



**2016 Round of Monitoring
Development Effectiveness in Health
Guide for Participants**

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PURPOSE OF THIS GUIDE

IHP+R has developed this guide for IHP+ signatories and other stakeholders participating in the 2016 round of IHP+ monitoring. The guide provides:

- An **overview of the agreed approach**, including roles and responsibilities of governments, development partners, civil society organisations and private sector.
- Detailed information on the **monitoring framework** including indicator construction, key terms and definitions.

IHP+R can provide further information if necessary. Contact: helpdesk@ihplusresults.org

IMPORTANT NOTE

The survey, for the first time, also includes some questions on humanitarian aid for health. This will only apply to a selection of countries, where humanitarian aid for health has been significant in the fiscal year 2013 or 2014.

IHP+R will indicate in which countries these questions need to be answered (see section 6.1.5 for selection criteria and definitions).

IHP+R can provide further information if necessary. Contact: helpdesk@ihplusresults.org

1 Quick read: if you only read a brief note about IHP+ monitoring, read section 1.

1.1 What is the IHP+ Monitoring Round 2016?

This is the fifth round of IHP+ monitoring of effectiveness of health sector development cooperation. Governments, Development Partners (DPs), Civil Society Organisations and other health stakeholders, including the private sector, are invited to participate in the process. Emphasis is on the collation of existing publicly available data and collecting views of stakeholders in order to stimulate discussion of findings on effectiveness of development cooperation at national level; this is not a global survey. In the continued spirit of learning and adaptation to ensure IHP+ monitoring meets the needs of the partnership, the IHP+ Mutual Accountability Working Group (MAWG) has agreed changes to the framework to monitor progress on priority issues for IHP+ members. The IHP+ Results Consortium (known as **IHP+R**) is managing the monitoring process.

1.2 What are participating Ministries of Health expected to do?

IHP+ country governments will lead the process of data collation in their country, using the instruments provided. It will involve providing quantitative and qualitative data on both government and Development Partner (DP) performance against seven effective development cooperation behaviours (see table 1). We ask Ministries of Health to:

- promote shared understanding about the purpose and value of IHP+ monitoring;
- liaise with the IHP+R consortium, and with DP country-based representatives to ensure the submission of DP data through the MoH;
- provide data on the government performance using the agreed data collation instruments;
- submit all completed returns with both government and DP data to **IHP+R** by 31 May 2016;
- promote and enable an inclusive, transparent discussion of findings.

For the above work of data collation, interviews and discussion of findings, the Ministry will be supported by a national expert, contracted by IHP+R. The MoH will be invited to participate in the selection of the national expert.

1.3 What are participating Development Partners (DP) expected to do?

DP participation is at the country level. We ask Country DP representatives to:

- engage in a country-led discussion about the purpose and value of IHP+ monitoring;
- provide data on their organization's performance using the agreed data collation instruments;
- with their headquarters (as may be necessary) to ensure data submitted has been internally approved or validated; submit data to MoH within agreed timeframes;
- join a discussion of findings drawing on analysis by **IHP+R**.

For the above work and the collection of qualitative information through interviews, support will be provided by IHP+R through the same national expert.

1.4 What are participating Civil Society and Private sector organisations expected to do?

In addition, views will be collected from Civil Society Organisations and from the private sector about their involvement in the national policy dialogue, planning and monitoring. We ask representatives from CSOs and private sector to:

- engage in a country-led discussion about the purpose and value of IHP+ monitoring;
- provide information about their involvement and accountability in the health sector through an on-line survey, interviews or focus group discussions;
- submit information to MoH within agreed timeframes;

- join a national discussion of findings drawing on analysis by IHP+R.

1.5 What is the role of the IHP+ Results Consortium (IHP+R)?

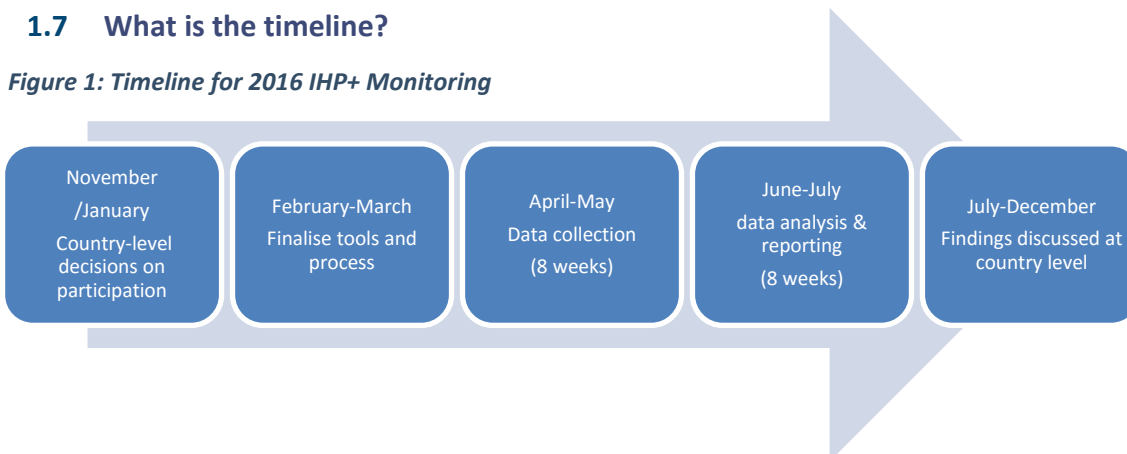
IHP+R is contracted to oversee the 2016 IHP+ monitoring process at the country-level. We will support participating countries and stakeholders to submit robust data, and provide analysis to inform country-level dialogue. Support will be provided by a national expert, contracted by IHP+R, for data collation, interviews, focus group discussions as well as for analysis of data and discussion of findings at country level. The national expert will be coached by an international IHP+R expert. IHP+R will analyse country data, store data in a global IHP+ database, and provide feedback to countries to stimulate national debate.

1.6 How will the data be analysed and used?

The IHP+ 2016 monitoring framework has a strong emphasis on using findings to support accountability for results at the country level. The outputs will be a) analysis to inform country-level dialogue, and b) data that feeds into a global report. Country-level data and findings will be summarised in a short country report and a visual country profile. This will be the basis for supporting national dialogue on effectiveness of development cooperation. National discussion will be supported by the national expert, preferably through an existing country forum or mechanism. This discussion aims at validating country findings and agreeing on actions for improvement. Country findings will be synthesised in a global report, contracted separately by IHP+.

1.7 What is the timeline?

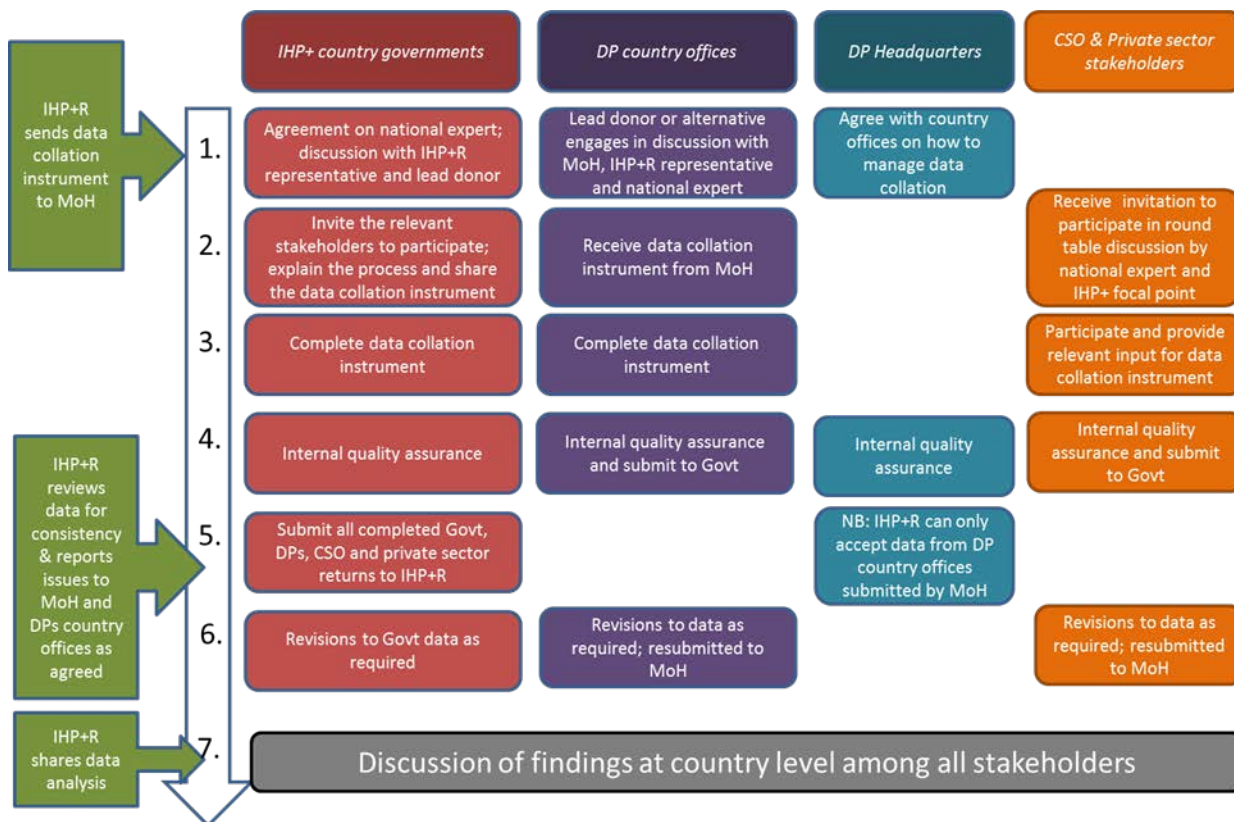
Figure 1: Timeline for 2016 IHP+ Monitoring



Step-by-step guide to data collation process: April to May 2016

Figure 2 highlights the key steps in the data collation window. It details the third stage of the overall monitoring timeline described in Figure 1.

Figure 2: Unpacking the data collation exercise (April-May 2016)



2 Background to IHP+ monitoring

In 2014 the approach to IHP+ monitoring was changed from centralised data collection from agencies and governments to data being collated at country level by ministries of health for both governments and development partners, with the aim of improving mutual accountability at country level. Whilst this country-based approach was welcomed, the expectation that IHP+ signatories would use the findings to initiate a dialogue and agree how to improve performance has not fully materialized. There remains a need to make mutual accountability processes more effective at influencing behaviour. This is partly a matter of strengthening and integrating them with other national and global processes. In addition, in order to provide a basis for remedial action, there needs to be a better understanding of the reasons why change is or is not happening, both in governments and agencies, beyond the scorecards or visual aids and quantitative assessments. Raising the profile of the monitoring findings including at global level, is also important to generate more pressure for behaviour change.

Following discussions within the IHP+ Mutual Accountability Working Group and consultations within the IHP+ Intensified Action Working Group, it was agreed that the fifth monitoring round of effective development cooperation (EDC) in health will have the following features.

- monitoring remains voluntary
- it is not limited to IHP+ signatories, in order to include all relevant players at country level
- monitoring of development cooperation practices in individual countries will be based at country level, with the aim to institutionalize processes of data collection and discussion of findings for improved mutual accountability
- it will combine quantitative data and qualitative information to better understand reasons for and barriers to behaviour change
- it will include CSO
- it will include an analysis of agencies' policies, practices and procedures to assess compliance with the EDC practices (contracted separately by IHP+)

In addition, the IHP+ core team has agreed that **IHP+R** will track an indicator on Private Sector participation, which will mean involving Private Sector representatives in the monitoring process for the first time.

Through these components, the overall aim is to get more political influence in support of adhering to the IHP+ principles and trigger pressure for behaviour change.

The data will be used for decision-making at country and partner level. In order to deliver robust, useful findings for discussion, **IHP+R** will need to be firm about the tight timeframe. We will try to be flexible, and offer a range of helpdesk mechanisms for participants, but we cannot guarantee that data submitted after agreed deadlines can be incorporated in **IHP+R** analysis and reporting. Please let us know quickly if you are unable to meet agreed deadlines.

3 What is the monitoring framework?

3.1 Indicators

IHP+ signatories worked through the IHP+ Mutual Accountability Working Group (MAWG) to advise on specific indicators to track the issues that are a priority for IHP+ members. The indicators in Table 1 form the basis of the 2016 round of IHP+ monitoring and come from the GPEDC or the last round of IHP+ monitoring. Detailed information on each indicator is provided in section 6.1 (Annexes).

Table 1: Eight indicators for monitoring Government performance and eight for DPs performance¹

		Government indicators		Development Partner (DP) indicators		Method
#	Issue	Indicator	Source	Indicator	Source	
1	Partners support a single national health strategy	National Health Sector Plans/ Strategy in place with current targets & budgets that have been jointly assessed.	G	Extent to which JANS (or equivalent) are used in programming decisions, and to which programmes are aligned with national priorities.	DP	Qualitative survey
2a	Health development co-operation is more predictable.	Proportion of health sector funding disbursed against the approved annual budget.	G	Percentage of health sector aid for the government sector disbursed in the fiscal year for which it was scheduled.	DP	Quantitative data collection tool (MS Excel) & qualitative survey
2b		Projected government expenditure on health provided for 3 years.	G	Estimated proportion of health sector aid covered by indicative forward expenditure and/or implementation plans covering at least three years ahead.	G/DP	
2c	Health aid is on budget.	Health sector resources reflected in the national budget include contributions of individual development partners	G	% of health sector aid scheduled for disbursement that is recorded in the annual budgets approved by the legislatures of developing countries.	G / DP	
3	Developing countries' PFM systems are strengthened and used.	Country public financial management systems either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	World Bank CIA data	Amount of health sector aid disbursed for the government sector that uses national public financial management systems in countries where systems are generally considered to adhere to broadly accepted good practices, or to have a reform system in place	DP	Quantitative data collection tool (MS Excel) & qualitative survey
4	Developing countries' procurement systems are strengthened and used.	Extent to which a government-led plan for procurement and supply systems exists, which is supported by development partners.	G	Extent to which procurement/supply systems are harmonized and aligned; and national systems are used or strengthened.	DP	Qualitative survey
5	Mutual accountability is strengthened.	Extent to which an inclusive mutual assessment of progress in implementing agreed health sector commitments exists.	G	Extent to which mutual assessments have been made of commitments in the health sector, including on aid effectiveness.	DP	Qualitative survey

¹ With the following exceptions: indicator 1DP and 2Gc are new; indicator 8 has been added by IHP+R in consultation with IHP+.

		Government indicators		Development Partner (DP) indicators		Method
#	Issue	Indicator	Source	Indicator	Source	
6	Technical support is coordinated and south-south/triangular cooperation supports learning	Extent to which an agreed national TA plan exists, informed by the national health strategy, on which all DPs are basing their support. Extent to which the MOH is benefitting from SSC and/or TrC	G	Extent to which TA provided in accordance with an agreed national TA plan Extent to which DPs are supporting SSC and TrC	DP	Qualitative survey
7	Civil Society engagement.	Evidence that Civil Society operates within an environment that maximises its engagement in and contribution to health sector development.			G, DP, CSO	Qualitative survey using GPEDC methodology
8	Private sector engagement*	E Evidence that Private Sector operates within an environment that maximises its engagement in and contribution to health sector development.			G, DP, PS	Qualitative survey using GPEDC methodology

**The indicator on private sector engagement has been added for the first time, based on the IHP+R proposal*

G	Data to be provided by Government representatives
DP	Data to be provided by Development Partners either at country- or Headquarters level (DP chooses which)
CSO	Data to be provided by CSO representatives
PS	Data to be provided by private sector representatives

3.2 Additional or alternative indicators

In opting to participate in the 2016 monitoring, stakeholders are committing to provide data against the core set of indicators (Table 1). However, if countries or DPs are tracking appropriate alternative indicators, **IHP+R** will seek to use available data for these alternatives. Any such modifications to the agreed framework should be agreed with **IHP+R** at the earliest opportunity.

4 Data collection tools²

IHP+R has developed the following mechanisms to support stakeholders to collate and collect data.

4.1 Data collection tools

The focus of the 2016 IHP+ monitoring round will be more on qualitative data as compared to the previous rounds. For this purpose, the data collation will consist of three processes:

- 1) Collation of quantitative/financial data: for this purpose a Microsoft Excel survey tool is available at www.ihplusresults.org. This survey tool is similar as in the previous rounds but much shorter. It

² One key development in the 2016 monitoring, compared with 2014, is the development of two new tools: one to capture qualitative data against the monitoring framework; and a second to support dialogue with CSOs and private sector on maximising their engagement. These are in addition to the MS Excel survey tool used in previous rounds, to capture quantitative data on performance against key IHP+ principles and commitments.

targets the government and the development partners. This excel tool should be filled in preparation of the interview with the national expert.

- 2) Provision of qualitative information (a): for this purpose the national expert will organise an interview with the relevant stakeholders, including government and development partners. This qualitative survey tool in pdf format is also available online at www.ihpplusresults.org and can be downloaded in preparation of the interview. Once the national expert has completed the survey tool after the interview, it will be shared with the relevant stakeholders for verification and quality assurance.
- 3) Provision of qualitative information (b): a special qualitative tool has been developed for CSO and private sector stakeholders. This qualitative survey tool in pdf format is also available online at www.ihpplusresults.org and can be downloaded in preparation of the interview. For the CSO, the interview will be pre-ceded by an on-line survey. Once the national expert has completed the survey tool after the interview, it will be shared with the relevant stakeholders for verification and quality assurance.

The completed quantitative tool (excel) and qualitative tool (pdf format) will be shared with the MoH who will then submit to IHP+ Results the latest by 31 May 2016.

4.2 Quantitative excel tool

FILLING OUT THE QUANTITATIVE TOOL

For Development Partners, the quantitative tool tracks 4 indicators, with in total 6 questions. For IHP+ Governments there are 3 quantitative indicators with in total 4 questions. There are usually two questions for each indicator. The first question gathers data on the numerator, and the second for the denominator. Collecting these data will enable the analysis of progress by country and by development partner and where possible over time and across countries.

For Development Partners, there are 3 different quantitative tools as per the list below. Please make sure you fill in the correct tool:

- **IHP+2016_DP Survey Tool EN_Standard tool for DPs_160330 final draft:** This tool will be filled out by all DPs in those countries where there is *no significant amount of humanitarian aid for the health sector*. These are the majority of the countries.
- **IHP+2016_DP Survey Tool EN_Humanitarian Aid_for DPs_160330 final draft:** This tool will be filled out by the DPs in in countries where *a significant amount of humanitarian aid for health equivalent to at least 10% of the national health sector budget is provided*. IHP+R will indicate in which countries this question needs to be answered by DPs.
- **IHP+2016_DP Survey Tool EN_Humanitarian Aid_for Cluster Coordinator_final draft:** This tool will be filled out by the Health Cluster Coordinating Agency in countries where *a significant amount of humanitarian aid for health equivalent to at least 10% of the national health sector budget is provided*. IHP+R will indicate in which countries this question needs to be answered by DPs.

IMPORTANT INFORMATION, PLEASE NOTE FOR FILLING OUT THE EXCEL FILE:

- You should only input data into the cells that are highlighted in green.
- Some cells have drop-down menus – click ▼ to select the most appropriate option.
- Other cells have automated checks inserted to promote the consistency and quality of data. These cells are protected. Please do not change the formulae that enable the automatic checks.

TERMS HIGHLIGHTED IN RED

It is really important that terms highlighted in red in the survey tool are interpreted in the same way by all respondents, so that the data submitted are consistent and can be compared. We have provided interpretation notes for these terms in Annex 6 below, drawing on OECD/DAC definitions where possible.

CURRENCY

You should enter financial data in USD. Please use the average exchange rate for the year that you are providing data, as listed in the tab entitled “Conversion Rates” in the excel tool.

LATEST YEAR DATA

The reporting year of reference is the **latest fiscal year of the country** for which there is comprehensive information available on financial expenditures. This also means that **all quantitative data from development partners is expected to be provided for the same fiscal year**. Note that for most indicators, the reporting year of reference is likely to be 2014 (or the fiscal year 2014/2015). If data on expenditures are not available for 2014, use the 2013 (or 2013/14) fiscal year. If you have data available for the fiscal year 2015 (for example from the GPEDC Monitoring Round), you are also welcome to use this. Please indicate for which fiscal year data are being provided.

BASELINE DATA

Participants are not requested to provide baseline data. Where we have relevant data from previous IHP+ monitoring rounds, we will look to use it in our analysis. Whilst this will place constraints on the extent to which analysis can highlight trends, we have taken this decision to maintain clarity and minimise transaction costs. It is consistent with the approach taken in GPEDC monitoring.

NOTES ON SPECIFIC INDICATORS

Note on Indicator 2DP (Disbursement and predictability)

In the Government survey tool, data are requested on DP performance for 2 indicators (2DPb and 2DPc). For indicators 2DPb and 2DPc, (Q3 and Q4) use the voluntary information column to list the DPs for which data is being provided by the Government, using drop down menus. For Q3 and Q4 only ten rows are shown in the tool, but additional space is hidden in the tool. **IHP+R** national expert can advise on accessing this additional space if required. We encourage governments to discuss their responses to these questions with relevant DPs in advance of submitting the completed survey tool to the **IHP+R** consortium.

4.3 Qualitative survey tools (PDF)

The 2016 IHP+ monitoring exercise will include, for the first time, a qualitative survey to gather data to support the explanatory power of the monitoring exercise and make the monitoring more meaningful for the national policy dialogue on development cooperation effectiveness. This was proposed by the IHP+ Mutual Accountability Working Group (MAWG) as a direct response to observed limitations with previous monitoring, which has focused on quantitative data and lacked the ability to explain reported results and to help identify solutions for corrective action.

Two separate qualitative surveys were developed for the government and DPs and will be completed through a 90 minutes interview focusing on the eight issues highlighted above (table 1). In principle the IHP+R national expert will organise the interviews with government and with each of the participating stakeholders. The exact method for administering the survey may differ from country to country. The semi-structured qualitative survey tools are included at Annexes 4.1 (government) and 4.2 (DPs).

Different versions of the Government and DP qualitative survey tools are available as follows:

2 different Government qualitative tools:

- **IHP+ 2016_GOV QUAL SURVEY tool_160330:** This tool should be completed by all country governments that do not receive significant amounts of Humanitarian Aid for the Health Sector. These are the majority of the countries.
- **IHP+ 2016_GOV QUAL SURVEY_Humanitarian Aid tool_160330:** This tool includes 2 additional questions related to humanitarian aid are only applicable to countries which received a significant amount of humanitarian assistance for the health sector in the fiscal year 2013, 2014 or 2015. A *significant amount of humanitarian aid for health means equivalent to **at least 10% of the government health sector budget***. IHP+R will indicate in which specific countries will be invited to fill out this specific tool.

3 different Development partner qualitative tools:

- **IHP+ 2016_DP QUAL SURVEY_STANDARD_for all DPs_160330:** This tool will be filled out by all DPs in those countries where there is *no significant amount of humanitarian aid for the health sector*. These are the majority of the countries.
- **IHP+ 2016_DP QUAL SURVEY_HUM AID_for DPs_160330:** This tool will be filled out by the DPs in the countries where a *significant amount of humanitarian aid for health equivalent to **at least 10% of the national health sector budget*** is provided. IHP+R will indicate in which countries the DPs will be invited to use this tool.
- **IHP+2016_DP Survey Tool EN_Humanitarian Aid_for Cluster Coordinator_final draft:** This tool will be filled out by the Health Cluster Coordinating Agency in countries where *a significant amount of humanitarian aid for health equivalent to at least 10% of the national health sector budget is provided*. The Health Cluster Coordinator is the agency responsible for coordinating the humanitarian aid for the health sector in a given country, it is often either WHO or UNICEF. IHP+R will indicate in which countries the Cluster Coordinating Agency will be invited to fill out this tool.

4.4 CSO qualitative survey

All previous rounds of IHP+ monitoring have experienced challenges in measuring the meaningful engagement of CSOs in health sector policy and planning processes. In 2016, IHP+ will use a new indicator, for which the measurement methodology has been developed through the GPEDC monitoring process, including piloting at country level; and has been adapted by **IHP+R**. A description of the methodology is provided below, and a template for collecting responses from CSOs is included at Annex 4.3.

Questions for government and DPs regarding CSO involvement have been included in the respective qualitative tools. After an on-line survey to most of the relevant CSOs (covering a limited number of questions), more detailed questions will be shared with a sample of CSOs and discussed in one or more focus group discussions, organised by the IHP+R national expert. Information provided by CSOs (anonymous if so preferred) will be synthesised by the national expert in a short report, to be validated by the participating CSOs. The process of data collection and analysis should be coordinated by the Ministry of Health, with support by the national expert and in partnership with the GPEDC focal point as far as possible (see Annex 2 for a list of relevant contacts); this should help to minimise transaction costs associated with this qualitative exercise.

4.5 Private sector qualitative survey

In 2016, IHP+ will also use a new indicator for the private sector, for which the measurement methodology has been developed through the GPEDC monitoring process, including piloting at country level; and has been adapted by IHP+R. A description of the methodology is provided below, and a template for collecting responses from the private sector stakeholders is included at Annex 4.4.

Questions for government and DPs regarding private sector involvement have been included in the respective qualitative tools. Detailed questions will be shared with a sample of private sector stakeholders and discussed in one or more focus group discussions, organised by the IHP+R national expert. Information

provided by private sector stakeholders (anonymous if so preferred) will be synthesised by the national expert in a short report, to be validated by the participating private sector stakeholders. The process of data collection and analysis should be coordinated by the Ministry of Health, with support by the national expert and in partnership with the GPEDC focal point as far as possible (see Annex 2 for a list of relevant contacts); this should help to minimise transaction costs associated with this qualitative exercise. How will the data be analysed and used?

4.6 Country profiles and country reports

Analysis of IHP+ progress at country level will be presented in the form of country profiles (a one or two pager summarising country performance) and a PowerPoint presentation. In addition a brief country report will be developed presenting performance, national discussion of findings and national proposed actions.

4.7 Discussion of findings at country level

The discussion of the findings at country level is a key component of the 2016 Monitoring Round. How the findings will be discussed may be different in each country. Joint Annual Reviews (JARs) could be one of the main country-level fora for discussion of results and mutual accountability efforts. Another forum could be the sector forum where main health policy and health strategies are being discussed with stakeholders.

IHP+R will tailor its analysis and presentation of country-level data for use in Joint Annual Reviews or equivalent forums. Given the importance of promoting discussion on findings from this process, in contrast with previous monitoring rounds, **IHP+R** will be contracted to the end of 2016 - substantially beyond the completion of data collation, analysis and reporting. This is to ensure that **IHP+R** has time and resources to support an in-country dialogue.

4.8 Integration of data collection and discussion of findings on development cooperation effectiveness in national systems and fora

During data collection, government and DPs will be invited to discuss the opportunity to integrate a selection of indicators into the national or sector performance framework and in the existing national mechanisms or fora for discussion of performance. This would strengthen accountability at national level; give higher priority to the efforts of government and DPs to improve their performance; allow local follow-up of progress and monitor actions taken on an annual basis; and reduce local transaction costs of global monitoring exercises.

In those countries willing to integrate monitoring of development cooperation effectiveness, IHP+R will support the government to achieve this by providing national (and if required international) expertise to support the national brainstorming on best modalities for integration, taking into account local context and develop concrete proposals for adapting national systems.

Countries are invited to inform IHP+ R by May 31 whether they would like support from IHP+R. This support would be provided between June and December 2016, depending on the country's preference.

4.9 Global report

Country-level data will be synthesised in a global report, to be contracted separately by the IHP+ core team. The report will cover three key outputs:

1. Evidence from participating countries on how governments and donors are performing both individually and as a group in terms of behaviour and resource allocation. And on how CSOs and private sector maximise / optimise their engagement. This will cover quantitative and qualitative analysis based on data collected, as described above.

2. A global level review of agencies' policies, regulations, procedures and practices in terms of how far they make compliance with effective development cooperation practices a requirement or default option for their support in health. This will also be contracted separately by the IHP+ core team.
3. Experience in the use of country-level data, as supported by **IHP+R**, described above.

5 Where can I get help with IHP+ monitoring?

All participating signatories will receive proactive and flexible support in the 2016 monitoring round by a national expert or institution who will be supported by an international point person of **IHP+R**. Furthermore, **IHP+R** will provide a range of helpdesk functions to support the countries in the data collection and discussion of findings process.

Depending on your query, the helpdesk will help you out directly through email, Skype or phone. If the question requires higher-level support the helpdesk will forward your request to the dedicated **IHP+R** contact person for your country or agency (see Annex 4 for a list of **IHP+R** contact persons).

Documents such as this guidance document, data collation tools, and toolbox documents are available at www.ihpplusresults.org. At a later stage the IHP+ website will provide monitoring data in different formats.

Contact: helpdesk@ihpplusresults.org

Annexes

The following Annexes accompany the 2016 IHP+ Monitoring Guide for Participants and associated data collation tools. They provide detailed information on the agreed monitoring framework that will guide the 2016 IHP+ monitoring process. They are intended for use by participants in the monitoring process, designed to promote consistency of interpretation for key definitions and terminology relating to the monitoring framework. The Annexes cover the following content:

Annex		Page No.
1	Detailed guidance on key terms and definitions for the agreed monitoring framework	16
2	List of IHP+ and GPEDC focal points in participating IHP+ countries	32
3	Detailed methodology for quantitative indicators	34
4	Data collection tools	39

5.1 Annex 1. Detailed guidance on key terms and definitions for the agreed monitoring framework

Annex 1 provides detailed information about each of the indicators in the agreed monitoring framework for the 2016 round of IHP+ monitoring. The Annex is structured as follows:

Effective development cooperation practices in the health sector: The Seven Behaviours	Page No.
1. A strong national health strategy is supported by both government and development partners; they agree on priorities reflected in the national health strategy, and underpinning sub-sector strategies, through a process of inclusive development and joint assessment, and a reduction in separate exercises.	14
2. Resource inputs are recorded on the national health budget and in line with national priorities, with predictability of government and development partner funding.	15
2a Predictability - disbursement vs scheduled expenditure	15
2b Predictability - forward expenditure plans	16
2c Aid on budget	19
3. Financial management systems are harmonized and aligned; requisite capacity building done or underway, and country systems strengthened and used.	21
4. Procurement/supply systems are harmonized and aligned, parallel systems phased out, country systems strengthened and used with a focus on best value for money. The definition of national ownership can include use of global procurement systems..	24
5. Joint monitoring of process and results is based on one information and accountability platform; joint processes for mutual accountability on EDC are in place, such as Joint Annual Reviews or compact reviews.	25
6. Technical support is strategically planned and provided in a well-coordinated manner; opportunities for systematic learning between countries are developed and supported by agencies through south-south and triangular cooperation.	26
7. Civil society operates within an environment which maximizes its engagement in and contribution to health sector development	27
8. Private sector has the space to participate in the development and implementation of effective, efficient and equitable health policies	28

For each indicator the following information is provided:

- **General definitions:** terms that are important for the consistent interpretation of the indicator
- **Government indicator definitions:** terms that are specific to the Government indicator and important for the consistent interpretation
- **Development Partner indicator definitions:** terms that are specific to the DP indicator and important for the consistent interpretation
- **Additional information:** information not covered above and which respondents need to know for the consistent completion of the data collation tool or understanding of intended work for each indicator.

Documents such as this guidance document, data collation tools, and other documents are available at www.ihpplusresults.org and on the IHP+ website.

Further support is available from a dedicated **IHP+R** national expert who will support the data collation exercise and the discussion of findings in your country; as well as from the **IHP+R** team (see Annex 2): helpdesk@ihpplusresults.org

5.1.1 INDICATOR 1G/1DP: USE OF NATIONAL HEALTH STRATEGIES

The indicators on alignment with national plans will be tracked through use of a qualitative assessment, which can be seen at Annexes 4.1 and 4.2.

The purpose of this indicator is to verify whether a strong single national health strategy is in place and supported by both government and development partners; whether they agree on priorities reflected in the national health strategy and underpinning sub-sector strategies, through a process of inclusive development and joint assessment, and a reduction in separate exercises.

General Definitions:

A National Health Sector Plan or Strategy provides a common strategic framework to guide all interventions by all parties involved in the national health system during a specific period. These strategies/plans are typically prepared to cover a clearly identified period of time, often covering four to eight years. The quality of these national development strategies in operational terms depends on the extent to which they constitute a unified strategic framework to guide the country's health policy and include strategic priorities linked to a medium-term expenditure framework and reflected in annual budgets. They are expected to have been developed through an inclusive consultative process involving the full range of relevant development stakeholders at country level, as to ensure legitimacy and sustainability of national development plan in the medium term.³

Joint Assessments of National Strategies (JANS): Joint assessment is a shared approach to assessing the strengths and weaknesses of a national strategy. IHP+ partners have developed a process for the Joint Assessment of National Strategies (JANS) with the intention that a JANS assessment is accepted by multiple stakeholders, and can be used as the basis for technical and financial support. In this definition, a plan has been jointly assessed if the JANS process, or a similar joint assessment, has been completed.

Sub-sector or sub-programme level refers to a specific aspect within the health sector. This can be for example a health programme (e.g. maternal health or Nutrition) or an institutional level (e.g. District-level or Primary Care Provision) or at a health system building block (e.g. human resources for health; health information; pharmaceutical supplies).

5.1.2 INDICATOR 2Ga/2DPa: HEALTH DEVELOPMENT CO-OPERATION IS MORE PREDICTABLE

The indicator on health development co-operation is more predictable will be measured through a quantitative assessment tool, available in Annex 3.

The purpose of this indicator is to measure whether the resources for the health sector from both the Government and the Development Partners are predictable. It focuses on predictability of development co-operation within a reporting year.

General Definitions:

The ability to predict aid flows is related to aid reliability which is the extent to which partner countries can rely on donor pledges/being translated into actual flows is a major component of predictability. Note that reliability is related to the existence of clear rules governing aid disbursements. If rules are clear (e.g. the pre-conditions for disbursement) then aid is more predictable – variations between what was anticipated and what actually occurred can be explained with reference to the rules in operation.⁴

³ Source: adapted from GPEDC 2015 Monitoring Guide.

⁴ Source: OECD (2011). Aid Predictability – Synthesis of Findings and Good Practices.

Definitions for Government indicator (2Ga):

What does the indicator measure?

The intention of this indicator is to track the disbursement of available resources (or budget execution), as indicated by the amount of the overall health budget (domestic and external resources) that is disbursed.

Definitions:

Approved annual budget for the health sector: is the annual budget as it was originally approved by the legislature. In order to support discipline and credibility of the budget preparation process, subsequent revisions to the original annual budget — even when approved by the legislature — *should NOT be recorded* here. This is because it is the credibility of the original, approved budget that is important to measure and because revisions to the annual budget in many cases are retroactive.

Under disbursement occurs when the amount that was budgeted is not fully disbursed.

Over disbursement occurs when more funding was disbursed as compared to what was approved in the budget.

Balanced budget: a budget where there are no under or over disbursements.

Definitions for Development Partner indicator (2DPa):

What does the indicator measure?

This indicator focuses on predictability of development co-operation within a reporting year. In doing so, it recognises that shortfalls in the total amount of funding for the government sector and delays in the annual disbursements of scheduled funds can have serious implications for a government's ability to implement development policies and strategies as planned. This indicator measures the gap between development co-operation funding scheduled by DPs and development co-operation funding effectively disbursed as reported by the DP.

Definitions:

Health sector development cooperation: Health sector development co-operation funding includes all transactions undertaken with the promotion of economic development and welfare as the main objective. This includes Official Development Assistance (ODA), as defined in OECD-DAC Statistical Directives (OECD, 2013)¹², including grants or loans to developing countries which are concessional in character (if a loan, having a grant element of at least 25%).

Health sector development co-operation funding for the government sector scheduled for disbursement. Health sector development co-operation funding is considered to have been "scheduled for disbursement" when notified to government within the reporting year of reference n-1; it includes health sector development co-operation funding scheduled for disbursement in agreements entered during year n.

5.1.3 INDICATOR 2Gb/2DPb: HEALTH DEVELOPMENT CO-OPERATION IS MORE PREDICTABLE (MID-TERM)

The indicator on health development co-operation is more predictable will be measured through a quantitative assessment tool, available in Annex 6.

The purpose of this indicator is to measure whether the resources for the health sector from both the Government and the Development Partners are predictable. It focuses on predictability of development co-operation for the next 3 years.

General Definitions:

The ability to predict aid flows is also related to aid transparency which is important for reliability (see above), since accurate prediction is hampered if the rules of the game are obscure. The timely availability of information on expected future aid flows, with the appropriate degree of detail, is an important element of predictability. Aid volatility: Aid is volatile when fluctuations in aid flows are large, relative to the volume involved. Aid may fluctuate but still be predictable if the fluctuations can be foreseen.⁵

Definitions for Government indicator (2Gb):

What does the indicator measure?

This indicator focuses on medium-term predictability of government resources for the health sector.

MTEF: Medium Term Expenditure Framework (MTEF) - A set of broad principles for sound budgeting that are implemented in different ways in different institutional settings. An approach that links expenditure allocations to government policy priorities using a medium-term (i.e. three to five year time horizon) budget planning and preparation process, and typically with the following core elements⁶:

- **A unified, whole-of-government' approach.**
- **A 'top-down' hard budget constraint** consistent with macroeconomic sustainability that limits overall levels of spending over the medium-term. This should involve credible, realistic resource projections that are in turn based on explicit and carefully considered macroeconomic assumptions.
- **Top-down set of strategic policy priorities.**
- **'Bottom-up' forward estimates** of the costs of existing policies, programmes and activities over the medium-term supported by expenditure reviews.
- **A single nationally owned political process** at the centre of government that reconciles the bottom-up and top-down components, forcing policy priorities to be established within the overall resource constraint through resource allocation decisions.
- **A strong and clear link between MTEF projections and the annual budget process**, so that multi-annual targets (duly updated for changes in the macroeconomic situation) set in the previous years should form the basis upon which the budget is prepared.
- **A focus on results** (i.e. outputs and outcomes) rather than on financial inputs both in the structure of the budget and in terms of accountability.

In place: Has been finalised and adopted by the government – ie not under development.

Definitions for Development Partner indicator (2DPb):

NB: Data for DP performance on 2DPb will be provided by Governments.

What does the indicator measure?

This indicator focuses on medium-term predictability of development co-operation. In doing so, it recognises that lack of comprehensive and credible forward information on development co-operation funding can have serious implications for a government's ability to plan and implement policies and strategies, deliver public services and design and conduct sound macro-economic policy.

This indicator measures whether developing country governments have at their disposal a forward expenditure and/or implementation plan for each provider of development co-operation over the period of the next three years (2016-2017-2018). Such plans must cover all known components of the co-operation provider's country programme. For example, they cover all development co-operation modalities used by that provider (e.g. budget support, projects, technical co-operation, in-kind aid) and include estimates of

⁵ Source: OECD (2011). Aid Predictability – Synthesis of Findings and Good Practices.

⁶ <http://www.oecd.org/env/outreach/42942138.pdf>

future flows that have yet to be allocated to specific activities or signed in co-operation agreements (i.e. “unallocated” resource envelopes, which will be provided to the developing country, but where the modality/sector/activity of spending has yet to be decided).

Definitions

Health sector development cooperation: Health sector development co-operation funding includes all transactions undertaken with the promotion of economic development and welfare as the main objective. This includes Official Development Assistance (ODA), as defined in OECD-DAC Statistical Directives (OECD, 2013), including grants or loans to developing countries which are concessional in character (if a loan, having a grant element of at least 25%).

Comprehensive forward spending and/or implementation plan. The developing country government should, for every DP participating in the global monitoring process, establish whether or not it holds information on that DP’s forward spending and/or implementation plans in the country. The IHP+ focal point /reporting entity should ascertain whether adequate information has been received from each DP.

A forward spending and/or implementation plan meets **ALL THREE** of the following criteria:

1. Made available by the DP in written or electronic form (e.g. a single document or – where appropriate systems are made available in country – entered appropriately in an aid information management system).
2. Sets out clearly indicative information on future spending and/or implementation activities in the country, including:
 - a. programmed or committed resources, where the activity and modality is known; and
 - b. other resources that have yet to be allocated to specific activities in the country.
3. Amounts are presented by year (or in greater detail – e.g. by quarter or month) using the developing country’s fiscal year.

Expected development co-operation flows in fiscal year ending in year 2016, 2017 and 2018. A plan may be available which meets all of the criteria above, but the information provided may vary for different years. In responding to question 3 of the Government data collation tool IHP+ focal points should examine the data for each year. (The reason for this is that a forward spending/implementation plan may provide comprehensive information for next year, but not the following year).

For each year, answer 1 (“Yes”) if the information provided meets **BOTH** of the following additional criteria:

1. Comprehensive in its coverage of types and modalities of support (for example, a DP using both project and budget support modalities should include the amounts foreseen under both modalities); and
2. The amount and currency of development co-operation funding is clearly stated (where support takes the form of technical co-operation and the provision of goods and services in kind, the cost of these planned activities is provided).

Where these above additional criteria are NOT met for a given year, or where the three criteria defining a forward spending / implementation plan (definition above) are NOT met, answer 0 (“No”).

NB: In the spirit of this indicator, respondents are asked to provide data based on the availability of forward spending information at the time of completing the data collation tool (which may differ from the reporting fiscal year).

5.1.4 INDICATOR 2Gc/2DPc: HEALTH SECTOR DEVELOPMENT COOPERATION IS ON BUDGET

This indicator tracks whether resource inputs are recorded on the national health budget and in line with national priorities.

NB: It is worth emphasising that, as with a number of indicators, performance against this indicator can be attributed to the efforts of *both* developing country governments and their DPs. The aim of the indicator is to offer insight into how – together – they facilitate domestic oversight of aid. It is intended to offer a starting point for broader dialogue on parliamentary oversight of aid, rather than a narrow “scorecard” of either developing country governments’ or co-operation DPs’ efforts

Definitions for Government indicator (2Gc):

What does the indicator measure?

The purpose of this indicator is to track whether the national budget reflects the resources for the health sector including the contributions of the development partners.

Definitions

Contributions of development partners included in the annual budget: the national budget for the health sector stipulates how much funding is available from each of the development partners for the fiscal year in question.

Definitions for Development Partner indicator (2DPc):

What does the indicator measure?

The formulation of the budget is a central feature of the policy process in all countries. So the degree to which financial contributions from providers of development co-operation to the government sector are fully and accurately reflected in the budget provides a significant indication of the degree to which there is a serious effort to connect development co-operation programmes with country policies and process and to support domestic oversight and accountability for the use of development co-operation funding and results. Budget support is always on budget, but other modalities including project support can and should also be recorded on budget, even if funds do not pass through the country’s treasury.

The indicator tries to capture the extent to which budgets cover resources expected at the time of their formulation. The denominator is now the amount of development co-operation funding scheduled for disbursement at the outset of year n, rather than ex-post disbursements. This separates the measurement of the extent to which government budgets reflect ex-ante aid estimates (indicator 2DPc) from the measurement of predictability, that is the extent to which scheduled funds are actually disbursed or the realism of estimates (captured by indicator 3DPa).

Definitions

Health sector development cooperation: Health sector development co-operation funding includes all transactions undertaken with the promotion of economic development and welfare as the main objective. This includes Official Development Assistance (ODA), as defined in OECD-DAC Statistical Directives (OECD, 2013), including grants or loans to developing countries which are concessional in character (if a loan, having a grant element of at least 25%).

Annual budget: the annual budget as it was originally approved by the legislature. In order to support discipline and credibility of the budget preparation process, subsequent revisions to the original annual budget — even when approved by the legislature — **should NOT be recorded** under question Q6 in the DP excel tool. This is because it is the credibility of the original, approved budget that is important to measure and because revisions to the annual budget in many cases are retroactive.

Agreed financing framework is an agreement between different stakeholders (i.e. Development Partners) on how to finance a specific sector, sub-sector or sub-programme. An example is the Joint Financing Arrangement, signed by many development partners in Nepal.

5.1.5 ADDITIONAL MODULE ON HUMANITARIAN AID FOR HEALTH

This indicator tracks whether the humanitarian system, including government and relief agencies, is able to plan ahead and can determine quickly how resources can be allocated to best meet emerging humanitarian priorities.

2 different Government qualitative tools exist:

- **IHP+ 2016_GOV QUAL SURVEY tool_160330:** This tool includes a question concerning the government **plan for health emergencies**. This is a standard plan and applies to all countries – the question should be completed by all country governments.
- **IHP+ 2016_GOV QUAL SURVEY_Humanitarian Aid tool_160330:** This tool includes 2 additional questions related to humanitarian aid are only applicable to countries which received a significant amount of humanitarian assistance for the health sector in the fiscal year 2013, 2014 or 2015. A *significant amount of humanitarian aid for health means equivalent to **at least 10% of the government health sector budget***. IHP+R will indicate in which specific countries questions 2 and 3 need to be answered by government.

3 different Development partner qualitative tools exist:

- **IHP+ 2016_DP QUAL SURVEY_STANDARD_for all DPs_160330:** This tool will be filled out by all DPs in those countries where there is *no significant amount of humanitarian aid for the health sector*. These are the majority of the countries.
- **IHP+ 2016_DP QUAL SURVEY_HUM AID_for DPs_160330:** Question 1 is covered in the quantitative tool and the answer copied in the qualitative tool. The question enquires about the amount of humanitarian aid that was provided by the DP in question. It applies only to the countries where a *significant amount of humanitarian aid for health equivalent to **at least 10% of the national health sector budget*** is provided. IHP+R will indicate in which countries this question needs to be answered by DPs.
- **IHP+ 2016_DP QUAL SURVEY_HUM AID_for Cluster Coordinating Agency_160330:** This tool is developed specifically for the Health Cluster Coordinating Agency in countries where there is significant amounts of humanitarian aid for the health sector. The Health Cluster Coordinator is often either WHO or UNICEF. Questions 2 to 5 enquire specifically about the overall humanitarian budget for the health sector and the implementation of the response plan.

3 different Development partner quantitative tools exist:

- **IHP+2016_DP Survey Tool EN_Standard tool for DPs_160330 final draft:** This tool will be filled out by all DPs in those countries where there is *no significant amount of humanitarian aid for the health sector*. These are the majority of the countries.
- **IHP+2016_DP Survey Tool EN_Humanitarian Aid_for DPs_160330 final draft:** This tool will be filled out by the DPs in in countries where *a significant amount of humanitarian aid for health equivalent to at least 10% of the national health sector budget is provided*. IHP+R will indicate in which countries the DPs will be invited to fill out this tool.
- **IHP+2016_DP Survey Tool EN_Humanitarian Aid_for Cluster Coordinator_final draft:** This tool will be filled out by the Health Cluster Coordinating Agency in countries where *a significant amount of humanitarian aid for health equivalent to at least 10% of the national health sector budget is provided*. IHP+R will indicate in which countries the Cluster Coordinating Agency will be invited to fill out this tool.

Definitions for Government indicator (2H-G):

What does the indicator measure?

The purpose of this indicator is to track to what extent the government is prepared to respond to health emergencies.

Definitions

Plan for health emergencies: A plan for health emergencies is a proactive plan to deal with unforeseen emergencies such as in case of **disease outbreaks, earthquakes, flooding, etc.** Often countries have an early warning system in place to detect such health emergencies, which triggers the activation of the emergency plan. Each country is supposed to have such an early warning system (often supported by WHO) and plan in place.

Emergency response plan: The emergency response plan (ERP; also called **humanitarian action plan or strategic response plan (SRP)**) articulates the shared vision of how to respond to the affected population's assessed and expressed needs. It plans for the implementation of humanitarian aid. The strategic response plan is a management tool for response and supports decision-making by the humanitarian country team. It has two interlinked components: a country or context strategy, with strategic objectives and indicators; and cluster plans, with objectives, activities and accompanying projects. Together they detail how the strategy will be implemented and how much funding is required.⁷ As a standard the emergency response plan covers all sectors including health. It specifies the health cluster plan, activities, resources, etc. Usually WHO is the coordinator for the health cluster and UNICEF for the nutrition cluster. Only countries receiving humanitarian aid have a humanitarian aid action plan (ERP; SRP).

Health emergencies: A "public health emergency" may be defined as an event, either natural or manmade, that creates a health risk to the public. Health emergencies include disease outbreaks, health care for refugees, health response to natural disasters, etc.

Humanitarian aid budget for health: is the budget that is included in the annual budget to be able to respond to health emergencies.

Humanitarian Aid for Health: is an intervention to help people who are victims of a natural disaster or conflict meet their basic health needs and rights. The financial or material aid is earmarked to be used by the health sector and can consist of direct assistance, indirect assistance or infrastructure support. Humanitarian assistance must be provided in accordance with the basic humanitarian principles of humanity, impartiality and neutrality, as stated in General Assembly Resolution 46/182.

Definitions for Development Partner indicator (2H-DP):

What does the indicator measure?

The purpose of this indicator is to track to what extent the DPs disbursed the humanitarian aid for health in the fiscal year for which it was scheduled.

Definitions

Humanitarian aid contributed for the health sector: is the payment or transfer of funds or in-kind goods from the donor to the appealing/recipient organisation (this can be the partner Government but also CSO organisations, UN organisations or other entities) resulting from a commitment. This funding or in-kinds goods are earmarked to be used for addressing health needs or rights.

Humanitarian aid committed: is a contractual obligation regarding funding between the donor and appealing organisation/recipient. It almost always takes the form of a signed contract. This is the crucial stage of humanitarian funding: organisations cannot spend money and implement before a funding commitment is made; once it is made, they can begin spending against it, using cash reserves.

⁷ Source: www.humanitarianresponse.info

5.1.6 INDICATOR 3: EFFECTIVE INSTITUTIONS: DEVELOPING COUNTRIES' PUBLIC FINANCIAL MANAGEMENT SYSTEMS ARE STRENGTHENED AND USED

This indicator assesses whether the financial management systems are harmonized and aligned; whether requisite capacity building was done or is underway, and whether country systems are strengthened and used.

General Definitions:

Country Policy and Institutional Assessment (CPIA): The Country Policy and Institutional Assessment (CPIA) assess the quality of a country's present policy and institutional framework. "Quality" refers to how conducive that framework is to fostering poverty reduction, sustainable growth, and the effective use of development assistance⁸.

The following three dimensions are rated by the World Bank using established criteria:

- a. a comprehensive and credible budget, linked to policy priorities;
- b. effective financial management systems to ensure that the budget is implemented as intended in a controlled and predictable way; and
- c. timely and accurate accounting and fiscal reporting, including timely and audited public accounts and effective arrangements for follow up.

All three dimensions are given equal weighting. See World Bank (2010) for the detailed criteria underpinning each dimension. The higher the score, the more reliable the country's budget and financial management systems.

Definitions for Government indicator (3G):

What does the indicator measure?

This indicator tracks whether the country public financial management systems: (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.

Definitions

Public Financial Management Systems (PMF) is the country system to manage financial resources. It includes four components, the first three of which are focused on PFM (the fourth one is assessed in indicator 4):

⁸ See: <http://data.worldbank.org/indicator/IQ.CPA.FINQ.XQ>

- a. national budget execution procedures;
- b. national financial reporting procedures;
- c. national auditing procedures; and
- d. national procurement procedures.

Legislative frameworks normally provide for specific types of financial reports and audit reports to be produced as well as periodicity of such reporting. The use of national financial reporting and/or auditing means that donors (in principle) do not impose additional requirements on governments for financial reporting and/or auditing.

Broadly accepted good practices: The objective indicator that IHP+R is using is drawn directly from the CPIA scale of performance, as described above. The CPIA assessments are completed annually, and data is available on a country basis on the World Bank website (from 2005).

Reform programme in place: the government has a plan in place to strengthen the PMF system, which is supported by the DPs.

Definitions for Development Partner indicator (3DP):

What does the indicator measure?

This indicator focuses on the use of developing countries' public financial management (PFM) systems when funding from providers of development co-operation is provided to the government sector, without applying safeguard measures. National systems for the management of funds are those established in the general legislation (and related regulations) of the country and implemented by the line management functions of the government.

No particular development co-operation modalities automatically qualify as using country PFM. Most modalities including project support can be designed to use country PFM. A set of criteria are presented below to help DPs determine when they are, and when they are not, using country PFM and procurement systems.

Definitions

Health sector development cooperation: Health sector development co-operation funding includes all transactions undertaken with the promotion of economic development and welfare as the main objective. This includes Official Development Assistance (ODA), as defined in OECD-DAC Statistical Directives (OECD, 2013)¹², including grants or loans to developing countries which are concessional in character (if a loan, having a grant element of at least 25%).

In addition, developing countries are encouraged to also include non-concessional official development flows, defined as development co-operation funds coming from bilateral or multilateral official sources – provided that the main objective is the promotion of economic development and welfare.

Disbursed for the government sector: Health sector development cooperation disbursed in the context of an agreement with administrations (ministries, departments, agencies or municipalities) authorised to receive revenue or undertake expenditures on behalf of central government. This includes works, goods or services delegated or subcontracted by these administrations to other entities such as:

- Non-Governmental organisations (NGOs);
- Semi-autonomous government agencies
- Private companies

Use of national budget execution procedures: DPs or development co-operation use national budget execution procedures when the funds they provide are managed according to the national budgeting procedures established in the general legislation and implemented by government. This means that programmes supported by DPs are subject to normal country budgetary execution procedures, namely

procedures for authorisation, approval and payment. DPs are invited to review all their health sector development co-operation activities with a view to determining how funding for the government sector meet three **out of the four criteria** below (anything less does not qualify):

1. Are your funds **included in the annual budget** approved by country legislature? (Y/N)
2. Are your funds subject to established country **budget execution procedures**? (Y/N)
3. Are your funds processed (e.g. deposited & disbursed) through the **established country treasury system**? (Y/N)
4. You do NOT require the **opening of separate bank accounts** for your funds? (Y/N).⁹

Use of national financial reporting procedures: Legislative frameworks normally provide for specific types of financial reports to be produced as well as periodicity of such reporting. The use of national financial reporting means that DPs do not impose additional requirements on governments for financial reporting. In particular DPs do NOT require: i) maintenance of a separate accounting system to satisfy the DP's reporting requirements, and ii) creation of a separate chart of accounts to record the use of funds from the DP.

DPs are invited to review all their development activities with a view to determining how much health sector funding for the government sector meet BOTH criteria below (anything less does not qualify):

1. You do NOT require maintenance of a **separate accounting system** to satisfy your own reporting requirements? (Y/N)¹⁰
2. You ONLY require financial reports prepared using **country's established financial reporting arrangements**? (Y/N)

Use of national auditing procedures. DPs rely on the audit opinions, issued by the country's supreme audit institution, on the government's normal financial reports/statements as defined above. The use of national auditing procedures means that DPs do not make additional requirements on governments for auditing. DPs are invited to review all their health sector development activities with a view to determining how much health sector development co-operation funding for the government sector meet **BOTH criteria** below¹¹ :

1. Are your funds subject to audit carried out **under the responsibility of the Supreme Audit Institution**? (Y/N)
2. You do **NOT** under normal circumstances **request additional audit arrangements**¹²? (Y/N)¹³

AND at least one of the two criteria below:

3. You do NOT require **audit standards different** from those adopted by the Supreme Audit Institution? (Y/N)¹⁴
4. You do NOT require the Supreme Audit Institution to change its **audit cycle** to audit your funds? (Y/N)¹⁵

⁹ Budget execution — **Yes:** you do not require opening separate accounts. **No:** you do require opening separate accounts.

¹⁰ Financial reporting — **Yes:** you do not require a separate accounting system. **No:** you do require a separate accounting system.

¹¹ Note: where development co-operation funding is provided to parastatal entities (for example, public enterprises) and these entities are not subject to audit by the Supreme Audit Institution, the following criteria should be considered: DPs of development co-operation are invited to review all their development activities with a view to determining how much development co-operation funding for the government sector meet BOTH of the following criteria: 1. Are your funds subject to audit carried out under the regular audit procedures established for the audit of parastatal entities? (Y/N) 2. You do NOT under normal circumstances request additional audit arrangements? (Y/N) AND at least one of the two of the following criteria: 3. You do NOT require audit standards different from those adopted by the partner country for the audit of parastatal entities? (Y/N) 4. You do NOT require a change in the audit cycle of the parastatal entity to audit your funds? (Y/N)

¹² Reserving the right to make an exceptional audit (e.g. when fraud or corruption is discovered) does not count against this criteria.

¹³ **Yes:** DPs do not require additional audits. **No:** DPs do require additional audits.

¹⁴ **Yes:** DPs do not require different audit standards. **No:** DPs do require different audit standards.

¹⁵ **Yes:** DPs do not require to change the audit cycle. **No:** DPs do require change to the audit cycle.

5.1.7 INDICATOR 4: DEVELOPING COUNTRIES' PROCUREMENT SYSTEMS ARE STRENGTHENED AND USED

This indicator assesses whether the procurement and supply systems are harmonized and aligned; whether parallel systems are phased out, country systems strengthened and used with a focus on best value for money.

General Definitions:

Procurement is defined as the overall process of acquiring goods, works and services including functions from the identification of needs, solicitation and selection of sources, preparation and award of contract, and all phases of contract administration through to the end of a contract. For the purpose of this questionnaire it does **exclude technical assistance**.

Public procurement is procurement falling under the jurisdiction of a Government or other public sector organisation including all entities that use public funds. In practical terms public procurement ranges from the buying of fuel to construction of roads and highways, from school books to medicines and from office supplies to consulting services.

Definitions for Government indicator (4G):

What does the indicator measure?

This indicator assesses the extent to which a government-led plan for procurement and supply systems exists and is supported by development partners.

Definitions

National procurement and supply system: The national procurement system is the overall framework for public procurement in a country including the legal framework, organisational set-up including arrangements for control and oversight, as well as the procedures and practices.

Use of global or regional procurement systems: National ownership of the procurement and supply system can include using global procurement systems (such as for example GAVI), providing this has been a decision taken by the Ministry of Health.

Definitions for Development Partner indicator (4DP):

What does the indicator measure?

This indicator assesses the extent to which procurement/supply systems are harmonized and aligned; and national systems or used or strengthened.

Definitions

Harmonization and alignment with procurement and supply systems: DPS harmonise their procurement and supply systems instead of maintaining agency-specific separate procurement and supply systems. They reduce the number of parallel systems.

Use national procurement systems: DPs use national procurement systems when the funds they provide for the implementation of projects and programmes (e.g. for the procurement of medicines or ambulances) are managed according to the national procurement procedures as they were established in the general legislation and implemented by government. The use of national procurement procedures means that DPs do not make additional, or special, requirements on governments for the procurement of works, goods and services (where weaknesses in national procurement systems have been identified, providers of development co-operation may work with developing countries in order to improve the efficiency, economy, and transparency of their implementation).

Strengthening of national procurement and supply systems: DPs support the strengthening or development of national / public procurement and supply systems when they provide financial or technical support to improve the national / public procurement systems in place.

5.1.8 INDICATOR 5: MUTUAL ACCOUNTABILITY IS STRENGTHENED

This indicator tracks whether the joint monitoring of progress and results is based on one information and accountability platform; and whether joint processes for mutual accountability on EDC, such as Joint Annual Reviews or compact reviews, are in place.

General Definitions:

Mutual Accountability: is a situation where two or more parties (i.e. governments, donors and involved stakeholders) have shared development goals, in which each has legitimate claims the other is responsible for fulfilling and where each may be required to explain how they have discharged their responsibilities, and be sanctioned if they fail to deliver.

M&E: Monitoring, evaluation and review of activities of the national health strategy. The purpose of monitoring and evaluation (M&E) is to know whether activities are being implemented and the intended results are being achieved as planned in the national health sector strategy or plan, and whether health interventions are making positive contributions towards improving people's health..

M&E plan for health sector: Is an integral part of the national health strategy that addresses all the monitoring and evaluation activities of the strategy. It institutionalises the use of M&E as a tool for better public sector management, transparency and accountability. The purpose of the sector monitoring and evaluation plan or system is to coordinate and support the MoH, related Ministries, Development Partners and stakeholders to regularly and systematically track progress of implementation of priority interventions of the strategic plan and assess performance of the sector in accordance with the agreed objectives and performance indicators as specified in the M&E framework

Compact or partnership agreement: A document which sets out agreed approaches to the delivery of development co-operation in the partner country, containing agreed principles, processes and/or targets designed to improve its effectiveness. This may take the form of a stand-alone policy or strategy document, or may be addressed within another document (for example, as part of a national development strategy or similar). The document has been the subject of an inclusive consultation between the partner country government, development partners and other interested development stakeholders.

Joint Annual Review (JAR): is a process that can be part of monitoring and planning the implementation of the health sector strategic plan. The JAR helps to identify whether the plan is on track and the strategies are adequate to achieve the intended results. The term 'Joint' refers to a range of stakeholders interested in health sector performance and participating in the review.

Mid-term Review (MTR): a MTR aims to assess the continued relevance of an intervention and the progress made towards achieving its planned objectives. It provides an opportunity to make modifications to ensure the achievement of these objectives within the lifetime of the project. In addition MTRs provide an opportunity to ascertain if the intervention is still coherent with the strategic objectives; is relevant and useful to the key stakeholders and is being conducted in an efficient manner.

5.1.9 INDICATOR 6/COORDINATED TECHNICAL ASSISTANCE AND SOUTH-SOUTH/TRIANGULAR COOPERATION

This indicator tracks whether technical support is strategically planned and provided in a well-coordinated manner; and whether opportunities for systematic learning between countries are developed and supported by agencies (south-south and triangular cooperation).

General Definitions:

Technical assistance (TA): can be aimed at delivering different objectives that impact individuals, systems and organisations¹⁶:

- Capacity substitution/gap filling – the use of TA to undertake tasks and duties that would normally fall to a regular member of staff
- Capacity supplementation – the use of TA to provide time-limited advice and guidance for existing members of staff, often on particularly challenging areas of decision-making. All organisations make use of this.
- Capacity development – the use of TA to explicitly transfer skills, knowledge and capability to permanent staff members.

National Technical Assistance (TA) or Capacity Development Plan: sets out how technical assistance is going to be procured, provided and used to strengthen national systems and capacity. It is linked to the health strategic plan and / or the human resource development plan.

South-South Cooperation (SSC) refers to a partnership in which two or more South countries pursue their individual and/or shared national or institutional capacity development objectives. The common factor is that all arrangements should be country-led and based on exchanges of knowledge, skills or technical know-how through collective actions and inclusive partnerships, involving governments, civil society, academia or the private sector, for the individual or mutual benefit of the countries involved¹⁷.

Triangular Cooperation (TrC) refers to an SSC partnership as defined above that is assisted by a development partner of one of the OECD-DAC member countries, an emerging economy, a multilateral agency, international foundation, or international NGO. The assistance may be in the form of financial, technical or administrative support¹⁸.

5.1.10 INDICATOR 7: CSO ENABLING ENVIRONMENT

This is a new indicator. The methodology for measuring this indicator has been developed by the GPEDC monitoring process, including piloting at country level. A description of the methodology is provided below, and the tools for collecting responses from the three key stakeholder groups (government, development partners and CSOs) are included at Annex 4. Each qualitative tool (Government, DP and CSO) includes specific questions to assess progress against this indicator.

The process of data collection and analysis will be coordinated by the Ministry of Health, with support of the national expert and IHP+ focal point as far as possible (see Annex 3 for a list of relevant contacts); this should help to minimise transaction costs associated with this qualitative exercise.

What does the indicator measure?

This indicator seeks to assess the extent to which Civil Society Organisations operate within an environment that maximises its engagement in and contribution to health sector development.

¹⁶ Source: IHP+ (2014): Demand and supply of technical assistance and lessons for the health sector.

¹⁷ Source: IHP+ (2014), South-South and Triangular Cooperation in Health Current status and trends.

¹⁸ Source: idem.

This indicator is included in the 3 different tools to seek the perspectives of the Government, Development Partners and CSO on progress against the above indicator. Progress will be measured by seeking answers on the 4 following questions:

1. What space does the Government provide for CSOs to effectively participate in health sector policy, planning and monitoring?
2. How effective are the mechanisms that assure that CSOs working in health are accountable for their contributions to effective, efficient and equitable health policies?
3. How effectively is the participation of CSOs in national health policy processes supported by international development partners?
4. How conducive is the national legal and regulatory environment to the maximisation of CSO contribution to national health policy?

See annex 4 for the specific questions in each of the qualitative tools as well as the detailed process for collecting data from CSO:

- Annex 4.1: Qualitative Government Tool: EDC Practice 7
- Annex 4.2: Qualitative Development Partner Tool: EDC Practice 7
- Annex 4.3: Qualitative CSO Tool and Process

Definitions

CSO included under this category are:

- National non-governmental and faith-based organisations and that deliver health services or that are involved in health sector advocacy or in monitoring national health policies and programmes. These include national membership organisations, civil society watchdog groups and chapters of regional and international organisations or federations that are constituted in the country as independent legal entities with a national governance structure.
- National federations or network organisations representing community-based organisations or NGOs working in health, including umbrella organisations for groups with special health service needs.
- National academic institutions that operate as policy think-tanks, independent research organisations, or providers of services in the health sector.

CSO enabling environment: The political, financial, legal and policy context that affects how CSOs carry out their work. (OECD, 2011)

Enabling law on CSO registration: Includes voluntary registration allowed for any legal, not-for-profit purpose; requiring a small number of founders and/or small amount of assets; based on reasonable, transparent, objective criteria; and providing avenues for judicial or other forms of appeal.

Health partnership processes or mechanisms are regular, predictable and transparent processes which are announced in time to allow participants' preparation and participation in the health policy dialogue. These can include technical working groups, periodic stakeholder meetings, joint assessment of health strategies, joint annual health sector reviews, preparation of major funding proposals, preparation of the health strategic plan, etc.

5.1.11 INDICATOR 8: PRIVATE SECTOR ENABLING ENVIRONMENT

This is a new indicator. A description of the methodology is provided below, and the tools for collecting responses from the three key stakeholder groups (government, development partners and CSOs) are

included at Annex 4. Each qualitative tool (Government, DP and CSO) includes specific questions to assess progress against this indicator.

The process of data collection and analysis will be coordinated by the Ministry of Health, with support of the national expert and IHP+ focal point as far as possible (see Annex 3 for a list of relevant contacts); this should help to minimise transaction costs associated with this qualitative exercise.

What does the indicator measure?

This indicator seeks to assess the extent to which the private sector operates within an environment that maximises its engagement in and contribution to health sector development.

This indicator is included in the 3 different tools to seek the perspectives of the Government, Development Partners and Private Sector on progress against the above indicator. Progress will be measured by seeking answers on the 4 following questions:

1. What space does the Government provide for professional associations and unions to effectively participate in health sector policy, planning and monitoring?
2. How effective are the mechanisms that assure that professional associations and unions are accountable for their contributions to effective, efficient and equitable health policies?
3. How effective is the support provided by development partners to professional associations and unions to foster their contribution to national health policy development, implementation and monitoring?
4. How conducive is the national legal and regulatory environment to the development and active engagement of professional associations and unions in national health policy?

See annex 5 for the specific questions in each of the qualitative tools as well as the detailed process for collecting data from Private Sector:

- Annex 4.1: Qualitative Government Tool: Indicator 8
- Annex 4.2: Qualitative Development Partner Tool: Indicator 8
- Annex 4.4: Qualitative Private Sector Tool and Process

Definitions

Private sector stakeholders included under this category are:

- Health workers' trade unions and professional associations
- Public health associations or other thematic associations of health professionals
- Organised private interest groups or organisations representing, for instance, the health insurance, private hospitals, private clinics / health centres or pharmaceutical industry in the country.

Private sector enabling environment: The political, financial, legal and policy context that affects how private sector stakeholders carry out their work.

Health partnership processes or mechanisms are regular, predictable and transparent processes which are announced in time to allow participants' preparation and participation in the health policy dialogue. These can include technical working groups, periodic stakeholder meetings, joint assessment of health strategies, joint annual health sector reviews, preparation of major funding proposals, preparation of the health strategic plan, etc.

5.2 Annex 2. List of IHP+ and GPEDC focal points in participating IHP+ countries

Country (date joined)	IHP+ Signatory contact	GPEDC Focal Point	IHP+R responsible person
Afghanistan (2014)	Noor Shah Kamawal	Sousan R. RASULI	Josef Decosas
Benin (2009)	Raymond Amoussou	Francis AMOUSSOU	Elisabeth Sandor
Burkina Faso (2009)	Bassirou Ouedraogo	Mrs. Alimatou ZONGO/KABORE	Jaak Labeeuw
Cambodia (2007)	Vandine Or	Mr. Chhieng Yanara	Alice Schmidt
Cameroon (2010)	Emmanuel Maina Djoulde; Englebert Manga	Mr. Dieudonné Takouo	Leen Jille-Traas
Cape Verde (2012)	Antonio Pedro Delgado, Tomas Valdes	Ms. Miryam VIEIRA	Anna Cirera
Chad (2011)	Aissatou Diack (TTL World Bank)	Adoum BACHAR Brahim	Olivier Weill
Comoros (2015)	Koulthoum Djamadar	No contact	Olivier Weill
Cote d'Ivoire (2012)	Samba Mamadou	Patrick Gbakou Adama SALL	Olivier Weill
DRC (2009)	Alain Iyeti	Theo KANENE MUKWANGA	Sandro Colombo
El Salvador (2011)	Fressia Cerna;Dr. Patricia Figueroa	Ana Vásquez Javier A. Flores Rubio Marcela Martínez Carranza	Anna Cirera
Ethiopia (2007)	Biruk Abate	Habtamu SHEWALEMMA Admasu Nebebe	Anna Cirera
Gambia (2012)	Mrs. Safi Lowe-Ceesay	Lamin Bojang Gaye Sulayman	Alice Schmidt
Guinea (2012)	Lamine Yansane	Ibrahima SECK	Jaak Labeeuw
Guinea Bissau (2013)	Alfa Umaru Jalo	Bamba Kote	Marieke Devillé
Liberia (2015)	Momolu Sirleaf	Frederick B. Krah	Anna Cirera
Madagascar (2008)	Tiana Lalaoarijona Vololontsoa	Isaora Zefania ROMALAHY	François Boillot
Mali (2007)	Aboubacrine Maiga	Mr. Mamadou Amadou DEMBELE, Mr. Sidiki TRAORE	Elisabeth Sandor
Mauritania (2010)	Ould Majoub Isselmou	Mr. MEJDOUB houssein	François Boillot
Mozambique (2007)	João Carlos Mavimbe	Isabel Sumar	Leen Jille-Traas

Country (date joined)	IHP+ Signatory contact	GPEDC Focal Point	IHP+R responsible person
Myanmar (2014)	TBC	U Tun Tun Naing U Myo Min	Josef Decosas
Niger (2009)	Ranao Abaché, DEP; Idrissa Maiga	Moustapha Issa MOUTARY	François Boillot
Nigeria (2008)	Ngozi Azodoh	Bassey Akpanyung Henry Asor	Alice Schmidt
Pakistan (2010)	Malik Muhammad	Zafar Hasan	Josef Decosas
Senegal (2009)	Amadou Djibril Ba	Mr. Mayacine CAMARA,	Elisabeth Sandor
Sierra Leone (2010)	Brima Kargbo	Ms. Abie Elizabeth KAMARA,	Sandro Colombo
Sudan (2011)	Mohammed Ali Yahya Elabassi; Imad Kayona	, Mariam HAIDER	Sandro Colombo
Togo (2010)	Romain Tchamdja; Hokameto Edohr	Mr. Pierre Awade, Akedague Adjoussi	Olivier Weill
Uganda (2009)	Sarah Byakika	Fredrick Twesiime Tabura	Kathy Attawell
Vietnam (2010)	Do Dang An	Cao Manh Cuong	Anna Cirera
Zambia (2007)	Amadeus Mukobe; Mubita Luwabelwa	Paul Lupunga Chasiya Kazembe	Kathy Attawell

5.3 Annex 3: Detailed methodology for measurement of quantitative indicators

5.3.1 INDICATOR 2Ga/2DPa: HEALTH DEVELOPMENT CO-OPERATION IS MORE PREDICTABLE

2a	2Ga	2DPa ¹⁹
	Governments	Development Partners
Proposed measure	Proportion of health sector funding disbursed against the approved annual budget .	Percentage of health sector development cooperation for the government sector disbursed in the fiscal year for which it was scheduled.
Indicator construction	Numerator: Total amount of funding disbursed against the approved annual budget for the health sector Denominator: Total amount of the approved annual budget for the health sector	Numerator: Health sector development cooperation flows reported by DP as disbursed in year n Denominator: Health sector development cooperation flows scheduled for disbursement by DP in year n and communicated to developing country government
Data source	Country-level: partner country government self-assessment	Country-level data (self-reporting by DPs).
Aggregation	Global	In order to avoid the situation in which under- and over-disbursements cancel each other out, disbursements “as scheduled” are presented separately from disbursements “beyond scheduled”. Aggregates are obtained as a weighted average. Scheduled disbursements is used as the weighting variable for disbursements “as scheduled”. For disbursements “beyond scheduled”, actual disbursements is used as the weighting variable. This is consistent with the approach taken in OECD (2015).
Target	Halve the proportion of health sector funding not disbursed against the approved annual budget	Halve the gap – halve the proportion of health sector development cooperation not disbursed within the fiscal year for which it was scheduled.

MEASUREMENT OF INDICATOR

When disbursements to the government sector are less than or equal to what was scheduled, disbursements “as scheduled” take the value:

$$\text{Indicator 2DPa1 (\%)} = 100 \times \frac{Qp12}{Qp13}$$

Global aggregates for Indicator 5a1 are calculated using scheduled disbursements for the government sector as the weighting variable.

When disbursements to the government sector are greater than what was scheduled, disbursements “beyond scheduled” take the value:

¹⁹ This is identical to GPEDC indicator 5a, but with adaptations to make it specific to the health sector.

$$\text{Indicator 5a2 (\%)} = 100 \times \frac{Qp12 - Qp13}{Qp12}$$

Global aggregates for Indicator 5a2 are calculated using actual disbursements for the government sector as the weighting variable.

5.3.2 INDICATOR 2Gb/2DPb: HEALTH DEVELOPMENT CO-OPERATION IS MORE PREDICTABLE (MID-TERM)

2b	2Gb	2DPb ²⁰
	Governments	Development Partners
Proposed measure	Projected government expenditure on health provided for 3 years.	Estimated proportion of health sector development cooperation covered by indicative forward expenditure and/or implementation plans covering at least three years ahead.
Indicator construction	<p>Numerator: Evidence that the government has either a rolling 3-year budget or an MTEF of sufficient quality in place.</p> <p>Denominator: In this country</p>	<p>Developing country government determines whether, on the basis of its records, a forward expenditure plan is available for each DP covering the next one, two and three years. The forward spending plan must meet ALL THREE of the following criteria:</p> <ol style="list-style-type: none"> 1. Made available by the DP in written or electronic form; 2. Sets out clearly <i>indicative</i> information on future spending and/or implementation activities in the country; 3. Amounts are presented (at least) by year using the developing country's fiscal year. <p>Additionally, for each year, to answer "YES" the information provided must meet the following criteria:</p> <ul style="list-style-type: none"> • Comprehensive in its coverage of known types and modalities of support; and • Amount and currency of funding is clearly stated.
Data source	Country-level: partner country government self-assessment	Data collected at country level (reporting by developing country governments on the availability of forward plans by each DP).
Aggregation	Global	Indicator values for individual DPs and for developing countries will serve as a basis for global aggregation.
Target	A rolling 3-year budget or an MTEF of a sufficient quality in place.	Halve the gap – halve the proportion of health sector development cooperation not covered by indicative forward spending plans provided at the country level.

²⁰ This is identical to GPEDC indicator 5b, but with adaptations to make it specific to the health sector.

MEASUREMENT OF INDICATOR

Indicator value for provider P in country C

$$P_c = \frac{(Qg5 + Qg6 + Qg7)}{3}$$

For country C for 1, 2 and 3 years ahead (y=1, 2, 3) Cy = average of Qg5, Qg6 and Qg7 respectively across all providers, weighted by the volume of the provider's development co-operation disbursed in the reference year used for question Qp5.

$$C1 = \frac{\sum_{p=1}^n (Wp * Qg5)}{n}$$

$$C2 = \frac{\sum_{p=1}^n (Wp * Qg6)}{n}$$

$$C3 = \frac{\sum_{p=1}^n (Wp * Qg7)}{n}$$

Where Wp = weight assigned to each provider P based on disbursements reported for question Qp11

$$Wp = \frac{Qp11}{\sum_{p=1}^n (Qp11)}$$

Note that using weighted averages is intended to provide an estimate of the scale of resources covered by indicative forward expenditure and/or implementation plans. This reflects the relative importance that a developing country attaches to obtaining forward spending information from a large co-operation provider vis-à-vis a small provider.

The above indicator values for individual providers and for developing countries will serve as a basis for global aggregation.

5.3.3 INDICATOR 2Gc/2DPc: HEALTH SECTOR DEVELOPMENT COOPERATION IS ON BUDGET

2c	2Gc	2DPc ²¹
	Governments	Development Partners
Proposed measure	Health sector resources are reflected in the national budget, including showing contributions of individual development partners	Percentage of health sector development cooperation scheduled for disbursement that is recorded in the annual budgets approved by the legislatures of developing countries.
Indicator construction	<p>Numerator: Evidence that health sector resources are reflected in the national budget, including showing contributions of individual development partners</p> <p>Denominator:</p>	<p>Numerator: Health sector development cooperation recorded in annual budget for year n.</p> <p>Denominator: Health sector development cooperation scheduled for disbursement in year n by DPs and communicated to</p>

²¹ This is identical to GPEDC indicator 6, but with adaptations to make it specific to the health sector.

	In this country	partner government at the outset of year n Note that the denominator used in this indicator is the same as that used in the calculation of indicator 2Ga (annual predictability)
Data source	Country-level: partner country government self-assessment	Data collected at the country level (data taken from existing government budgets and self-reporting by DPs).
Aggregation	Global	The funds recorded in the government annual budget may be greater than or less than those funds scheduled for the government sector from a provider. To avoid these two cases from cancelling each other out, the funds recorded in the government annual budget in excess are reported separately as “beyond scheduled”. Aggregates are obtained as a weighted average. Scheduled disbursements is used as the weighting variable for funds recorded “of scheduled”. For funds recorded “beyond scheduled”, funds recorded in the government annual budget is used as the weighting.
Target	Health sector resources are reflected in the national budget, including showing contributions of individual development partners	Halve the gap – halve the proportion of health sector development cooperation flows to the government sector not reported on government’s budget(s) (with at least 85% reported on budget).

MEASUREMENT OF INDICATOR

When funds recorded in the government annual budget are less than or equal to scheduled disbursements for the government sector, disbursements “of scheduled” takes the value:

$$\text{Indicator } 6_1 (\%) = 100 \times \frac{Q^{98}}{Q^{P13}}$$

Global aggregates for Indicator 61 are calculated using scheduled disbursements for the government sector as the weighting variable.

When funds recorded in the government sector annual budget are greater than scheduled disbursements for the government sector, disbursements “beyond scheduled” takes the value:

$$\text{Indicator } 6_2 (\%) = 100 \times \frac{Q^{98} - Q^{P13}}{Q^{98}}$$

Global aggregates for Indicator 62 are calculated using funds recorded in the government annual budget as the weighting variable.

5.3.4 INDICATOR 3: EFFECTIVE INSTITUTIONS: DEVELOPING COUNTRIES' PUBLIC FINANCIAL MANAGEMENT SYSTEMS ARE STRENGTHENED AND USED

3	3G	3DP
	Governments	Development Partners
Proposed measure	Country public financial management systems either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these	Percentage of health sector development cooperation disbursed for the government sector that uses national public financial management systems in countries where systems are generally considered to adhere to broadly accepted good practices, or to have a reform system in place
Indicator construction	This indicator takes the form of a score ranging from 1.0 (lowest) to 6.0 (highest), scored in half-point increments (0.5).	<p>Numerator:</p> <p>Health sector development co-operation flows using country systems (average of a, b ,c)</p> <p><i>Where:</i></p> <p>a = Health sector development co-operation funding disbursed for the government sector using national budget execution procedures</p> <p>b = Health sector development co-operation funding disbursed for the government sector using national financial reporting procedures</p> <p>c = Health sector development co-operation disbursed for the government sector using national auditing procedures</p> <p>Denominator:</p> <p>Total health sector development co-operation flows for the government sector</p>
Data source	World Bank (existing international dataset, published on an annual basis and available for IDA countries).	Country-level data (self-reporting by DPs)
Aggregation	The unit of observation is the individual developing country. When aggregating to the global level, the measure used is the percentage of developing countries moving up at least one measure (i.e. 0.5 points) since the baseline year.	Developing country, DP, global: total of numerators divided by total of denominators.
Target	Improvement of at least one measure (ie 0.5 points) on the PFM/CPIA scale of performance	Reduce [by two-thirds where CPIA score is >=5; or by one-third where between 3.5 and 4.5] the % of health sector development cooperation to the public sector not using partner countries' PFM systems (with at least 80% using country PFM systems).

MEASUREMENT OF INDICATOR

At the global level, this indicator is calculated as follows:

$$\text{Indicator 9b (\%)} = 100 \times \frac{\frac{1}{4}(Q^P15 + Q^P16 + Q^P17 + Q^P18)}{Q^P12}$$

5.4 Annex 4: Data collection Tools

Please visit the IHP+ Results website (www.ihpplusresults.org) to download the following tools and supporting documents in English, French, Spanish and Portuguese:

Quantitative tools:

For the Government:

- IHP+2016_GOV Survey Tool EN_160330 final draft

For the Development Partners

- IHP+2016_DP Survey Tool EN_Standard tool for DPs_160330 final draft
- IHP+2016_DP Survey Tool EN_Humanitarian Aid_for DPs_160330 final draft
- IHP+2016_DP Survey Tool EN_Humanitarian Aid_for Cluster Coordinator_final draft

Qualitative tools:

For the Government:

- IHP+ 2016_GOV QUAL SURVEY tool_160330
- IHP+ 2016_GOV QUAL SURVEY_Humanitarian Aid tool_160330

For the Development Partners:

- IHP+2016_DP Survey Tool EN_Standard tool for DPs_160330 final draft
- IHP+2016_DP Survey Tool EN_Humanitarian Aid_for DPs_160330 final draft
- IHP+2016_DP Survey Tool EN_Humanitarian Aid_for Cluster Coordinator_final draft

For the CSO:

- IHP+ 2016_CSO Data Collection_160330 final draft

For the Private Sector:

- IHP+ 2016_Private Sector Data Collection_160330 final draft