Federal Ministry of Health

The HSDP Harmonization Manual (HHM)

First Edition

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Foreword by His Excellency the Federal Minister of Health

The Ethiopian Government with continued support and collaboration from the development partners, as well as the effort of the general public on its health has achieved a lot towards improving the health status of its citizens. The Ethiopian health policy focuses on prevention and promotion of health services and is being implemented through the Health Extension Program (HEP). Currently, close to 18,000 health extension workers are assigned in over 6000 kebeles and assisting the rural population to promote healthy behavior.

From the very outset, the government recognized that health problems in the country are huge in magnitude and complex in nature. We are also aware that solving these multi-faceted problems of the sector requires time and concerted efforts of the government, the private sector, non-governmental organizations, multilateral and bilateral development partners, and above all the public at large.

Although we appreciate the support accorded to us by development partners, the innumerable plans, budget channels and reporting requirements are causing serious burden to the already weak health system and capacity we have. Therefore, this situation triggered the need to harmonize and align the procedures and practices of development partners with ours.

The Ethiopian Government and the FMOH has been pushing the harmonization agenda for the last couple of years, and I am happy that harmonization and alignment become a global agenda, and the major global actors agreed to pursue harmonization and alignment as clearly stated by the Paris Declaration. This was also reflected at country level when the major partners in the Ethiopian Health Sector signed the Code of Conduct in 2005. I personally appreciate and welcome all our partners for their recognition and commitment of the importance of harmonization and alignment. This Manual is a follow up move and step towards harmonization and alignment through implementation of one plan, one budget and one report at all levels in the health sector.

I would like to assure all development partners, and my colleagues in the sector that the FMOH is ready and committed to continue playing lead role in bringing all health sector stakeholders together and involving them in the consultative process. This has been witnessed in a number of shared and participatory undertakings in the sector. The HSDP-III design has passed through a number of reiterative consultative processes and has been instrumental in bringing together stakeholders. Thus, the HSDP-III is a shared sector-wide strategic document, and we agreed the one plan motto is achieved at a strategic plan level.

This manual further defined mechanisms of developing Regional and local SPMs, to reflect the country level SPM at local levels. Thus, Regions, Zones, Woredas and Health facilities are encouraged and required to revisit and harmonize their SPMs with HSDP-III. Similarly, annual plans need to be developed to realize the SPMs. In this Manual, mechanisms are shown through which various actors in the sector should follow towards one plan, one budget and one report.

We know that harmonization is a process and we need to be flexible to accommodate the procedures and operational mechanisms of various partners especially in the short-run. We also recognize that harmonization and alignment is tough and it depends on mutual understanding and commitment. .

I would like to bestow the responsibility to all stakeholders in the health sector to study the Manual and encourage their staff and others to adhere to this Manual and operate within the flexibility provided in it.

Finally, I would like to appreciate and thank all institutions and individuals who have been involved in the preparation of this valuable operational document. I also would like to thank all development partners for their valuable contribution and comments during the preparation of the Manual and above all for their endorsement of the Manual as a common guiding reference in our operations and practices.

Tedros Adhanom Gebreyesus (PhD)
Minister of Health

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Abbreviations

ARM	Annual Review Meeting
ART	anti retroviral therapy
BIs	budget institutions
BoFED	Bureau of Finance and Economic Development (regional)
BPR	Business Process Re-engineering
CBE	Commercial Bank of Ethiopia
CJSC	Central Joint Steering Committee
CPR	contraceptive prevalence rate
CRDA	Christian Relief and Development Association
DPT	diphtheria, pertussis and tetanus vaccine
EDHS	Ethiopian Demographic and Health Survey
EFY	Ethiopian Fiscal Year
EHSP	Essential Health Service Package
FMOH	Federal Ministry of Health
FOAG	Federal Office of the Auditor General
GAVI	Global Alliance for Vaccines and Immunization
GP	general practitioner
HC	health center
HEW	health extension worker
HI	health institution
HMIS	health management information system
HP	health post
HPF	Health Pooled Fund
HPN	Health, Population and Nutrition
HR	human resources
HSDP	Health Sector Development Program
HSDP-III	Third Health Sector Development Program
HEP	Health Extension Program
HHM	HSDP Harmonization Manual
IDA	International Development Association (World Bank)
ITN	insecticide treated net
JCCC	Joint Core Coordinating Committee
JCM	Joint Consultative Meeting (FMOH and HPN Group)
KHHC	Kebele Health/HIV Committee
KRA	Key results area
M&E	monitoring and evaluation
MBB	Marginal Budgeting for Bottlenecks
MEFF	Macro-economic and Fiscal Framework

Abbreviations

MDGs	Millennium Development Goals
MoFED	Ministry of Finance and Economic Development
NBE	National Bank of Ethiopia
NGO	non-governmental organization
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PIM	Program Implementation Manual
PIP	Public Investment Program
PLWHA	People living with HIV/AIDS
PPD	Planning and Programming Department
RHB	Regional Health Bureau
RJSC	Regional Joint Steering Committee
SNNPR	Southern Nations, Nationalities and Peoples Region
SPM	Strategic Planning and Management
TA	Technical assistance/assistants
USAID	United States Agency for International Development
WHO	World Health Organization
WorHO	Woreda Health Office
WoFED	Woreda Office of Finance and Economic Development
ZHD	Zonal Health Department

Chapter 1

The HSDP Harmonization Manual – towards One plan, one budget, one report

This chapter introduces the HHM as a whole and then describes the overall vision of strong health sector planning and implementation and why harmonization is such a vital part of this vision.

Chapter 2 highlights HSDP-III's priorities, goals, objectives and strategies. Chapter 3 and 4 are practical "how to" aspects of moving from HSDP to one plan, one-budget and one-report at all levels of the health system. Chapter 5 deals with governance mechanisms that need to be put in place to ensure proper implementation of harmonization and alignment.

A The HSDP Harmonization Manual

This HSDP Harmonization Manual (HHM) describes an updated basic set of planning and implementation activities for the Health Sector Development Program (HSDP). The HSDP is a 20-year sector program. The first and second phases of HSDP were completed in 2002 (1994 EFY) and in June 2005 (1997 EFY) respectively. The third phase – described in the third Health Sector Development Programme, HSDP-III - covers the period July 2005 to June 2010. Whilst the manual makes specific reference to the current HSDP-III, it should be equally relevant to the future fourth plan, HSDP-IV.

The HHM has 5 chapters:

1. The HSDP Harmonization Manual– towards One plan, one budget, one report
2. HSDP-III
3. Planning and budgeting
4. Monitoring and evaluation
5. Governance.

HSDP-III describes shared objectives. HSDP-III was developed with substantial consultation, including Regional Health Bureaus and the HPN (Health, Population and Nutrition) Donor Group. HSDP-III is thus a truly national document, reflecting the con-

sensus of the major stakeholders in the health sector. All these partners have signed up to working together to achieve the objectives described in HSDP-III.

HSDP-III implementation depends on concentrating on a limited number of priorities through systematic planning, monitoring and problem-solving. This HHM concentrates on the health sector from Woreda and Zonal Health Offices through Regional Health Bureaus to the Federal Ministry of Health. Health sector operates within the decentralization framework, where WorHOs and RHBs are directly accountable to their respective governments. HSDP-III prioritizes a small number of cost-effective health interventions which can provide good value for money in health sector spending. This HHM describes how these priorities can be integrated into the decentralized system. It is recognized that zones – and hence Zonal Health Departments - have different roles in different regions. Some regions do not have zones; some have zones which provide technical support to woredas; in SNNPR, zones have an elected administration and a broader function. This HHM cannot deal separately with these different situations. As a practical solution, zones are generally mentioned in brackets. It should be clear from the context what is meant for regions with and without zones.

HHM is a practical document focusing on institutionalizing one-plan, one-budget and one-report in the health sector. It is very different from previous PIM in that:

- Studies have shown that the previous PIM was not widely used.
- Some activities in the previous PIM were unrealistic – this HHM aims at simplicity.
- Previous PIMs were not explicitly linked to the sector plans (HSDP-III etc.), meaning that priorities were not identified.
- Decentralization in Ethiopia is evolving – this HHM reflects the changed roles of the woreda, zonal, regional and federal levels.
- Many activities in the health sector follow standard civil service procedures – there is no need to describe these procedures in a health-specific document.
- Ethiopia is part of an international movement called harmonization – this means that the role of donors has to be integrated into the overall HHM. This is why the name has changed from PIM to HSDP Harmonization Manual.

The HHM is intended for use in health offices at the woreda, zonal, regional and federal levels – by government staff, donors, non-governmental organizations and other bodies which are stakeholders in Ethiopia's health system. It is particularly relevant for people involved in planning, finance, HMIS and technical programs in the health sector.

!KEY POINTS!

- This HSDP Harmonization Manual is intended for use in health sector at the woreda, zonal, regional and federal levels – by government staff, donors, non-governmental organizations and other stakeholders. It is particularly relevant for people involved in planning, finance, HMIS and technical programs.

B The vision of One plan, one budget, one report

This HHM is about improving the whole system of health sector planning and implementation. Without it, the health sector plans will not be implemented systematically.

Planning can be seen as a road to travel along with a known destination (the targets). Monitoring is the road-signs along the way which help the traveler to stay on the road and to reach the final destination. This is illustrated in Diagram 1.1 on the next page.

Planning is about making decisions about what to do – and then ensuring that these activities actually happen. Good planning involves making good decisions about how scarce resources should be used. With the amount of money and the number of staff that we have, how can we best design the health service? What technical interventions are the most important? Plans identify priorities – "priority" means that implementation must focus on these issues as the most important part of plan implementation.

- FMOH has the mandate to prepare a national strategic plan that sets broad health priorities and to oversee its implementation – this is HSDP-III. Regional, zonal and woreda plans should reflect the priorities of the national strategic plan.
- FMOH needs to have a complete picture of achievements and resource use in the health sector. This is partly to inform its strategic planning and prioritizing. But it is also vital for the credibility of the health sector in Ethiopia. A lot of the money spent on the health sector in Ethiopia comes from international sources and is dependent on the reputation of the health sector as a whole. The health sector needs to be able to demonstrate that it can plan effectively, implement its plans and report on the achievements and costs of this implementation.
- Regions, (zones) and woredas should have local plans, accountable to their local governments, but also reflecting national priorities.

Monitoring a plan means finding out if the plan is being implemented. Plans usually have a small number of indicators – such as DPT3 coverage – which measure whether

the plan is being implemented. Plans also have targets – the level an indicator should reach by a given date. An example of a target is "85% national DPT3 coverage by end 2010." Monitoring happens regularly (quarterly, for example) throughout the lifetime of the plan. When monitoring finds out that implementation is not happening (or it is too slow), it is the job of managers to ask why this is happening, to solve problems and to move towards better implementation.

This picture is made more complicated, however, by the reality that regions, (zones) and woredas receive resources through a large number of different channels – including BOFEDS/WOFEDs, the FMOH and a variety of donors. This immediately complicates the planning system because resources are arriving at different times, for a variety of different purposes and with different monitoring requirements. This situation does not make for good planning, because it is impossible to make sensible decisions about priorities and their implementation when no one has a complete knowledge of all the resources that are available.

This problem of fragmented decision-making has been recognized by government and by donors in a movement called harmonization and alignment. Harmonization and alignment refers to the way in which government and donors should work together. A significant proportion of the money which is spent on the health sector in Ethiopia comes from external donors and development agencies. The Government of Ethiopia is extremely grateful for the international support which it receives. It is important, however, that this external support is harmonized and aligned.

Harmonization means coordination of activities amongst all stakeholders to reduce the transaction cost of delivering aid and services. A lot of extra work is created when donors set up separate channels for their resources.

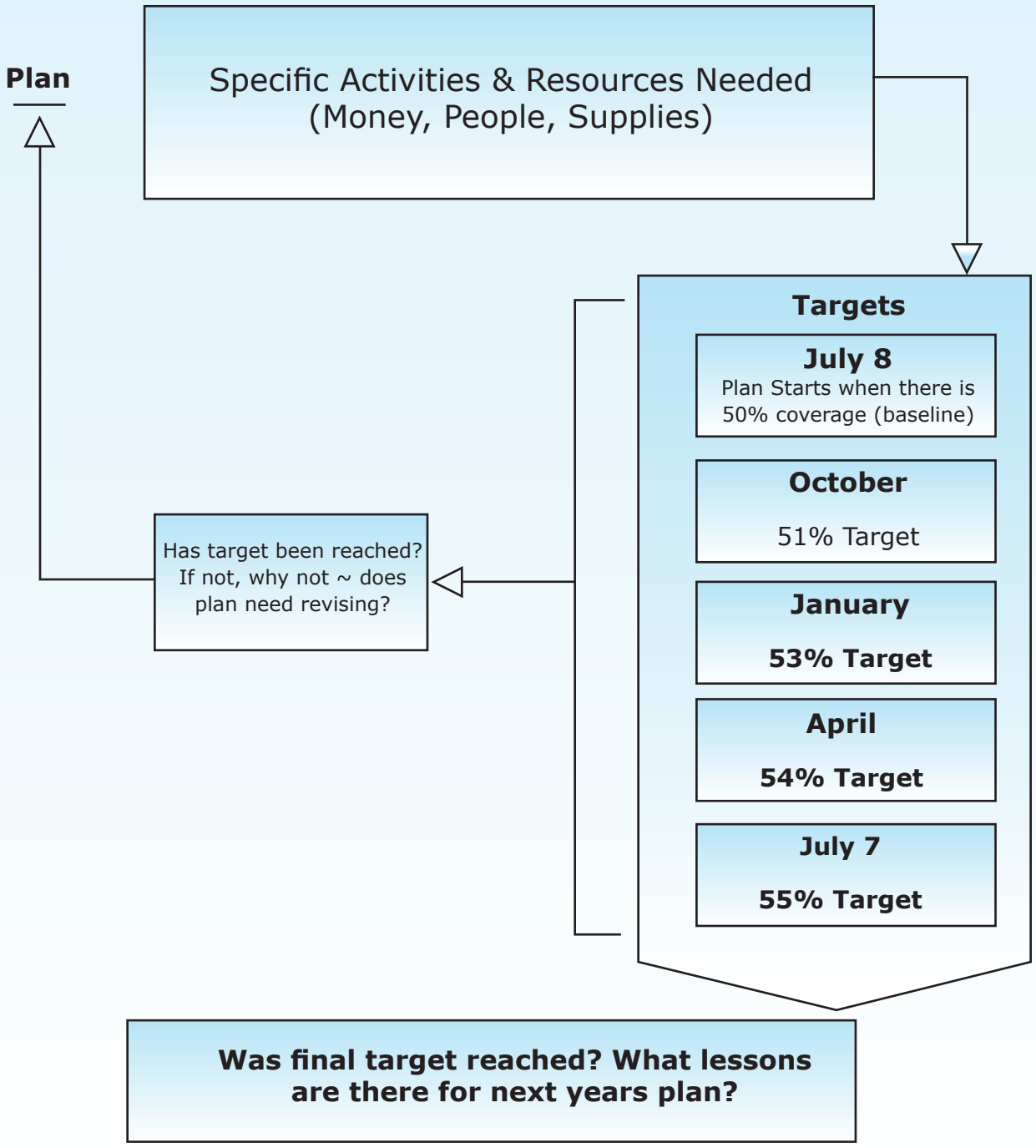
Examples of harmonized procedures – the Health Pooled Fund and the MDG Performance Package Fund – are described in Annex 5.

Alignment means "lined up with government priorities". The development partners' community has officially endorsed HSDP-III – in other words the government and donors are aligned in their commitment to HSDP-III and its priorities.

The ultimate goal of harmonization is that there is an effective planning system that makes decisions about how all resources are to be used and that monitors overall implementation in a relatively simple way. This goal is described using the term "one plan, one budget, one report".

Diagram 1.1 Planning and Monitoring

Plan to increase DPT3 (or pentavalent) coverage by 5% (50→55%) in 1 year



This refers to each woreda, zone and region having one costed and monitored plan each, which includes all their health sector activities. Planning and monitoring would be timed according to a set calendar. Ideally, BoFEDs, WoFEDs, local governments, the FMOH and donors would all accept the plan, budget and monitoring report. There should not be separate plans, budgets or monitoring activities for one particular donor or program.

"One budget" means bringing together all the sources of money received by a woreda, zone or region into one document (and ideally even into one, pooled account). This is a vital management tool - planning and setting priorities cannot be done properly without this.

"One plan, one budget, one report" is further explained in the box below.

Box 1.1 "One plan, one budget, one report"

Defining one plan, one budget, one report	
One plan	The health sector will have one country-wide shared and agreed strategic plan (HSDP) developed through extensive consultation. All other regional, zonal, woreda and facility plans are local sub-sets of this strategic plan and should be consistent with the latter. The HSDP at all levels will have annual plans which are developed in similar consultation process and feed into the SPMs. This is explained further in Chapter 3.
One budget	Every cost center (federal, regional, zonal, woreda, facility) should know about all financial and non-financial resources allocated and spent in the health sector at all levels. Incorporating resources from different sources (government, donor, NGO) for implementation of the plan is "one budget". Ideally, the money should be in one, pooled health account. This is explained further in Chapter 3.
One report	A set of indicators has been identified to monitor progress in achieving HSDP. Reports should be based on these indicators without duplicating the channels of reporting. This is explained further in Chapter 4.

"One plan, one budget, one report" is very different from the current situation of many plans and sub-plans; reports being provided on an ad hoc basis; and multiple sources of funds, many of them with different financial reporting rules. Moving towards a more integrated system (i.e. towards one plan, one budget, one report) has many advantages, including:

- Managers at the woreda, zonal, regional and federal level have a whole-picture view of the resources available to them and what they are trying to achieve. When the system is fragmented, situations arise, such as having too many resources for one technical program and too few for another. It is necessary to be able to see the whole picture before resources can be allocated sensibly.

- Transaction costs will reduce. "Transaction costs" are the administrative costs of having multiple planning, budgeting and reporting systems. Managers can spend a lot of time planning and reporting according to multiple systems – the simpler the systems, the more time managers have to spend on effective planning and implementation.

- Priorities are muddled when there are multiple systems. The latest deadline – i.e. the next report which is due – becomes the latest priority. In a more integrated system, real priorities can be identified and followed through systematically.

!KEY POINTS!

1. A strong planning and implementation system requires good linkages:
   Vertically - from facilities and kebeles, to woredas, (zones), regions and federal levels.
   Horizontally – among the various stakeholders working at one level: government, donors, NGOs, etc.

2. Planning and implementation is currently fragmented – because of inadequate horizontal and vertical linkages. This leads to implementation gaps and the duplication of some efforts.

3. This Manual describes a harmonized planning system that makes decisions about how all resources are to be used and that monitors overall implementation in a relatively simple way.

4. Harmonization can be described as one plan, one budget, one report. Each woreda, zone and region should have one costed and monitored plan each, which in cludes all their health sector activities. All other plans should be sub-sets of this one plan and consistent with its priorities and activities.

Moving towards one plan, one budget, one report will, in practice, be a process. In the short term, it is recognized that some development partners may require separate plans, budgets or reports in return for funding. However, this should be phased out as soon as possible – the aim is that no new government/donor agreements will require completely separate plans, budgets or reports.

One very positive point is that almost all the main donors in the health sector in Ethiopia have signed a Code of Conduct in which they agree to follow the principles of harmonization and alignment.

The Code of Conduct is reproduced in Annex 1. Note how it reflects the principles of one plan, one budget, one report:

- "HSDP-III is recognized as the centerpiece of health policy. Donor support should follow the priorities and procedures specified in this plan. Government and donors should engage in active debate about the contents and implementation of the plan."

- "The aim is to reduce the number of financing channels to a minimum. Funds will be pooled wherever possible - opportunities for pooling arrangements should be actively explored."

- "The Ethiopian fiscal year and chart of accounts should be used for financial reports."

- "There should be greater coordination of reports, analytical work, reviews and missions. Findings of studies should be openly shared. Single-donor activities should be kept to a minimum; wherever possible donors should work together on particular issues."

The intention is to monitor adherence to this Code through regular reviews of the behavior of agencies which have signed it.

This HHM describes the first steps towards this improved system of planning and implementation. It is hoped that as the system improves, stakeholders will trust the health sector planning system more and gradually become more confident in using its plans, budgets and reports.

!KEY POINTS!

1. Moving towards "full" harmonization is a process. HSDP-III and its set of monitoring indicators provide a strong basis for one plan and one report. At the very least, woredas, (zones), regions and the federal level require comprehensive information about budgets for health sector activities in their locality.

2. The Code of Conduct, which has been signed by almost all the main health sector donors in Ethiopia, is a key harmonization document.

Chapter 2 HSDP-III: the third Health Sector Development Plan

It is important that everyone involved in health sector planning – from kebele to federal level – is aware of the broad content of HSDP-III and its main objectives. This section summarizes the content and priorities of HSDP-III. It describes the broad structure of HSDP-III and demonstrates the implications for different levels of the health system.

This chapter concentrates on HSDP-III because it is necessary to use a specific example when talking about planning, budgeting and monitoring. All of these activities need to focus on the priorities identified by a particular plan. In general, however, this HHM should be applicable to the future HSDP-IV as well.

HSDP-III is constructed in terms of goals, objectives, strategies and key activities. Whilst regions, zones and woredas will have their own ways of achieving these, the idea is that all levels of the system contribute to the national goals and objectives. HSDP-III offers guidance on the most efficient strategies for achieving these goals and objectives, and suggests key activities to be performed at various levels, including health centers, hospitals and the programmatic level.

The broad overall goal, of HSDP-III is gradually broken down into its component objectives, strategies and key activities.

The ultimate goal of HSDP-III is:

"to improve the health status of the Ethiopian peoples through provision of adequate and optimum quality of promotive, preventive, basic curative and rehabilitative health services to all segments of the population."

Contributing to this overall goal are 3 sub-goals:

1. to improve maternal health
2. to reduce child mortality
3. to combat HIV/AIDS, malaria, TB and other diseases

These broad sub-goals are then described in more detail through 8 major objectives:

1. to cover all rural kebeles with HEP to achieve universal primary health care coverage by 2008

2. to reduce the maternal mortality ratio to 600 per 100,000 live births from 871
3. to reduce the under 5 mortality rate from 123 to 85 per 1,000 live births and the infant mortality rate from 77 to 45 per 1,000 population
4. to reduce the total fertility rate from 5.9 to 4
5. to reduce the adult incidence of HIV from 0.68 to 0.65 and maintain the prevalence of HIV at 3.5%
6. to reduce morbidity attributed to malaria from 22% to 10%
7. to reduce the case fatality rate of malaria in age groups 5 years and above from 4.5% to 2% and the case fatality rate in under 5 children 5% to 2%
8. to reduce mortality attributed to TB from 7% to 4% of all treated cases

These objectives are then re-structured as 7 implementation components, to reflect the way in which health services are delivered and financed:

1. health service delivery and quality of care
2. access to services: health facility construction, expansion and transport
3. human resource development
4. pharmaceutical service
5. information, education and communication (IE&C)
6. health management information system and monitoring and evaluation
7. health care financing.

In effect, components 1 describe the main service delivery activities and components 2 -7 are the inputs and activities required to provide these services.

Component 1 - health service delivery and quality of care – is about the type and quality of work which is done in hospitals, health centers and health posts.

A key aspect of this component is the Essential Health Service Package (EHSP), which specifies the basic services that should be available at a certain level of the health system. EHSP consists of an essential package for the community level, plus basic curative care and the treatment of major chronic conditions, to be provided at health centers. The ESHP has five components:

1. Family Health Services
2. Communicable Disease Prevention and Control Services
3. Hygiene and Environmental Health Services
4. Health Education and Communication Services
5. Basic Curative Care and Treatment of Major Chronic Conditions

Component 1 of HSDP-III gives targets for family health; communicable disease prevention and control; hygiene and environmental health; and curative services.

An example of a strategy in this component is to "facilitate the proper implementation of the National Strategy for Child Survival". A related key activity for health centers is "health centers to be able to manage common childhood illnesses using the IMCI algorithm". (IMCI=Integrated Management of Childhood Illnesses)

Component 2 - access to services: health facility construction, expansion and transport – is about expanding the network of health posts and health centers, and ensuring that they are adequately equipped.

One strategy in this component is "implement the accelerated expansion of Primary Care services by constructing new health posts and health centers and upgrading health stations to health centers". A related key activity for Woreda Health Offices is "to supervise the construction, equipping and furnishing of new health posts and new and upgraded health centers".

Expanding on the 3 sub-goals listed above, Table 2.1 describes the most important priorities of HSDP-III.

Table 2.1 Key priorities of HSDP-III

Priority area	Target	Vehicles – what staff and institutions are required for delivering the services	Bloodlines – i.e. support systems required
Maternal health	CPR > 60%	• 30,000 Health Extension Workers • 13,635 Health Posts • 3,200 Health Centers • 5,000 health officers • Train General Practitioners • Improve quality assurance system	• Human Resources • Logistics • Finance • Health Management Information System • Harmonization
Child health	Immunization > 85%		
HIV/TB	• Reach every household • 263,000 people on ART		
Malaria	20 million ITNs		

In other words – the 5 targets related to family planning, immunization, HIV/TB and nets are the most important priorities of HSDP-III. Improvements in these 5 areas would significantly improve the health of Ethiopians. To reach these targets, there needs to be 13,635 health posts and 3,200 health centers. To work well, these facilities need staffing (human resources, including 30,000 health extension workers and 5,000 health officers), supplies (logistics) and money. The facilities also need to produce accurate information about their work through the Health Management Information System. Woreda and regional health offices/bureaus provide a vital role in supporting these facilities.

"Priorities" means activities that have been selected as the most important and urgent for improving the health of Ethiopians. When resources are in short supply – money, staff, managers' time, drugs, etc. – then they should be allocated first to the priority activities. Supervision and monitoring should look first at priority areas.

Each woreda and region has to show how its own local health plans relate to HSDP-III. In particular, each level has to show its plans related to the 5 targets above - what is it doing to contribute towards these priorities?

!KEY POINTS!

1. HSDP-III has five priority targets, related to maternal and child health, HIV/AIDS, TB and malaria.

2. All key stakeholders should be aware of these priorities.

Table 2.2 shows the types of questions which everyone involved with health planning and delivery should be asking regularly. The table describes nation-wide priorities. Following the principle of harmonization explained in Chapter 1, government and donors should be working together to address these issues.

The table suggests some specific questions about HSDP-III objectives which the woreda, zonal, regional and federal levels should be asking in their supervisory capacity. More generally, these levels should be looking for examples of good practice related to the priority objectives and spreading the good practice throughout their region, woreda, etc. Supervisory levels should also be looking out for areas which are falling behind in implementation, and support them appropriately.

Table 2.2 HSDP-III sub-goals: implications for implementing and supervisory levels of the health system

Objective	Implementation level	Supervisory level
CPR > 60%	Are health facilities and community-based programs doing everything they should to increase the contraceptive prevalence rate?	Are all parts of the woreda/zone/region/country implementing activities that will really increase CPR? Which facilities and programs could do more? What practical problems are being encountered and how can these be overcome?
Immunization > 85%	Are all health facilities and community-based programs doing everything they should to increase immunization coverage?	Are all parts of the woreda/zone/region/country being reached by immunization activities? If not, what can be done to cover the gaps?
Reach every household	Are there any missed opportunities where immunizations could be promoted or given?	Which facilities could do more? What practical problems are being encountered and how can these be overcome?
	Have all households participated in a community conversation and social mobilization in HIV/AIDS, malaria and TB?	Has each kebele administration ensured the development of a Plan of Action after the community conversations?
263,000 people on ART	How does this national target break down? How many people should be on ART in your region, zone, woreda or facility? Do you have adequate resources to reach your local target? When people are on ART, do you monitor the quality of care?	Have you translated your target into targets for particular woredas, hospitals, etc.? Are there adequate resources (health workers, supplies) to meet this target? If not, what can be done about this? What practical problems are being encountered and how can these be overcome?
20 million ITNs	How does this national target break down? How many ITNs should be used in your catchment area? Do local people know about ITNs and their advantages? Are we using the best people and institutions to distribute the nets locally?	Have you translated your target into targets for particular woredas etc? Why are some areas doing better than others and how can the areas with fewer ITNs be helped?

HSDP-III describes its linkages with Civil Service Reform. During the lifetime of HSDP-III, an important part of this reform is Business Process Re-engineering (BPR). The health sector has identified 7 core processes for BPR:

1. Harmonization, including the production of this HHM
2. Health Management Information System (HMIS)
3. Financial/resource mobilization and utilization
4. Logistics Master Plan
5. Human Resource Development for Health
6. Improving access and quality of health service
7. Reduction of occurrence of epidemics

There is clearly considerable overlap between the above processes and the HHM. This document essentially describes the overall planning, budgeting, monitoring and governance framework within which these processes take place.

The rest of this HHM is about how to operationalize HSDP-III and its priorities.

Chapter 3 Planning and Budgeting

This chapter describes the health sector's planning and budget systems and how they can become more harmonized – i.e. how they can develop into "one plan, one budget". The heart of this chapter is the section on Annual Plans, which describes the link between the vertical focus on national priorities and the horizontal linkages which bring in local resources and. priorities.

"One plan" is the idea that all the major activities happening at various levels of the health system are included in one joint plan. "One plan" means that all stakeholders (government, donor, NGOs and the community) agree to be part of a broader sectoral plan. For instance, requests for separate single-donor plans should be resisted – the idea is that donors can see how their inputs fit into the broader sector plan. Donors can still have their own internal plans for their own use but should fit into the "one plan" of the health sector. This move towards one plan is new and challenging – it will require changes in behavior from government and donors. To achieve one plan/one budget, two rules have to be applied rigorously:

- Agreements with all funders need to reflect the terminologies, priorities and targets of the strategic and annual plans.

- Finances from all sources need to be translated into the Ethiopian chart of accounts and fiscal year.

These rules are compatible with the health sector Code of Conduct, which has been signed by all Ethiopia's major donors. (See Annex 1)

A The overall planning framework – strategic and annual plans

HSDP plans are strategic, nation-wide 5-year plan. How can they be implemented?

Learning from past problems with planning and implementation, this HHM proposes that each health facility (hospitals and health centers), woreda, zone and region, plus the federal level, should have two plans (and only two plans) – a Strategic Plan and an Annual Plan. The Strategic Plan is a reflection of HSDP in a particular region or woreda. Annual plans further break down these strategic plans into shorter periods of time. The connections between the overall strategic plan, geographical strategic plans and annual plans should always be clearly stated. Neither the strategic nor the annual plan is a new idea – what is new is the focus on these as the only kinds of "health sector" plan.

Both strategic and annual plans should be:

- Linked to resource mapping at the appropriate level, which includes financial and non-financial resources received from all financing sources - government, donors, fees, etc. This is the connection with "one budget". (See Annex 5 for an example of resource mapping.)

- Approved by the relevant local government authority.

- Linked to other plans by time (strategic→annual) and geography (federal→ regional (zonal)→woreda).

- Comprehensive (covering all relevant activities in the health sector). This means including relevant NGO, private sector and donor-funded activities. It is important that all major activities are reflected in government plans, even if, in the short-term at least, they are not reflected in the main government budget.

How can strategic and annual plans at all levels be compatible with the phrase "one plan, one budget, one report"? The "one plan" refers to the fact that these plans are all link together in effect as sub-plans of HSDP, broken down by time and geography. "One plan" also refers to the fact that there are no separate donor or program-specific plans which describe different sets of activities. There can, of course, be plans for a particular program or similar to describe its detailed work – the crucial point is that these should be explicitly linked to the overall annual health plan for the area and should reflect its overall priorities and actions.

Annex 2 illustrates the relationships between strategic and annual plans at the various levels of the system.

!KEY POINTS!

1. Each level of government should have 5-year strategic plan and annual plans.

2. Strategic and annual plans should reflect both national (HSDP) and local priorities.

3. "One plan" means that all strategic and annual plans at all levels in the system should be consistent with the priorities and targets of HSDP. They are essentially "sub-plans" of the national strategic plan.

4. Programs and donors may of course have their own, more detailed plans, for their own internal use. The point is that these plans should be consistent with the priorities and activities of the public sector strategic and annual plans.

5. Key features of plans include being:
   - linked to resource mapping which details the available resources;
   - logically linked to other plans by time (strategic→annual) and geography (federal→(zonal→) regional→woreda);
   - approved by the relevant local government authority;
   - comprehensive - covering all relevant activities in the health sector.

B Strategic – "SPM" – plans

The Ethiopian Government, through the Civil Service Reform Program, requires all public bodies in Ethiopia to plan using the Strategic Planning and Management (SPM) approach. This is part of the wider work of the Reform Program to improve the performance of the public sector by promoting results-based performance appraisal.

HSDP-III, which covers the period July 2005 – June 2010, is the health sector's strategic plan and was developed using the SPM approach. In addition, facilities, Woreda, Zonal and Regional Health Offices should all have a strategic plan. In effect, these are localized versions of HSDP-III. However, we need to be realistic. It is recognized that many woredas and facilities have problems producing good annual and strategic plans. In such situations, the place to start is with the annual plan, as this is a more

practical, operational piece of work. Technical support can be requested from regions/FMOH for development of strategic plans.

The contents of strategic plans should follow the contents of HSDP. This is a generic list – obviously the contents can be adapted and simplified as appropriate for (zones) woredas and facilities.

The Strategic Plan should follow the guidelines of the Strategic Planning and Management Approach. The SPM approach emphasizes the importance of shared goals and objectives among as many partners as possible, from the federal level to the level of the institution. The SPM approach encourages the participation of stakeholders and developing consensus during the various stages of the planning process. The visions, goals and objectives jointly formulated through this process, and cascaded down, but adapted to the realities of regions, zones and woredas, constitute the basis of the linkage between the respective plans.

Strategic plans need to:

- Specify strategic issues which they want to address
- Describe major activities for improvement
- Be consistent with HSDP and its timeframe, priorities, focus areas, targets, vehicles and bloodlines. (See table 2.1 in Chapter 2 for HSDP-III's main priorities, targets, vehicles and bloodlines.)
- Reflect on HSDP nationwide targets for their locality – what targets need to be met locally and how will this be achieved?
- Give the timeframe for achieving targets, with clear definition of the responsible body within the public institutions and in collaboration with other stakeholders.

Regions are required to develop their own regional strategic plans based on HSDP. The following points apply:

- Producing the plan is ultimately the responsibility of the Director of the relevant health office - a multi-disciplinary technical planning team should be formed with clear terms of reference to assist in developing the strategic plan.

- All relevant stakeholders, including the FMOH, should be involved/consulted about the development of the regional plan.

- The key targets, priorities, outputs, activities and program components of HSDP should be considered and incorporated into regional programs. Regional targets need to be specified.

- In developing the plans, the planning team should make use of various documents, such as the current HSDP, regional study/research reports, local Review Meeting reports, HMIS reports and supervision feedback reports.

- Regional strategic plans should include a budget and financing plan, which includes all sources of finance.

- Every five years, regional strategic plans need to be submitted to the Ministry, which will submit them to the Annual Review Meeting for discussion. Regions can then amend their strategic plans based on comments from ARM.

Zonal and woreda strategic plans. Zones and woredas also need to develop strategic plans. The points for regions, above, all apply. Zonal and woreda plans should be a local reflection of the regional plan. Woredas should consult with individual facilities and communities about their strategic plan. These strategic plans need to be discussed with the respective region, which will comment on the plans' alignment with HSDP and the region's strategic plan.

Health Facility Level Strategic Plan. HSDP and the Strategic Plans, at various levels, are the source documents for facilities' strategic plans and targets. Zones and woredas may need to assist health facilities - mainly hospitals and health centers - to prepare their strategic plans. Woredas need to make sure that woreda targets are adequately reflected in facility and Kebele plans.

All strategic plans should link together logically – in other words, they should be harmonized up the chain from facility to federal. Facility targets should be reflected in woreda plans, woreda plans in regional (or zonal) plans, etc. The planning templates are a tool to help ensure this logical linking of plans and targets. This process of linking targets at different levels is described in detail in Section 3C, below on Annual Plans.

Strategic planning is an activity for the start of the HSDP periods. By the time of the HSDP Mid-Term Review, all strategic plans should be ready and logically linked to each

other. The HSDP Mid-Term Review assesses whether this has been done properly or not.

Table 3.1 summarizes who is responsible for what, in terms of strategic plans.

!KEY POINTS!

1. FMOH, regions, (zones), woredas and facilities should each have a strategic plan, developed in consultation with community and partners.

2. These should be logically linked in terms of geography (to the strategic plans at the levels above and below) and time (to annual plans).

3. Strategic planning is an activity for the start of the HSDP periods.

Table 3.1 Strategic plans – activities and responsible bodies

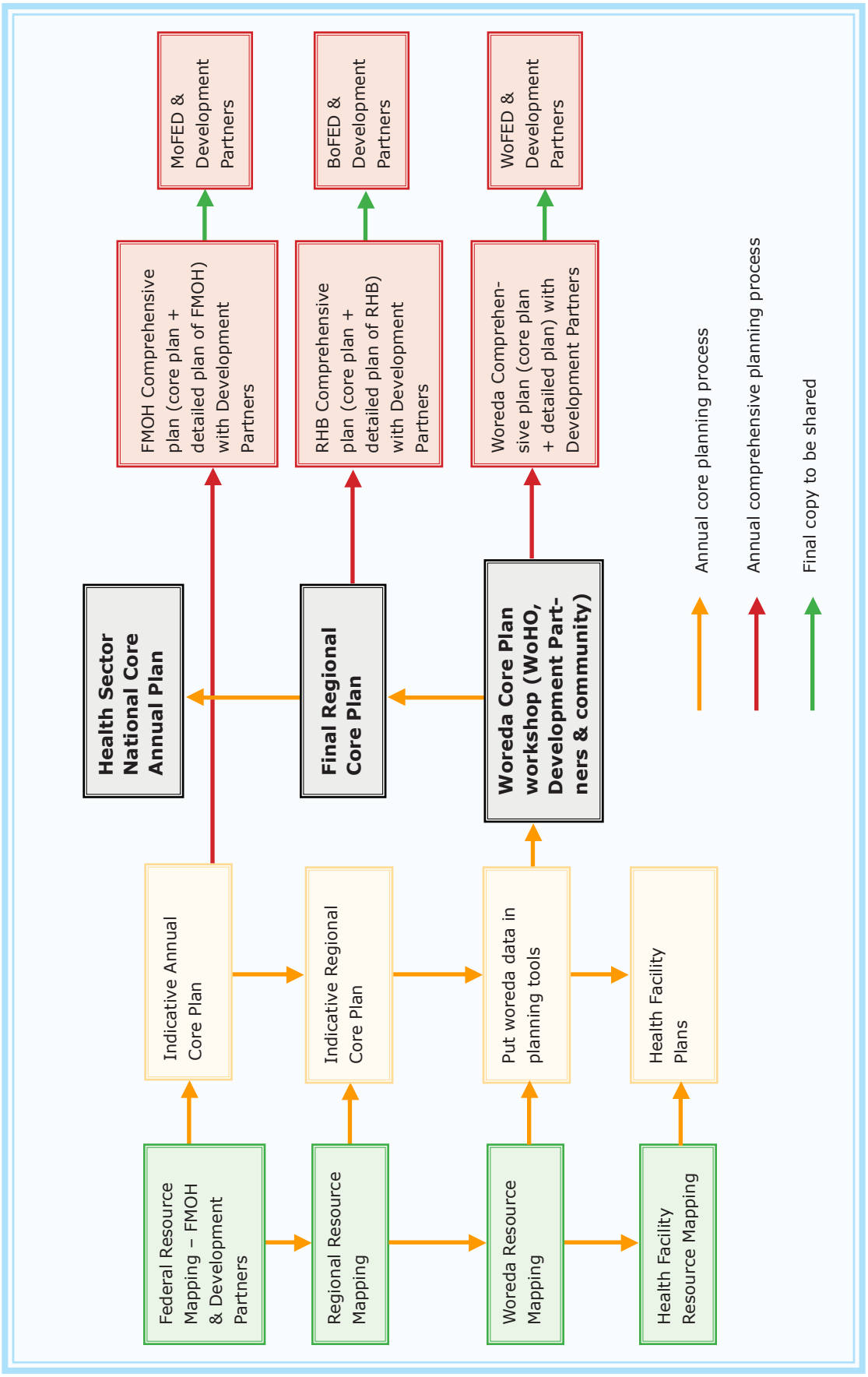
Institution	Activity for which responsible
Woreda Health Office	Develop and implement Strategic Action Plan with involvement of community and partners
	Secure approval of strategic plans by woreda government
	Share plan with Regional Health Bureaus (or ZHDs).
Regional Health Bureaus	Develop and implement Strategic Action Plan
	Secure approval of plan by regional government
	Share plan with FMOH and Woreda Health Offices.
	Support woredas in the development of their strategic and plans. Ensure that the woreda plans are consistent with national and regional priorities.
	Ensure all Woreda Health Offices and senior RHB managers Have copies of HSDP-III and this HHM
FMOH	Develop Strategic Plan (HSDP)
	Secure approval of plan by the Central Joint Steering Committee
	Share plan with Regional Health Bureaus.
	Support regions in the development of their strategic and plans. Ensure that regional plans are consistent with national priorities.
	Ensure all RHBs and senior Federal managers have copies of HSDP-III and this HHM
Donors	Work with FMOH and Regions to ensure that all donor-funded activities are included in the strategic plans and resource mapping exercises. This requires a multi-year timeframe.
	Ensure all staff and consultants working in the health sector have copies of HSDP-III and this HHM

C Annual plans

Once strategic plans are finalized, the next step is to develop the annual plan. Annual plans show how the broader objectives, priorities and targets of the strategic plan will be translated into practical activities. Annual plans are operational. Developing annual plans involves consultation with major stakeholders, including relevant government institutions, donors, NGOs and the community at each level.

Annual plans are developed in two stages. The core plan is about mainstreaming priorities and setting national targets; the detailed plan is the core plan plus other activities of local importance.

The annual planning cycle is illustrated in Diagram 3.1.



The Core Plan template guides the preparation of core plans at all levels of the health system. It contains the core priorities of HSDP, organized in 10 sections:

1. Strengthening implementation capacity
2. Expansion of primary health care coverage
3. Strengthening hospital services
4. Promoting maternal and adolescent health services
5. Improving child health services
6. Promote nutrition
7. Strengthening hygiene and environmental health service
8. Prevention and control of major communicable diseases
9. prevention and control of non communicable diseases
10. Strengthening monitoring and evaluation and operational research

Each section consists of:

- national targets for the fiscal year
- key activities to achieve the targets, allocated between FMOH and RHBs

Core planning starts in February, when a draft is prepared at the federal level. This draft is then discussed and finalized with RHBs during a routine FMOH-RHBs Joint Steering Committee meeting. (See Chapter 5 for governance arrangements.)

The Core Plan has associated tools that enable national priorities and targets to be addressed at all levels of the health system. The tools include:

- Woreda profile forms used by WorHOs to record the woreda health profile in preparation for the Regional Core Planning Workshop.

- Woreda planning forms used to set woreda targets; identify gaps in service delivery; and list key activities to be implemented at woreda level to address issues in the Core Plan.

- Regional planning forms that serve the same purpose as the woreda planning forms, but at regional level.

- Federal planning forms – as above, for the federal level.

Core plans are compiled up the system, culminating in the Sectoral National Annual Plan produced by the FMOH. This is the consolidated national plan (with regional dis-aggregations) which is presented to the Annual Review Meeting (ARM) each year.

Targets are the most important element in the annual plan – they are a vital way of linking HSDP and annual plans. All woreda targets need to add up to the regional target, for example. Core planning works by setting the next level down a range within a target – e.g. 55-85% DPT3/pentavalent coverage. The next level chooses specific target level within the limits of available resources from various sources and in such away that it helps the achievement of targets agreed up on. This is illustrated in Box 3.1.

Box 3.1 HSDP-III target translated into annual, woreda targets

Woreda X Strategic Plan 2007-2010

HSDP-III target	85%+ Pentavalent coverage by end 2009/10
Regional strategic plan target	80-85%+ Pentavalent coverage by end 2009/10
Woreda strategic plan target	85%+ Pentavalent coverage by end 2009/10 In absolute numbers this means that 3,000 (for example) children need to be immunized with Pentavalent in 2009/10. The woreda could have chosen an 80% target, if it felt that 85% was unrealistic.

Target broken down by year

2006/7	60% (actual) – 2,100 out of a birth cohort of 3,500
2007/8	65% (target) – 2,353 out of a birth cohort of 3,620
2008/9	75% - 2,760 out of a birth cohort of 3,680
2009/2010	85% - 3,187 out of a birth cohort of 3,750

Detailed plans

The detailed annual plan is the full core plan + other issues that are locally important. It is prepared at all levels, from facility to federal. Detailed annual plans have the following features:

- Scope: should reflect all activities and budgets, including those implemented by the public sector, donor agencies, NGOs and communities.

- Resource and Source of Finance: estimation of the total amount of resources available from all sources (government, specific donors, internal revenue, NGOs, etc.). This is also called resource mapping. (See Annex 5 and the section on budgeting later in this chapter.)

- Implementation schedule: a list of major activities, a quarterly/monthly implementation schedule and the responsible body for the implementation of each activity.

- Monitoring framework for assessing progress during implementation. This includes key performance indicators, baseline data, annual targets, information sources and collection mechanisms, as well as reporting and feedback mechanisms. (See Chapter 4 for more about monitoring.)

The detailed annual plan consists of the following basic elements:

- A narrative summary outlining objectives, specific targets, expected outputs, key activities for the fiscal year and the monitoring framework.

- A tabular description of the plan in two main parts:

  i) activity section, with the following key columns:
     - Priority/Activity
     - Indicator
     - Baseline
     - Target
     - Implementation schedule
     - Total budget
     - Source of budget
     - Responsible implementer.

  ii) financial section with the following key columns:
     - Priority/Activity
     - Implementation schedule
     - Total budget subdivided into government, donor, NGO and community.

!KEY POINTS!

1. Annual plans are developed in two stages. The core plan is about achieving national targets; the detailed plan is the core plan plus other activities and implemented by partners at that level of the health system.

2. A template and planning tools exist to help with the development of core plans.

The Process of "One Annual Plan"

Federal level

What is one plan at the federal level?

One plan at the FMOH means:

- The annual core plan. Starting in February, each year, the FMOH and RHBs agree on priorities, targets and the allocation of tasks. This draft core plan cascades down the system as a guide for the preparation of local annual core plans. Once the local core plans have been finalized and consolidated, they are brought together at federal level as the Sectoral National Annual (core) Plan.

- The detailed annual plan for the FMOH itself for federally-mandated activities. This incorporates all federally-implemented activities and budgets in donor program documents. This detailed plan indicates who does what and when, financed by whom. It is the only document that should be referred to during federal-level annual implementation, monitoring and evaluation.

How is one plan produced at the FMOH?

1. FMOH conducts a resource mapping exercise to identify available resources from all sources for activities to be implemented in the next Ethiopian Fiscal Year. This is done mainly through review of documents. A generic template for resource mapping is given in Annex 5.

2. In line with HSDP, FMOH produces a draft Core Plan which indicates priorities, targets and key activities of FMOH and RHBs.

3. The draft Core Plan is formally agreed by the FMOH-RHBs Joint Steering Committee.

4. Targets are specified in the draft core plan and its set of planning tools. Each target has a range. Teams of TAs, trained to use the tools, are deployed to the RHBs to orientate and assist RHBs, ZHDs and WorHOs in the preparation of their core annual plans. At each respective level, plan development is guided by the Minister and heads of departments for FMOH, heads of RHBs, heads of ZHDs and heads of WorHOs.

5. FMOH prepares its own detailed annual plan, using inputs from the Core Plans from lower levels. As this includes the activities of all relevant stakeholders, this is done through a consultative process (for example, a joint planning work shop). This is the time for partners to incorporate activities they finance in the annual plan of FMOH for the year under consideration. Although this is for federally-mandated activities, inputs from regional and woreda core plans are vital because these affect federal activities. For example, the number of health posts to be built locally affects medical equipment procurement at the federal level.

6. After the approval of the government budget at all levels, the core plans are aggregated into the Sectoral National Annual Plan.

7. FMOH presents the Sectoral National Annual (core) Plan at the Annual Review Meeting in September/October. This Plan is limited to the priorities of HSDP. It includes numerical targets for the fiscal year by region and recurrent and capital budgets by source and region.

The FMOH detailed annual plan includes activities of Ministry departments and federal hospitals, which are financed from the government budget. FMOH extracts these activities from the detailed annual plan and presents this as the government financing document to MOFED.

Table 3.2 details the stages, timing and responsible bodies for the preparation of annual plans. In addition, Annex 3 gives an overall calendar for HSDP.

The process of 'One Annual Plan" at the Regional level

What is one plan at regional level?

One plan at Regional level means:

- The regional Core Plan, which specifies regional targets that respect the minimum targets set by the Federal Core Plan. It is finalized after the development of the woreda core plans. The plan includes numerical targets for the fiscal year by woreda and recurrent and capital budgets by source and woreda.

- The detailed annual regional plan incorporates all regionally-implemented activities and budgets in donor program documents. This detailed plan indicates who does what and when, financed by whom. It is the only document that should be referred to during annual implementation, with monitoring and evaluation at the regional level.

How is one plan produced at Regional level?

1. RHBs conduct a resource mapping exercise to identify available resources from all sources for activities that will be implemented in the region during the next Ethiopian Fiscal Year. (See Annex 4.) This is done through review of documents and consultation with stakeholders (BOFED, FMOH and other partners).

2. Based on the agreed draft Core Plan from the federal level and the resources available, regions produce a draft Regional Core Plan that indicates priorities, targets and key activities. Technical assistance is available, if required. RHB heads are responsible for the production of this plan.

3. The draft Regional Core Plan and the core planning tools are shared with WorHOs. Technical assistance is provided to woredas as needed.

4. RHBs organize core planning workshops of woredas/zones to draft the woreda and zonal plans and amend the regional core plan with the assistance of the TAs.

5. RHBs prepare their own detailed regional Annual Plans for activities implemented at regional level. As this includes the activities of all relevant stakeholders, this is done through a consultative process (for example, a joint planning workshop). This is the time for partners to incorporate activities they finance in the annual plan of RHBs for the year under consideration. Inputs from zonal and woreda core plans are vital because they affect regional activities.

6. After the approval of woreda and regional government budgets, the regional core plan is finalized. The plan is limited to HSDP priorities and should include numerical targets by woreda and recurrent and capital budgets by source for each woreda (and zone).

7. Submit the regional core plan to FMOH and regional ARM.

The RHB detailed annual plan includes activities of RHB departments and hospitals/ institutions under its jurisdiction, which are financed from the government budget. RHBs extract these activities from the detailed annual plan and present them as the government financing documents to BOFED and local partners.

Table 3.2 details the stages, timing and responsible bodies for the preparation of annual plans.

Zonal Level Annual Plans

Zones in SNNPR and nationality zones in Amhara which are mandated with planning and resource allocation have to develop annual plans. Zonal planning follows the logic of the regional planning described above.

Woreda level

What is one plan at the woreda level?

One plan at woreda level means:

- The Woreda Core Plan, which specifies woreda targets that respect the minimum targets set by the Regional Core Plan. The plan includes recurrent and capital budgets by source. This plan is developed with the help of the core planning tools.

- The detailed annual woreda plan incorporates all woreda activities implemented by all relevant stakeholders. This detailed plan indicates who does what and when, financed by whom. It is the only document that should be referred to during annual implementation, monitoring and evaluation at woreda level.

How is one plan produced at Woreda level?

1. WorHOs conduct a resource mapping exercise to identify available resources from all sources for activities to be implemented in the woreda during the next Ethiopian Fiscal Year (See Annex 4). This is done through review of documents and consultation with stakeholders (WOFED, RHB/ZHD, NGOs, etc.).

2. WorHOs receive the draft annual regional core plan and the associated core planning tools. They complete the woreda profile form in readiness for the core planning exercise to be organized by the RHB/ZHD. Technical assistance is available, as required.

3. WorHOs participate in the core planning workshops organized by RHBs/ZHDs to draft the woreda core plan and submit to RHBs/ZHDs. This plan should consolidate the relevant activities of the various desks of the WorHO and the activities of Primary Health Care Units (Health Centers and Health Posts).

4. WorHOs also use the opportunity of the workshop to prepare the detailed woreda annual plan. This includes the core plan, other WorHO activities not in the core plan, and activities of the stakeholders at woreda level. This is the time for partners to incorporate activities they finance in the annual plan of woreda health office for the year under consideration. This will be submitted to WoFED and woreda council for approval. Information learnt during stage 1 – the resource mapping – will be useful at this stage.

5. Finalize the core woreda annual health plan based on the approved woreda budget and communicate to the RHBs/ZHDs. This plan is limited to HSDP priorities and should include numerical targets and recurrent and capital budgets by source for each woreda.

The WorHO detailed annual plan includes activities of WorHO departments and health facilities under its jurisdiction which are financed from the government budget. WorHOs extract these activities from the detailed annual plan and present them as the government financing documents to WOFED.

Table 3.2 details the stages, timing and responsible bodies for the preparation of annual plans.

Facility level

Hospital or Health Center management, with the active participation of the staff, shall prepare work programs taking into account the objectives, priorities and strategies of HSDP and local health plans. The plan should describe activities for the facility and its catchment area, new projects and how service quality will be improved.

Table 3.2 Planning processes, timetable and involved parties

	Annual planning activities Federal Ministry of Health	Timeframe	Involved Parties
1	Mapping of next year's resources at FMOH level	10th February	All departments of FMOH in consultation with MOFED and health partners
2	Develop a draft annual Core Plan and share it with RHBs	28th February	All departments of FMOH
3	Finalize the Core Plan at FMOH-RHBs steering committee meeting	9th March	FMOH-RHBs Joint Steering Committee members
4	Workshop on FMOH capital and recurrent budget proposal to MOFED	10th March	All departments of FMOH
5	Finalization of FMOH capital and recurrent plan and submission to MOFED	23rd March	All departments of FMOH
6	Set up, orient and deploy teams of Technical Assistance (TAs) to assist RHBs, ZHDs, and WorHOs in the preparation of core plans	13th to 18th March	PPD/ FMOH
7	Prepare a Sectoral National Annual Plan based on the core plans of the RHBs, FMOH activities and activities of all stakeholders obtained through a consultative process	20th April	PPD/ FMOH , partners
8	Revise and finalize the Sectoral National Annual Plan based on the approved regional/ woreda annual core plans	June	PPD/ FMOH
B	Regional Health Bureaus		
1	Conduct consultation with stakeholders to identify available resources and discuss priorities and targets	15th February	RHBs, in consultation with BOFED, FMOH and health partners in the respective regions
2	Based on the agreed Core Plan and the resources available, regions will prepare a draft Regional Core Plan that indicates priorities, targets and key activities and share it with woredas	18th March	RHBs
3	Guide and assist the WorHOs to complete the planning information format produced by FMoH	14th to 26th March	RHBs and Technical Assistants
4	Organize and guide Regional Planning Workshops to discuss and refine the woreda annual health plans	27th March to 13th April	RHBs /ZHDs RHBs

5	Consolidate the Regional Core Plan and submit to the FMOH/PPD.	18th April	RHBs
6	Revise and finalize the regional annual core plan based on the approved woreda, regional and zonal budgets and communicate to the FMOH/PPD	June	RHBs
C	Zonal Health Departments		
1	Participate in the Regional planning workshop and assist the woredas in the preparation of their draft annual plans	27th March to 13th April	ZHDs
2	Compile and produce zonal core plan	13th to 20th April	ZHDs
D	Woreda Health Offices		
1	Conduct stakeholder consultation to map resources available for the next fiscal year	20th to 28th February	WorHOs in consultation with WOFED, Woreda Joint Steering Committees and health partners
2	Complete the woreda profile form for the core planning exercise at the regional planning workshop	14th to 26th March	WorHOs and Technical Assistants
3	Participate in the regional planning workshop, revise the woreda annual health plan and submit to RHBs/ ZHDs	27th March to 13th April	WorHOs, RHBs, ZHDs and TAs
4	Use the opportunity of the regional level workshop to finalize the detailed woreda plan that includes the core plan, other WorHO activities not in the core plan, and activities of the stakeholders at woreda level	27th March to 13th April	WorHOs, RHBs, ZHDs and TAs
5	Submit the detailed woreda annual plan to WoFED and woreda council for approval.	15th April June	WorHOs
6	Finalize the woreda annual plan based on the approved woreda budget and communicate to the RHBs/ZHDs	5th April	WorHOs
E	Health Facilities (Hospitals and Health Centers)		
1	Prepare facility annual plan		Facility management in consultation with management boards

!KEY POINTS!

1. Annual planning starts with resource mapping, which lists all the planned expenditure in the health sector over the next year – by government, donors, NGOs, etc.

2. Annual plans should describe all the activities in the health sector in the geographical area – government, donor, NGO, etc.

D Budgeting

"One budget" ideally means all funding for health activities pooled and channeled through government channels. However, there is also a less radical definition of "one budget" – all funds for health activities reflected in one plan and one documented budget, but actually disbursed through separate channels. This section reflects both interpretations of "one budget".

- It is the role of the FMOH to actively pursue the "one budget" ideal – i.e. all funding for health activities pooled and channeled through government channels. Aspects of this work are described in the "federal" section below.

- Regions, (zones) and woredas have to work with the existing arrangements for channeling resources. At these levels, therefore, the relevant definition of "one budget" is that all funds for health activities are reflected in one plan and one documented budget, but actually disbursed through separate channels.

Federal level concerns

This section describes what the move towards "one budget" means in practice. Many types of donor budgets currently operate in Ethiopia. They can be categorized by channels recognized nationally by MOFED and other Federal institutions:

Channel 1a (unearmarked): Donor money goes into the government's account and is disbursed though government procedures. The money is pooled with government money to finance the activities in the government's plan. A typical example of this channel is direct budget support. In this type of support, the disbursement and accounting functions remain with MOFED, BOFEDs, and WoFED offices. This is the chan-

nel that is used by donors providing budget support. However, there are also fund flowing to the health sector which are highly flexible, such as GAVI Health Systems Strengthening funding and pooled funds managed by the FMOH according to government procedures.

Channel 1b (earmarked): can be used by several of the larger multilateral and bilateral donors, such as the World Bank, the African Development Bank, and the British DFID. Donor money goes into the government channel and the money is earmarked for specific use (consistent with government priorities). There are also donors which require a separate planning document with their own separate format.

Channel 2: is used by a number of bilateral and multilateral partners. Sector units at each administrative level expend and account for funds. There are variations on this channel. Some donors centralize disbursement responsibility at the Federal level (so that even regional contractors are paid centrally). Other donors have worked directly with regional and/or woreda administrations.

Channel 3: Money is not in a government account and is not disbursed according to government procedures. The money is used to finance activities in the plan, but requires a separate planning document in a different format. Type 3 examples include some funding from UN agencies and some project funding. Most of the UN agencies and some bilateral donors currently use Channel 3. As part of this channel, there is a resource the sector has no control at all. Money is not in a government account and is not known to the government - hence is not included in government plans. Some NGOs have this variant of channel 3 funding.

These categories may not be exhaustive, but demonstrate the range of possible budget modalities operating in the country's fiscal system. Annex 5 describes in more detail various budget modalities in operation in Ethiopia.

These various types of budgets can be assessed according to their characteristics:

- Predictability. A budget is predictable when the government knows in advance the amount and timing of funding and the disbursement procedures to be used. Predictability makes it possible to look at priorities systematically. This is because the budget shows how all the planned activities will be paid for. If there is not enough money, some lower priority activities have to be cancelled. The Code of Conduct acknowledges the importance of predictability of donor resources by indicating their multi year commitments.

- Flexibility is the degree of freedom that the government has to use partner resources for priority activities/under-financed areas in the government plan. It is the opposite of earmarking. With a flexible budget, the government can reallocate funds to under-financed priorities half-way through the fiscal year, as long as this is within the broad parameters of the government/partner agreement.

- Transaction costs are the administrative costs of having multiple planning, budgeting and reporting systems. Managers can spend a lot of time planning and reporting according to multiple systems – the simpler the systems, the more time managers have to spend on effective planning and implementation.

Table 3.3 assesses the 4 types of budget according to the above characteristics. Type 1, and to a lesser extent type 2 – the more harmonized budget types - have clear advantages.

Table 3.3 Characteristics of budget channels

Type of budget	Predictability	Flexibility	Lowest transaction cost	Remark
Channel 1 a	****	****	****	
Channel 1b	****	*	***	Earmarked and requires separate documentation at least for some donors
Channel 2	****	**	**	Different procedures and planning formats.
Channel 3	*	*	NA	Funds may not be known, plans and reports not shared with the local public sector.

**** excellent
*** good
** problematic
* poor

The FMOH will move towards channel 1b support. Until 2010, FMOH activities will include:

- Expanding the MDG PPF by encouraging other partners to join.
- Ensuring that pooled funds at the FMOH are managed by the public sector and disbursed using public sector procedures.
- Reducing the number of funding channels/budget types.

In addition, the Government of Ethiopia will continue to encourage partners to move towards direct budget support(1a). This is a government-wide Channel 1 Budget, which is MOFED's responsibility.

!KEY POINT!

The FMOH wishes to move towards more pooled type 1b funding. In particular, it wishes to increase the number of contributors of the MDG Performance Package Fund.

Current requirements for "one budget"

This HHM recognizes the difference between the ideal harmonized one budget and the reality on the ground - at present, there are donors operating according to all 4 types of budget.

This is where the less radical definition of "one budget" comes in – i.e. all funds for health activities reflected in one plan and one documented budget, but actually disbursed through separate channels. To achieve this, the minimum requirements from all partners at each level are outlined below.

Minimum requirements from all partners at Federal Level

- All stakeholders to inform FMOH of the amount and purpose of funds during the resource mapping exercise. (This is step one of the Annual Federal Core Plan, described above and in Annex 4.)
- All the activities of partners to be described in the FMOH detailed annual plan – and the funds specified in the accompanying budget.

- This means that there will be no need for the FMOH to refer to individual donor documents during implementation and monitoring.

- The existing pooled funds should move to be managed and disbursed through government channels and procedures.

Minimum requirements from all stakeholders at Regional Level

- All stakeholders (FMOH, BOFED, Disaster Prevention and Preparedness Bureaus , NGOs, etc.) to inform RHBs of the amount and purpose of funds during the resource mapping exercise. (This is step one of the Annual Regional Core Plan.)

- All the activities of stakeholders to be described in the RHB detailed annual plan – and the funds specified in the accompanying budget.

- This means that there will be no need for the RHBs to refer to separate stakeholder documents during the implementation and monitoring phases.

Minimum requirements from all stakeholders at Woreda Level

- All stakeholders (RHBs, WOFED, NGOs, etc.) to inform WorHOs of the amount and purpose of funds during the resource mapping exercise. (This is step one of the Annual Woreda Core Plan.)

- All the activities of stakeholders to be described in the WorHO detailed annual plan – and the funds specified in the accompanying budget.

- This means that there will be no need for the WorHOs to refer to separate stakeholder documents during the implementation and monitoring phases.

!KEY POINTS!

1. Detailed annual plans at all levels should include the activities of all relevant stakeholders/partners– and the funding should be specified in the accompanying budget.

2. This means that there will be no need for government to refer to individual donor documents during implementation and monitoring.

[1] The Disaster Prevention and Preparedness Bureaus register NGOs at regional level.

The government budget

The planning and budgeting system described above obviously needs to fit within the government's systems. The connections between the harmonized plan/budget and the government budget are illustrated in Table 3.4, using the woreda as an example. This applies equally at the federal, regional (and zonal) levels.

E Procurement

Procurement means the purchasing, hiring or obtaining by any other contractual means of goods, works and services.

Government documents dictate regulations for procurement with government funds. Using government channels and procedures is the preferred method of procurement in HSDP-III.

At the sector level, the Pharmaceutical and Logistics Master Plan is being implemented. The Master Plan establishes a new PHARMID. This will procure essential drugs and health commodities, using a rolling procurement plan prepared in collaboration with FMOH, program departments, regions/cities and donors.

Table 3.4 Connections between the woreda harmonized plan/budget and the government budget

Government budget cycle for a WorHO	**Relevant stages in harmonized planning and budgeting**
Woredas receive block grants from their respective regional governments for further allocation to sector offices, including health, education, etc.	
The Woreda Finance and Economic Development Office (WOFED) prepares the allocation proposal based on the woreda priorities.	The core plan and its associated planning tools are useful documents for WorHOs to use to inform WOFEDs and woreda councils of priorities in the health sector and the required inputs, such as salaries.
Each WorHO prepares an activity plan and budget for itself and associated health facilities based on the allocation/ceiling provided by WOFED.	WorHOs are helped to do this with technical assistance and at the regional Planning workshop. This is part of the wider harmonized detailed plan prepared by WorHOs.
The activity plan and budget are submitted to WoFED, which compiles them from all sectors and submits a proposal to the Cabinet.	
The Cabinet reviews the allocation proposal, makes necessary adjustments and submits the agreed allocation to the Woreda Council.	WorHOs need to keep the woreda cabinet well-informed about the health sector. (See Governance chapter.)
After discussion, the Woreda Council approves the allocation.	
WOFED notifies WorHO of the approved budget.	WorHOs revise their draft plans, based on the government budget, and inform their RHB/ZHD.

Chapter 4

Monitoring and evaluation

A Monitoring HSDP

This chapter describes how monitoring will be standardized and implemented – it is the "one report" part of "one plan, one budget, one report". "One report" means using one monitoring system and one monitoring calendar. It means all institutions and stakeholders report according to the standard reporting format based on the common set of indicators.

Moving towards "one report" will rightly focus attention on the quality of a limited number of indicators which are regularly measured by the government system. In the framework of the HMIS and M&E reform, the national set of cascaded indicators has been agreed upon for monitoring sectorally, as well as programme-specific performance: these indicators should be reported quarterly or annually according to the agreed schedule . The core set of key indicators (see Annex 6A) is a sub-set of the national cascaded indicators reflecting the priority HSDP-III areas described in Chapter 2 – maternal and child health, HIV, TB and malaria. Key indicators are used at each health institution for monthly or quarterly self-assessment and performance monitoring according to the agreed schedule (see Annex 6B). "Health institution quarterly key indicator self-assessment and reporting form" is presented in Annex 7. The core set of key indicators is therefore part and parcel of the national set of cascaded indicators. Of note is the fact that data for the estimation of all the national cascaded indicators are available at the appropriate levels of the health system and can be used whenever information needs arise (i.e. for reporting or monitoring purposes).

Monitoring is the follow-up of a plan during its implementation to ensure that activities are proceeding as planned and on schedule. The objective of monitoring is to improve the management and optimum use of resources and to make timely decisions to resolve constraints and/or problems of implementation. In practical terms, monitoring HSDP means finding out if implementation is according to the plan and taking the required action when deviation from the plan is detected. Monitoring happens regularly (quarterly, for example) throughout the lifetime of a plan. It includes the

[2] Reference can be made to the document "HMIS / M&E Indicator Definitions - HMIS /M&E Redesign: Technical Standards Area 1".

[3] Reference can be made to the document "HMIS Procedures Manual: Data Recording and Reporting Procedures - HMIS /M&E Redesign: Technical Standards Area 3"

collection and review of information available from HMIS sources; supervisory visits; review meetings and annual reports.

The following concepts are important in monitoring:

Indicator: a measure which is used to demonstrate the change or the result of an activity or program – for example, pentavalent (DPT3+HepB3+Hib3) immunization coverage is an indicator.

Baseline: the level of the indicator at the beginning of the plan period when the target is set. For example, 61% pentavalent (DPT3+HepB3+Hib3) immunization coverage in 1999 in woreda X is a baseline.

Target: this is the specific level of the indicator which will be achieved by a certain date. For example, 80% pentavalent (DPT3+HepB3+Hib3) immunization coverage by the end of 2007 in woreda X is a target.

Setting baselines and targets is at the heart of monitoring. There is an observable, explicit statement of service performance, described in terms of achievement of a target against which performance can be measured. Baselines and targets enable the translation of policies into actions.

!KEY POINT!

"One report" means using one monitoring system and one monitoring calendar. It means all institutions and stakeholders report according to the standard reporting format and use the national set of indicators.

Monitoring – the building blocks

Core set of key indicators: in order to monitor the implementation of HSDP, it is important to concentrate on a limited set of indicators ("key indicators"). The key indicators are useful for monitoring the implementation of HSDP, PASDEP and the MDGs.

4 The Millennium Development Goals are global development goals. The health specific goals are:
Goal 4 – reduce child mortality; Goal 5 – improve maternal health; Goal 6 – combat HIV/AIDS, malaria and other major diseases.

5 Reference can be made to the relevant technical documents "HMIS /M&E Re-design Technical Standards". Of particular note are Number 1 "HMIS / M&E Indicator Definitions", Number 3 "HMIS Procedures Manual: Data Recording and Reporting Procedures" and Number 4 "HMIS/M&E Information Use Guidelines and Display Tools".

They are relevant at the community, facility, woreda, zonal, regional and federal levels. These key indicators:

1. are relevant for the Millennium Development Goals
2. are consistent with the priority HSDP-III areas and the PASDEP policy matrix (the Plan for Accelerated and Sustained Development to End Poverty)
3. are available on a quarterly/annual basis, mainly from routinely collected data
4. have standard formats for recording and reporting
5. are able to measure key factors of sector performance
6. provide scope for monitoring input, output and outcome of the health system.

The indicators have a standard definition, a standard formula, a baseline in 2005/6 (available for most indicators) and a target to be reached by 2009/10. Every region and woreda must report on this core list, according to set monitoring timetables.

In addition, a larger set of indicators may be used for the management of health services at different levels of the health system (as mentioned above, this is the national set of cascaded indicators). The selection of cascaded indicators is based on the information needs at each level of the health care system; indicator definitions, as well as standard recording and reporting formats, are specified in the guidelines and manuals developed in the framework of the HMIS and M&E reform. It is important that indicators have local ownership and relevance - for example, in practice some malaria-free woredas can ignore the malaria and ITN indicators.

Target Setting has been described in Chapter 3, Section C (Annual Plans).

Standardization: For the set of indicators to be useful, there needs to be standardization of recording and reporting formats, procedures, definitions and classifications. Each level should estimate the reporting completeness from lower levels (e.g. at the regional level from woredas) in order to assess the representativeness of the data collected. Standardization also means that data should flow through a single well-defined reporting line. This avoids duplication and enables quality assurance checks at pre-defined points.

Benchmarking is the identification of "best-in-class" performance and analysis of the process by which that performance is achieved. It aims at promoting best practices in a decentralized and accountable health system. Box 4.1 gives an example of benchmarking.

Box 4.1 An example of benchmarking

A rural district had achieved 80% immunization coverage each year for 5 years – a higher level and for a longer time than any similar district. A special study was made of its success. This revealed that district health staff actively worked with a number of women's and mothers' organizations in the district. Grandmothers and mothers were encouraged to ensure that their children and grandchildren – as well as the children of their friends – were immunized. Women were encouraged to talk to families with immunized children and to tell them about the services available. This communication strategy was successful. Other districts were therefore told about it and encouraged to do similar activities.

B Monitoring Reports

This section describes what monitoring reports need to be prepared, when and for whom.

Quarterly Reports

Quarterly monitoring reports mainly serve the management information needs of woreda, zonal and regional health authorities that have the day-to-day responsibility for implementing program activities. The role of this information is to identify problem factors early enough to be able to initiate corrective measures related to implementation, in order to achieve the expected annual performance.

Quarterly monitoring reports focus on the core set of key indicators and include targets and achievements for each key indicator, providing an outline of actions undertaken and/or planned to make up any shortfalls detected. These reports are the responsibility of the RHBs, Woreda Health Offices and health facilities. Annex 7 is the "key indicator self-assessment and reporting form", to be filled in quarterly by health institutions.

Annual Reports

The consolidated report for the Annual Review Meeting (ARM) will use a core set of key indicators, common across regions and standardized in procedures of data collection and analysis. All regions should report on progress with key indicators at their ARMs. The annual statistical report should also be published based on this report.

The Planning and Programming Department (PPD) at FMOH will issue clear guidelines on data collection and analysis, including standard definition of each indicator, interpretation and use. The consolidated report will thus be able to make geographical (i.e. regional) comparisons and analyze trends over time. The aim is to examine performance and review the direction and vision of the health sector.

Report Flow

The reporting line follows the supervisory line, with health institutions reporting to their supervising institutions. Diagram 4.1 illustrates the flows of reports:

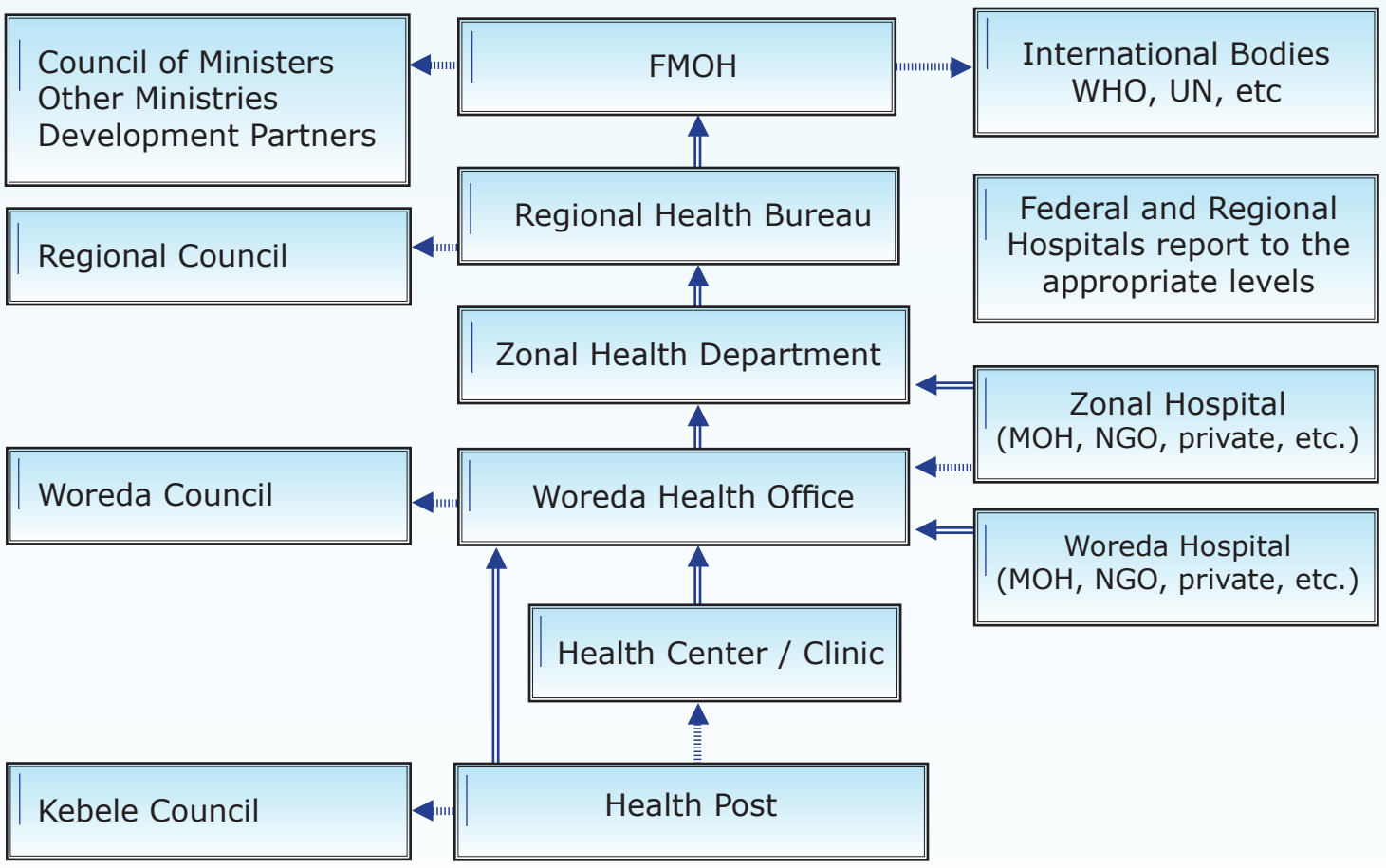
- Health posts and health centers report to the woreda or sub-city
- Woreda hospitals report to the woreda in which they are located.
- Other hospitals report to the zone or region
- Woredas report to the zone or region
- Zones report to regions
- Regions report to the FMOH.

Information also needs to be exchanged between institutions that have a collaborative relationship. These "informative" reporting channels are optional and may be used as the need arises. The "supervisory" reporting channel is not optional - its guidelines must be strictly observed to ensure completeness of reporting and to avoid double-counting. Examples of optional, informative reporting channels are:

- Health posts to the local health center – because they collaborate over service delivery
- Health posts to the kebele administration - because of their local collaboration
- Hospitals to the Woreda Health Office in which they are located - the woreda has a particular interest in hospital performance because many of its services are delivered to woreda residents.
- Administrative offices (regional, (zonal) and woreda health offices) have a collaborative relationship with the local governing bodies that fund their operations.

All this is to ensure standardization of procedures and comparability of results across geographical units and over time. Information should be shared with partners at all levels.

Diagram 4.1 Flows of monitoring reports



Reporting Schedule

The reporting schedule from health post, health center, woreda, (zone) and region to FMOH is described in Table 4.1.

Table 4.1 Reporting Schedule by level

From	To	Report arrival date at reporting destination	Frequency of	
			Reporting	aggregation / assessment
Health post	WorHO with copy to HC	8th of month	Quarterly and annual	Monthly
Health center	WorHO	8th of month	Quarterly and annual	Monthly
District hospital	WorHO / ZHD	8th of month	Quarterly and annual	Monthly
Regional / referral hospital	RHB / FMOH	8th of month	Quarterly and annual	Quarterly
WorHO	ZHD / RHB	15th of month	Quarterly and annual	Quarterly
ZHD	RHB	21st of month	Quarterly and annual	Quarterly
RHB	FMOH	28th of month	Quarterly and annual	Quarterly

C Using the Key Indicators for Decision Making

Monitoring is not just about collecting numbers. It is about comparing actual achievements with targets and making decisions based on these findings. It is a practical management tool, which indicates implementation problems as early as possible, so that managers can take immediate corrective action. The key indicators are the specific areas where monitoring should concentrate. There are a number of steps to using key indicators for decision making:

[7] Arrival date in all cases refers to the following month after each quarter or fiscal year

- Each woreda and region should have annual baseline data and targets for each indicator. These should be specified in annual plans – monitoring is about the implementation of these annual plans.

- Performance, in relation to these targets, should be reported and discussed at regular self-assessment meetings, followed by performance monitoring meetings at all levels of the health system. These performance monitoring meetings are described in more detail below.

- Where progress means that targets are unlikely to be met, action should be taken. Where relevant, lessons from successful regions, zones and woredas should be transferred to ones facing problems.

- Data collected for monitoring should be used to make management decisions – this is true from the health facility to the federal level.

Pentavalent (DPT3+HepB3+Hib3) immunization coverage can be used as an example of how key indicators are used for decision-making:

1. The process starts at the facility level. Facilities collect data monthly on the numbers of children under 1 year of age receiving pentavalent (DPT3+HepB3+Hib3) immunization. Using information on the population, they convert these absolute figures into a coverage rate and compare this with targets. If performance falls short of what was planned, a problem solving process is started and results reviewed.

2. Woredas calculate their own coverage rates and review the coverage reported from each facility.

3. Woreda managers identify parts of their woredas with particularly low immunization coverage and decide how to improve this.

4. Woredas report to regions (zones), which act to improve the situation in low-coverage woredas.

5. Regions report to the federal level, which also acts to improve the situation in low-coverage regions.

Feedback

In the past, data and information tended to circulate one way only – to and for the center. Information flowed upwards and often through several channels - feedback was minimal. An unfortunate result was the long time lag between data generation and data reporting. By the time data reached decision-makers, they were often out of date or too aggregated for useful feedback to peripheral levels. A well-designed feedback system should be put in place:

- monthly self-assessment and performance monitoring at facility level
- quarterly performance monitoring meetings at all levels
- quarterly feedback in the form of a bulletin/ newsletter and/or integrated supportive supervision at woreda level; integrated supportive supervision, building on an institution's own performance monitoring, is particularly effective for strengthening the related skills of data interpretation, problem-solving, and micro-planning directed towards performance improvement
- quarterly bulletin should be published and biannual/annual supervision should be performed from zonal, regional and federal levels.

Integrated supervision

Supervision works best when it is done in an integrated way, rather than separately for individual departments – this is too fragmented for woredas and health facilities. It is good practice to perform regular supervision using a standard integrated checklist, based on the priorities of the local annual and strategic plans. Technical programs can identify specific issues of concern and ask supervisory teams to pay special attention to them. Integrated checklists for supervisory visits to health facilities should include questions about the key indicators.

Performance monitoring meetings

Performance monitoring meetings are held by the Kebele HIV and Health Committee and Woreda, (Zonal), Regional and Central Joint Steering Committees. The periodicity is every month for self-assessment at facility level and every three months for performance monitoring meetings at the kebele level and above. Meetings of these committees can be used for both planning and monitoring purposes, and also for data quality control and providing feedback to peripheral units. The purpose of these meetings is

[8] See the forthcoming Integrated Supervision Manual

to see whether the institution is on target for successful completion of its annual plan (see Section 3C) - the indicators and targets used are thus the ones in the annual plan. If an indicator shows a problem, the root causes should be identified and corrective action taken. Ongoing monitoring is needed to ensure that the solution has the desired result. For performance to be monitored systematically there needs to be continuity between successive performance review meetings, in the form of written minutes and action plans

Annual Review Meetings also serve as performance review meetings.

D Summary of monitoring responsibilities at federal, regional and woreda levels

This section summarizes monitoring responsibilities at the federal, regional and woreda levels.

Federal MOH

1. Use key indicators and appropriate cascaded indicators for federal level.
2. Use the standard HMIS integrated reporting format.
3. Receive and compile own quarterly monitoring report as per the report flow in the diagram above.
4. Share the report with MOFED and HSDP partners.
5. Review performance at self-assessment quarterly meetings at FMOH with FMOH management and CJSC, and every other quarter with CJSC and RJSCs.
6. Act on issues revealed by monitoring information.
7. Provide feed back to regions quarterly.
8. Consolidate an annual report for ARM.

RHBs

1. Use key indicators and appropriate cascaded indicators for regional level.
2. Use the standard HMIS integrated reporting format.
3. Receive and compile own quarterly monitoring report, as per the report flow in the diagram above.
4. Share the report with BOFED and partners operating at regional level
5. Review performance at self-assessment quarterly meetings of RHB management, RJSC and regional monitoring meetings with woredas/(zones).
6. Act on issues revealed by monitoring information.
7. Provide feed back to woredas/(zones) quarterly.
8. Consolidate an annual report for regional ARM.

Woreda Health Office

1. Use key indicators and appropriate cascaded indicators for woreda level.
2. Use the standard HMIS integrated reporting format.
3. Receive and compile own quarterly monitoring report from health facilities as per the report flow in the diagram above.
4. Share quarterly report with (ZHD), RHB, WOFED and partners operating at woreda level.
5. Review performance at self-assessment quarterly meetings of WorHO management, WJSC and regional monitoring meetings with regions/(zones).
6. Act on issues revealed by monitoring information.
7. Provide feed back to health facilities quarterly.
8. Consolidate an annual report for woreda ARM.

E Monitoring the implementation of HHM and adherence to its principles

Monitoring the implementation of HHM and the adherence to its principles should be performed annually; the indicators to be used for this purpose include:

- for Government performance:

1. Number (and percentage) of regions, Zones and Woredas trained on HHM
2. Proportion of regions and woredas implementing "one plan, one budget and one report"
3. Proportion of departments/agencies of MOH running parallel planning, reporting and supervision
4. The number of CJSC, FMOH-HPN Joint Consultative Meetings conducted during the year
5. Proportion of regions and woredas that have established functional governance structures as per the recommendation of HHM.

- for partners' performance:

1. Proportion of partners that have aligned their priorities with the priorities of the Government [proportion of partners that have supported filling of gaps identified by the Government]
2. Proportion of partners providing information on resources committed for 5 years and more
3. Proportion of partners that have provided information on committed resources during annual pre-planning resource mapping (disaggregated by programme, region/woreda)

4. Proportion of partners that have incorporated their annual plan in the public sector's annual plan at all levels of the health system
5. Proportion of partners that have moved from PBS2 to MDG Performance Package Fund
6. The number of new partners that joined the MDG Performance Package Fund
7. Percent of donors and of aid flows that use public financial management systems according to HHM
8. Percent of aid disbursed within the fiscal year as per the schedule
9. Percent of aid flows to the health sector that is reported on government's budget
10. Proportion of partners using HMIS for reporting (formats, frequency, and channels)
11. Proportion of partners using the Government's monitoring system and supervision framework (as indicated in HHM and HMIS)
12. Proportion of existing donor specific coordination mechanisms integrated into the frameworks in HHM
13. Proportion of partners using Logistic and Pharmaceutical Master Plan's recommendations for procurement
14. Number of parallel Project Implementation Units (PIUs) driven by partners
15. Proportion of partners providing technical assistances managed according to the Government system.

Most of the indicators for partners' performance are derived from or consistent with the list of "Indicators of Progress to be measured nationally and monitored internationally" from the "Paris Declaration on Aid Effectiveness (March 2005)" and adapted to the Ethiopian context.

F Evaluation

Evaluation is an independent and impartial assessment of the performance carried out by specialists who have not been involved in the day-to-day management of a program – the 1998 (2006) evaluation of HSDP-II is an example. The purpose of evaluation is to assess whether the implementation of the program has gone according to the plan and the desired outcomes and goals have been achieved. Its aim is to determine, as systematically and objectively as possible, the relevance, effectiveness, efficiency and impact of activities in the light of specified objectives so as to improve future programs.

The Final Evaluation of HSDP-III will be conducted after the end of the program phase, during the second quarter of the first year of the new plan period. The Mid-term Review will take place during the third quarter of the third year of the plan period. The Final Evaluation and the Mid-term Review will be conducted by teams of national and international experts working according to Terms of Reference prepared at the level of the JCCC and approved by the Central Joint Steering Committee (CJSC - see Governance chapter). Their reports will be submitted to the CJSC and eventually to the Annual Review Meetings.

Since evaluations are generally conducted by external people (i.e. not those involved with implementation) at the end of a program or planning period, this HHM does not deal in detail with this subject.

Chapter 5

Governance of HSDP

This chapter provides a conceptual definition of governance in the health sector and focuses primarily on the governance structures of HSDP at all levels. In practice, governance is dealt with in previous chapters, as and when relevant.

Governance, in the context of HSDP, means how the development and implementation of the plan is organized, managed and communicated - the responsibilities of the different organizations involved, the mechanisms for policy-making, planning, monitoring and evaluation, and coordination among them. This is not just about government officials – citizens, NGOs and development partners all have a relevant role to play in the governance of HSDP-III. Governance is important to ensure that plans are actually owned and implemented – and it is particularly important that governance responsibilities are clear in a highly decentralized country, such as Ethiopia.

The governance structure should encourage:

- responsiveness (making services needs-based)
- inclusiveness (taking different groups' needs into consideration)
- accountability (making responsibilities clear)
- transparency (making it clear how, when and where decisions were reached)
- participation (involving appropriate stakeholders).

The governance of HSDP must be viewed, defined and developed within the context and framework of the wider political system of the Federal Democratic Republic of Ethiopia. In other words, it is essential to link the governance structure of HSDP with that of the Country's overall governance structure and the decentralized system.

In the Ethiopian constitution, decentralization of powers and duties to woreda level is intended to improve accountability, responsibility and flexibility in health service delivery and to increase local participation in decision-making on local health issues. Regional constitutions focus on the division of power and structures to promote accountability and check-and-balance at regional, woreda and kebele levels. Basic functional responsibilities are transferred to woredas in most regions. Many basic public functions are highly decentralized – for example, kebeles have the HIV and Health Committee, School Parent and Teacher Associations, etc. HSDP uses such structures to improve accountability, community participation and decision-making at different levels.

On the other hand, HSDP is a sector-wide approach with national health targets and vast resource requirements. It cannot be implemented by the public sector alone, but must also involve the concerted effort of development partners, the private sector, non-governmental organizations and the community. The governance of HSDP comprises structured consultation forums and a joint decision-making framework. Therefore, to coordinate and oversee the implementation of the sector program, HSDP will have the consultative and review institutional frameworks described below. (This governance framework is summarized in the table later in the chapter.) The existing fragmented programme and/or donor specific coordination mechanisms should fit into these institutional frameworks.

1 Central/Federal Level

1.1 Central Joint Steering Committee (CJSC)

The CJSC is the highest governance body which decides, guides, oversees and facilitates the implementation of HSDP – see Annex 8 for its Terms of Reference. It is also a forum for dialogue and consultations on overall policy, reform and institutional issues of the health sector between the Government, development partners and other stakeholders. The CJSC plays a leading role in mobilizing resources to make the sector fundable on a sustainable basis; in promoting harmonization for aid effectiveness in the sector; and in closely monitoring the implementation of core tracker programs. (These include the Health Extension Program, HIV/AIDS prevention and control, Human Resources Development, Reproductive and Family Health/population and Health Systems Strengthening.) The CJSC will also play a leading role in expanding the involvement of the private and NGO sectors in health service delivery.

The CJSC shall be chaired by the Minister of Health. Its members shall include high level representatives of the appropriate federal government bodies (including the head of the Oromia Health Bureau), representatives of HPN Development Partner groups (multilateral and bilateral development partners), NGOs, the private sector and health professionals associations. The HPN donor chairperson will also be a member, representing the donor community.

The CJSC shall meet at least every quarter (possibly in the months of July, October, January and April) and shall convene joint meetings with the Chairpersons of the Regional Joint Steering Committees (RJSCs) every other quarter (October and April).

The Planning and Programming Department (PPD) of the Ministry of Health will serve as the Secretariat of the CJSC and of HSDP. The Secretariat is responsible for the follow-up of decisions; for the day-to-day matters of the CJSC; for organizing its de-

liberations, functioning as its rapporteur and creating an effective linkage with the RJSCs.

1.2 The FMOH-Development Partners Joint Consultative Meeting (Consultation)

The FMOH-Development Partners Joint Consultative Meeting is a broader consultative forum that functions under the auspices of the CJSC.

The Consultative Forum is chaired by the State Minister of Health and co-chaired by the Chairperson of the HPN Development Partners Working Group. It is attended by heads of departments and services of the Ministry of Health; heads of the Health Extension and Education Center, Drug Administration and Control Authority and the Ethiopian Health and Nutrition Research Institute; members of the HPN Development Partners Working Group, NGO representatives, the head of the Oromia Regional Health Bureau; and head of the Addis Ababa City Administration Health Bureau. It meets every two months.

The general objectives of the forum are to promote dialogue and regular exchange of information; enhance the spirit of partnership between the Government, development partners and other stakeholders; and facilitate the implementation, monitoring and evaluation of HSDP.

1.3 The Joint Core Coordinating Committee (JCCC) – (coordination/executive)

The Joint Core Coordinating Committee is a committee that serves as the technical arm of the CJSC and the FMOH-HPN Development Partners Joint Consultative Forum. The JCCC assists and works closely with the Secretariat of HSDP in following up the implementation of the decisions of the CJSC and the Joint Consultative Forum, as well as the recommendations of the various review missions of HSDP. (Each HSDP should have both a Mid-Term Review and a Final Evaluation.) It is also responsible for assisting the Secretariat in organizing the review, monitoring and evaluation activities of HSDP and in co-coordinating operational research and thematic studies.

The JCCC will be composed of PPD staff and 5 senior staff (with HSDP experience) from HPN Development Partners Group. Staff from other FMOH departments can be invited as required. The Head of Planning and Programming Department of FMOH will chair the JCCC.

1.4 FMOH-RHBs Joint Steering Committee (Consultation/Linkages)

The FMOH-RHBs Joint Steering Committee is a forum that brings together the Federal Ministry of Health and the Regional Health Bureaus. The meeting is chaired by the Minister of Health, and the participants include the State Ministers of Health, Regional Health Bureau Heads and heads of departments/services of the Ministry and the RHBs. The Committee should meet every 2 months.

The basic objective of this forum is to facilitate the effective and smooth implementation of HSDP priority issues. This is done by bridging communication gaps between the two levels; by improving internal harmonization and coordination; by closely monitoring progress and problems at the operational level; and by taking joint corrective measures. The Joint Steering Committee will focus on a number of implementation issues, including overview of implementation progress and problems; identification of major implementation bottlenecks such as resource flows, utilization, reporting etc.; the introduction of new initiatives, policy guidelines and programs, creating systems and mechanisms for information and experience sharing etc.

1.5 Annual Review Meeting (ARM)

The Annual Review Meeting is an important joint event bringing together representatives (usually over 200) from federal and regional government agencies, selected Woreda Health Offices, HPN Development Partners Working Groups, NGOs, Professional Associations, universities, the private sector and local and international consultants. The meeting takes place once a year in late September or early October. It reviews progress made during the previous year and the first half of the current year; the report of any Joint Review Mission [9]; and the plan for the coming year. It deliberates on studies, new policy issues and developments of sectoral significance. ARM is also the forum which reviews and endorses HSDP plans, reports of HSDP Mid-term Reviews and Final Evaluations. Its major outputs are Recommendations/Next Steps, the HSDP Annual Plan of Action for the coming year, and a Joint Statement of the Participants reflecting the major highlights of the meeting and pledges of commitment by all stakeholders.

[9] Joint Review Missions conduct interim reviews of HSDP implementation, if and when required.

2 Regional Level

2.1 Regional Joint Steering Committee (RJSC) (Regional policy/planning)

Regional Joint Steering Committees will be established in the 9 Regional States, and the Addis Ababa and Dire Dawa City Administrations. The structures and functions of the RJSCs will, to a large extent, be similar to those of the CJSC at the central level.

The RJSC will be chaired by the Head of the Regional Health Bureau. The members of the RJSC will include: the heads of Regional Bureau of Finance and Economic Development, Regional Bureau of Capacity Building, two Woreda Health Bureaus and representatives of development partners and NGOs operating in the area. The Regional Health Bureau can nominate the two best performing Woredas to sit on the RJSC on an annual basis in order to provide an insight into the practical situation at woreda level. Possible Terms of Reference for the RJSCs are given in Annex 9.

The Planning and Programming Department/Service of the Regional Health Bureau will serve as the Secretariat of the RJSC, performing similar functions as the CJSC Secretariat. The RJSCs will also meet at least on a quarterly basis.

Note that the CJSC will convene joint meetings with the Chairpersons of the RJSCs at least every other quarter (i.e. every six months).

(Some regions may also opt to have Zonal Joint Steering Committees – this depends on the situation in individual regions.)

2.2 Regional Review Meetings

Twice a year regions should hold a review meeting to review their plans and progress. For plans, issues include the timeliness of plan preparation; whether plans are adequately linked with budgets; how priority health issues are dealt with; and the compatibility of woreda and regional targets.

Monitoring is reviewing progress against the plan. Concentrating on the priority targets, there should be discussion about progress. If problems are apparent, steps should be identified to address them.

The meetings are also a good opportunity to introduce and explore new policy or implementation issues.

Participants should include major health stakeholders, including RHB staff, WorHOs, hospitals, NGOs, development partners and major private providers. It is the responsibility of the Regional Health Bureau to initiate these review meetings and ensure they happen on time.

3 Sub-Regional Level

3.1 Woreda Joint Steering Committee (Planning/Execution /Monitoring)

Each woreda should have a Woreda Health Joint Steering Committee. This committee should be consulted about the strategic and annual woreda health plans and should review progress against the annual plan on a quarterly basis. Links between this committee and the woreda council are important – the committee should ensure that health is a regular item on the agenda at woreda council meetings.

Suggested membership is as follows:

- Woreda administrator/deputy (chair)
- Head of the Woreda Health Office (secretariat)
- Heads of the health centers in the woreda
- Medical director of the district hospital
- Representative from WOFED
- Regional Health Bureau Representative (in order to avoid communication/information gaps, woredas can be organized into groups so that the respective focal points from Regional (or Zonal) Health Bureaus can attend the woreda quarterly meetings).
- NGOs should be represented by their focal persons working at woreda level. It is important that WorHOs and NGOs closely collaborate and work together. NGOs should share their plans, budgets and activities with WorHOs; WorHOs should include NGOs in their main planning and review mechanisms.
- It is essential to maintain the multi-sectoral and inter-disciplinary dimensions of health at woreda level. For this reason the committee shall include Women's Affairs Office, Education, Water, Agriculture and Youth Association as much as possible, taking the woreda capacity into consideration.

Woreda Joint Steering Committees should meet quarterly.

3.2 Kebele HIV and Health Committee (Planning/Execution/Monitoring – community participation)

Each kebele should have one HIV and Health Committee. This committee plays a crucial role because it brings together different sectors at a practical level, and because it is a vital link between the health system and the community. The committee also provides a good opportunity to enhance community participation in the health sector, especially in relation to the Health Extension Program.

The committee should be consulted about the strategic and annual health post plans (with an emphasis on the annual plan), and should review progress against the annual plan on a quarterly basis.

Suggested membership is as follows:

- Kebele administrator (chair)
- Health Extension Workers (secretariat)
- Community health workers
- Representative from the Woreda Health Office (should at least attend one meeting in a quarter in every kebele)
- Community representative (Community Based Organizations, women, youth, PLWHA network, etc.)
- Development Agents (agriculture)
- Representative of the School Development Committee/Agents
- In places where there are health, education and agricultural government focal persons at kebele level (like in Addis Ababa) they should be members of this committee.
- NGOs should be represented if the kebele is their main base, or if they have a significant program in the kebele. However as NGOs tend to work in more than one kebele, representation at the woreda level may be more appropriate. Whatever the arrangement, it is important that health posts and the Kebele HIV and Health Committee have information on the plans, budgets and activities of NGOs in their kebele and that they involve these NGOs in their planning and review mechanisms.

The Kebele HIV and Health Committee should meet monthly.

Table 5.1 summarizes the HSDP governance framework – its forums, membership and calendar.

!KEY POINTS!

1. This chapter describes a series of joint governance bodies at federal, regional and sub-regional levels.

2. Together these bodies contribute to policy making, implementation, consultation, coordination, planning, monitoring and community participation.

3. The governance bodies are important because HSDP implementation relies on strong vertical and horizontal linkages.

4. Regional and Woreda Joint Steering Committees are vital. It is important that they meet regularly to discuss practical issues and to monitor the implementation of plans. They should be held regularly, rather than waiting each time until absolutely all potential members can be present.

1	Forums	Membership	Timeframe
1.1	Federal Level	• Minister of Health (Chairperson) • State Minister of Health • PPD of FMoH (secretariat) • Oromia Health Bureau Head • MoFED • Representatives of Multi-lateral and Bilateral Development partners • HPN Development Partner's Working Group Chairperson • NGOs • Private sector • Health professionals associations	Quarterly (July, October, January, April)
1.2	Central Joint Steering Committee FMoH-Development Partners Joint Consultative Meeting	• State Minister of Health (Chairperson) • Heads of departments and services of FMoH • Head of Extension and Education Center, • Drug Administration and Control Authority • Ethiopian Health and Nutrition Research Institute • HPN Development Partners Working Group (Chairperson is co-chair) • NGO representatives • Head of Oromia Health Bureau • Head of the Addis Ababa City Administration Health Bureau.	Every two months
1.3	Joint Core Co-coordinating Committee	• PPD staff, with Head as Chairperson • 5 senior staff (with HSDP experience) from HPN Development Partners Group • FMoH Department Heads (as required)	Weekly (or as needed)
1.4	FMoH-RHBs Joint Steering Committee	• Minister of Health (Chairperson) • State Ministers of Health • Regional Health Bureau Heads • Heads of departments/services • Team leaders of the Ministry and RHBs (as needed)	Every two months (July, September, November, January, March, May)
1.5	Annual Review Meeting	• Federal and regional government agencies • selected Woreda Health Offices • Representative of Health Cadres from different levels of the public sector • HPN Development Partners Working Groups • NGOs • Professional Associations • Universities • Private sector representatives • Local and international consultants	Annual (end September/early October)

	Regional Level		
	Regional Joint Steering Committee	• Head of the Regional Health Bureau (chair) • Regional Bureau of Finance and Economic Development • Regional Bureau of Capacity Building • two Woreda Health Bureaus • representatives of development partners and NGOs	Quarterly (August, November, February, May)
	Regional Review Meetings	RHB staff, WorHOs, hospitals, NGOs, deveopment partners and major private proviers.	Bi-annual (September, February)
	Sub-Regional Level		Quarterly
	Woreda Joint Steering Committees	• Woreda administrator/deputy (chairperson) • Head of the Woreda Health Office (secretariat) • Heads of the health centers in the woreda • Medical director of the district hospital. • WoFED • Regional Health Bureau • NGOs As far as is practical: Women's Affairs Office, Education, Water, Agriculture and Youth Association.	Monthly
	Kebele HIV and Health Committee	• Kebele administrator (chair) • Health Extension Workers (secretariat) • Community health workers • Representative from the Woreda Health Office • Community representative (Community Based Organizations, women, youth, PLWHA network, etc.) • Development Agents (agriculture) • school development committee • NGOs • Kebele level health, education and agricultural government focal persons, where they exist.	

Annex 1 Code of Conduct to Promote Harmonization in the Health Sector of Ethiopia

Preamble

Harmonization and Alignment has become a global movement to improve the effectiveness of aid management to achieve the Millennium Development Goals. Reflecting this, the Government of Ethiopia is currently implementing a Harmonization Action Plan in cooperation with development partners. Within this broader framework, the health sector launched a sectoral action plan to promote harmonization in July 2005. This Code of Conduct is a major output of this plan. Accordingly, the Federal Ministry of Health and some development partners have agreed to sign the following Code of Conduct. It is hoped that more development partners will in due course become part of this joint commitment.

The aim of harmonization is to reduce the administrative burden of separate donor procedures and to allow government and donors alike to concentrate on the more strategic issues of coordinated planning and policy dialogue. The quality of this dialogue is important – it should not be rushed and should be frank and mutually respectful.

The code

Finances

1. Greater predictability of aid flows help the Ministry to plan effectively. Donors should make information available about commitments for the next 3 years; should update the Ministry as soon as possible of any changes; and should ensure that these pledges are realized and disbursed.

2. Matrices of donor commitments by activity (EPI, reproductive health, etc.) help the Federal Ministry and Regional Health Bureaus to plan effectively. Donors should provide all necessary assistance to develop and use these matrices, and to respect the findings of these matrices about areas of funding duplication or gaps.

3. The aim is to reduce the number of financing channels to a minimum. Funds will be pooled wherever possible - opportunities for pooling arrangements should be actively explored.

4. The Ethiopian fiscal year and chart of accounts should be used for financial reports.

One plan

5. HSDP-III is recognized as the centerpiece of health policy. Donor support should follow the priorities and procedures specified in this plan. Government and donors should engage in active debate about the contents and implementation of the plan.

Support systems

6. Government recognizes the importance of the quality of its own systems if harmonization is to improve:

- Financial reporting must be timely and of a high quality.
- Monitoring progress is an essential part of joint working – the Health Management Information System is thus crucial. A practical information strategy needs to be adopted which quickly identifies a small number of meaningful indicators that reflect progress in the key areas of HSDP-III (and hence the health component of SDPRP2).
- Procurement needs to be timely, transparent and offer value-for-money.
- Systems should be subjected to regular independent audit.

Where a donor has doubts about the quality of these systems, this should be openly discussed. The first strategy should be to work to improve the Government system. As a fallback position, it may be necessary for donors to work through one parallel system for a time-limited period.

7. There should be greater coordination of reports, analytical work, reviews and missions. Findings of studies should be openly shared. Single-donor activities should be kept to a minimum; wherever possible donors should work together on particular issues. The number of missions, etc., will be monitored.

8. The Program Implementation Manual – PIM – should be updated. The new version should strongly reflect the principles of harmonization.

9. There are already good structures for Government/donor communication. Every effort should be made to continuously improve the quality of their work in terms of policy dialogues and greater harmonization.

Arrangements amongst donors

10. The system of having a lead donor for a particular issue facilitates communication with the Ministry. For all major activities/issues, there should be a lead donor. "Silent donors" – which do not actively participate in a particular area and explicitly rely on another donor for representation and communication – are another useful device which should be encouraged.

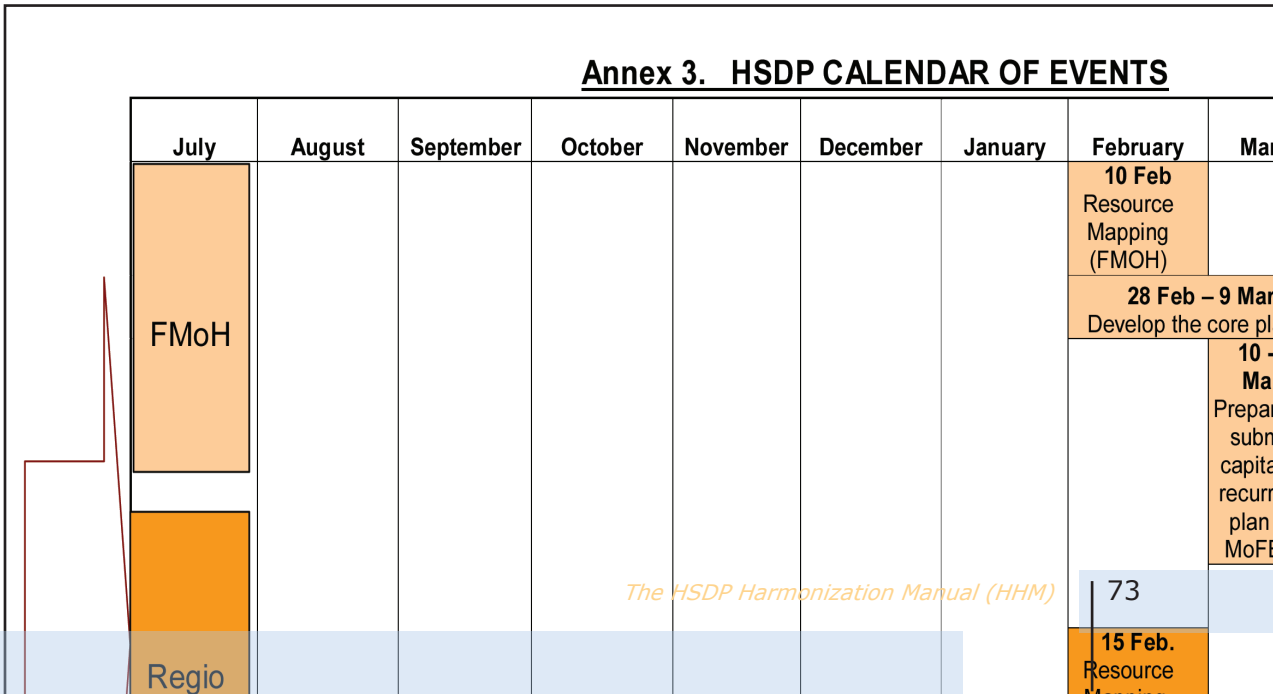
Tracker issues

11. Every year, two specific aspects of the health system – for example, a technical program or an input, such as human resources – should be identified as "tracker issues" for harmonization. They will be subject to particular scrutiny, lessons will be drawn, and particular efforts made to improve harmonization in these areas. This is a device to keep harmonization discussions and activities closely connected with the reality of what is happening.

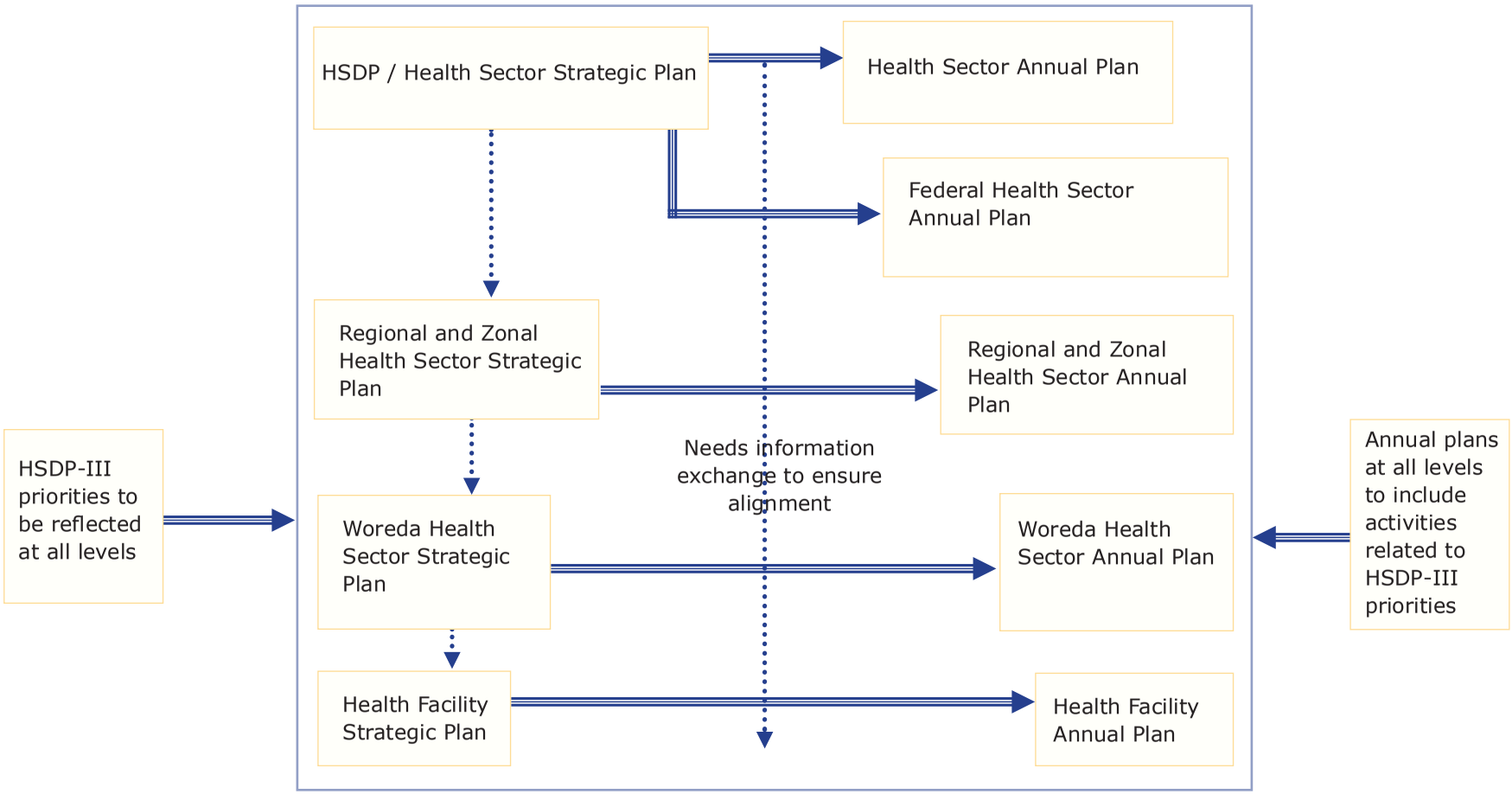
A living document

This Code is a living document, which has to be tested in practice. Progress and suggested changes should be reviewed annually, before the Annual Review Meeting of HSDP.

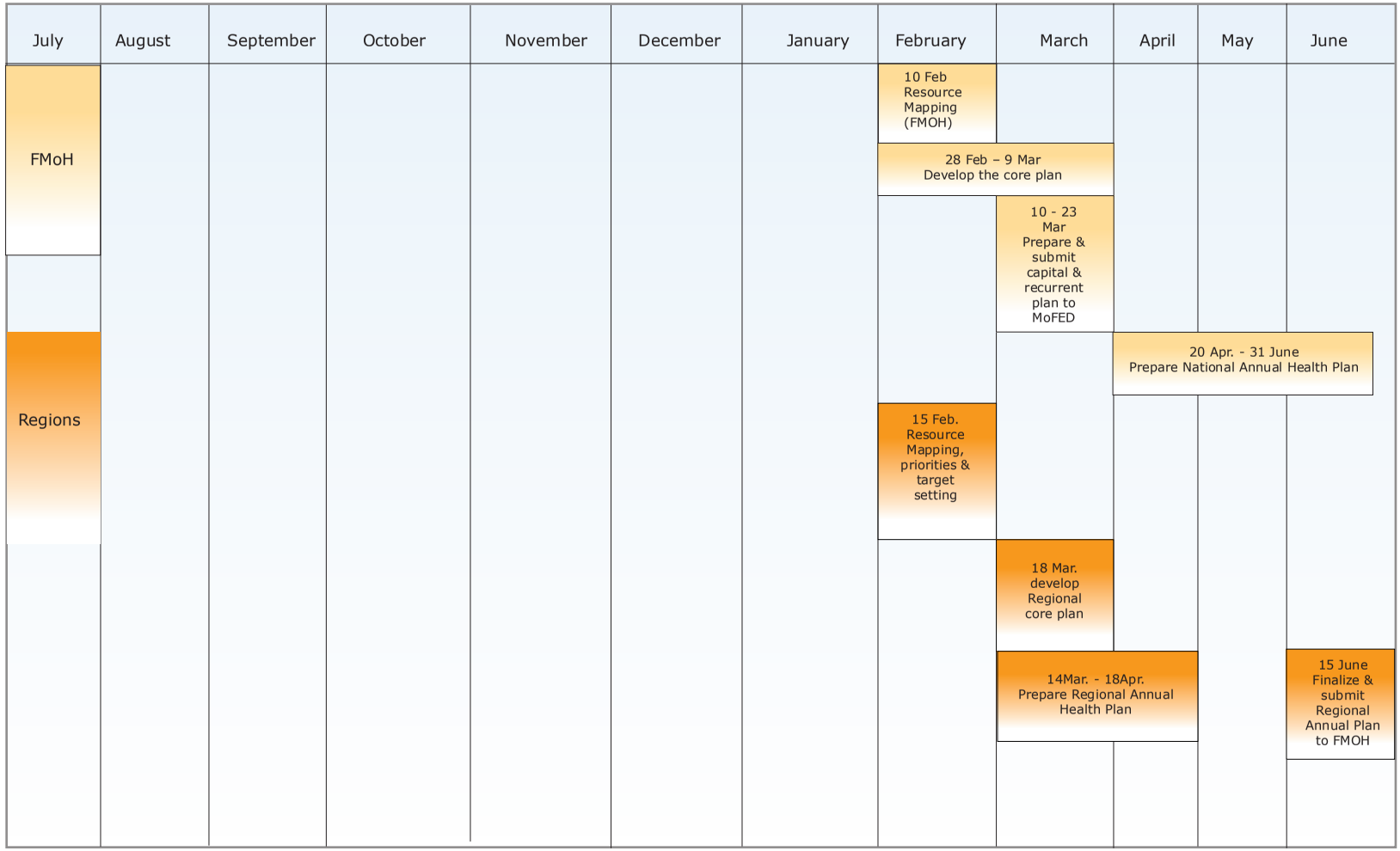
(Signed By Ministry of Health and many donors/development agencies.)

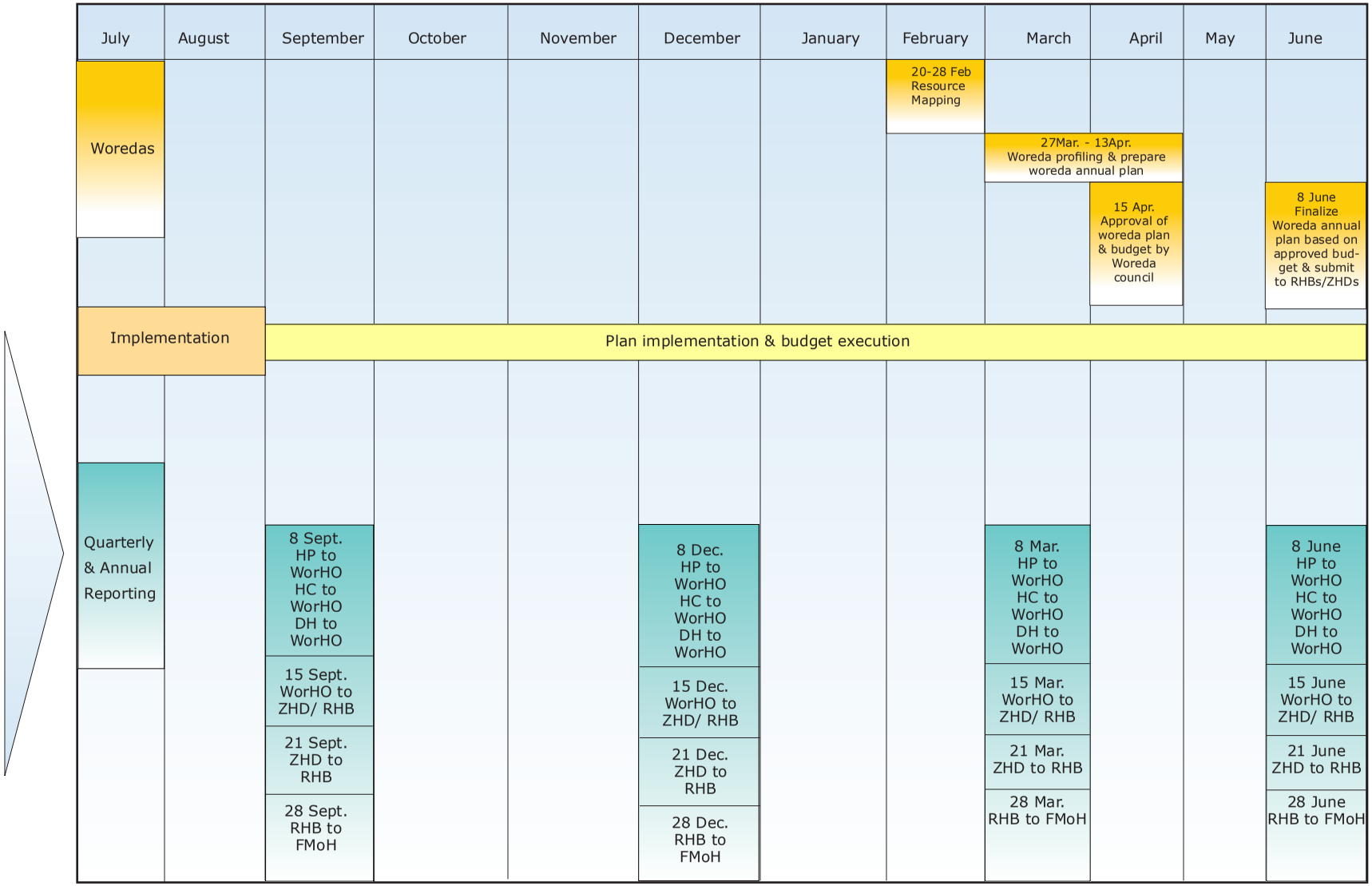


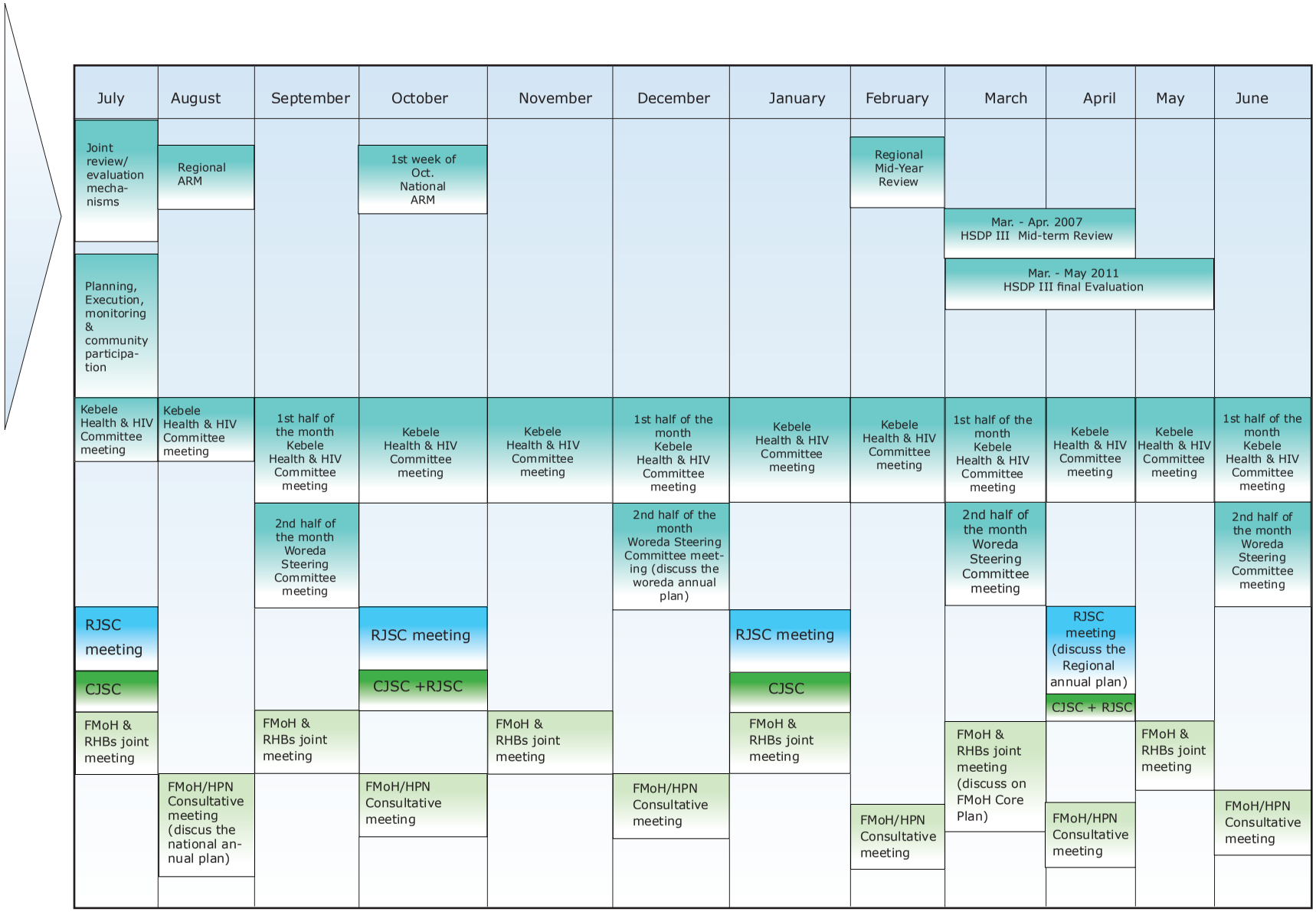
Annex 2 Strategic and annual plans



Annex 3. HSDP CALENDAR OF EVENTS




July
August
September
October
November
December
January
February
March
April
May
June
Woredas
20-28 Feb Resource Mapping
27Mar. - 13Apr. Woreda profiling & prepare woreda annual plan
15 Apr. Approval of woreda plan & budget by Woreda council
8 June Finalize Woreda annual plan based on approved budget & submit to RHBs/ZHDs
Implementation
Plan implementation & budget execution
Quarterly & Annual Reporting
8 Sept. HP to WorHO HC to WorHO DH to WorHO
15 Sept. WorHO to ZHD/ RHB
21 Sept. ZHD to RHB
28 Sept. RHB to FMoH
8 Dec. HP to WorHO HC to WorHO DH to WorHO
15 Dec. WorHO to ZHD/ RHB
21 Dec. ZHD to RHB
28 Dec. RHB to FMoH
8 Mar. HP to WorHO HC to WorHO DH to WorHO
15 Mar. WorHO to ZHD/ RHB
21 Mar. ZHD to RHB
28 Mar. RHB to FMoH
8 June HP to WorHO HC to WorHO DH to WorHO
15 June WorHO to ZHD/ RHB
21 June ZHD to RHB
28 June RHB to FMoH


July
August
September
October
November
December
January
February
March
April
May
June
Joint review/ evaluation mecha-nisms
Planning, Execution, monitoring & community participa-tion
Regional ARM
1st week of Oct. National ARM
Regional Mid-Year Review
Mar. - Apr. 2007 HSDP III Mid-term Review
Mar. - May 2011 HSDP III final Evaluation
Kebele Health & HIV Committee meeting
1st half of the month Kebele Health & HIV Committee meeting
2nd half of the month Woreda Steering Committee meeting
2nd half of the month Woreda Steering Committee meet-ing (discuss the woreda annual plan)
RJSC meeting
CJSC
CJSC +RJSC
RJSC meeting (discuss the Regional annual plan)
CJSC + RJSC
FMoH & RHBs joint meeting
FMoH & RHBs joint meeting (discuss on FMoH Core Plan)
FMoH/HPN Consultative meeting
FMoH/HPN Consultative meeting (discus the national an-nual plan)

Annex 4 Resource mapping
5A Template for resource mapping

Priority activity area	***EXPECTED FINANCING AND OTHER RESOURCES FROM…..***								
	Government of Ethiopia	Multilateral A	Multilateral B	Bilateral A	Bilateral B	Global Initiative A (e.g. Global Fund)	Foundation A	NGO A	Etc., etc.
Family planning (can be broken down into smaller categories/narrower activities)									
TB									
Malaria									
Health Extension Program – training activities									
Construction of health posts									
Etc., etc.									

Annex 4B
Extract from One plan, One budget for EFY 1999, Tigray Health Bureau

This table was drawn up after a resource mapping exercise.

Key result area by strategic objective	**Planned (1) (millions birr)**	**Government (2) (millions birr)**	**Donor support (millions birr)**		**Deficit (millions birr) [1-(2+3)]**
			Regular	**Other**	
Health extension program (7 targets)	**5**	**0.4**	1.3 UNFPA 0.2 UNICEF	0.3 UNICEF	2.8
Maternal and child nutrition (MDG1) (4 targets)	**9**		1.4 UNICEF	4.6 UNICEF	7.6
Child health (MDG4) (3 targets)	**8.6**		0.8 UNICEF		3.2
Maternal health (MDG5) (4 targets)	**8.5**		0.3	3.8 UNICEF 4.7 UNFPA	None

Note how there is one column for government money and another for donors'. The last column shows the deficit, or shortage of money.

Annex 5 Channels for funds from donors

Channel 1a (unearmarked) is the disbursement channel used by Government itself. At each administrative level, the specialized Finance bodies control the release of funds and report upwards on their utilization. The same principles apply to both recurrent and capital budgets. Although MOFED, at the Federal level, and BOFEDs, at regional level, have a special role in approving and supervising the capital budget, the disbursement and accounting functions remain with MOFED, BOFEDs, and WoFED offices. This is the channel that is used by donors providing budget support.

The Government of Ethiopia supports direct budget support for health and other sectors. In order to ensure that public funds are appropriately channeled towards priority areas for HSDP-III - particularly the implementation of the Health Extension Program (HEP) – public fund management and transfers (stemming from both domestic revenue and Direct Budget Support) need to be strengthened. The health budget allocation at the woreda level has to increase. This means progressively increasing resources that are channeled directly to the service delivery point. These resources can finance key local recurrent costs associated with the high performance of health services (e.g. wages, incentives and bonuses, maintenance and functioning costs of buildings and vehicles, fuel for transport, community events, etc.) but also local investment costs (such as buildings construction and rehabilitation, investment in seed funds for special pharmacies/drug revolving funds, local training, etc.)

Channel 1b (earmarked) can be used by several of the larger multilateral and bilateral donors, such as the World Bank, the African Development Bank, and the British DFID. Such donors are in favor of using existing government channels, with funds flowing from their special accounts to the MOFED, and then through the regional and woreda offices and health bureau, as described in Channel 1a above. However with this alternative, there will be no pooling of funds, with funds from each donor being tagged (with a two figure code) and sent to the region and zone/woreda (with a location code). The funds are reported on and accounted for separately; and used to pay only for activities agreed by the particular donor, often according to its specific procurement and disbursement procedures. As soon as expenditures are incurred for the sub-project, they are accounted for, so that replenishment requests to the donor special account (revolving fund) can be prepared. All other arrangements are as described in Channel 1a above.

Channel 2 is used by a number of bilateral and multilateral agencies. The Regional and Zonal/Woreda finance bodies are by-passed. Sector units at each administrative level expend and account for funds. There are variations on this channel. Some donors centralize disbursement responsibility at the Federal level (so that even regional contractors are paid centrally). Other donors have worked directly with regional and/or woreda administrations.

Channel 3: Most of the UN agencies and some bilateral donors currently use Channel 3. The donor usually carries out any procurement and pays the contractor itself. Government merely agrees to, and budgets for, what is to be provided by the donor, and ensures that the expenditures are included in any overall HSDP accounting and auditing. This channel is often used when the donor is providing technical assistance or commodities, either to the center or directly to the decentralized administrative units.

Channel 3 can take the form of funds sent to regions and woredas. The funds are replenished when information about disbursement is received and checked.

Protecting Basic Services (PBS) was developed when budget support ended. The World Bank and other international development partners (DFID, CIDA) provide funds through government channels, targeted at the delivery of basic services (including health). PBS also includes a Health Performance Pooled Facility, mostly for the purchase of basic health commodities such as contraceptives.

The MDG Performance Package Fund is described in HSDP-III and started working in 2007 with funds from GAVI for Health Systems Strengthening. The particular nature of health services – a large number of public good elements in service delivery and a high proportion of recurrent inputs bought internationally (medicines, commodities and equipment) – warrants the establishment of a strong Federal MOH Level MDGs Performance Package Fund to support the logistics of the implementation of HSDP-III. This pooled fund has three components.

i) Component # 1 HEP: The Health Extension Program is the flagship program for the Government of Ethiopia to achieve the child health MDG and prevention of communicable diseases. It is fully integrated into HSDP-III. Training of the health extension workers (HEWs) is progressing as planned to achieve two female HEWs within all rural kebeles. The government is committed to covering salaries and part of the health post construction costs. The effective implementation of HEP, however, requires basic infrastructure (health post);

equipment (cold chain, ORT kit, delivery kits, etc.), essential health commodities (vaccines, contraceptives, ITNs), well-trained HEWs and a well-functioning system for logistics, supervision and reporting. The HEP component of the MDG Performance Package Fund aims to provide these inputs to facilitate the implementation of the program.

ii) Component # 2 Obstetric Care: Considering the present level of the maternal mortality ratio and the coverage level of maternal health interventions, reaching the maternal MDG target represents an enormous challenge. It requires a concerted effort to enhance service delivery capacity at health centers. Access to health centers should increase as indicated in the Accelerated Expansion of Primary Health Services Coverage in Ethiopia. Health centers need to be equipped with basic emergency obstetric care commodities. Human resources trained in Basic and Comprehensive Emergency Obstetric Care need to be assigned to health centers. A well-functioning referral system with the required transport is needed. Hence, component 2 of the MDG Performance Package Fund should contribute to the resource requirements of quality obstetrical care.

iii) Component # 3 Technical Assistance: The technical assistance component aims to provide support in sectoral reviews, operational research, and other activities at FMOH level. This component was established in 2005. In the first phase, four donors pooled over US$650,000, with the fund out-sourced to UNICEF.

Annex 6: Key indicators

6A) Key Indicators for Monthly / Quarterly Monitoring by Health Institutions

	Health Institutions					Indicator Set		
Indicator	**HP**	**HC**	**Hosp**	**WorHO**	**RHB FMOH**	**MDG**	**PASDEP**	**HSDPIII**
Family Health								
Reproductive Health								
Contraceptive acceptance rate	x	x	x**	x	x			x
Antenatal care coverage	x	x	x**	x	x			x
Proportion of deliveries attended by skilled health personnel		x	x**	x	x	x	x	
Proportion of deliveries attended by HEWs	x			x	x			
Immunization								
Pentavalent (DPT3+HepB3+Hib3) immunization coverage (under 1s)	x	x	x**	x	x		x	x
Measles immunization coverage (under 1s)	x	x	x**	x	x	x		x
Disease Prevention and Control								
New malaria cases per 1000 population*	x	x	x	x	x			
Malaria case fatality rate amongst under 5 years			x	x	x			
New pneumonia cases amongst under 5s per 1000 population under 5 years*	x	x	x	x	x			
TB case detection rate		x	x**	x	x	x		x
TB cure rate		x	x**	x	x	x	x	x
Number of clients receiving VCT services		x	x	x	x			x
PMTCT treatment completion rate		x	x	x	x			x
Number of PLWHA currently on ART		x	x	x	x			x
Resources								
Tracer drug availability (in stock)	x	x	x	x	x			x
Utilization								
OPD attendance per capita	x	x	x**	x	x		x	x
In-patient admission rate			x**	x	x			x
Average length of stay			x	x	x			x
Bed occupancy rate			x	x	x			x
HMIS/M&E								
Reporting completeness rate				x	x			x
Reporting timeliness rate				x	x			x

* Malaria and pneumonia cases are not specific national or international priority indicators. They are recommended for monthly / quarterly monitoring because of their importance as causes of morbidity and mortality. When cases are compared across different locations, or reported to a higher level, they should be calculated per 1000 population to permit comparison. Internally, a HI may simply compare number of cases over time, since the population remains relatively constant.

** Population-based coverage rates estimated at woreda hospitals only.

6B) Key Indicators: Frequency of Monitoring and Tools

	Health Institutions					Monitoring Tool
Indicator	**HP**	**HC**	**Hosp**	**WorHO**	**RHB FMOH**	Monitoring Tool
Family Health						
Reproductive Health						
Contraceptive acceptance rate	monthly	monthly	monthly**	quarterly	quarterly	Achievement vs plan
Antenatal care coverage	monthly	monthly	monthly**	quarterly	quarterly	Achievement vs plan
Proportion of deliveries attended by skilled health personnel		monthly	monthly**	quarterly	quarterly	Achievement vs plan
Proportion of deliveries attended by HEWs	monthly			quarterly	quarterly	Achievement vs plan
Immunization						
Pentavalent (DPT3+HepB3+Hib3) immunization coverage (under 1s)	monthly	monthly	monthly**	quarterly	quarterly	Achievement vs plan
Measles immunization coverage (under 1s)	monthly	monthly	monthly**	quarterly	quarterly	Achievement vs plan
Disease Prevention and Control						
New malaria cases per 1000 population*	monthly	monthly	monthly	quarterly	quarterly	This year vs last year
Malaria case fatality rate amongst under 5 years			monthly	quarterly	quarterly	This year vs last year
New pneumonia cases amongst under 5s per 1000 population under 5 years*	monthly	monthly	monthly	quarterly	quarterly	This year vs last year
TB case detection rate		quarterly	quarterly**	quarterly	quarterly	Achievement vs plan
TB cure rate		quarterly	quarterly**	quarterly	quarterly	Achievement vs plan
Number of clients receiving VCT services		monthly	monthly	quarterly	quarterly	This year vs last year vs plan
PMTCT treatment completion rate		monthly	monthly	quarterly	quarterly	This year vs last year vs plan
Number of PLWHA currently on ART		monthly	monthly	quarterly	quarterly	This year vs last year vs plan
Resources						
Tracer drug availability (in stock)	monthly	monthly	monthly	quarterly	quarterly	Achievement vs plan
Utilization						
OPD attendance per capita	monthly	monthly	monthly**	quarterly	quarterly	This year vs last year vs plan
In-patient admission rate			monthly**	quarterly	quarterly	This year vs last year vs plan
Average length of stay			monthly	quarterly	quarterly	This year vs last year vs plan
Bed occupancy rate			monthly	quarterly	quarterly	This year vs last year vs plan
HMIS/M&E						
Reporting completeness rate				quarterly	quarterly	Achievement vs plan
Reporting timeliness rate				quarterly	quarterly	Achievement vs plan

* Malaria and pneumonia cases are not specific national or international priority indicators. They are recommended for monthly / quarterly monitoring because of their importance as causes of morbidity and mortality. When cases are compared across different locations, or reported to a higher level, they should be calculated per 1000 population to permit comparison. Internally, a HI may simply compare number of cases over time, since the population remains relatively constant.

** Population-based coverage rates estimated at district hospitals only.

Annex 7

HMIS / M&E
HEALTH INSTITUTION QUARTERLY KEY INDICATOR REPORTING FORM

REGION _____ ZONE _____ WOREDA _____

QUARTER _____YEAR _____

A	B		C		D		E	F	G
Indicator	**Numerator** / **Denominator**		**Current Quarter**		**Cumulative to date**		**Target this year**	**Value last year**	**Investigation / Action Needed?**
			Actual figures	**Value of the Indicator**	**Actual figures**	**Value of the Indicator**			
Family Health *Reproductive Health*									
Contraceptive acceptance rate	Number of new and repeat acceptors / Total number of non-pregnant women of reproductive age (15-49 years) in period	x100		x100					
Antenatal care coverage	Number of first antenatal visits / Total number of expected pregnancies in period	x100		x100					
Proportion of deliveries attended by skilled health personnel	Number of deliveries attended by skilled health personnel / Total number of expected deliveries in period	x100		x100					
Proportion of deliveries attended by HEWs	Number of deliveries by attended by Health Extension Workers / Total number of expected deliveries in period	x100		x100					

Annex 7

A	B		C	D	E	F	G
Indicator	**Numerator** **Denominator**		**Current Quarter** **Actual figures** / **Value of the Indicator**	**Cumulative to date** **Actual figures** / **Value of the Indicator**	**Target this year**	**Value last year**	**Investigation / Action Needed?**
Immunization							
Pentavalent (DPT3+HepB3+Hib3) immunization coverage (under 1s)	Number of children who received the third dose of pentavalent vaccine before 1st birthday Total number of surviving infants in period	x100	_____ x100	_____ x100			
Measles immunization coverage (under 1s)	Number of children who received measles immunization before 1st birthday Total number of surviving infants in period	x100	_____ x100	_____ x100			
Disease prevention and control							
New malaria cases per 1000 population	Number of new malaria cases Total population in period	x1000	_____ x1000	_____ x1000			
Malaria case fatality rate amongst under 5 years	Number of malaria deaths amongst inpatients under 5 years Number of inpatient malaria discharges and deaths amongst inpatients under 5 years of age	x100	_____ x100	_____ x100			
New pneumonia cases amongst under 5s per 1000 population under 5 years	Number of new pneumonia cases amongst under 5s Population under 5 years in period	x1000	_____ x1000	_____ x1000			
TB case detection rate	Number of new sputum smear-positive TB cases detected Estimated number of new sputum smear-positive pulmonary TB cases in period	x100	_____ x100	_____ x100			
TB cure rate	Number of new sputum smear-positive TB cases that were cured (that completed treatment and had a negative sputum smear result in the last month of treatment and on at least one previous occasion during treatment) Total number of new sputum smear-positive TB cases registered for treatment	x100	_____ x100	_____ x100			

A	B		C	D	E	F	G
Indicator	**Numerator** **Denominator**		**Current Quarter** **Actual figures** / **Value of the Indicator**	**Cumulative to date** **Actual figures** / **Value of the Indicator**	**Target this year**	**Value last year**	**Investigation / Action Needed?**
Number of clients receiving VCT services	Number of clients receiving VCT services Number of HIV-positive deliveries with full course of ARV prophylaxis (for woman and newborn)						
PMTCT treatment completion rate	Number of HIV-positive deliveries with full course of ARV prophylaxis (for woman and newborn) Total number of HIV-positive deliveries	x100	x100	x100			
Number of PLWHA currently on ART	Number of PLWHA currently on ART		x100	x100			
Resources							
Tracer drug availability (in stock)	Number of months with tracer drug in stock, summed for all tracer drugs Number of months in period x number of tracer drugs	x100	x100	x100			
Utilization							
OPD attendance per capita	Number of outpatient visits (first and repeat) Population in period	x100					
In-patient admission rate	Number of in-patient admissions Population in period	x1000	x1000	x1000			
Average length of stay	Number of admission days (total length of stay) Number of in-patient admissions						

Annex 7

A	B		C	D	E	F	G
Indicator	**Numerator** / **Denominator**		**Current Quarter** — **Actual figures** / **Value of the Indicator**	**Cumulative to date** — **Actual figures** / **Value of the Indicator**	**Target this year**	**Value last year**	**Investigation / Action Needed?**
Bed occupancy rate	Number admission days (total length of stay) / Number of beds x number of days in period	x100	x100	x100			
HMIS/M&E							
Reporting completeness rate	Total number of reports received / Total number of reports expected	x100	x100	x100			
Reporting timeliness rate	Total number of reports received on time / Total number of reports expected	x100	x100	x100			

Annex 8 Terms of Reference: Central Joint Steering Committee

(A) Structure of the CJSC

I. A Central Joint Steering Committee shall be established at the country level.

II. The steering committee shall consist of the appropriate representative of the government, the donor community, non-governmental organizations, the private sector and the civil society .

III. The CJSC of HSDP shall be chaired by the Minister of Health

IV. Members shall include

- the Minister of Health,
- the State Minister of Finance and Economic Development,
- the State Minister of Health,
- Resident Representatives of World Health Organization, the World Bank and USAID
- one ambassador of the EU partners,
- Chairperson of the Health, Population and Nutrition (HPN) Donors Group,
- Head of Oromia Health Bureaus,
- CRDA or CORHA representing the NGOs,
- A representative of the private sector (Medical Association of Physicians in Private Practice (MAPPP) or any other),
- An elected member representing the various associations of health professionals (Professional associations will seat on CJSC on rotation basis (rotate every year). There should only be one representative of professional association in CJSC at a time, representing all professional associations. The associations have to decide who should be the first, the next and so on).

V. The CJSC shall set-up a broader joint consultative forum for the FMOH and HPN Donors Group and other partners to facilitate the implementation process of HSDP.

VI. The CJSC shall, whenever the need arises, set-up sub-committees and technical working groups to assist it in technical matters.

(B) Duties and Responsibilities of the CJSC

1. The CJSC shall meet at least on a quarterly basis, possibly in the months of July, October, January and April. Two of the four meetings will be with the RJSC.
2. The CJSC shall be the highest body set-up to decide, guide, oversee and coordinate the health sector development program.
3. The CJSC shall focus on policy related issues such as HEP, health human resource, health system development, reproductive health/population, and diseases of poverty (HIV/AIDS, TB, malaria and others) and create an enabling environment, so that the policy decisions can be implemented.
4. The CJSC shall serve as a joint forum for dialogue on sector policy and reform issues between the Government, development partners and other stakeholders, in line with the principles laid down for the partnership and dialogue framework of SDPRP/PASDEP.
5. The CJSC shall give general guidance and framework for the preparation of health sector strategic plans, annual review meetings, Joint Review Missions and evaluations of the sector plan.
6. The CJSC shall consult on ways of mobilizing resources to support the implementation of the sector plan and to make the sector finance-able on a sustainable basis. It shall also monitor the effective utilization of the resources.
7. The CJSC shall oversee the proper implementation of Component 2 (Health MDG Performance Facility) of the Protection of Basic Services Project (PBS), with special attention to the procurement of commodities.
8. The CJSC shall oversee and regularly monitor the implementation of the Health Sector Harmonization Action Plan and the Code of Conduct jointly developed with development partners.
9. The CJSC shall, whenever necessary, consult and advise the government on matters arising from or affecting the implementation process of the program. It shall create mechanisms for informing and consulting bilateral government, multilateral agencies, non-governmental organizations and the private sector.
10. The CJSC shall convene joint meetings with the Chairpersons of the RJSCs. To this end, the expanded CJSC including heads of RJSCs shall meet every other quarter. It shall render support to the RJSCs and ensure that effective linkage and communication with them is maintained and strengthened.

(C) Duties and Responsibilities of HSDP Secretariat:

The Secretariat shall:-

1. Be responsible for following up the day to day matters of the Central Joint Steering Committee and for facilitating its deliberations.

2. Support the efficient functioning of the CJSC by ensuring:

   a. The efficient organization of the agenda in consultation with the Chairperson and members of the CJSC
   b. The timely circulation of programs and working documents
   c. The timely delivery of reports and minutes to the wider development partners and RJSCs.
   d. systematic follow-up to implement the decisions of the Committee
   e. Create close operational linkage between the CJSC and the RJSCs through a two-way exchange of reports and minutes.

3. Receive timely reports from implementing bodies, consolidate and present them to the CJSC, and when endorsed, communicate them to the appropriate users. It shall also be responsible for the consolidation and presentation of the annual implementation report of the sector at the ARMs.

4. Coordinate program implementation, facilitate information flow and keep consolidated documents on a country- wide basis.

5. Chair the Joint Core Coordinating Committee (JCCC) which is the technical arm of the FMOH-HPN Donors Joint Consultative Forum.

6. In collaboration with the JCCC, organize the Annual Review meetings, Joint Review Missions and Evaluations of HSDP, and other meetings as may be required and instructed by the CJSC and report on their outcomes.

7. In collaboration with the JCCC, organize and facilitate the Joint Consultative Meeting of the FMoH and the HPN Donors Group, which shall be held every two months, and follow-up the implementation of its decisions.

8. Organize and facilitate the bi-annual joint meeting of the CJSC and the Chairpersons of the RJSCs, and follow up the implementation of the joint decisions.

Annex 9 Terms of Reference: Regional Joint Steering Committees (Can be adapted locally.)

(A) Structure of the RJSC:

1. RJSCs shall be established in all the 9 Regional States and in Addis Ababa and Dire Dawa City Administrations.

2. The RJSC shall consist of the appropriate heads of Regional Government institutions, donors' and other stakeholders' representatives.

3. The RJSC shall be chaired by the Head of the Regional Health Bureau.

4. Members of the RJSC will include Head and Deputy Head of RHBs, Heads of Finance and Economic Development and other relevant Regional Sector Bureaus, representatives of donors and NGOs operating in the region.

5. The Planning and Programming Department/Service of the Health Bureau shall act the Secretariat for the RJSC.

6. The RJSC may set up consultative and technical working groups to facilitate its functions.

(B) Duties and Responsibilities of the RJSC:

1. The RJSC shall meet at least on a quarterly basis, preceding the quarterly meetings of the CJSC i.e. in the months of December, March, June and September.

2. The RJSC shall be the highest body in the region set-up to oversee, coordinate and facilitate the implementation of the health sector program.

3. The RJSC shall regularly monitor, endorse and submit to the CJSC, the regional plans, recommend alterations in the plans, implementation activities and progress reports.

4. The RJSC shall coordinate activities towards making the regional plans fundable on a sustainable basis, mobilize local resources and monitor their effective utilization.

5. The RJSC shall coordinate and harmonize the activities of the community, donors and non-governmental organizations in the region.

6. The RJSC shall make sure that the appropriate financial and activity reports are submitted to the CJSC in time. It shall also facilitate communications, joint reviews and evaluation of the program.

7. The RJSC shall, whenever necessary consult and advice the Regional Government and the CJSC on matters arising from or affecting the implementation process of the sector program in the region.

(C) Duties and Responsibilities of the Regional Secretariat

1. The Secretariat shall be responsible for following up the day to day matters of the RJSC and for facilitating its deliberations.

2. The Secretariat shall, on the basis on the guidance given by the RJSC, lead and coordinate the preparation of the regional sector strategic and annual plans. It shall also provide the necessary assistance and guidance to the zonal and woreda health offices to ensure harmonized and integrated approach in plan preparation.

3. The Secretariat shall coordinate program implementation, organize and facilitate the monitoring, review and evaluation programs of the region. On the basis of the guidance given to by the RJSC, it shall coordinate the preparation of the Regional Annual Review Meeting.

4. The Secretariat shall, in collaboration with Bureaus of Finance and Economic Development, collate woreda and regional reports, and consolidate them for presentation to RJSC and when endorsed, communicate them to the appropriate regional government bodies and the CJSC Secretariat.

5. The Secretariat shall provide the necessary assistance to Zonal and Woreda Health Offices, federal and regional government bodies, sub-committees, technical working groups, monitoring, review and evaluation teams and other stakeholders.

6. The Secretariat shall receive and consolidate zonal/woreda reports on the activities of WJSCs, and present regular reports on the same to the RJSC.

7. The Secretariat shall prepare brief reports on the quarterly meetings of the RJSC, and when endorsed by the RJSC, transmit the report to the Secretariat of the CJSC. It shall likewise, receive the reports on the quarterly meetings of the CJSC from HSDP Secretariat and present the same to the RJSC.

8. The Secretariat shall maintain close communication with the HSDP Secretariat to organize the agenda and the preparation of the biannual Joint Consultative Meeting of the Federal Ministry of Health and the Regional Health Bureaus.

9. The Secretariat shall be responsible for organizing, keeping and disseminating consolidated documentation on the health profile, programs and activities of the region.