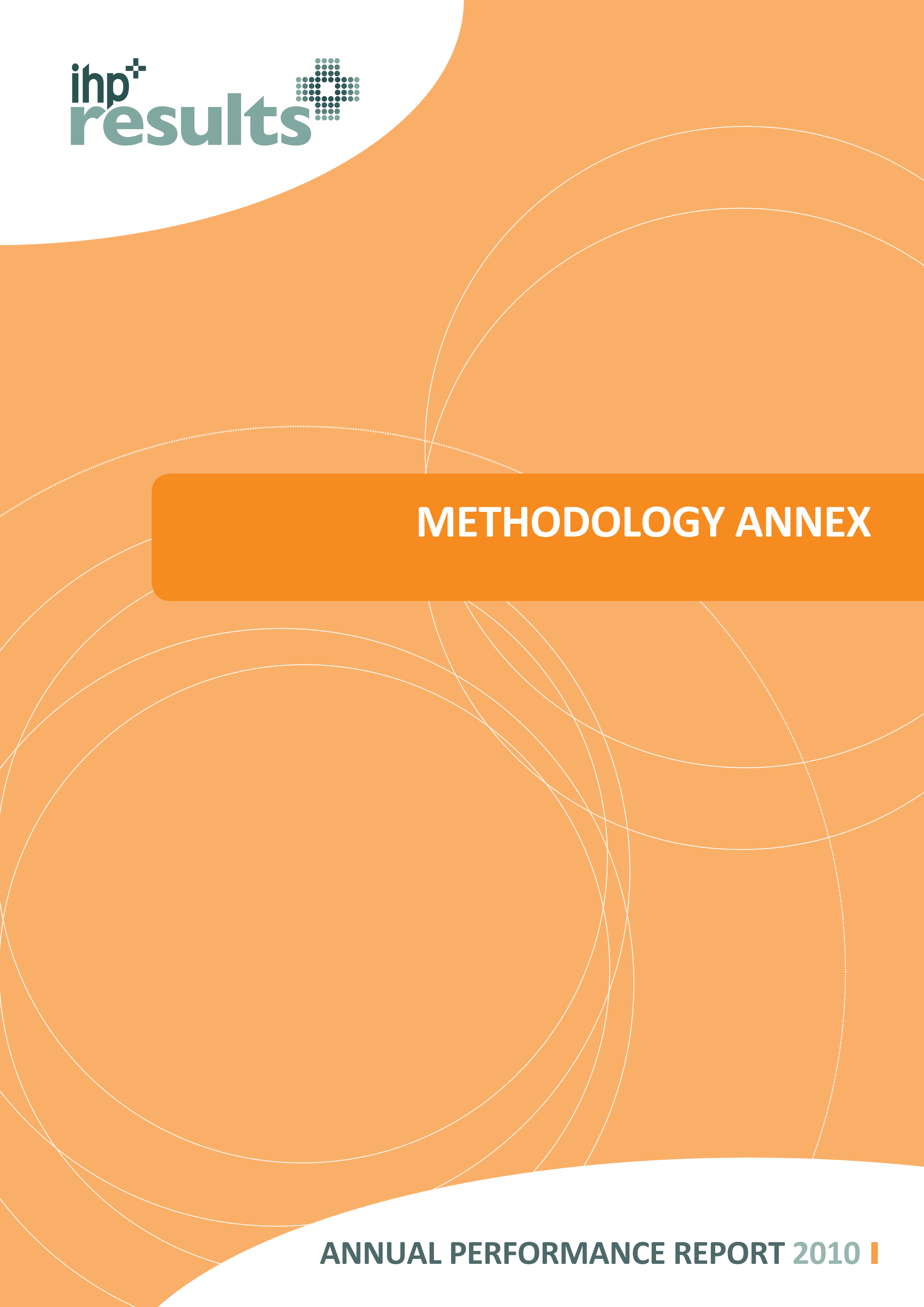
ihp+ results
METHODOLOGY ANNEX
ANNUAL PERFORMANCE REPORT 2010

BACKGROUND TO THE IHP+RESULTS APPROACH

The IHP+Results mandate is taken from the IHP+ Global Compact, which calls for an independent assessment of progress.[1] The reporting framework used in producing this report was developed and agreed by IHP+ signatories during the first part of 2010. Following a recommendation from the IHP+Results 2009 performance review, the IHP+ SuRG established a Working Group on Mutual Accountability.[2] The role of the Working Group was to develop a set of Standard Performance Measures (SPMs but hereafter referred to as 'measures') for IHP+ Country Governments and Development Partners; to agree on an improved process for data collection; and on how the results would be reported using Development Partner and Country Scorecards. The IHP+ SuRG approved these measures and the process for the IHP+Results 2010 survey.

The Working Group put forward a list of 10 measures for IHP+ country governments and 12 for Development Partners that were agreed by the SuRG. The list was based as far as possible on the Paris Declaration Aid Effectiveness indicators[3], as a means to minimise the transaction costs associated with the reporting framework. These measures were selected to track progress against the results expected from implementing the IHP+ Global Compact. Health outcomes and impacts were not included as these are tracked elsewhere, although a limited number of these sorts of complementary measures are reported in the Country Scorecard to contextualise the findings of IHP+Results.

Targets for each measure were also agreed, again drawing on Paris Declaration targets where applicable. The Working Group did not set deadlines for achieving these targets and this presents an unresolved question throughout the performance report that IHP+ signatories should decide to address in future performance reviews (see below). The IHP+ SuRG and Working Group were keen to ensure that the survey should be conducted with minimal possible transaction costs for country and development partner officials. This has impacted on the data available because, from the outset, flexibility was allowed to survey participants to provide existing (near enough) data rather than generate new (perfect) data. However, this does not weaken the survey findings if these results are used in an appropriate way. The findings can be used to inform conversations about whether partners are accurately reflecting their progress to IHP+Results, to improve the rigour of their reporting, and to ask what has changed since the period that the data come from.

[1] http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_global_compact_EN.pdf (accessed 27 January 2011).

[2] Chaired by UNAIDS, and including the following members: Governments of Burundi and Ethiopia, the Global Fund to fight AIDS TB and Malaria, the GAVI Alliance, UNICEF, World Health Organisation (WHO), World Bank, the German Development Cooperation, the Netherlands Ministry of Foreign Affairs, UK Department for International Development (DFID), Oxfam GB, the London School of Hygiene and Tropical Medicine, Re-Action!

[3] http://www.oecd.org/dataoecd/57/60/36080258.pdf accessed 27 January 2011.

HOW THE 2010 REVIEW WAS CONDUCTED

The Mutual Accountability Working Group recommendations were discussed by the IHP+ Executive Team and agreed by the IHP+ SuRG on 2nd July 2010 and the timeframes for data collection and reporting were agreed. IHP+ signatories were asked to opt into the IHP+Results' 2010 review process. 25 signatories agreed to participate, including 10 country governments (not all the same as the 10 countries that participated in IHP+Results 2009 process); and 15 development partners (up from 9 in 2009).

PARTICIPANTS IN IHP+RESULTS 2010 MONITORING

As with OECD/DAC – IHP+Results process in 2010 was voluntary. The following country governments and development partners opted to participate:

10 IHP+ COUNTRY GOVERNMENTS: Burkina Faso, Burundi, Djibouti, DRC, Ethiopia, Mali, Mozambique, Nepal, Niger and Nigeria

15 DEVELOPMENT PARTNERS: AusAID, Belgium, EC, GAVI, GFATM, Netherlands, Norway, Spain, Sweden, UK, UNAIDS, UNFPA, UNICEF, WHO and World Bank

A number of IHP+ signatories expressed an interest in participating but were unable to for various reasons. These include: ILO, German Development Cooperation, Governments of Rwanda, Uganda, Vietnam. The remainder of the 50 IHP+ signatories[4] did not volunteer to participate.

Data collection and analysis

IHP+Results used the agreed measures to formulate a question-based survey tool[5] and guidance documentation, drawing as far as possible on the OECD/DAC guidance for the 2011 Paris Survey process to ensure consistency with the Paris Survey methodology.

Survey tools and guidance documentation[6] were available in English and French. For each SPM, denominator and numerator data were requested, rather than percentage data. Participants had 6 weeks to provide their data (starting on 2 September 2010). Responses were collected from the participating IHP+ country governments through liaison with the IHP+ focal point in the Ministry of Health (MoH). In all countries, the MoH was asked whether they preferred to conduct the data collection with the support of an in-country consultant or through conversation with the IHP+Results team (not based in country). In 4 out of 10 countries (Burkina Faso, Burundi, Mozambique, Nigeria) a country-based consultant was identified in consultation with the MoH. These consultants worked with MoH officials, under close supervision by the IHP+Results team[7], to collect the data and ensure that the MoH IHP+ focal point had signed off the completed survey tool and country scorecard. It was intended that the process would include consultation with Country Health Sector Teams based on guidance from the MoH, with the objective that the outputs of IHP+Results process could be used as legitimate, credible inputs to ongoing country-level discussions on health sector aid effectiveness, and to strengthen mutual accountability. In practice, this happened only in a limited number of cases (Nepal and Burundi) largely due to constraints on timing. This has limited the visibility and ownership of this exercise at country level, in particular for civil society stakeholders. The IHP+Results 2011 review process should be located at country level wherever possible to ensure broader country ownership.

[4] For a full list of IHP+ signatories, see http://www.internationalhealthpartnership.net/en/partners (accessed 27 January 2011).

[5] A sample survey tool is available at www.ihpresults.net/how/data_collection/

[6] Available at www.ihpresults.net/how/data_collection/

[7] This included regular phone calls to clarify process and ensure a common understanding of key terms and definitions as set out in the Overview and Detailed Guidance documentation produced by IHP+Results (available at www.ihpresults.net/how/data_collection/)

Data from Development Partners were collected through each agency's headquarters[8]. Data were collected for the countries in which the agency considered **themselves** to be active (see reflections section below) within the 10 countries participating in the survey.

IHP+Results reviewed the completed survey tools and cleaned the data to ensure, as far as possible, consistent application of guidance on key terms and definitions[9]. Draft scorecards were shared with all participating signatories to ensure that the interpretation and presentation of data were accurate. Qualifying/explanatory text was agreed between IHP+Results and each Development Partner to be presented on the reverse of their scorecard. The Annual Performance Report provides an independent synthesis of the findings, with conclusions and recommendations based on this evidence. An Independent Advisory Group of academic and civil society leaders intensively reviewed this methodology, the findings and report, to provide their view of the integrity of the process and to produce their assessment that is included as a foreword to the report.

SCOPE AND LIMITATIONS

Analysing and interpreting the data

The reporting framework includes both qualitative and quantitative Standard Performance Measures (SPMs) (see p11, for full list). We have completed our analysis by aggregating data in various ways:

Quantitative data

- To provide an **overall indication of whether progress has been made, and whether targets have been met.** At the highest level, we have aggregated all Development Partner data, to show one value for baseline and one value for 2009, for each quantitative Standard Performance measure (measures 2DPa, 2DPb, 2DPc, 3DP, 4DP, 5DPa, 5DPb and 5DPc).
- To **provide a per agency/country perspective on progress for each Standard Performance Measure, using the Partner and Country Scorecards,** we have provided an objective rating (✓ , ⇨ , !), based on qualitative or quantitative data and targets (depending on the measure). These ratings have been aggregated across the countries in which the agency is active. For the Country Scorecards, there is no aggregation – only government data have been used as the basis for rating progress. Ratings are derived from published criteria[10]. Data from Development Partners were aggregated using the formula below. Where data were not provided, a question mark (?) is used. In some cases agencies indicated that one or more measures are not applicable to their business model – in these cases a grey bar (▬) has been used[11]. For Standard Performance Measure 5Ga and 5Gb, data were used from World Bank and OECD sources[12].
- We have also provided **disaggregated data by development partner and by country** as online annexes.[13] These development partner annexes present the calculated figures for each of the indicators and are presented by development partner (to show how each development partner performance compares across all the countries they are supporting), by country (to show the ratings of all development partners

[8] There was one exception – IHP+Results established direct contact with AusAID's office in Nepal, on instructions from AusAID HQ.

[9] In line with the Detailed Guidance documentation that was circulated at the start of the data collection process – available at www.ihpresults.net/how/data_collection/

[10] Available on the IHP+Results website www.ihpresults.net/how/methodology/rating/

[11] This symbol was also used in a number of cases where action was not possible by Development Partners (DP). For example, DP use of a national performance assessment framework is only possible where one exists. In those countries where Governments reported that they did not have a national performance assessment framework in place, all DPs that provided data for any country where this applied were rated with a ▬ . This applies to SPMs 1DP, 6DP and 7DP; and to 5DPb (see below).

[12] For more information, see Detailed Guidance document (www.ihpresults.net/how/data_collection/). More information on 5DPb (Public Financial Management, is included below)

[13] These can be found at www.ihpresults.net/how/data/

providing support to each country) and by indicator (to show how development partner performance compares across indicators), with graphs for quantitative indicators. Some concerns have been raised about comparisons that can be drawn using these tables, as development partner performance will vary from country to country according to the country context. It is also possible that the Development Partners within each of these different settings might have interpreted some of the technical terms and definitions differently. These variations will affect the comparability of results by country (for instance, this was a particular concern highlighted by development partners in Burundi[14]).

FORMULA FOR AGGREGATING DATA PRESENTED IN PARTNER SCORECARD RATINGS

(same as the approach used to calculate the indicator value (weighted average) in the Paris Survey 2008)

Aggregate Numerator ÷ Aggregate Denominator = Result

Example:

Numerator (country1) + Numerator (country 2) + Numerator (country 3)
-- = Result
Denominator (country1) + Denominator (country 2) + Denominator (country 3)

The Paris Survey in 2008 used an alternative approach to aggregation (unweighted average). This calculates the result (numerator / denominator) for each country to sum these results and then divide the totals by the number of countries to derive an unweighted average. We did not have time to conduct an alternative analysis using unweighted aggregation, but would hope to do so during 2011 for comparison.

Qualitative data

Qualitative data are analysed and presented in two ways:

1. Through partner scorecards.
2. Through disaggregated annexes online.

It is important to note that there is limited qualitative information to fully analyse these indicators. Questions in the survey tool for these measures focused on, for instance, the existence of a plan or the use of a national performance assessment framework and were interpreted as quantitative data. Supplementary questions were asked about quality or obstacles to use etc[15]. But answers were not mandatory for supplementary questions and consequently the quality and comprehensiveness of data limit our ability to provide a qualitative assessment of the quantitative and qualitative measures. This is particularly relevant for the consistent understanding and quality of compacts, national plans, performance frameworks and mutual accountability processes.

A number of stakeholders have stressed the importance of qualitative data in order to make sense of the Standard Performance Measures and, in particular, to contextualise how these results are interpreted in the Development Partner and Country scorecards. These scorecards have been designed to provide a clear, easily accessible presentation of complex information mainly for a high-level political audience. For this reason, they might be of limited use to those interested in what is happening at the individual country level. Scorecards should be interpreted with care and take into consideration the limitations presented below. However, we

[14] For more information, see www.ihpresults.net/how/lessons_learnt/

[15] See sample survey tool at www.ihpresults.net/how/data_collection/

have also taken steps to address these concerns through providing space on the reverse side of the Partner Scorecard, where DPs can qualify the results reported in the scorecard ratings; and through providing online disaggregated data for each Development Partner and country[16]. It would be possible to produce country-specific scorecards from these disaggregated ratings to only reflect the performance of partners within a specific country and IHP+Results will be able to assist with requests for such reports from 2011.

Civil Society Data and Analysis

Civil society engagement is measured through a Government Standard Performance Measure 8G and through a DP Standard Performance Measure 8DP. Both of these are semi-quantitative measures developed in consultation with a range of stakeholders, including civil society representatives. To supplement these measures, we also conducted a brief qualitative survey of local civil society organisations in each of the 10 surveyed countries. We aimed to gather completed questionnaires from 10 civil society organisations chosen in consultation with the Ministry of Health and using contacts provided by IHP+ civil society representatives. Responses were received from civil society organisations (CSOs) in Burkina Faso (9 returns), Burundi (5), DRC (5), Ethiopia (10), Nepal (11), Mozambique (7), Mali (6), and Niger (4). We did not attempt to survey a representative sample, as we felt it unreasonable to ask questions of CSOs that are not directly involved in health sector policy and coordination processes. This enabled us to get a sense of the quality of civil society engagement within each country. The survey rated each respondent's opinion on a set of statements, using a four point scale: 1 = strongly disagree, 2 = disagree, 3 = agree and 4 = strongly agree. These responses were aggregated for all CSO respondents in the country. An aggregate of over 3.5 was given a green tick, between 2.2 and 3.5 a yellow arrow, and below 2.2 an orange exclamation mark. The results presented were largely extremely positive which may reflect the selection bias and brevity of the CSO survey. Further work to cross check with other ongoing CSO work would be valuable.

Assumptions and potential limitations

The reporting framework requires making a number of assumptions in how the Standard Performance Measures are reported on and interpreted.

A number of the performance targets are stated as point–in-time targets (e.g. achieve 66% of something), whilst others require demonstration of progress over time from a baseline (e.g. achieve a reduction of 66% of something to at least 85%). The target statements therefore need to be read carefully to understand how performance is being presented and rated.

Primary Biases and Limitations

Self-selection and sample size

The sample of IHP+ signatories that volunteered to participate in 2010 monitoring is limited and there are key Development Partners who are not signatories to the IHP+. This means that only a partial picture of Development Partner progress in each country can be presented.

Consistency of interpretation

Is likely to vary, due to complexity of terminology. In some instances, key terms are likely to have been interpreted differently by different participants in the survey, including as a result of language (for instance understanding what mutual accountability processes or performance assessment frameworks are, which can be perceived quite differently by different actors). IHP+Results did produce detailed guidance for respondents[17], but we do not know to what extent this was consistently applied, used, or sufficiently clear. Different interpretations

[16] Available at www.ihpresults.net/how/data/

[17] Available at www.ihpresults.net/how/data_collection/

could have been introduced due to language translations, different understanding of concepts, who was filling in the forms and what criteria were used by respondents to make judgements on their levels of contribution or progress. This has been a particular concern raised by Development Partners in Burundi, who decided to sit and establish a common understanding of the key terms and to resubmit data. We have not been able to incorporate that revised data in this report, but an analysis of the differences between the two sets of data is provided at www.ihpresults.net/how/lessons_learnt/.

The concepts most likely to be open to interpretation include:

- Reporting aid on-budget (on health budget or general budget and also information given to government or given and also confirmed as reported on budget by government),
- Programme Based Approach – the official definition of this is not straightforward to apply and many development partners do not collect data disaggregated by this;
- Capacity building – we provided a definition in our guidance but many people have their own views and do not often collect data disaggregated by this;
- Mutual Accountability process – this is particularly subjective as it could be a single meeting, an integrated annual review, or a range of other events;
- Compact or equivalent – definition of what qualifies as an equivalent agreement is open to interpretation;
- Performance Framework – definition open to interpretation depending on what partners feel constitutes a complete and comprehensive framework.
- The way in which the government budget allocation to health was reported varied considerably, as some government reports included federal and state allocations, whilst others only included federal allocations; some included external assistance in the national budget, whilst others did not[18]. We considered using WHS data, but this is only available up to 2007 and so does not provide two points for comparison since the IHP+ was launched in 2007. We therefore decided to present the reported data, but to state clearly that the data should not be used to make comparisons between countries (see p20 of the Annual Performance Report).
- The use of country consultants to support country governments complete the survey tool might have resulted in additional interpretation bias or differences between how data were reported in these countries compared to others where this technical assistance was not used.

Assumptions on Specific Standard Performance Measures

- Interpreting measure 4DP on the percent of health sector aid disbursements released according to agreed schedules in annual or multi-year frameworks – there are two ways in which 4DP measure can be interpreted. The first is as the proportion of planned funding that was actually disbursed in a given year by the development partner. The second is the proportion of actual disbursement in a year, which was planned for that year. Both tell us something valid, albeit slightly different, on the predictability of health aid that a government receives. The IHP+Results survey was unintentionally ambiguous on this. The responses provided fit the second interpretation, while on reflection we believe that the working group had in mind the first interpretation. We have calculated and reported on the second interpretation and provided a clear provisional indicator statement to reflect this. We suggest that the desired meaning of this indicator is revised for future surveys.

[18] Burkina Faso and Mozambique excluded external assistance in their calculations; Djibouti and Niger included external assistance. Burundi, Ethiopia, Mali, Nepal and Nigeria did not provide information on whether they included or excluded external funding in their reported figures.

- The Paris target on PFM (our Standard Performance Measure 5DPb) includes a two-tiered target: 66% reduction in aid not using PFM systems in countries with a CPIA/PFM score[19] of 5+, and 33% in countries with 3.5 of more. None of the 10 survey countries have a CPIA/PFM score of 5+; and 5 countries[20] were scored with 3.5 or above. IHP+Results therefore used 33% as the target for ratings. IHP+Results guidance also stated that agencies should only provide data for those countries with a score of 3.5 or more[21]. Whilst DPs have provided a significant amount of data for those countries with a CPIA/PFM score of less than 3.5, we decided to not count these data as it is not possible to know to what extent data was missing as a result of our guidance. Instead the disaggregated ratings for all agencies operating in these countries were marked as N/A (▭)[22]; and IHP+Results reporting on 5DPb is based on the five countries with strong PFM systems. This means that overall findings, ratings and graphs are biased towards good performance[23]. We have included some analysis of DP use of PFM systems in countries with weaker systems in the Annual Performance Report (see p25), but a more systematic analysis would be useful; we will make changes to our guidance and approach for 2011 to enable this.

Limited data on a number of indicators

From a number of development partners – which could skew the overall rating of certain DPs and for specific indicators.

	N/A	?	Response	Total
1DP	35	0	63	98
2DPa	9	27	62	98
2DPb	34	14	50	98
2DPc	6	12	80	98
3DP	11	5	82	98
4DP	5	18	75	98
5DPa	26	21	51	98
5DPb	47	12	39	98
5DPc	21	10	67	98
6DP	25	1	72	98
7DP	36	1	61	98
8DP	0	6	92	98

The use of N/A (shown by a grey bar ▭) is described on p5 above. The high number of N/As results in part from our handling of those indicators where DP performance is linked to government performance[24]. We have not been able to verify whether other 'N/A' responses are valid, but we will ask DPs for feedback of how they would improve completeness of data through a follow-up exercise. In some instances the performance measure is 'N/A' because it legitimately does not apply to the agency's business model (for instance, WHO does not provide donor funding so the related indicators are not relevant). In other cases, where data were not easily available, the respondent might have reported this as 'N/A'.

[19] Standard Performance Measure 5Ga

[20] Burkina Faso, Ethiopia, Mali, Mozambique and Niger

[21] We included this in order to simplify and reduce transaction costs for DPs.

[22] For more details, see the 5DPb disaggregated ratings at www.ihpresults.net/how/data/

[23] The effect of excluding data for five countries with weaker PFM systems was to increase the overall proportion of DP funds using PFM systems (by 12% in baseline, and by 23% in 2009); consequently the increase in performance between baseline and 2009 also increased (from 7% to 18%).

[24] This applies to SPMs 1DP, 6DP and 7DP; and to 5DPb. For example, DP use of a national performance assessment framework is only possible where one exists. In those countries where Governments reported that they did not have a national performance assessment framework in place, all DPs that provided data for any country where this applied were rated with a ▭ .

We cannot exclude the possibility that there is a reluctance to report data that show poor performance, but many DPs have already knowingly reported such data anyway.

Triangulation

The exercise has been largely self-reported, and it has been difficult to find opportunities to triangulate data without imposing significant transaction costs on Ministry of Health officials. This means that we have not been able to verify for example, whether a DPs participates in a mutual accountability process in a country, and if it is the same mutual accountability process that the government has reported exists. Nonetheless there is great value in the data that has been reported in the 2010 IHP+ survey because it provides a statement of what governments and DPs consider they have done, and the survey results are an invaluable tool and starting point for discussions of mutual accountability.

Risk of double-counting

IHP+Results guidance documentation[25] clearly set out that funds should be reported by the agency that completes the final disbursement. We are confident that this has been broadly followed, but the possibility of double-counting cannot be discounted. For example Development Partner X provides $200,000 to Development Partner Y to do capacity building in country Z. It is possible that in some instances both development partners X and Y have reported this funding.

Baseline

DPs and countries could select baseline in keeping with IHP+ light touch principle, with suggestion to be 2007 or 2005. This table provides a summary of the chosen baselines for the key indicators requiring a measurement of change over time (2DPa, 2DPb, 2DPc, 5DPa and 5DPb).

	2005	2007	Other
On Budget	50	45	3
Capacity Development	56	40	2
PBA	56	40	2
Procurement	56	40	2
PFM	50	45	3

We chose not to nominate a particular baseline year because of the approximately equal split between development partner using either 2005 or 2007 in their reports. There were also a few respondents that reported 2006 and 2008 baseline data points. In the aggregate calculations for all DP performance, we have grouped 2005-2007 data as baseline and put 2008-2009 data as latest. If we were provided 2008 data as baseline, we have used this for scorecard ratings but have taken these figures and the corresponding latest data out of the aggregates. We have referred to "baseline" throughout the document. The major implication of this is that readers cannot draw a conclusion that X has been achieved in Y years. But one can draw a conclusion that X has been achieved by 2009 in recent years. We are not able to calculate how far on or off track the indicators are because we do not have a target date for attainment, so the lack of a precise baseline does not cause an issue in this regard.

[25] Available at www.ihpresults.net/how/data_collection/ – see definition of disbursement (eg on pp16).

Imputing values from General Budget Support (GBS)

Capturing information on these and incorporating them in the survey represents a number of challenges if the survey is to remain light touch. We have used the following assumptions.

- We have calculated the proportion of GBS for health based on the % of country budget allocated to health. We have assumed that this is reported on budget, that it is 100% through country financial management systems, and that it is 100% programme based approach. We have not included it for capacity building calculations or country procurement. It should be noted that this can lead to a decrease in health sector aid, which is due to factors outside the control of DP decision makers (i.e. declines in imputed GBS to health are not due to DP decisions). It should also be noted that the data provided by governments on their allocation of country budget to health differed (see p7 and p8 above) which affects the comparability of the findings.

- We have counted the use of national procurement systems through Sector Budget Support (GBS) through a proxy measure: It is not possible to report the *volume* of procurement funding in SBS scenarios, but it is possible to report the *proportion* of funds that use procurement systems. We therefore asked DPs to confirm what mechanisms they used to deliver their health aid, what proportion of their health aid used those mechanisms, and whether each mechanism used national procurement systems. This enabled us to enter figures that represented the proportion, but not the volume of funds using country procurement systems.

Capacity building

Francophone respondents may, in some instances due to differences in meaning in the translated terminology, have understood "capacity building" to include all development assistance, and this might have unintentionally inflated their responses. Our initial analysis on this suggests that it has not proved a significant distortion, but steps should be taken for 2011 monitoring to limit this possibility.

REFLECTIONS AND ISSUES FOR REFINEMENT FOR 2011 SURVEY

Target dates

No target dates were formally agreed by the Working Group, and so it is not possible to make firm statements about whether the progress reported here is sufficient or significantly off-track. In advance of the 2011 monitoring process, the IHP+ should come to a clear decision on whether to establish target dates for these indicators, and if so what year. On one hand targets can provide useful focus and galvanise action, on the other aid governance is dynamic, subject to huge variables and contextual shifts, and a target reached in 2010 may not be met in 2012 if DPs, governments, bureaucrats, country or global priorities change.

Weakness in specific indicators

In particular the Development Partner indicator for supporting civil society engagement (8DP) is poorly defined: there are questions about 8DP, and what constitutes Development Partner "support", and on how a broader definition (which includes advocacy by DPs for civil society engagement) could be tracked. Further work is also needed on civil society qualitative survey. Other Standard Performance Measures that would benefit from a closer look include: 2DPb – where many partners report 0 or 100% for this indicator, suggesting that the metric and assumptions behind it are too crude to accurately measure; 1DP/1G – definitions of "equivalent agreement" and "documented support for a compact" need to be tightened and better communicated; 6DP/6G – need to promote greater understanding that single national performance assessment frameworks should be used to assess DP programmes; 7DP/7G – a clearer understanding of mutual assessments. The value of collecting information on specific health indicators should also be reconsidered where WHS or other data already exists.

Tighten criteria for rating

In general it is important for the 2011 monitoring to be clear about whether ratings are based on absolute or trend data. In most cases, for quantitative Standard Performance Measures, an absolute target has been established (either through the Working Group or using the Paris Framework as a precedent). But the rating criteria include a measure of progress, which requires baseline data – which has not always been available, making ratings impossible in some cases. We need to decide whether we are rating progress, over time/ between two points OR performance at a given point in time.

Risk that measuring skews priorities

As with the OECD/DAC Paris survey, there is a concern that the Standard Performance Measures agreed by the SuRG to monitor IHP+ progress "assume importance in their own right, becoming a barrier to rigorous thinking and innovative practice that aims to meet the broader objective of aid effectiveness"[26]

Data verification

IHP+Results 2011 survey should seek additional information from respondents to enable verification of the self-reported answers provided. For example when Development Partners report that they support civil society engagement in the health policy process they should provide documentation to support this claim.

Where and when a Development Partner (DP) should report

In 2009, we left the decision to DPs on where they are "active" in supporting health sector development. Where we were asked to, we advised that data should be collected in only those countries where the agency is actively involved in health sector coordination mechanisms (either directly or indirectly through a silent partnership). It was also agreed, in order to limit transaction costs for development partners, that data should only be submitted for those countries where the government had volunteered to participate (i.e. 10 in 2010). The SuRG may wish to reconsider this decision. These issues should be discussed and agreed in time for the 2011 monitoring process.

Questions not applicable or data not available

IHP+Results 2011 survey should include tighter guidance on when a question may be considered not applicable to a development partner. This needs to be sensitive to their various business models but also to relate accurately to the transaction costs experienced by countries in managing the health aid they receive.

Evaluation

The reported data throws up many interesting questions about why progress has or has not happened. But the agreed 2010 reporting framework did not provide opportunity to systematically evaluate the findings against the OECD/DAC evaluation criteria. The critical evaluation questions will be to ask whether the results seen in this survey really have been obtained, and to ask 'why?' to try understand the factors or actions that might have contributed to any changes, or lack of changes.

We have made a recommendation to the IHP+ SuRG that the Mutual Accountability Working Group should be re-constituted for a short period to consider these lessons and to provide technical recommendations that address the methodological issues that we have raised here. The 2011 High-level Forum on Aid Effectiveness in Busan can also reflect on our experiences of collecting sector-specific Aid Effectiveness data using the existing Paris Indicators and targets, to make improvements in the indicators and processes for collecting data to address updated sectoral targets.

[26] 2008 Survey on Monitoring the Paris Declaration: Making Aid More Effective by 2010, P27.

IHP+RESULTS STANDARD PERFORMANCE MEASURES (SPMs) THAT HAVE BEEN AGREED BY IHP+ SIGNATORIES

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

These Standard Performance Measures from the basis of IHP+Results reporting framework in 2010. For more information on these Measures, see www.ihpresults.net/how/methodology/spm/

PARIS INDICATOR The box is indicating a connection the the Paris Declaration Indicator. For more information, please visit www.oecd.org/dataoecd/57/60/36080258.pdf

CRITERIA USED TO PROVIDE RATINGS IN IHP+RESULTS PARTNER SCORECARDS

FOR IHP+ DEVELOPMENT PARTNERS

INDICATOR NO	TARGET	CRITERIA		
		✓	⇨	!
1DP	100% of IHP+ countries where the signatory operates have support for/ commitment to the IHP+ compact (or equivalent) mutually agreed and documented.	In all countries have demonstrated commitment.	Target not reached, but there is demonstrated evidence of progress towards reaching the target.	No demonstrated evidence of progress towards the target.
2DPa	Halve the proportion of aid flows to the health sector not reported on government's budget(s) (with at least 85% reported on budget).	50% reduction in aid not reported on budget, compared with baseline data.	Target not reached, but there is demonstrated evidence of progress towards reaching the target, compared to the previous year.	No demonstrated evidence of progress towards the target, compared with previous year.
2DPb	50% or more of capacity development support to each IHP+ country in which the signatory operates are based on national health sector plans/strategies.	50% or more.	Target not reached, but there is demonstrated evidence of progress towards reaching the target, compared to the previous year.	No demonstrated evidence of progress towards the target, compared with previous year.
2DPc	66% of aid flows are provided in the context of programme based approaches.	66% or more.	Target not reached, but there is demonstrated evidence of progress towards reaching the target, compared to the previous year.	No demonstrated evidence of progress towards the target, compared with previous year.
3DP	90% (or an equivalent published target) of health sector funding provided through multi-year commitments [min. 3 years].	90% (or equivalent published target).	Target not reached, but there is demonstrated evidence of progress towards reaching the target, compared to the previous year.	No demonstrated evidence of progress towards the target, compared with previous year.
4DP	Halve the proportion of health sector aid not disbursed within the fiscal year for which it was scheduled.	90% (or equivalent published target).	Target not reached, but there is demonstrated evidence of progress towards reaching the target, compared to the previous year.	No demonstrated evidence of progress towards the target, compared with previous year.
5DPa	One-third reduction in the % of health sector aid to the public sector not using partner countries' procurement systems. (with ≥ 80% using country systems).	One-third reduction in the % of health sector aid to the public sector not using partner countries' procurement systems, compared with baseline.	Target not reached, but there is demonstrated evidence of progress towards reaching the target, compared to the previous year.	No demonstrated evidence of progress towards the target, compared with previous year.
5DPb	One-third reduction in the % of health sector aid to the public sector not using partner countries' PFM systems. (with ≥ 80% using country systems).	One-third reduction in the % of health sector aid to the public sector not using partner countries' PFM systems, compared with baseline.	Target not reached, but there is demonstrated evidence of progress towards reaching the target, compared to the previous year.	No demonstrated evidence of progress towards the target, compared with previous year.
5DPc	Reduce by two-thirds the stock of parallel project implementation units (PIUs).	Two-third reduction in the stock of parallel project implementation units (PIUs), compared with baseline data.	Target not reached, but there is demonstrated evidence of progress towards reaching the target, compared to the previous year.	No demonstrated evidence of progress towards the target, compared with previous year.
6DP	Single national performance assessment frameworks are used, where they exist, as the primary basis to assess progress in all IHP+ countries where the signatory operates.	Yes - Single National Performance Assessment Framework is used as the primary basis to assess progress.	Target not reached, but there is demonstrated evidence of progress towards reaching the target.	No demonstrated evidence of progress towards the target, compared with previous year.
7DP	Annual mutual assessment of progress in implementing health sector commitments & agreements (such as the IHP+ country compact and on aid effectiveness in the health sector) is being made in all the countries where the signatory operates.	100% of countries.	Target not reached, but there is demonstrated evidence of progress towards reaching the target.	No demonstrated evidence of progress towards the target.
8DP	DP can provide some evidence of supporting active Civil Society engagement.	Demonstrated evidence of progress for all countries.	Target not reached, but there is demonstrated evidence of progress towards reaching the target.	No demonstrated evidence of progress towards the target.

CRITERIA USED TO PROVIDE RATINGS IN IHP+RESULTS PARTNER SCORECARDS

FOR IHP+ COUNTRY GOVERNMENTS

INDICATOR NO	TARGET	CRITERIA		
		✓	⇨	!
1G	An IHP+ Compact or equivalent mutual agreement is in place.	IHP+ Compact or equivalent mutual agreement in place.	Evidence of progress towards signing IHP+ Compact or equivalent mutual agreement (i.e. under active development).	No current plans to develop IHP+ Compact or equivalent mutual agreement.
2Ga	A National Health Sector Plan/Strategy is in place with current targets & budgets that have been jointly assessed	National Health Sector Plans/Strategy in place with current targets & budgets that have been jointly assessed.	National Health Sector Plans/Strategy in place with current targets & budgets with evidence of plans for joint assessment	National Health Sector Plans/Strategy in place with no plans for joint assessment
2Gb	A costed, comprehensive national HRH plan (integrated with the health plan) is being implemented or developed.	A costed and evidence-based HRH plan in place that is integrated with the national health plan.	A costed and evidence-based HRH plan under development, OR in place but not yet integrated with the national health plan	No costed and evidence-based HRH plan in place.
3G	15% (or an equivalent published target) of the national budget is allocated to health.	15% (or an equivalent published target) of the national budget is allocated to health.	Less than 15% (or an equivalent published target) of the national budget is allocated to health BUT with evidence of increase since baseline or concrete/ published plans to increase.	Less than 15% (or an equivalent published target) of the national budget is allocated to health AND with no plans to increase or evidence of increase since baseline.
4G	Halve the proportion of health sector funding not disbursed against the approved annual budget.	Proportion of health sector funding not disbursed against the approved annual budget has reduced by 50% since baseline.	Proportion of health sector funding not disbursed against the approved annual budget has decreased since baseline " but not by 50%".	Proportion of health sector funding not disbursed against the approved annual budget has not decreased since baseline.
5Ga	Improvement of at least one measure (i.e. 0.5 points) on the PFM/CPIA scale of performance.	Improvement of at least one measure (i.e. 0.5 points) on the PFM/CPIA scale of performance.	Improvement of at least one measure (i.e. 0.5 points) on the PFM/CPIA scale of performance	PFM/CPIA scale of performance does not show targeted improvements.
5Gb	Improvement of at least one measure on the four-point scale used to assess performance for this sector.	Improvement of at least one measure on the four-point scale used to assess performance for this sector.	Improvement of at least one measure on the four-point scale used to assess performance for this sector.	Four-point scale doesn't show targeted improvements.
6G	A transparent and monitorable performance assessment framework is in place to assess progress against (a) the national development strategies relevant to health and (b) health sector programmes.	A transparent and monitorable performance assessment framework is in place to assess progress against (a) the national development strategies relevant to health and (b) health sector programmes.	Evidence that a transparent and monitorable performance assessment framework is UNDER DEVELOPMENT to assess progress against (a) the national development strategies relevant to health and (b) health sector programmes.	NO transparent and monitorable performance assessment framework is in place and NO plans to develop one are clear or being implemented.
7G	Mutual assessments (such as a joint Annual Health Sector Review) are being made of progress implementing commitments in the health sector, including on aid effectiveness.	Mutual assessments (such as a joint Annual Health Sector Review) are being made of progress implementing commitments in the health sector, including on aid effectiveness.	Mutual assessments (such as a joint Annual Health Sector Review) are being made of progress implementing commitments in the health sector, but NOT on aid effectiveness.	Mutual assessments (such as a joint Annual Health Sector Review) are NOT being made of progress implementing commitments in the health sector, including on aid effectiveness.
8G	Evidence that Civil Society is actively represented in health sector policy processes including Health Sector planning, coordination & review mechanisms	10% or more of seats in the country's Health Sector Coordination mechanisms are allocated to Civil Society representatives.	1-9% of seats in the country's Health Sector Coordination mechanisms are allocated to Civil Society representatives.	No seats in the country's Health Sector Coordination mechanisms are allocated to Civil Society representatives.