

## **D6 | THE INTERNATIONAL HEALTH PARTNERSHIP+: GLASS HALF FULL OR HALF EMPTY?**

Development assistance for health has risen sharply in the past two decades and continues to be a priority in aid discussions, owing partly to the focus on the Millennium Development Goals (MDGs). Many of the world's poorer countries rely on health aid for sizeable portions of their health budgets. The problems with these financial transfers and the 'aid dependency' they produce are well known: episodic allocations preventing effective planning; donor preferences driven by strategic interest rather than need;<sup>1</sup> aid funding used to pay for the donor country's 'technical assistance' while essentially subsidising foreign contractors; fungibility and (at times) corruption in the misuse of aid funds in recipient countries; a proliferation of new global health initiatives leading to an enormous 'overburden' in recipient-country accountability; and, fundamentally, health issues and means of addressing them being increasingly defined by donor countries or international funders.

These problems are well recognised by donors and recipients. The 2005 Paris Declaration on Aid Effectiveness emphasised three means for allocating aid more efficiently and meaningfully: harmonisation amongst donors; alignment of donors to recipient-country plans; and coherence to ensure that donor policies in trade or intellectual property do not undermine the developmental value of aid (OECD 2005). But where is the donor (and recipient) accountability for such reasonable goals?

### **IHP+ to harmonise donor funding**

In part-answer to this question, and in response to the lagging progress on the health MDGs, the UK government announced the International Health Partnership in September 2007. Its intent, with explicit reference to the Paris Declaration, is 'to better harmonize donor funding commitments, and improve the way international agencies, donors, and developing countries work together to develop and implement national health plans'. Shortly after its launch, it rebranded itself as the International Health Partnership 'plus related initiatives' (IHP+) to promote coordinated health systems, strengthening efforts across a number of other multilateral programmes. Twenty-three of the world's poorest and 13 of the world's wealthiest nations, together with a number of multilateral donors and international agencies, have signed up to the initiative (Box D6). The need for the initiative was argued by the UK's Department for International Development (DfID) at the time of its launch: over 40 bilateral

donors and 90 global health initiatives in operation; only 10 per cent of donor support for health in Zambia (as one example) going to the government to support comprehensive health systems, with the rest going to disease-specific programmes; and 22 different donors providing support for health in Cambodia through 109 separate projects (DfID 2007).<sup>2</sup>

### **Insufficient Progress**

The IHP+, with its ‘Global Compact’ committing all signatories to support ‘one national health plan’ in recipient Partners, aims to become the grand health-aid coordinator, where sector-wide approaches (SWAps) and other efforts in the past have failed. Three years into the initiative, how well are the Partners delivering on these commitments or holding themselves publicly accountable for their efforts? To its credit, the IHP+ is undertaking a ‘real-time’ evaluation of its work, allowing some partial answers to this question to emerge. The IHP+ Results group, an independent consortium, completed their first evaluation report in early 2010, with a publicly released update presented at the 2010 World Health Assembly (IHP+ Results 2010). The

#### **Box D6 Signatories of IHP+**

*International donor agencies:* World Bank; European Commission; WHO; Global Fund to Fight AIDS, TB and Malaria; GAVI Alliance; UNFPA; UNAIDS; UNICEF; UNDP; ILO; Bill and Melinda Gates Foundation; Africa Development Bank

*Bilateral donors:* Australia, Belgium, Canada, Finland, France, Germany, Italy, Norway, Portugal, Spain, Sweden, the Netherlands, the United Kingdom

*Developing-country partners:* Benin, Burkina Faso, Burundi, Cambodia, Democratic Republic of Congo, Djibouti, Kenya, Madagascar, Mauritania, Niger, Nigeria, Pakistan, Rwanda, Senegal, Sierra Leone, Togo, Uganda, Vietnam, Zambia

*Developing-country partners with a completed ‘country compact’:* Ethiopia, Mali, Mozambique, Nepal

*Related initiatives:* Health Metrics Network, G8 Providing for Health, Global Health Workforce Alliance, Harmonization for Health in Africa, Innovative Results-Based Financing and the Catalytic Initiative to Save a Million Lives.

[www.internationalhealthpartnership.net/en/partners](http://www.internationalhealthpartnership.net/en/partners) (accessed 6 November 2010)

report and update, while signalling some positive developments, suggest a need for considerable improvement if IHP+ is to become more than another unfulfilled international gesture.

Consider, first, the status of country compacts. These compacts are signed agreements between donor and recipient Partners, and are intended to be the principal tools for aid alignment. Country compacts are meant to include agreements on supporting civil society engagement in the development of the national health plan (this is similar to the idea that civil society should be supported in developing national poverty-reduction plans as part of the Poverty Reduction Strategy Paper (PRSP) process) and to keep both donor and recipient countries focused on the purpose: more rapid progress towards achieving the health MDGs. There is some good news. Having a country compact in place, with good civil society engagement, appears to have helped some recipient countries focus on improving donor practices as well as recipient behaviour. But there is also bad news. Only four of the projected 10 country compacts were completed by the end of 2009.

In fairness, the formal (and unenforceable) country compacts may be less important than the willingness of the Partners to abide by the intent of the IHP+. It is here that the lack of transparency is more troubling. IHP+ Results, for its initial accountability evaluation, developed a method for Partner self-reporting using verifiable criteria and a core set of indicators based on the Paris Declaration and adapted specifically to the needs of the health sector. The Results report found that none of the Partners had supplied the information on the Paris Declaration health sector indicators. Only nine had provided enough self-reported data for the Results consortium to generate a reasonable narrative of the Partners' aid delivery at the recipient-country level. Of these, all but two (AusAID, the Australian development agency, and DfID, the UK development agency) were multilateral agencies, which already tend to comply more with the aims of the Paris Declaration than do bilateral donors.

The Results consortium created a second set of indicators for more detailed accounts of nine selected recipient Partners. Again, much of the information provided by the donor Partners was too sparse to allow the recipient Partners to determine how well the IHP+ was meeting its goals. Limited data suggest that donors are making some efforts to align with national plans. Most of the funding, however, still reflects donor priorities, and recipient countries continue to tailor their national health plans to available funding streams rather than the reverse. Very little evidence of health-system strengthening could be found, or of making aid commitments more predictable and longer-term.

These first-cut findings do not necessarily mean that the IHP+ is failing to deliver. They do mean that insufficient information to make this assessment has (at least so far) been forthcoming. In an era of donor insistence on 'results-based' aid, it is somewhat ironic that those same donors are failing to provide the data that would measure their own performance in meeting

the agreed-upon results. This non-compliance may partly have resulted from disagreements over the initial reporting mechanism developed by the Results consortium, and a working group to refine a consensus set of measures has since been established. The reticence of donors to hold themselves accountable to meeting their commitments, however, is a recurrent theme in aid commentaries and critiques (Sridhar 2010). The Results update itself noted that ‘accountability has yet to become embedded in the ways most agencies work’ (IHP+ Results 2010: 11). It remains an open question whether the IHP+, through the Results consortium, can succeed in gaining agreement on measures that matter and in obtaining reports that are meaningful, especially given the caveat that the Partners’ ‘participation in the IHP+ Results mechanism is voluntary’ (ibid.: 16).

### **Recommendations to ensure progress**

To that end, an independent advisory group to the Results consortium, consisting of experienced international health workers and scholars, called for a number of actions on the part of IHP+ signatories, including:

- 1 Agreement on the Standard Performance Measures against which signatories should report to measure behaviour change in line with the IHP+ commitments. Analysis of these indicators should be conducted for each recipient country as well as for the overall performance of individual signatories.
- 2 Official commitment to incorporating the Standard Performance Measures as part of the joint annual review of the health sector in every IHP+ country, as well as within the Common IHP+ Monitoring & Evaluation Framework. This should reduce the high transaction costs of multiple evaluations and ensure that necessary and appropriate data are being systematically produced each year.
- 3 The production of a narrative report by IHP+ signatories on how well they are increasing coherence across a range of other sectoral policies known to affect health outcomes and the capacities of countries to develop and sustain equitable and effective health systems. Key sectoral policy areas would include: trade, intellectual property, foreign investment, macroeconomic or other conditions associated with aid and debt relief, and may extend to policies related to migration and human rights (ibid.: 5).

A final caution was voiced about the importance of guarding against the erosion of Results’ independence from the initiative’s ‘Scaling-up Reference Group’, a governing body made up of IHP+ Partners and to which the consortium reports. The consortium in its update expressed concern that it had ‘been significantly restrained from publicly reporting findings or the information that has been reported by agencies’ on the argument that these releases need ‘to be “signed off” at the senior level’ (ibid.: 22). This does not bode well for the initiative’s ambitions.

Nor does the emphasis placed by IHP+ on aid *effectiveness*, at least without reference to the acknowledged need for considerably greater levels of health-aid financing. A 2008 task force report, released in 2009, estimated an annual health funding gap of US\$10 billion to meet the health MDGs (Taskforce on Innovative International Financing for Health Systems 2009). This estimate preceded the 2008 global financial crisis, which has created a much larger budget shortfall of US\$65 billion in low- and middle-income countries, which aid transfers have failed to fill (DFI 2010). There is concern that absolute levels of official development assistance (ODA) from donor countries will decline as they deal with the consequences of bank bailouts, toxic debt, and stimulus spending. Against 2005 G8 commitments to aid increases, now abandoned by most donor nations that made them, OECD-DAC is predicting a shortfall of between US\$18 and 22 billion in 2010 (OECD-DAC 2010b), and a drop of 3 percentage points relative to GNI (OECD-DAC 2010a). Preliminary OECD-DAC figures for 2009 nonetheless found that overall aid levels crept slightly upwards (by 0.7 per cent) compared to 2008, with IHP+ donor Partners outperforming the average with a group increase of 3 per cent (OECD-DAC 2010c). The IHP+ positive tally was due to increased financing generosity on the part of just six Partners: Belgium, Finland, France, Norway, Sweden, and the UK. Other donor Partners saw their aid levels fall. Despite this modest increase, aid funding by IHP+ donor Partners, even in the aggregate, remains below globally committed levels, and several donor Partners (France, Italy, Canada) have announced reductions or caps on future aid expenditures.

### **Action by recipient partners**

None of this diminishes the parallel need for improvements on the part of recipient Partners. One of the consortium's proposed measures here is the portion of the national budget allocated to health, a straightforward marker of a country's intention to use health aid to support, and not substitute for, domestic efforts. The 2001 Abuja Accord committed African Union members to a target of 15 per cent of annual government budgets to their health sectors, a target that only six of the 53 African Union nations have met so far (Campbell 2010). Earlier in 2010, African finance ministers rejected even this budgetary commitment, arguing that it was too constraining on their policy choices; it was later reaffirmed, reportedly the result of civil society pressure. A singular but not exceptional case is that of Zambia, an IHP+ recipient country, which has had much of its health aid suspended owing to 'whistle-blower' evidence of substantial embezzlement of donor funding, including that earmarked for government health programmes (Usher 2010). The risk of corruption and the lack of capacity for transparent accountability in (at least some) recipient Partner countries reinforce the channelling of health aid by donor Partners into non-governmental organisations or global health initiatives, undermining the very premise of the Paris Declaration and the IHP+ initiative.

### **Lack of coherence between aid and trade policies**

But of all the concerns about aid adequacy, effectiveness, and accountability, the most troubling one (for both the IHP+ and the Results consortium) is the lack of coherence between the aid policies of the donor Partners and their trade or national security policies. As far back as the 1969 Pearson Commission, which launched the concept of ‘official development assistance’ (ODA), there was a clear warning that ‘it is futile ... to nullify the effects of increased aid by inconsiderate trade policies’ (Pearson 1969, cited in World Bank 2003). That caution has not been well heeded. The Economic Partnership Agreements (EPAs) still being negotiated between the European Union and its former colonies in Africa, the Caribbean, and the Pacific (ACP countries) contain many WTO+ provisions (on government procurement, intellectual property rights, agricultural liberalisation, and services trade), as well as schedules to lock in tariff reductions.

One study estimates that these EU demands could eventually cost ACP countries as much as €550 million annually in lost revenues, with as little as €12.7 in offsetting gains through increased Eurozone market access (ODI 2008). All projections of net gains and losses from the completion of the Doha ‘Development’ Round of WTO negotiations similarly calculate net income gains to developed countries that are four- or fivefold greater than those to developing nations, with the latter bearing the brunt of losses associated with tariffs reductions (Labonté et al. 2010). There is also the persistence of offshore financial centres (tax havens) under the protection of some donor Partners and the use of transfer pricing or illicit trade mispricing by multinational corporations (most based in donor Partner countries) that cost developing nations far more in lost tax revenues than they receive in aid disbursements (GFI 2010). And then there is the recent working paper from the IMF Research Department that argues that low-income countries should not spend their ‘scaled-up’ (MDG) aid monies as intended because of the attendant risk of currency inflation; rather, they should put all or at least some of it in foreign currency reserves (Berg et al. 2010). This reflects long-standing IMF policy advice (or conditionality) that developing countries ‘sterilise’ aid transfers through a number of means that essentially reduce domestic demand for goods or services and sustain a reliance on exports for economic growth (Balakrishnan and Heintz 2010).

### **Conclusions**

These problems are not unfixable, but their persistence feeds a certain fatigue with the discourse on the need to reform the global aid architecture. The MDGs themselves, for all the aid promises they have engendered, suffer from the same vertical approach to health that the IHP+, in improving delivery on the health MDGs, is supposed to overcome. From the perspective of social determinants of health, *all* of the MDGs are health goals, and those

supposedly identified as such (extreme hunger, maternal/child mortality, HIV/malaria/TB) are in large measure manifestations of the success or failure in achieving others (extreme poverty, education, gender equality, environmental sustainability, global partnership). There is now some acknowledgement of this interconnectedness, with the UN in its September 2010 meeting on MDG progress identifying health as a cross-cutting outcome of all of the goals rather than being a stovepiped sector (UN General Assembly 2010). But, in unsurprising UN-speak, the September declaration, on the one hand, acknowledges that countries must individually assess the trade-offs between international disciplines (e.g. trade rules) and policy space (e.g. fiscal capacity and regulatory authority), while, on the other hand, it identifies global trade as the engine of development and as being important to the achievement of the MDGs (which is empirically contestable) and calls for rapid completion of a Doha round of the World Trade Organization (WTO) talks (which, as previously noted, will disproportionately reward already wealthier nations).

The two challenges confronting IHP+ (and its Results' accountability consortium), then, are the extent to which the Partnership's agreement to allow meaningful scrutiny of its efforts to put teeth into the goals of the Paris Declaration is honoured, and the depth to which that scrutiny will plunge below the surface of disease interventions and into the policies and practices of donor and recipient Partners that influence the social determinants of health.

## Notes

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2 A recent study of the four major donors in global health noted that in 2005 funding per death varied widely by disease area, from \$1,029.10 for HIV/AIDS to \$3.21 for non-communicable diseases (Sridhar 2010).

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