID); Shona Wynd (UNAIDS) and Phyllida Travis (IHP+ core team). IHP+Results Consortium: Shaun Conway; Anna Marriott (Oxfam, and chair IHP+Results Advisory Group); Neil Spicer (LSHTM); Tim Shorten.
During the World Health Assembly 2010, there will be an IHP+ technical side event on promoting mutual accountability, for all interested IHP+ signatories.

Lessons learned

- Monitoring of mutual accountability is difficult. Political commitments are not easy to translate into measurable actions, and these are often not monitored routinely. The work done by IHP+ Results is innovative - some have called it ‘cutting edge’ - but it needs to be improved.
- Monitoring mutual accountability can be sensitive. Some country level development partner representatives would prefer collective rather than individual agency assessment, on the grounds that such exercise can counter efforts for more united approaches to policy dialogue with government.
- Monitoring mutual accountability and discussing progress is important. The Core Team and SuRG members need to re-engage with IHP+’s more ‘silent’ signatories, and encourage them to participate.

Progress on harmonization among international agencies in 2009 / 2010

A selective rather than comprehensive overview is given here, focusing on areas particularly supported through the IHP+ workplan.

Harmonizing tools

There has been significant progress in harmonizing tools for planning and monitoring health sector strategies and plans: the JANS tool; the Common Monitoring Framework, and the development of a tool for monitoring progress against Compact Commitments have already been mentioned.

One area in which multiple tools exist, and where there has been confusion, is costing. The Inter-Agency Working Group (IAWG) on costing has participants from UNAIDS, UNDP, UNFPA, UNICEF, the World Bank and WHO. It is working on a joint UN costing tool, called the ‘Unified Health Model’. An online costing tool guide will be launched in the second half of 2010. The Marginal Budgeting for Bottlenecks tool (MBB), has been improved and will be used until the Unified Costing Model is launched.

Harmonizing procurement policies and procedures

Harmonization of procurement policies is one of the six action points from the 2009 Ministerial Review. The fourth Global Face-to-Face meeting of WHO, UNAIDS, UNICEF, World Bank and other development agencies interested in health system strengthening, in December 2009 (called ‘the Delhi meeting’ for short) agreed that a discussion paper on procurement issues would be drafted by UNICEF and WHO, and tabled through IHP+ in early 2010. This paper will build on previous work, and agreement on “standard contract language” between the World Bank and UNICEF, UNFPA and more recently WHO.

Improving quality and coordination of technical assistance

The Delhi meeting also discussed how to get to more coordinated and harmonized approaches to technical assistance on health systems development between UN agencies and other development

---

9 For full list, see Annex 3
agencies. This is an old problem with no easy solutions, and many different initiatives and approaches. A discussion paper will be drafted by WHO and UNICEF, to be tabled for discussion through IHP+ channels in early 2010. Efforts at more coordinated technical support are also underway under the rubric of Harmonization for Health in Africa (HHA). Improved technical support for health systems development will be discussed at a side event at the WHA in May 2010.

The health systems funding platform
While not part of the IHP+ workplan, the health systems funding platform is closely linked to IHP+ in that it is based on its principles; shares the same objectives of better and more equitable health services and health outcomes, and uses a number of IHP+ tools. It is a mechanism for making better use of new and existing funds for Health System Strengthening (HSS). At country level, the Platform aims to make the financing of HSS more transparent and efficient, and simplify funding channels and financial management procedures. At global level, the agencies involved in the Platform so far are GAVI, Global Fund and the World Bank, facilitated by WHO.

Progress:
- In practice there are two tracks of work, one on the better use of existing funds, and one on new funding. The first track pursues better harmonization between existing GAVI and Global Fund projects. Under the second track, there are two options. The first option consists of merging current GAVI and Global Fund HSS funding application processes. This will become operational in 2011. The second option concerns the funding of national health sector strategies/plans. Here, use of the JANS tool developed by IHP+ as a basis for funding decisions by these agencies will be piloted with 4-5 countries in 2011. The Platform supports the use of the IHP+ common M&E framework as the basis for tracking progress with strategy implementation.
- At country level significant progress has been achieved. Discussions in both Nepal and Ethiopia have involved a wider range of agencies. In Nepal, since the joint assessment of the new health strategy using the JANS tool, a new Joint Financing Agreement (JFA) which includes both pooled and non-pooled development partners has been drafted. GAVI will be one of the new signatories. The JFA should enhance the transparency of funding flows and accountability of partners, and help harmonize reporting procedures. Similar consultations took place in Ethiopia in February, where significant transaction costs were found from the number of separate financial reports and audits required by development partners. It has been suggested that the Ethiopia JFA be expanded to non-pooling partners, to increase transparency and reduce transaction costs.
- Moving forward, the work around M&E in the context of joint assessment of national strategies will be critical.

Harmonizing action on health workforce development
Signatories of IHP+ are committed to tackle challenges facing country health systems. Health workforce shortages are recognized as a major problem in sub-Saharan Africa. In four IHP+ countries, Ethiopia, Kenya, Mozambique and Zambia, leaders have been taking forward a major effort to increase the numbers of health workers. Ministries of Health and country partners were involved in structured reviews of human resources for health in each country, with commitments to supporting the agreed action agenda and 6 measures of success. DFID and PEPFAR have jointly pledged major financial support and are revising country actions in line with the action agenda.
IHP+ management and communications

Management and representation in management structures

During 2009, Boston Consulting Group was contracted to review IHP+ global management arrangements and recommend ways to strengthen them. Based on this, a new management structure in which the different groups have clear terms of reference has been in place since January 2010.

The key changes are

- The SuRG, which provides overall strategic direction, now includes one representative from each of the 47 signatories to the IHP+ Global Compact, including developing countries, and civil society representatives. It meets twice a year, with options for additional meetings should the need arise.
- An Executive Team oversees IHP+ operations. It has monthly ‘virtual’ meetings, with representatives from the eight H8 agencies (4), bilateral donors (3), developing countries (3), and civil society (one northern, one southern).
- Civil Society: the four IHP+ global CSO representatives have created a wider Consultative Group, which will provide them with more diverse inputs into IHP+ discussions.

---


11 Innocent Laison, Regional HIV/AIDS Coalition (AFRICASO), Senegal; Semu Ketema Teffera, Christian Relief & Development Association (CRDA), Ethiopia; Sam Adjei, Centre for Health and Social Transformation, Ghana; Yaya Zan Konare, National Federation of Community Health Associations of Mali (FENASCOM), Mali; Cesar Mufanequico, National Network on HIV/AIDS (MATRAM), Mozambique; Emma Kang’ethe, African Council of Religious Leaders, Kenya; Carol Nawina Nyirenda, Community Initiative for TB, HIV/AIDS & Malaria (CITAM+), Zambia; David Sanders, University of Western Cape/People’s Health Movement, South Africa; Sin Somuny, Network of Health NGOs (Medicam), Cambodia; John Worley, Int’l Planned Parenthood Federation; Eric Friedman, Physicians for Human Rights; Tobias Luppe, Oxfam; Paul Jensen, Results Educational Fund; Grace Mukasa, AMREF UK.
It is early days, but one positive result is greater developing country participation in global IHP+ discussions - such as at the recent SuRG on mutual accountability. However, these virtual meetings are complex to manage: there are issues of multiple time zones; language and connectivity.

Again in line with the principle of working through existing institutions, the IHP+ core team, co-located in Geneva and Washington, remains small. More staff in IHP+ signatory agencies are being engaged in the different work streams, along with selective use of consultants to carry out time-limited activities.

**Communications**

There are many dimensions to good communication. Transparency is one, and IHP+ has always been transparent in that almost all documents are on its website. However, effective communication by IHP+ of its priorities, decision making processes, achievements and challenges has not been as easy to manage, especially between global and country levels.

During 2009 there has been a big effort to clarify main messages; improve access to documents and materials; improve communication related to management meetings, and improve communications between country, regional and global levels.

**Progress**

- A standard IHP+ PowerPoint presentation and an updated IHP+ brochure, with clear and consistent messages are now available on the website and in hard copy. Quarterly IHP+ Updates for the general public continue.
- Documents related to the joint assessment of national strategies have been developed. Some core IHP+ documents have been revised, including the guidance document for accessing IHP+ country grants. More French translations are available.
- The IHP+ website was redesigned and continues to be regularly updated. Minutes of SuRG and Executive Team meetings continue to be posted there.

**Lessons learned**

- In the core team, WHO and the World Bank have both increased communications, and made efforts to get greater joint understanding between agencies, with positive results.
- Communication is not only the responsibility of the Core Team. The partnership should capitalise more on opportunities through all partners' headquarters and their country staff. The roll-out of joint assessment has increased country missions, which has had positive side effects in communicating IHP+’s goals and ways of working more generally.
- The greater 'meeting hygiene' introduced into Executive Team and SuRG meetings, has improved their quality. Agendas are more focused, documents are shorter and circulated further in advance. More people engage; perspectives are broader, and meeting conclusions clearer.

---

12 PowerPoint: and brochure: [http://www.internationalhealthpartnership.net/en/about](http://www.internationalhealthpartnership.net/en/about)
13 All documents available via [www.internationalhealthpartnership.net](http://www.internationalhealthpartnership.net)
14 IHP+ Country Grant Revised Guidance Note: [http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_country_grant_proposal_guid EN.pdf](http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_country_grant_proposal_guid_EN.pdf)
Looking ahead

Opportunities, challenges and risks for IHP+ in 2010

Based on the analysis of what IHP+ was designed to achieve, this review of the last year suggests that the Partnership continues to evolve, making real progress, albeit not as fast as many would like. The Partnership has doubled in size since it began. A wider group of development agencies and countries are now actively engaged in the different tracks of work. There is considerable momentum associated with the 'joint assessment of national strategies' process, in which an increasing number of countries are engaged. Six to eight new country compacts are planned in 2010. Efforts to promote mutual accountability are under way, with a range of development agencies and developing countries engaged in the current working group. There are now a number of 'generalisable products' with inter-agency endorsement that are genuine public goods. The Executive Team and SURG meetings are more representative and the discussions more lively. Sources of funding have diversified. Expenditures for 2009 show that IHP+ is actually not that costly (Annex 1).

But there is a real sense that countries are moving faster than development partners - leading to legitimate developing country frustration at lack of development partner behaviour change. A common question is 'Are development partners really committed'? And the perennial quest for quick results means that there is also a significant degree of pressure for IHP+ to behave more like a project than a catalyst for organisational change.

The way forward

1 IHP+ must continue to strive to be part of the solution, not part of the problem

- IHP+ is about catalysing changes in procedures and behaviours within organizations - in national Ministries of Health/other government agencies, but especially among development partner agencies. The more IHP+ behaves like a stand-alone project, the more it will be harder to achieve those changes, and the more likely it will become part of the problem not part of the solution. IHP+ should hold to the principle of working through existing staff in partner agencies, not having a large secretariat. Working through existing institutions does create demands on already busy people, and also some lack of visibility for the Partnership - but if visibility is a goal, this has to be dealt with in other ways. The bottom line is that IHP+’s achievements are a result of contributions of expertise from a wide range of partners.

- At the same time, there is a need to re-emphasize that all signatories are responsible for success of IHP+, and for all partners to maintain the impetus to meet the commitments they have made.

- IHP+ needs to continue to be responsive to new related developments, such as President Obama’s new Global Health Initiative, the Health Systems Funding Platform, the UN Secretary General’s Joint Action Plan to help improve maternal health.

- Widening understanding of the possible uses of IHP+’s range of ‘generalisable’ products, such as the JANS tool etc, beyond the immediate partnership, should continue to be encouraged.
2 Put greater focus on two concrete areas in 2010: JANS and mutual accountability

*Joint Assessment of National Strategies,* using the JANS tool and approach, is widely seen as something tangible, timely and with possibly multiple benefits.

- There has been pressure at the global level to move faster in this area, but it is critical that IHP+ sticks to its own principles, by fitting in with countries' own planning cycles and adhering to the other agreed principles described in the earlier section on joint assessment. In practice, there seems to be a building momentum after a slow start, which would appear to vindicate the approach taken. More links to efforts on common reporting systems are needed.

- There is an impressive range of approaches to the joint assessment evolving. Systematic documentation of the experience of different countries, and what happened after the assessment, is a key part of this programme of work. This includes looking at the role of civil society in these assessment processes. Documentation is being completed in Nepal, and lined up for Uganda and Ethiopia.

- Joint assessment is also taking off through partner development agency activities quite independently of the immediate IHP+ programme of work. This is to be encouraged.

*Mutual accountability*

IHP+ is designed in a way that creates more opportunities for putting greater mutual accountability into practice. However, it has been proving quite difficult to realise. Despite the difficulties, IHP+ should maintain focus on this area:

- Through support to develop a simplified and more systematic approach to the 2nd round of independent monitoring of progress against Compact commitments by IHP+ Results.

- By making greater use of IHP+ virtual meetings as a platform to capture/share changes within agencies.

- By strategic use of face to face meetings. These are costly and time consuming to organize, and for many there are already too many meetings, but IHP+ partners now have an increasing range of concrete country experience to digest. IHP+ will be opportunistic, for example by organising the side event on Mutual Accountability during the World Health Assembly. A third Country Teams Meeting will be organized late in 2010 and a ministerial level meeting in 2011.

- There is a very specific role for CSOs in promoting mutual accountability, and an interesting challenge of how to ensure CSOs themselves are held accountable as well.

3 Continual active management of communications

Effective communication is a continuing challenge for IHP+. In terms of *strategic* communication, the issue is to effectively convey that IHP+ is not a project, but about implementing a set of principles and commitments which all signatories have agreed to. And that as a result of IHP+ activities, there are indeed some results coming on line. These need to be made visible to a wide audience. Second, there are some more *operational* communication issues. During the rest of 2010 the main focus will be to continue to communicate to all IHP+ partners, and to encourage better communications within partner agencies - for example between HQ and country levels.
Annex 1 Interim Financial Status Report: budget, available resources, gap and priorities

The phase II work plan is from April 2009 - December 2011. The total agreed budget was $17,420,000.

April 2009 - March 2010

1. **Continued disbursement of funds committed during phase I**
   At the end of phase I: 70% of available funds had been transferred to different activities, and 37% of available funds had been disbursed - disbursement being lowest for the country grants. By end March 2010, 85% of phase I funds had been transferred, and 81% disbursed.

2. **Additional commitments and expenditures April 2009 - March 2010**
   Funds for phase II were pledged by several donors but did not arrive until March 2010. In practice, from April 2009 to March 2010 IHP+ has operated on carry-over funds from phase I plus some specified funds from Norway and the UK\(^{15}\). Total available funds for this period was $2,968,400. The main consequence has been to delay or cut allocations to different aspects of the work plan, but to protect country level activities as far as possible.

**Phase II work plan: expenditure of available funds April 09 - March 2010**

<table>
<thead>
<tr>
<th>Funds available for work plan</th>
<th>Funds committed by area ($)</th>
<th>Funds expended by area ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area 1 Country level activities*:</td>
<td>1,822,913 (61%)</td>
<td>1,386,993</td>
</tr>
<tr>
<td>New country grants; JANS rollout; operationalising common M&amp;E framework; CSO country grants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area 2 Global level activities:</td>
<td>150,000 (5%)</td>
<td>150,000</td>
</tr>
<tr>
<td>Working group on costing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area 3 Mutual accountability (IHP+ Results, international meetings)</td>
<td>272,018 (9%)</td>
<td>272,018</td>
</tr>
<tr>
<td>Area 4 IHP+ management and communication**:</td>
<td>595,000 (20%)</td>
<td>595,000</td>
</tr>
<tr>
<td>Core team financial support; management review; communications development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2,968,400 (100%)</td>
<td>2,839,931 (95%)</td>
</tr>
</tbody>
</table>

\(^*\) $1 million of funds awarded to new country grants, of which 564,080 has been spent to date.

\(^**\) Excludes WHO and World Bank 'in kind' contributions to core team operations

**Priorities from April 2010 onwards**

As of April 2010 about half the Phase II budget ($8,300,000) has become available. New voluntary funds from Australia, DFID and Sweden are confirmed. There are indications of additional funding from EC and Spain in late 2010 or 2011 - exact amounts are uncertain but the minimum expected is $2 million additional funds. Looking ahead, priorities will be country level activities, especially related to joint assessment of national strategies and country grants, and mutual accountability.

**Phase II work plan: approved budget; available resources and priorities for new funds**

<table>
<thead>
<tr>
<th>Area 1 Country level activities: country grants; implementing JANS and common M&amp;E framework; CSO country grants</th>
<th>Budget approved at start of phase II $</th>
<th>Planned allocations of known income $, April 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area 2 Global level activities: working groups eg on UN costing tool or service delivery; civil society consultative group</td>
<td>1,000,000 (6%)</td>
<td>498,000</td>
</tr>
<tr>
<td>Area 3 Mutual accountability (IHP+Results, international meetings)</td>
<td>4,500,000 (25%)</td>
<td>2,075,000</td>
</tr>
<tr>
<td>Area 4 IHP+ management and communication</td>
<td>2,555,000 (15%)</td>
<td>1,245,000</td>
</tr>
<tr>
<td>Total</td>
<td>17,420,000</td>
<td>8,300,000</td>
</tr>
</tbody>
</table>

\(^{15}\) These figures do not include 'in kind' contributions from many partners participating in IHP+ related activities
**IHP+ country grants report**

At the start of IHP+, one-off country catalytic grants were introduced to help improve health aid coordination and support analysis of constraints to scaling up health services. WHO acts as grant manager for these funds, on behalf of the partnership. A February 2009 review of the first 8 IHP+ country grants concluded that proposed activities by individual countries were broadly appropriate but unlikely to lead to a 'step change' because of slow transfers of funds; slow implementation, a heavy focus on analytical rather than coordination activities and insufficient involvement of 'country team' members in implementation and oversight of activities. Since the start of IHP+, 11 countries have applied for grants.

**Progress since March 2009**

- Countries applying for grants since March 2009 are DRC, Niger, Nigeria, Uganda and Zambia. Within countries, reports mostly suggest progressively more consultation between partners, as well as with the MOH, on the use of IHP+ catalytic country grants.
- Since early 2009, transfers of funds by IHP+ core team to the country level have become quicker.
- In the majority of countries, over 80% of the first tranche has been committed. Actual disbursements are quite commonly slower than planned. Reasons include: activities move more slowly than expected; political developments may disrupt planned activities.
- Main uses of funds: to strengthen partner coordination capacity; support partnership events and processes; sub-national planning processes, including costing; to strengthen civil society engagement; sector monitoring instruments and processes including partnership monitoring; to support selected sector studies, assessments and gap analyses.
- With more countries joining IHP+, and the gap in the IHP+ budget, the amount available for country grants has been reduced for newly joining countries. Given that most types of activities supported by these grants are not that costly, this is not seen as a problem.
## Annex 2: IHP+ Partners, and focal points as of 1 May 2010

<table>
<thead>
<tr>
<th>Partner Country/Organization</th>
<th>Partner since</th>
<th>Agency or country IHP+ focal point</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Development Bank</td>
<td>September 2007</td>
<td>Ilunga Tshinko</td>
</tr>
<tr>
<td>Australia</td>
<td>May 2008</td>
<td>Timothy Poletti</td>
</tr>
<tr>
<td>Bill and Melinda Gates Foundation</td>
<td>September 2007</td>
<td>Dan Kress</td>
</tr>
<tr>
<td>Belgium</td>
<td>January 2010</td>
<td>Ignace Ronse</td>
</tr>
<tr>
<td>Benin</td>
<td>September 2009</td>
<td>Valère Goyito</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>October 2009</td>
<td>to be confirmed</td>
</tr>
<tr>
<td>Burundi</td>
<td>September 2007</td>
<td>Longin Gashubije</td>
</tr>
<tr>
<td>Cambodia</td>
<td>September 2007</td>
<td>to be confirmed</td>
</tr>
<tr>
<td>Canada</td>
<td>September 2007</td>
<td>Nicolas Gilbert</td>
</tr>
<tr>
<td>Civil Society - Northern</td>
<td>February 2008</td>
<td>Sue Perez</td>
</tr>
<tr>
<td>Civil Society - Southern</td>
<td>January 2009</td>
<td>Lola Dare</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>November 2009</td>
<td>to be confirmed</td>
</tr>
<tr>
<td>Djibouti</td>
<td>October 2009</td>
<td>Abdourahman Mohamed</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>August 2008</td>
<td>Roman Tesfay</td>
</tr>
<tr>
<td>Finland</td>
<td>May 2008</td>
<td>to be confirmed</td>
</tr>
<tr>
<td>France</td>
<td>September 2007</td>
<td>Gustavo Gonzalez-Canali</td>
</tr>
<tr>
<td>GAVI Alliance</td>
<td>September 2007</td>
<td>Geoff Adlide</td>
</tr>
<tr>
<td>Germany</td>
<td>September 2007</td>
<td>Simon Koppers</td>
</tr>
<tr>
<td>Global Fund to fight AIDS, Tuberculosis, and Malaria</td>
<td>September 2007</td>
<td>Rifat Atun</td>
</tr>
<tr>
<td>International Labour Organization</td>
<td>September 2007</td>
<td>Xenia Scheil-Adlung</td>
</tr>
<tr>
<td>Italy</td>
<td>September 2007</td>
<td>Enrico Vicenti</td>
</tr>
<tr>
<td>Joint United Nations Program on HIV/AIDS (UNAIDS)</td>
<td>September 2007</td>
<td>Tim Martineau</td>
</tr>
<tr>
<td>Kenya</td>
<td>September 2007</td>
<td>Prof. James Ole Kiyiapi</td>
</tr>
<tr>
<td>Mali</td>
<td>September 2007</td>
<td>Salif Samake</td>
</tr>
<tr>
<td>Madagascar</td>
<td>May 2008</td>
<td>to be confirmed</td>
</tr>
<tr>
<td>Mauritania</td>
<td>May 2010</td>
<td>to be confirmed</td>
</tr>
<tr>
<td>Mozambique</td>
<td>September 2007</td>
<td>Gertrud Machatine</td>
</tr>
<tr>
<td>Niger</td>
<td>May 2009</td>
<td>Mahaman Hamissou Ouedraogo</td>
</tr>
<tr>
<td>Nigeria</td>
<td>May 2008</td>
<td>Mohamed Lecky</td>
</tr>
<tr>
<td>Nepal</td>
<td>September 2007</td>
<td>Laxmi Raj Pathak</td>
</tr>
<tr>
<td>Netherlands</td>
<td>September 2007</td>
<td>Monique Kamphuis</td>
</tr>
<tr>
<td>Norway</td>
<td>September 2007</td>
<td>Paul Fife</td>
</tr>
<tr>
<td>Portugal</td>
<td>September 2007</td>
<td>to be confirmed</td>
</tr>
<tr>
<td>Rwanda</td>
<td>February 2009</td>
<td>Stephen Karengera</td>
</tr>
<tr>
<td>Senegal</td>
<td>October 2009</td>
<td>to be confirmed</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>January 2010</td>
<td>to be confirmed</td>
</tr>
<tr>
<td>Spain</td>
<td>January 2010</td>
<td>Sergio Galan</td>
</tr>
<tr>
<td>Sweden</td>
<td>May 2008</td>
<td>Anders Molin</td>
</tr>
<tr>
<td>Togo</td>
<td>January 2010</td>
<td>to be confirmed</td>
</tr>
<tr>
<td>Uganda</td>
<td>February 2009</td>
<td>Christine Tashobya</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>September 2007</td>
<td>James Droop</td>
</tr>
<tr>
<td>United Nations Development Program (UNDP)</td>
<td>September 2007</td>
<td>to be confirmed</td>
</tr>
<tr>
<td>Vietnam</td>
<td>February 2010</td>
<td>to be confirmed</td>
</tr>
<tr>
<td>World Bank</td>
<td>September 2007</td>
<td>Julian Schweitzer</td>
</tr>
<tr>
<td>World Health Organization (WHO)</td>
<td>September 2007</td>
<td>Carissa Etienne</td>
</tr>
<tr>
<td>Zambia</td>
<td>September 2007</td>
<td>Collins Chansa</td>
</tr>
</tbody>
</table>
## Annex 3 Ministerial Review Communiqué 5 February 2009
### Action points and summary of progress

<table>
<thead>
<tr>
<th>Area</th>
<th>Agreed action</th>
<th>Progress</th>
<th>Prospects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improve implementation of agreements in Country Compacts, and expand partnership</strong></td>
<td>10 country compacts by September 2009</td>
<td>4 new compacts signed, plus Zambia delayed; Kenya and Cambodia considered to have equivalent. There are now 47 signatories</td>
<td>7 new or revised agreements planned during 2010</td>
</tr>
<tr>
<td><strong>Joint process for in-country assessment of national health and HIV/AIDS plans and strategies</strong></td>
<td>Final acceptance of assessment process for future national health plans by September 2009</td>
<td>Draft tool and guidelines approved; 8 countries signalled interest in assessment process in late 2009 / early 2010</td>
<td>Will have 3-4 countries completed by mid 2010</td>
</tr>
<tr>
<td><strong>Accelerated progress by development partners on realising behaviour changes set out in Compacts</strong></td>
<td>All funds mobilised should appear in national budgets; engagement of additional EU member states, US and Japan</td>
<td>Engagement of more EU member states: Belgium and Spain joined; active engagement with US government in context of Global Health Initiative</td>
<td></td>
</tr>
<tr>
<td><strong>Establishment of robust framework for mutual accountability</strong></td>
<td>Annual independent monitoring of IHP+ signatories. Review of progress against commitments in compacts and in this Communiqué</td>
<td>IHP+ Results completed first round of monitoring in 9 countries; revised approach for round 2</td>
<td>Revisions to Consortium methods and process agreed</td>
</tr>
<tr>
<td><strong>Support for civil society engagement at all levels</strong></td>
<td>In all aspects of compact development; M&amp;E, national planning processes</td>
<td>Globally - through IHP+ management structures; in IHP+Results; country level - explicit part of joint assessment</td>
<td>CSO country grants for engagement in policy dialogue now being implemented</td>
</tr>
<tr>
<td><strong>Harmonization of procurement policies</strong></td>
<td>All partners strive to reach common approach to procurement</td>
<td>Agreement on standard contract language between WB and UNICEF</td>
<td>Discussion paper being drafted by WHO and UNICEF, and Working Group discussions begun</td>
</tr>
</tbody>
</table>
Questions or comments, please contact:

**Nicole Klingen**  
IHP+ Core Team  
The World Bank, Washington D.C.  
nklingen@worldbank.org  
Tel: +1 202 458 7413

**Phyllida Travis**  
IHP+ Core Team  
World Health Organization, Geneva  
travisp@who.int  
Tel: +41 22 791 2566

www.internationalhealthpartnership.net