Roadmap for Enhancing the implementation of One Plan, One Budget and One Report in Ethiopia

Consultancy to take forward the International Health Partnership

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FINAL REPORT

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Summary

From April to October 2011, work was undertaken to develop a Roadmap for improving harmonisation and alignment in the health sector in Ethiopia. This work is known as "Enhancing One Plan, One Budget, One Report".

This report presents the main outputs of the work – the quantitative data on progress and the final Roadmap. It is not a comprehensive description of the work which culminated in this Roadmap. Interested readers are referred to the three previous reports for details.

Quantitative findings from the questionnaire showed that in Ethiopian Fiscal Year 2002 (2009/10):

- Over 70% of development assistance came from the Global Fund for AIDS, TB and Malaria and the US Government
- 76% of DP-funded activities were on-plan, but only 39% of spending was on-budget (i.e. reflected in the sector's overall budget).
- Despite an increase in the number of DPs which pooled funds, only 14% of funding was through pooled funds. Pooled funds were (and remain) the FMOH's preferred aid modality for federal level health sector funding.

Before giving the details of the Roadmap, it is important to stress that the Roadmap will only be implemented successfully if the right "operating environment" exists. This is explored further in Chapter 4. Some examples of developing a favourable "operating environment" are:

- Building confidence in partnership and co-ordination – developing a shared vision of what One Plan/Budget/Report can achieve.
- Maintaining strong co-ordination structures, including JCCC and JCF, as well as HPN for co-ordinating DPs
- The timely updating of the HSDP Harmonization Manual and a high profile given to its launch and dissemination. Follow-up of adherence to the manual.

The final Roadmap is shown overleaf. It is important to understand that the "activities" column was discussed and presented at ARM. The "monitoring" column, in contrast, is new in this report. The overall Roadmap is summarised in the graphic below.

Activity in Roadmap	Government	Development Partners	NGOs/Implementing Partners
Improve adherence to One Plan, One Budget, One Report			
Expand MDG Performance Fund			
Strengthen co-ordination and representation of (a) NGOs and (b) Implementing Partners			
Write and disseminate an international advocacy paper		(Support role if required)	
Monitor harmonization and alignment using the indicators in HSDP IV and the IHP+ Compact			

Major role Support role

The Roadmap is designed to complement other workstreams initiated by the Government of Ethiopia, but not to overlap with them. For this reason it does not include actions related to HMIS or actions which are already included in the Plan of Action responding to the Financial Management Assessment of the MDG Performance Fund.

The report ends with a discussion of how One Plan, One Budget, One Report can be thought of as changing a whole **mindset**, rather than something which can be achieved by merely completing a list of activities. All parties need to actively seek to contribute to making the cycle of *strategic plan/budget → annual plan/budget → monitoring* work effectively.

ROADMAP FOR REVITALIZING ONE PLAN, ONE BUDGET, ONE REPORT	
Activity	**Monitoring – how, who, when?**
1. Improve adherence to One Plan, One Budget, One Report	
1(a) Ministry to provide clarity on, and speak with one voice about, One Plan, One Budget, One Report. One Plan/Budget/report to be institutionalized within the workings of HPN.	All plans and budgets (from Service Delivery, Planning etc) to clearly fit together. (by July 2012) Final TOR and action plan of HPN by latest February 2012.
1(b) Government to enforce adherence to the HSDP Harmonization Manual at all levels and by all parties (government, DPs, IPs, NGOs).	HHM to be updated, discussed, printed, disseminated and translated. (JCCC to approve TORs and timetable by end February 2012) Documented actions demonstrating how adherence is enforced. (Government to present to JCF 6 months after launch of HHM)
1(c) Government to continue strengthening regional and woreda planning and implementation, resource mapping, and co-ordination.	JCF to review after publication of 20012/13 woreda plans. JCCC to commission a review to inform the JCF.
1(d) Government to strengthen planning units' links with (and where appropriate co-ordination of) NGOs and IPs. (All levels of planning units)	JCF to review by end 2012. JCCC to commission a review to inform the JCF.
1(e) Government to hold DPs publically accountable (e.g. scores for 3 indicators)	HHM to specify indicators for annual accountability. FMOH annual performance report to include these indicators.
1(f) DPs to monitor government performance based on agreed frameworks – i.e. DPs to hold Government publically accountable. (HHM, IHP+, JFM, JRIS)	HHM to specify indicators of government performance. Annual report at ARM.
1(g) Development Partners to advocate and provide information to HQ about harmonizing and aligning their support, as stipulated in HSDP IV.	HPN to collate evidence to present in ARM 2012.
1(h) DPs to enforce adherence to HHM by the NGOs and IPs which they fund.	HPN to develop register and monitor – report to be included in annual performance report for ARM.
1(i) DPs to consider DP and IP thematic groups to work together for one plan, one budget and one report.	JCF to develop action plan for TWGs, including monitoring. HPN to consider how IPs can be involved in HPN and if any role for sub-groups within HPN.
1(j) DPs to align to EFY calendar.	All documents produced by DPs to be aligned to EFY calendar. (See HSDP IV, Annex 5)

2. Expand MDG Performance Fund	
2(a) Government to promote the advantages of MDG PF, in view of its flexibility in resourcing priority areas of HSDP.	Monitor impact of this activity in terms of amount of funding, number of donors, % of overall funding. Include in FMOH's Annual Performance Report.
2(b) Government to ensure that MDG PF spending at regional level complements PBS and the Block Grant.	Through regular MDG PF reports.
2(c) Government *r*e-enforces its systems (FMA plan) to ensure accountability and transparency. (Included in Plan of Action resulting from Financial Management Assessment, 2011)	Separate piece of work. Oversight by JCF. Plan of Action monitored by JCCC.
2(d) Government to enhance its Value For Money and effective utilization.	The Joint Financing Arrangement specifies how the MDG PF will be monitored, reviewed and evaluated.
2(e) DPs: HPN to work towards increasing the overall contribution of MDG PF from total Sector Funding (IHP+ compact target for 2010 was 60%)	As 2(a).
2(f) DPs – regular updates about MDG PF and how it relates to One Plan/Budget/Report as a standing item on HPN agenda.	HPN to agree frequency of these updates by end February 2012. Then this can be monitored through HPN minutes.
2(g) DP funders – use peer influence to increase funding of MDG PF.	As 2 (a).
3. Strengthen co-ordination and representation of (a) NGOs and (b) Implementing Partners	
3(a) NGOs to strengthen their coordination mechanisms. (Possible NGO Co-ordination Secretariat run by CORHA, CCRDA or an NGO, perhaps like HENNET in Kenya?)	Progress to be reported in the next ARM. Options to be ready for discussion by March 2012.
3(b) DPs to ensure that the IPs which they fund adhere to HHM – including by reflecting their activities and resources in sector plans and budgets.	As 1(a).
4. **Write and disseminate an international advocacy paper**	
4. Write and disseminate an international advocacy paper**.** Include health outcomes and how one plan/budget/report (the partnership) has contributed to this. See Box 3 for a brief description of the proposed paper.	Director-General of Planning to approve TORs and commission a writer(s). Final draft ready by February 2012. JCCC to monitor development of document and ensure it is completed on time. JCF to review usefulness of the document after ca 6 months (June 2012). What further uses? International fora where it could be used?

In the 1950s:

The novel *Cutting for Stone* by Abraham Verghese (2009) describes “Missing”, a fictitious Christian hospital in Addis Ababa in the 1950s. Quotations from this book illustrate that issues of “aid effectiveness” are nothing new!

> “If Harris wanted an accounting of money, she had nothing to show him. Matron submitted progress reports under duress, and since what donors wanted to spend on had no link to the reality of Missing’s needs, her reports were a form of fiction. She’d always known a day like this would come.” (Page 153)

> “She walked over to the door and beckoned him to join her outside. “Let’s take a walk,” she said. “Look,” Matron said when they were in the hallway, pointing to a sign above a door: OPERATING THEATER 1. The room was a closet, jammed full of Bibles. Wordlessly she pointed to another room across the way which Harris could see was a storeroom for mops and buckets. The sign above it read OPERATING THEATER 2. “We only have one theater. We call it Operating Theater 3. Judge me harshly if you will, Mr. Harris, but I take what I am given in God’s name to serve these people. And if my donors insist on giving me another operating theater for the famous Thomas Stone, when what I need are catheters, syringes, penicillin and money for oxygen tanks so I can keep the single theatre gong, then I give them their operating theater in name.” (Pages 155/6)

And now:

An extract from HSDP IV:

> “HSDP-IV will build on these efforts to achieve the “one” principles of harmonisation and alignment at national and sub-national levels. Government leadership will take forward the agenda of harmonisation and alignment by improving the transparent, accountable and socially equitable use of donor funds. Development partners are expected to develop strategies to ensure the predictability of funding; delegate decision-making power to country offices; and to make effective use of the government systems and processes for planning, implementation, monitoring and evaluation. Both government and development partners will make every effort to achieve value for money by improving resource allocation for priority health interventions; to avoid creating gaps and overlaps in financing; and to conduct regular independent evaluations. Both will make a commitment and adhere to principles of harmonisation and alignment and use the lessons learnt from such processes for continuous improvement.”

Acronyms

AfDB	African Development Bank
ARM	Annual Review Meeting
CCM	Country Co-ordinating Mechanism (Global Fund)
CCRDA	Consortium of Christian Relief and Development Associations
CDC	Centers for Disease Control, one of the 5 agencies which make up PEPFAR.
CHAI	Clinton Health Access Initiative
CORHA	Consortium of Reproductive Health Associations
CSO	Civil Society Organisation
DP	Development Partner
EFY	Ethiopian fiscal year
FMA	Financial Management Assessment
FMOH	Federal Ministry of Health
HEP/HEW	Health Extension Program/Worker
HHM	HSDP Harmonization Manual
HMIS	Health Management Information System
HPF	Health Pooled Fund
HPN	Health, Population and Nutrition Donor Group
HSDP	Health Sector Development Program
IHP	International Health Partnership
IP	Implementing Partner (of USG)
JCCC	Joint Core Co-ordinating Committee
JCF	Joint Consultative Forum
JFA	Joint Financing Arrangement
MDG PF	MDG Performance Fund (pooled)
MNH	Maternal and newborn health
MTEF	Medium Term Expenditure Framework
NAC	(HMIS) National Advisory Committee
NGO	Non-governmental Organisation
PBS	Protection of Basic Services
PFSA	Pharmaceutical Fund and Supply Agency
RHB	Regional Health Bureau
TOR	Terms of reference
TWG	Technical Working Group
USG	United States Government

Contents

Annexes

Boxes

Tables

Chapter 1 Context

Contents of this report

From April to October 2011, work was undertaken to develop a Roadmap for improving harmonisation and alignment in the health sector in Ethiopia. This work is known as "Enhancing One Plan, One Budget, One Report".

This report presents the main outputs of the work – the quantitative data on progress and the final Roadmap. To keep it to a manageable length, this report is not a comprehensive description of the work which culminated in the Roadmap. Interested readers are referred to the three previous reports for details.[1]

Context

A series of documents record work to improve aid effectiveness in the health sector in Ethiopia. Landmark documents include:

- Code of Conduct, 2005
- HSDP Harmonization Manual, 2007
- Ethiopia IHP+ Compact, 2008
- Joint Financing Arrangement, 2009.

The central focus of these efforts has been to operationalise "One Plan, One Budget, One Report" at all levels of the health system. Progress towards one plan/budget/report has been made in a number of areas, including[2]:

- HSDP IV – developed using the Joint Assessment of National Strategies (JANS) approach
- The introduction of woreda based planning.
- The sector has been able to produce regularly annual sector performance reports and presented them in the various ARMs
- Strengthening of the Health Management Information System (HMIS) – this is work in progress
- The establishment and expansion of the MDG Performance Fund.
- Studies and surveys undertaken in consultation with development partners (DPs)
- Annual resource mapping exercise.

Despite this progress, the health sector's Joint Core Co-ordinating Committee (JCCC) decided in March 2011 that it was a good time to commission work:

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[1] Inception Report (May), Interim Report (July) and Post-Workshop Report (October 2011). Available from the authors. (catriona.waddington@hlsp.org; abebe.alebachew2008@gmail.com; j.chabot@etcnl.nl)

[2] List adapted from the TORs.

> "to take stock of progress towards the objective of all development partners (including NGOs and other service providers and implementing partners in the case of 'one report') using 'One Plan, One Report and One Budget' in the health sector and identify ways to accelerate future progress."

The full Terms of Reference are given in Annex 1. The TORs stipulate that main output should be – "a Roadmap for removing barriers where possible and accelerating and monitoring progress". The Roadmap is the focus of this report.[3]

What is "One Plan, One Budget, One Report"?

"One Plan, One Budget, One Report" is defined in Box 1. The overall idea is that all stakeholders' plans and budgets should be reflected in one strategic plan which is then broken down into annual plans – implementation is then monitored using an agreed set of indicators and reporting formats.

The Federal Ministry of Health would prefer Development Partners to pool their funds and channel them through government channels – preferably using the MDG Performance Fund for federal level funding. However this is <u>not</u> a pre-condition to adhering to One Plan, One Budget, One Report. Adherence involves sharing information about plans and budgets, and monitoring according to jointly agreed indicators.

Process of Roadmap Development

The Roadmap for accelerating progress towards One Plan/Budget/Report was developed in five stages, making the development process highly participatory. The aim was for as many people as possible – from government, NGOs, development and implementing partners – to feel that they had something to contribute to the development and implementation of the Roadmap. After all, the whole point of One Plan, One Budget, One Report is that all stakeholders work *together* for the benefit of the Ethiopian health sector.

The Five stages of developing the One Plan, One Budget, One Report Roadmap

Stage 1	Inception – agreeing the methodology and definitions, April/May 2011
Stage 2	Collecting information through interviews and questionnaires, June 2011
Stage 3	Workshop to identify possible areas for action – government, NGOs, implementing and development partners, July 2011
Stage 4	Refinement of draft Roadmap, September 2011
Stage 5	Discussion at the Annual Review Meeting; final Roadmap, October 2011

Following the *Inception Report* in May 2011, **Stage 2** involved gathering information through questionnaires and interviews. The aims of this work were to understand attitudes towards One Plan, One Budget, One Report and to identify ways in which adherence might be improved. Based on the interviews, the Interim Report discussed

[3] This work did not include considering the role of the private sector.

progress with, and barriers to, One Plan, One Budget and One Report. It identified four areas for further discussion:

Box 1 Definitions of "one plan", one budget" and "one report"[4]

Formal definitions are as follows:

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. (Source; HSDP Harmonization Manual (HHM), 2007)

One Budget: Incorporating resources from different sources (government, donor, NGO) for implementation of the plan in a single document is "one budget". (Source: HHM)

The HHM also includes a "more radical" definition which cannot be ignored: ""One Budget ideally means all funding for health activities pooled and through government channels." However we are clear that this is a separate issue and does not fall within the formal definition of "one budget". (page 41)

One Report: The use of a set of (key) indicators, identified to monitor progress in achieving HSDP targets. All (health) institutions and stakeholders report according to the standard reporting format and use the national set of (key) indicators, without duplicating the channels of reporting". (Source: HHM).

Having used these definitions in presentations, it became clear that they are rather "heavy". We have, therefore, also developed some less formal, easy-to-understand, **practical definitions**:

One Plan: All stakeholders feel part of HSDP IV and the Annual Woreda-based core plan - and the implementation of these plans.

One Budget: Comprehensive budgeting to reflect the contributions of stakeholders to match the "one plan".

One Report: One reliable HMIS with core indicators; one reporting format.

Both sets of definitions are used – they are simply different ways of saying the same thing.

- Can there be clear guidance about what "one **plan** and one **budget**" looks like and what types of tools and instruments will be used in practice? What are the responsibilities of each stakeholder?

[4] These definitions were part of the Inception Report, which was formally accepted by the JCCC.

- How can the **preferred funding mechanisms** be expanded?

- What can realistically be expected of **HMIS** and what can be done about parallel reporting?

- **Governance**: How can NGOs and Implementing Partners be more effectively represented and involved? How might JCCC, HPN and JCF be strengthened?

These areas were used as the starting-point for a Workshop which aimed to identify areas to include in the Roadmap for enhancing One Plan/Budget/Report. The workshop (**Stage 3**) discussed and refined the four areas in four separate groups – government officials, Implementing Partners, NGOs and Development Partners (DPs). The output of the workshop was a list of areas for action, together with a view of how government, NGOs, DPs and Implementing Partners saw their responsibilities vis à vis these various areas. This matrix of activities and responsibilities is given in Annex 2 – this is an unedited reproduction of what was received from the four stakeholder groups at the time of the Workshop.

Key points emerging from the workshop included:

- **A realization that there was no shared understanding of what constituted "good planning" in Ethiopia -** many stakeholders did not understand the Ethiopian federal planning process and there were many legitimate questions about how and when stakeholders should be involved. This realization led to the identification of several activities about **clarifying the planning/budgeting process** and the responsibilities of various stakeholders.

- Acknowledgement of the importance of the **MDG Performance Fund**. Activities were specified for both government and DPs to increase the size of the Fund.

- A recognition that **NGO representation** is not working as well as it should, meaning that the NGO "voice" is not expressed effectively in governance bodies such as the Joint Consultative Forum. The NGO group proposed an activity for themselves: "to consider establishing a unit to co-ordinate members in relation to FMOH."

- The active **Implementing Partners'** group added a "general principle" at the start of their contribution: "GOE/FMOH provides leadership; DPs set the Scope of Work and guiding principles for IPs' engagement. IPs provide necessary TA and support." In other words, IPs are contractors and are guided by their contracts/co-operative agreements. These formal documents could have a role to play in improving adherence to One Plan/Budget/Report.

- Inclusion of an activity to "Improve **communication** within ministry, between DPs and FMOH, Agencies". The Government action point was "FMOH will devise a mechanism that will allow smooth/timely information sharing within the ministry & agencies." Communication and information-sharing are basic tenets of One Plan/Budget/Report.

In late August/early September 2011 the team leader discussed the matrix from the workshop with relevant parties in order to produce a draft Roadmap (**Stage 4**). This stage is described in the *Post-Workshop Report* of October 2011.

As a final step (**Stage 5**), the ideas about the Roadmap were discussed during a groupwork session at the Annual Meeting Review in October 2011. The resulting Roadmap is presented in Chapter 3.

Concurrent work related to the MDG Performance Fund and Joint Financing Arrangement

At the same time as this work on One Plan/Budget/Report, there was a lot of activity under way in relation to the MDG Performance Fund and the Joint Financing Arrangement. In March 2011 a Financial Management Assessment (FMA) was conducted of the MDGPF. In response to the FMA, a Plan of Action was developed in August 2011 to tackle the recommendations.

This Plan of Action is very significant for the wider agenda of One Plan, One Budget, One Report. The Roadmap developed here builds on the Plan of Action and does not repeat the same activities. For example the Roadmap acknowledges the plan to update the HSDP Harmonization Manual and builds on it.

This issue is dealt with in more detail in Chapter 5.

Chapter 2 Adherence to One Plan, One Budget, One Report – Quantitative Evidence

This chapter presents quantitative information about DPs' adherence to One Plan/ Budget/Report. The data can be compared with similar information collected in 2008. It is rare for comparative data about harmonization and alignment over time to be available. It is important to keep a record of this time series information – hence its inclusion in this summary report.

The Survey of Development Partners

The IHP Compact was signed by 13 development partners in 2008[5]. The Compact set out the following targets to be achieved by 2010:

- 95% of Development Partners provide confirmation on long term commitments disaggregated by programme and geographic area.
- 95% of Development Partners don't request the Government for a separate plan document
- 100% of Development Partners' activities and budgets are reflected in the government's plan
- 60% of funds provided through Government preferred modalities
- 90% of funds on budget and 90% disbursed on time.

The Roadmap includes the activity of revising and updating these targets.

A questionnaire was used in 2008 to collect baseline data from 12 development partners. The same questionnaire was used in 2011 to compare progress against the baseline. The aim of the questionnaire was to establish the extent to which support is provided on plan and on budget, and monitored through one report. 19 Development partners responded to the 2011 questionnaire. The hope was that the results of the comparative analysis would not only measure progress against the IHP+ targets, but also identify changes over time. In practice this aim was partially realised – comparisons were limited by the smaller sample size of the 2008 study.

19 of the requested 20 DPs filled in the questionnaire. The only exception was the Bill and Melinda Gates Foundation, which participated in an interview but declined to fill in the questionnaire. The Foundation said it could not identify how much it spent in Ethiopia because it worked through multi-country grants.

Of the 19 respondents in 2011, 11 had signed the IHP+ Compact in Ethiopia. (The other two signatories no longer provide funding to the health sector.[6]) However the Compact made clear that its framework should apply to all Development Partners working in Ethiopia:

[5] African Development Bank, DFID, France, European Commission, Italy, Irish Aid, Netherlands, Spain, UNAIDS, UNFPA, UNICEF, WHO and World Bank. (USAID and GAVI issued letters of support.)

[6] AfDB and UNAIDS.

> "The guiding principles and aid management procedures…..are based on the Government's Aid Policy. They are intended to apply to all Development Partners, not just those who are signatories to this Compact. The signatories commit to assist the Government of Ethiopia in implementing the principles and procedures of this Compact. The non signatories, when entering an agreement with the Government for development assistance, will be required to support Government's strategies and priorities and use, as far as possible, Government's procedures."

Main findings

The information provided here is about the years 2007/8 and 2009/10. This is Ethiopian Fiscal Years (EFY) 2000 and 2002. For ease of reading, the EFYs are not repeated in every reference to a date in this chapter.

Volume of support

Development Partners reported in their questionnaire responses that they had contributed a total of about ETB 14.3 billion to health sector funding in 2009/10 (EFY 2002). Figure 1 shows that almost 80% of international support was provided by the Global Fund, US Government and GAVI combined. Over 70% of support came from just the Global Fund and USG.

Assuming the Ethiopian population is 80 million, the per capita DP support to the health sector is estimated at about **$14.00**[7]. This figure is much higher than the figure in the fourth National Health Accounts (NHA4). NHA4 reported total per capita health spend in 2008 of $16.09, of which 21% was from government, 37% from households and 40% international (**$6.4**). Possible explanations for the difference are:

- The NHA excluded much of the US Government's spending, especially CDC's contribution.
- This survey reports disbursements, while NHA reported actual spending. (But the Ministry's 2009/10 Annual Performance Report gave a disbursement rate of 89%.)
- NHA described 2008/9 (EFY 2001), the survey 2009/10. We know from the Annual Performance Report that disbursements increased by 62% between 2008/9 and 2009/10.
- Our survey includes some DPs' overhead and management costs.

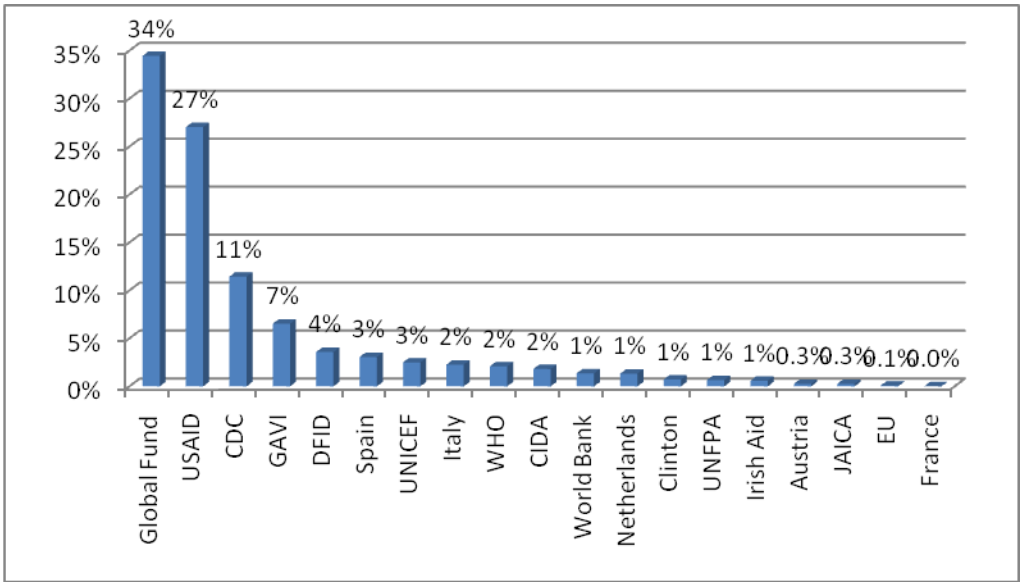
Predictability

According to aid effectiveness principles, DPs should provide reliable, indicative, multi-year commitments of aid and disburse aid in a timely and predictable fashion. The IHP Compact's target for the "percentage of Development Partners providing confirmation of long term commitments" was 95% by 2009/10. With 9/19 (47%) partners offering only one- or two-year commitments, this target has clearly not been met.

[7] Annual average exchange rate as provided by www.onada.com. The average rate for EFY 2002 was ETB 20.144, 17.7559 and 12.7963 for Pound, Euro and Dollars respectively.

Of the 19 responding DPs, five had made a financial commitment for five years. Another five had commitments for only one year. (Figure 2) Those with the five- and four- year

Figure 1: Individual DP's share of total DP support (2009/10)



Source: Survey results, 2011

commitments were those whose share in financing the health sector was relatively small. The big players – USG and Global Fund, which together provide more than 70% of funding –both had one-year or project-based commitments. Predictability therefore remains an issue - progress is slow.

The Government conducts an annual resource mapping exercise to inform the annual planning exercise. All except four DPs were able to provide information at the time of the annual resource mapping – the exceptions were USG, GAVI, the Global Fund and the Clinton Foundation. Obviously these significant gaps in information make the annual planning and budgeting cycle much more complicated and less comprehensive.

One Plan and One Budget

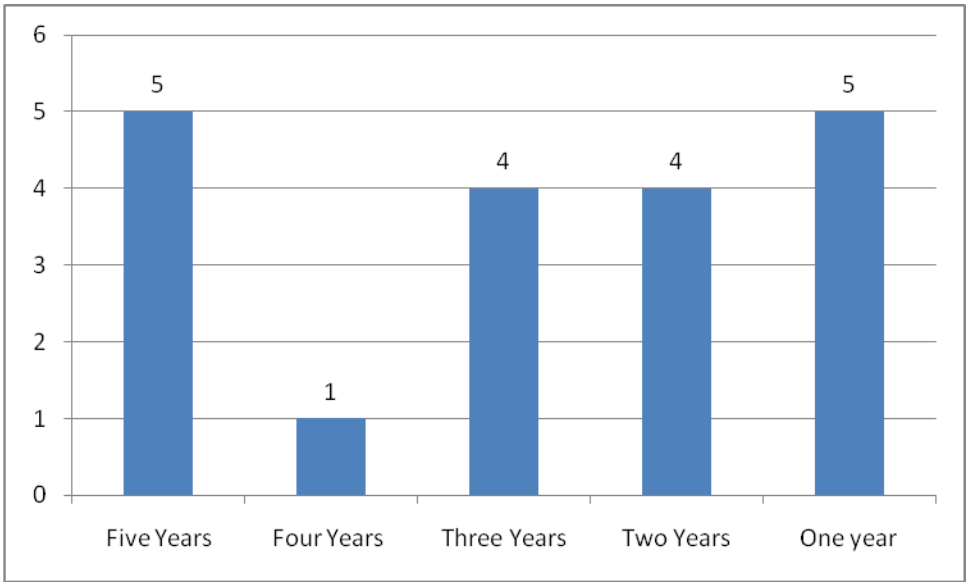
Table 1 compares four of the IHP Compact's indicators over time.

The first indicator is the percentage (by value) of DPs' activities which are reflected on the government's **plan**. This means that timely information was available to the Ministry of Health so that it could be included in annual federal, regional or woreda plans as appropriate. In 2007/8, the twelve responding DPs had 44% of their funding reflected in the government's plan. In 2009/10, 76% of the activities funded by the 19 respondents were reflected in government's plans. Most of the 24% of activities which were off-plan were funded by the US Government. The IHP Compact's target of 100% by 2009/10 was not achieved.

The idea of "one plan" is that all partners refer to the same set of national and local plans, without the need for separate plans for individual DPs. The second indicator in

Table 1 shows that a significantly lower proportion of DPs required a separate planning document in 2009/10. But again, the IHP Compact's target was not achieved. An encouraging development was that the proportion of DPs participating in

Figure 2: Number of DPs by length of commitment



Source: Survey results, 2011

the annual woreda-based planning process almost doubled between 2007/8 and 2009/10, from only quarter (25%) to almost half (47%).

Including aid in the overall sector **budget** is central to aid effectiveness principles, as this helps countries to ensure that resources are used in line with policy priorities. There is a general consensus that it is particularly important that development aid should be not only on plan but also on budget (see Box 1 for definitions); there is additional value to putting it on treasury[8].

Compared with DPs being on-plan, progress to be on-budget lagged behind. The third indicator in Table 1 shows that almost half of the activities that were included in the plan were not accompanied by information about their funding. Only 39% of DPs' support was on budget in 2010 - the target was 90%.

Still lagging far behind is use of the government's preferred aid modalities. (These are the three pooled funds, the MDG Performance Fund, the Health Pooled Fund and PBS Component 2). The fourth indicator in Table 1 shows that 14% of the total resources provided to the sector used the FMOH's preferred modalities – the figure was the same in 2008 and 2010. But in fact the comparison is rather misleading, as the 2010 data includes the huge sums of USG and Global Fund that used non-preferred modalities.

[8] OECD/DAC, Aid Effectiveness, a Progress Report on Implementation of Paris Declaration, 3rd High Level Forum on Aid Effectiveness, 2nd-4th September 2008, Accra, page 52.

This balanced out the progress made (by increasing the denominator) as compared to the findings of 2008.

The number of DPs using the MDG PF is increasing – but some DPs put a small percentage of their resources through the Fund to be "at the table" and keep their larger share outside it, meaning their contribution remains negligible as compared to the total resources coming to the sector. The challenge now is to increase the **share** of total health spending being channeled through preferred modalities.

All of the results from 2009/10 given in Table 1 fall short of the targets for 2010 set in the IHP+ Compact. It is important to note that **there has not been any retrogression by any development partner for which we have a 2008 survey response.** In other words, no DP is documented to be less aligned or harmonized in 2010 than in 2008.

Table 1: IHP+ Compact indicators: summary of Baseline and 2010

Indicators	Target for 2009/10 (EFY2002) (Compact)	Baseline 2007/8 (EFY 2000)	Achievement 2009/10 (EFY 2002)
Number of DPs mapped		12	19
% of Development Partners' activities reflected in the Government's plan (by monetary value)	100%	44%	76%[9]
% of Development Partners which ask Government for a separate planning document	77%	5%	42%
% of DPs' funding reflected in the Government's budget	90%	Not known	39%
% of Funds provided through Government preferred modalities (pooled funds – MDG PF, Health Pooled Fund, PBS Component 2)	14%	60%	14%

Source: Survey Results – self-reported questionnaire. Results affected by different sample for the two surveys. The more recent survey included huge amounts of money that are off-budget and financed through non-preferred channels.

One M&E System (One Report)

The use of country-defined indicators and accepting country reporting formats reduces a lot of transaction costs associated with monitoring and evaluation. Despite issues with the quality and reliability of information generated through the country system, more DPs have started to rely on Ethiopia's reporting and monitoring system. The percentage of

[9] Resources channeled from DPs through NGOs, plus some of the USG's implementing partners' activities, are not on-plan.

DPs requiring separate reports for their support declined from 75% in 2007/8 to 58 % (8 DPs) in 2009/10. This is a significant change, especially given the larger sample size for 2009/10.

Nevertheless, one out of three DPs still requires indicators outside HSDP IV and the annual woreda core plans. However, the *number* of indicators required outside the system is on the decline.

This information is summarized in Table 2.

Table 2: Progress towards One M&E System (One Report)

Indicators	**Target for 2009/10 (EFY2002) (Compact)**	**Baseline 2007/8 (EFY 2000)**	**Achievement 2009/10 (EFY 2002)**
Number of DPs mapped		12	19
% of DPs requiring a separate report		25%	42%
% of Development Partners only using indicators specified in HSDP IV and annual woreda plans	100%		67%

Source: Survey results

Another area for alignment and harmonization is reducing the number of missions and co-ordinating meetings that involve just one DP. In 2009/10 (EFY 2002), a total of 69 co-ordinating meetings were held between the top management of FMOH and individual development partners. Of these, 48 were conducted between government and four DPs (Clinton, 24; CDC 12; USAID 12 and World Bank 4).

56 joint review missions were carried out between government and individual DPs. Most of the joint missions carried out in 2009/10 were conducted by Global Health Initiatives (understandable as they have no presence at the country level) and UN agencies.

Other aspects of harmonization

Technical assistance
Overall 124 short-term and 922 long-term seconded staff/TA were identified through the questionnaires as being provided through the support of DPs. (Table 3)

Tied aid
Three DPs (Italy, USAID and JICA) reported providing tied aid.

Project Management Unit
Only Italy reported having a project management unit for its support. There seems to be a problem with definitions here – in practice, many of the CDC and USAID Implementing Partners operate as de facto project management units.

Table 3: TA/seconded staff by source, 2009/10 (EFY 2002)

	Short term	Long term
UNFPA	3	2
JICA	6	9
WHO	13	62
Italy		2
Clinton		10
UNICEF + HPF*	100	4
CDC		833
Others	2	0
Total	124	922

Source: survey result and related correspondence.

* The Health Pooled Fund is managed by UNICEF. Much of this TA was contracted by UNICEF on behalf of the Ministry.

Chapter 3 The Roadmap for Enhancing One Plan, One Budget, One Report

The Roadmap presented in this chapter was developed through a multi-stage, participatory process. Extensive interviewing of government staff, development partners, NGOs and Implementing Partners resulted in a discussion document which was debated during a two-day workshop. The output of this workshop was the beginnings of the Roadmap. This was further developed and discussed during the Annual Review Meeting in October 2011.

The operating environment for the Roadmap

Before giving the details of the Roadmap, it is important to stress that the Roadmap will only be implemented successfully if the right "operating environment" exists. This is explored further in Chapter 4. Some examples of developing a favourable "operating environment" are:

- Building confidence in partnership and co-ordination – developing a shared vision of what One Plan/Budget/Report can achieve.
- Maintaining strong co-ordination structures, including JCCC, JCF and HPN (for co-ordinating DPs)
- The timely updating of the HSDP Harmonization Manual and a high profile given to its launch. Follow-up of adherence to the manual.

Rationale for the five broad activities

The final Roadmap is shown overleaf. It is important to understand that the "activities" column was discussed and presented at ARM. The "monitoring" column, in contrast, is new in this report. The overall Roadmap is summarised in the graphic below.

Activity in Roadmap	Government	Development Partners	NGOs/Implementing Partners
Improve adherence to One Plan, One Budget, One Report			
Expand MDG Performance Fund			
Strengthen co-ordination and representation of (a) NGOs and (b) Implementing Partners			
Write and disseminate an international advocacy paper		(Support role if required)	
Monitor harmonization and alignment using the indicators in HSDP IV and the IHP+ Compact			

Major role Support role

ROADMAP FOR ENHANCING ONE PLAN, ONE BUDGET, ONE REPORT	
Activity	**Monitoring – how, who, when?**
1. Improve adherence to One Plan, One Budget, One Report	
1(a) Ministry to provide clarity on, and speak with one voice about, One Plan, One Budget, One Report. One Plan/Budget/report to be institutionalized within the workings of HPN.	All plans and budgets (from Service Delivery, Planning etc) to clearly fit together. (by July 2012) Final TOR and action plan of HPN by latest February 2012.
1(b) Government to enforce adherence to the HSDP Harmonization Manual at all levels and by all parties (government, DPs, IPs, NGOs).	HHM to be updated, discussed, printed, disseminated and translated. (JCCC to approve TORs and timetable by end February 2012) Documented actions demonstrating how adherence is enforced. (Government to present to JCF 6 months after launch of HHM)
1(c) Government to continue strengthening regional and woreda planning and implementation, resource mapping, and co-ordination.	JCF to review after publication of 20012/13 woreda plans. JCCC to commission a review to inform the JCF.
1(d) Government to strengthen planning units' links with (and where appropriate co-ordination of) NGOs and IPs. (All levels of planning units)	JCF to review by end 2012. JCCC to commission a review to inform the JCF.
1(e) Government to hold DPs publically accountable (e.g. scores for 3 indicators)	HHM to specify indicators for annual accountability. FMOH annual performance report to include these indicators.
1(f) DPs to monitor government performance based on agreed frameworks – i.e. DPs to hold Government publically accountable. (HHM, IHP+, JFM, JRIS)	HHM to specify indicators of government performance. Annual report at ARM.
1(g) Development Partners to advocate and provide information to HQ about harmonizing and aligning their support, as stipulated in HSDP IV.	HPN to collate evidence to present in ARM 2012.
1(h) DPs to enforce adherence to HHM by the NGOs and IPs which they fund.	HPN to develop register and monitor – report to be included in annual performance report for ARM.
1(i) DPs to consider DP and IP thematic groups to work together for one plan, one budget and one report.	JCF to develop action plan for TWGs, including monitoring. HPN to consider how IPs can be involved in HPN and if any role for sub-groups within HPN.
1(j) DPs to align to EFY calendar.	All documents produced by DPs to be aligned to EFY calendar. (See HSDP IV, Annex 5)

2. Expand MDG Performance Fund	
2(a) Government to promote the advantages of MDG PF, in view of its flexibility in resourcing priority areas of HSDP.	Monitor impact of this activity in terms of amount of funding, number of donors, % of overall funding. Include in FMOH's Annual Performance Report.
2(b) Government to ensure that MDG PF spending at regional level complements PBS and the Block Grant.	Through regular MDG PF reports.
2(c) Government *r*e-enforces its systems (FMA plan) to ensure accountability and transparency. (Included in Plan of Action resulting from Financial Management Assessment, 2011)	Separate piece of work. Oversight by JCF. Plan of Action monitored by JCCC.
2(d) Government to enhance its Value For Money and effective utilization.	The Joint Financing Arrangement specifies how the MDG PF will be monitored, reviewed and evaluated.
2(e) DPs: HPN to work towards increasing the overall contribution of MDG PF from total Sector Funding (IHP+ compact target for 2010 was 60%)	As 2(a).
2(f) DPs – regular updates about MDG PF and how it relates to One Plan/Budget/Report as a standing item on HPN agenda.	HPN to agree frequency of these updates by end February 2012. Then this can be monitored through HPN minutes.
2(g) DP funders – use peer influence to increase funding of MDG PF.	As 2 (a).
3. Strengthen co-ordination and representation of (a) NGOs and (b) Implementing Partners	
3(a) NGOs to strengthen their coordination mechanisms. (Possible NGO Co-ordination Secretariat run by CORHA, CCRDA or an NGO, perhaps like HENNET in Kenya?)	Progress to be reported in the next ARM. Options to be ready for discussion by March 2012.
3(b) DPs to ensure that the IPs which they fund adhere to HHM – including by reflecting their activities and resources in sector plans and budgets.	As 1(a).
4. **Write and disseminate an international advocacy paper**	
4. Write and disseminate an international advocacy paper**.** Include health outcomes and how one plan/budget/report (the partnership) has contributed to this. See Box 3 for a brief description of the proposed paper.	Director-General of Planning to approve TORs and commission a writer(s). Final draft ready by February 2012. JCCC to monitor development of document and ensure it is completed on time. JCF to review usefulness of the document after ca 6 months (June 2012). What further uses? International fora where it could be used?

The roadmap identifies five broad activities, with many sub-activities. The broad activities are:

1. Improve adherence to One Plan, One Budget, One Report
2. Expand MDG Performance Fund
3. Strengthen co-ordination and representation of (a) NGOs and (b) Implementing Partners
4. Write and disseminate an international advocacy paper
5. Monitor harmonization and alignment using the indicators in HSDP IV and the IHP+ Compact.

The rationale for including each of these activities is explained below.

1. Improve adherence to One Plan, One Budget, One Report

The rationale for having One Plan, One Budget and One Report is that this is the only way to get the full picture of what is happening in the health sector. Without the complete picture there will be avoidable gaps and duplications and resource allocation will not necessarily follow the agreed priorities of HSDP IV.

It needs to be completely clear what "One Plan, One Budget, One Report" looks like – for example what does the annual operational plan look like (federal + regional + woreda)? What is the core list of indicators and how can it be changed? The updated HSDP Harmonization Manual will operationalize the concept of One Plan/Budget/ Report by describing in detail the processes and responsibilities involved

One Plan/Budget/Report will only ever work as well as the quality of the government's plans, budgets and reports – hence the inclusion of systems strengthening activities.

It is well documented that DPs do not necessarily have incentives from their own Headquarters to adhere to One Plan/Budget/Report. These incentives therefore have to be established in Ethiopia – hence the inclusion of "enforcing" and "accountability" activities. Possible examples of "enforcement" are:

- Government health staff at all levels do not participate in training activities outside the plan and budget.
- Reference is made to existing reports that contain relevant information, rather than writing separate reports.
- Priority is given to implementing activities which are on plan and on budget.

2. Expand the MDG Performance Fund

The MDG Performance Fund is the Ministry's preferred channel for receiving DP funding. It is the only modality which gives the FMOH the flexibility to allocate DP funds in line with its overall priorities – be that a programme area such as maternal health, or a practical implementation gap such as unequal availability of priority supplies in different parts of the country.

To be attractive to funders, the MDG PF needs to be managed to a very high standard in terms of decision-making, reporting and audit. This includes documentation of how

decisions are made about what to use the Fund for; complete reporting with an analytical narrative; and timely audit.

Following a Financial Management Assessment (FMA) in early 2011, a number of activities to strengthen Fund management have been brought together in a Plan of Action to respond to the FMA recommendations.

3. Strengthen co-ordination and representation of (a) NGOs and (b) Implementing Partners

During the interview phase of this work, the most commonly raised issue related to governance was about "the third sector" – Ethiopian CSOs, International NGOs, USG Implementing Partners and the private sector. This is a large and complex group of organisations which do not neatly fit into one category. Together they should be playing vital roles in planning, budgeting, reporting and implementation/service delivery. Many questions were asked how best to organise this. What is the potential role of the umbrella organisations CORHA and CCRDA? Could there be a separate Secretariat responsible for streamlining communications in the health sector? (HENNET in Kenya was cited as an example of how this might work.)

Discussions at the workshop and ARM confirmed that this is a relevant issue. This action point takes forward the debate so that thought can be given to how NGO and Implementation Partner co-ordination and representation can be strengthened. The action will raise some difficult issues, including:

- Is there a possibility of developing the functioning of CCRDA and COHRA to create better structures and working arrangements? What sort of arrangement could also bring in Implementing Partners?

- If this possibility does not look promising, is there a need to establish a new network? If so, who should be included as members? Could an NGO Secretariat represent the interests of bodies as diverse as tiny Ethiopian CSOs and enormous international NGOs/Implementing Partners? Or should there be two Secretariats – one for NGOs and one for Implementing partners?

- What would be the relationship of an NGO Secretariat to CCRDA and CORHA? Or should the Secretariat be part of one of these organisations? Both CCRDA and CORHA have "umbrella" functions. However CCRDA is a multi-sector organisation which devotes a lot of energy to mobilizing funds for local NGOs/CSOs and capacity building. Is it realistic to also expect CCRDA to work on detailed co-ordination issues in the health sector? CORHA, in contrast, is active in issues related to reproductive health, but does not have a sector-wide mandate. There is currently no sector-wide, health-specific body responsible for co-ordination and representation of NGOs in health – what should such a body look like?

This is an area where international experience can provide valuable ideas. The *Interim Report* described HENNET, the Health NGOs Network in Kenya which aims to enhance collaboration, share experiences and promote advocacy. It brings together a broad range of Kenyan and international CSOs and Implementing Partners and is actively supported by the Government of Kenya and USAID. HENNET could provide a useful

reference point to inform discussions in Ethiopia. Box 2 reproduces the description of HENNET.

Development Partners can strongly influence Implementing Partners and NGOs which they fund. For example they can specify that they align with government indicators and the government planning calendar; and that their plans and budgets are part of the "one plan, one budget" at woreda, regional and federal levels.[10]

It is not the responsibility of government to take forward the above debate. The FMOH is currently working on the establishment of a Diaspora Co-ordination Unit as part of the Resource Mobilization Directorate. This Unit will have responsibilities for NGO co-ordination – but this is a different initiative from the one described here.

Post-ARM Update

In November 2011, staff from the FMOH, CORHA and CUAMM met with an individual from the NGO AMREF who was instrumental in the establishment of HENNET in Kenya (See Box 2). These discussions led to an agreement that a meeting including CCRDA and CORHA would start the process of discussing possible ways forward, probably based on a SWOT analysis (strengths, weaknesses, opportunities, threats). The basic choice is between either forming a new network, or CCRDA finding a way of organising health NGOs and mandating them to represent CCRDA on health issues.

[10] The planning and budgeting calendar is given in HSDP IV, Annex 5,

Box 2 HENNET, the Health NGOs Network, Kenya

Does Kenya's experience with an NGO network offer any lessons for Ethiopia?

HENNET (the Health NGOs Network) was founded in early 2005 as a result of a felt need to set up a forum for NGOs dealing with health issues. It aims to enhance collaboration, share experiences and promote advocacy. It brings together a broad range of CSOs, Kenyan and international.

HENNET has a small, active secretariat and is governed by a board of 11 members elected by HENNET members.

HENNET's mission is "To stimulate linkages and strategic partnerships among health Non-Governmental Organizations (NGOs), Government and private sector in order to enhance their responses towards health needs of Kenyans". It actively participates in, and comments on, national and local health planning and policies. It supports health NGOs in their advocacy role in critical issues affecting the health of Kenyans.

Key features of HENNET include:

- The Secretariat is an independent body with a small professional staff. It is a focal point for dissemination of information and participates in all major health sector partnership forums.
- HENNET was created, and is managed, by NGOs.
- Formal NGO recognition in health is premised on membership of HENNET.
- It is formally written into the Code of Conduct in Kenya – HENNET is an officially recognised partner.

4. Write and disseminate an international advocacy paper.

Many of the barriers to adhering to One Plan, One Budget, One Report originate in the headquarters of DPs. This activity is to write a short paper intended primarily for the Headquarters of Development Partners describing what effective aid looks like from the perspective of the FMOH. This is intended to complement the many documents which explain priorities, rules and monitoring requirements from the perspective of individual development partners. The document will be used for advocacy/awareness-raising at international meetings and DP headquarters. A brief description of key features of this piece of work is given in Box 3.

Box 3 Ethiopia's view of effective health sector aid: key features of an advocacy paper

There are many documents about how aid works from the point of view of the donor – application forms, proposal rules, books of procedures. Much less is written from the country perspective. This short document will describe what effective aid looks like from Ethiopia's perspective, and the difference that this makes to management of the sector as a whole.

The document should be four A4 pages long – it can then be printed in a user-friendly magazine style.

The document will start by showing how HSDP IV, the HSDP Harmonization Manual and the Joint Financing Arrangement together provide a framework for working in the health sector – from identifying broad priorities to the details of planning, financial management and monitoring. This framework is essentially the health sector "engine" – when all the parts work together well, the sector can move forward. The document can give practical examples – for example decreases in maternal morbidity require changes in a number of parts of the health system, including primary care, secondary care and access to transport.

The document will quote the recent DHS findings about health status in Ethiopia.

The document will briefly discuss the strengths and weaknesses of some aspects of health systems – for example financial management and HMIS. It will show how development partners can contribute to improving the quality of these systems – the idea is certainly not to ignore the shortcomings of the system.

DPs' global and Ethiopian commitments will then be summarised – for example, the Paris Declaration, the IHP and the Ethiopian Code of Conduct. Data will be used to show serious shortcomings in adherence to these commitments – for example in terms of being on-plan and on-budget, using the Ethiopian fiscal year, and co-ordinating TA.

Examples will then be given of why the principles of aid effectiveness are important – it is a matter of either supporting the health sector "engine", or disrupting it. The Ethiopian health sector faces many enormous challenges – it can well do without the distractions and transaction costs of unco-ordinated aid.

5. Monitor harmonization and alignment using the indicators in HSDP IV and the IHP+ Compact.

Annex 8 of HSDP IV gives "Detailed Indicators for Monitoring HSDP IV Quality Indications". One section of this is about "enhanced harmonization and alignment". Seven indicators are specified, together with baseline, targets, source and periodicity of reporting. This is summarised in Table 4.

Table 4 Summary of HSDP IV Indicators for Harmonization and Alignment

Indicator	Baseline	Target year 1 (2010/11; (EFY 2003)	Target year 5 (2014/15; EFY 2007	Source	Periodicity
Report completeness	57%	70%	90%	HMIS	Monthly
Report timeliness	57%	70%	90%	HMIS	Monthly
Correspondence between data and recorded (LQAS)	15%	45%	90%	HMIS	Monthly
Woredas with evidence-based plan aligned vertically and horizontally	100%	100%	100%	Admin. report	Annual
Partners implementing one plan	NA	100%	100%	Survey	Annual
Proportion of partners using the national M&E framework (Harmonization & alignment)	NA	100%	100%	Survey	Annual
Health developmental partners providing fund through MDG Pool Fund	NA	75%	75%	Admin. report	Annual

As shown in Table 4, there will be an annual survey of DP behaviour. This could be combined with the annual survey of IHP Compact indicators, once the targets are updated. Combining the two would have the advantage of bringing in an indicator of “one budget”, which is not included in the HSDP IV indicators.

Chapter 4 Changing our Overall Way of Working

This chapter discusses the overall way of working that promotes one Plan/Budget/ Report – in other words the mindset which is required for comprehensive collaboration.

Changing mindsets

Some action points identified by stakeholders in the July Workshop were actually about changing mindsets and overall ways of working. Examples include (from Annex 2):

- "We can work according to One Plan/Budget/Report if the FMOH provides appropriate leadership and if DPs give us an appropriate scope of work and guiding principles for how we engage with Government and other partners." (Implementing Partners' column - general principle for the way in which IPs operate.)

- "Smooth/timely information sharing within the ministry and agencies." (Government, action 10)

- "Promote involvement of partners so that we can have consensus about HMIS." (Action 13)

- "Create/maintain environment of accountability at the implementation level." (IPs, Action 1)

- "Inform the wider NGO constituency about the need for One Plan/Budget/Report. One Plan/Budget/Report needs to be institutionalized within all our organizations." (NGOs/CSOs, Action 1)

What all these actions have in common is an understanding that individual organisations are engaged in a communal activity and that they have a responsibility to ensure that their work as a whole relates to the overall sectoral plan, budget and report. It is not feasible to reduce these profound changes to time-limited activities in a Roadmap – this is not simply about activities which can be ticked off when completed. Progress with One Plan/Budget/Report requires a clear shared vision, leadership, and an overall way of thinking about the sector which informs every committee and every meeting. This chapter explores this idea and possible ways in which this overall change in mindset can be encouraged.

A vision of One Plan, One Budget, One Report

"Vision" means a clear view of how we want the health sector to be in the future, and how we want stakeholders to behave so that the vision can be achieved. So the vision of One Plan/Budget/Report means a clear picture of exactly what the phrase means, and why it is so desirable. For success, there need to be leaders in the Ministry, DPs and NGOs who articulate, and act on, this vision.

Box 4 The HSDP Harmonization Manual's Vision of One Plan/Budget/Report

The 2007 HSDP Harmonization Manual has an entire section called "The vision of One plan, one budget, one report". The following quotation describes the vision of a more focussed and effective health sector:

"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. "

It is important to be able to articulate the "vision" in an easy-to-understand and attention-catching way. Box 4 reproduces the HHM's vision of One Plan/Budget/Report (2007). In summary form, this could be expressed for example as:

> "All health sector stakeholders at all administrative levels are involved with the overall plans, budgets and reports, and share information transparently. This enables efficient co-ordination and increases the effectiveness of aid. It increases the overall impact of government and international funding; it harnesses the efforts of government and other implementing organisations to work together to meet the same goals."

Relating it to practical health challenges, the vision could, for example, be articulated as:

> "A key priority for the health sector is to increase the proportion of women with major direct obstetric complications who are treated in emergency obstetric facilities. To do this we obviously need to have a national picture of who is funding what activities. We are short of money to achieve this goal – and if we

don't co-ordinate fully, there will be wasteful duplication and unnecessary gaps in coverage. That's why we need One Plan/Budget/Report."[11]

Alongside the Roadmap activities, there needs to be a critical mass of people who articulate, believe and act on the vision of One Plan/Budget/Report. What does this mean in practice?

A Way of Working

The examples quoted at the beginning of this chapter point towards the way of working required if "One Plan/Budget/Report is to work in practice:

- Every partner has a stake in the HMIS because it produces much of the data by which overall performance is judged. Inevitably, the dataset used will be a compromise of the information desired by all partners.

- When an organisation has some information about what works and hence what should be included in future plans, it should share the information and ensure that it informs future plans.

- If an organisation is funding an NGO or Implementing Partner, the recipient should be asked to ensure that relevant information about plans, budgets and results is shared appropriately.

The phrase "a way of working" conveys that One Plan/Budget/Report is not a separate set of activities, but is more a guideline for an organizational culture. Staff members in government, development partners, NGOs and IPs need to understand what is expected of them and to demonstrate this through their everyday decisions. Committees and meetings should always be asking themselves "Does this adhere to One Plan/Budget/ Report and if not, why not? Have we involved all the relevant stakeholders to measure that we are acting efficiently? Are there avoidable duplications or gaps?"

There is clearly a need for some awareness-raising about One Plan/Budget/Report. Much of this can be linked to the revision of the HSDP Harmonization Manual. But what can be done in practice beyond simple awareness-raising? How can One Plan/Budget/ Report be promoted as a way of thinking that informs decisions across the sector? Issues to consider include:

- The **Ministry** needs to speak with one voice about One Plan/Budget/Report. (The Workshop specified an activity to "improve communication within the ministry".) Whilst both Planning/Policy and the Service Delivery programmes are taking forward practical aspects of "One Plan", the two processes are happening in parallel, rather than together. It is vital that the Ministry presents a consistent picture about its commitment. In practice this means assuring the Service Delivery programmes that their needs will be met through a comprehensive systems of planning, budgeting and

[11] A vision about One Plan/Budget/Report is of course complementary to HSDP IV's overall vision: "To see healthy, productive, and prosperous Ethiopians".

reporting. Indeed, if the system works well, it should bring benefits to them as it facilitates communication with all DPs and regions.

- The new co-chairs of the **HPN Development Partners' Group** are exploring the question of how HPN can contribute to improved co-ordination. This is an opportunity to institutionalize the One Plan/Budget/Report vision in the workings of HPN. One practical example would be to ensure that all new DP staff are fully briefed about One Plan/Budget/Report and what this means for the way in which they work. Other ways in which HPN could contribute are suggested in Box 5 – this large number of ideas were all generated by participants of the July Workshop.

- With the important exception of the issue of NGO representation, this work has not yet captured the imagination of the **US Government** in Ethiopia. This is a pity because any activities related to One Plan/Budget/Report which do not reflect USG support are of less value because they omit such a significant player. The US 2011 Ethiopia Global Health Initiative Strategy aims to "further collaborate with the GOE and other local partners". Given that both the Strategy and the Roadmap are about improving collaboration, how can they be brought closer together?

Box 5 Possible HPN contributions to promoting One Plan, One Budget, One Report

This Box suggests a number of ways in which the HPN Donors' Group can contribute to the Enhancing of One Plan, One Budget, One Report. This is not an exhaustive list – all the ideas here are taken from the output of the Workshop. (Annex 2)

- Discuss what One Plan, One Budget, One Report entails in practical terms and raise concerns at the Joint Consultative Forum. {This could be linked to the revision of the HSDP Harmonization Manual.}

- Develop instructions for NGOs and Implementing Partners which receive money from HPN members. The instructions should describe how the NGOs and IPs are expected to contribute to One Plan/Budget/Report.

- Issue guidelines about how to adapt other fiscal calendars so that all in-country documents use the Ethiopian fiscal year. Monitor adherence annually.

- Critically review HPN's role in sharing information. Is it meeting members' expectations? Are surveys and TA reports regularly shared? Could more information be made available on members' websites?

- Keep a list of all population- and facility-based surveys to be funded by members. Critically review the list to ensure that money spent on surveys is used efficiently.

- Review HPN's linkages with the CCM and with the HIV/AIDS donors' group.

- Critically review the structure and operations of Technical Working Groups.

- Implement peer review of DPs in terms of Paris/Code of Conduct/IHP/GHI commitments and agree on good practice in terms of attribution of results.

Chapter 5 Issues not Included in the Roadmap

Not everything that needs to be done to promote One Plan/Budget/Report can be captured in one Roadmap. Moreover, some activities have been deliberately left out of the Roadmap to avoid duplication with other workstreams. This chapter highlights two particular areas of work which do not feature in the Roadmap – the response to the Financial Management Assessment and strengthening HMIS.

Plan of Action based on recommendations of the Financial Management Assessment

In March 2011 a Financial Management Assessment (FMA) was conducted of the MDG Performance Fund. The Assessment mainly focused on arrangements and practices at the federal level – it also included a much less detailed assessment of financial management in the wider public health sector.

In response to the FMA, a Plan of Action was developed in August 2011 to tackle the recommendations. This Plan of Action is very significant for the wider agenda of One Plan, One Budget, One Report.

The FMA Plan of Action relates to the pooled MDG Performance Fund. In Chapter 1 of this report it was explained that One Plan/Budget/Report is **not** about pooling. Why then, is the FMA Plan of Action so important? – it is because for the MDG Fund to work efficiently, the whole One Plan/Budget/Report systems needs to function well.

The functioning of the MDG PF is described in the **Joint Financing Arrangement** (JFA)**.** This document is about much more than pooling funds – it is about how development partners can:

> "Align with the '*one plan, one budget, one report*' framework by using collectively agreed country-led arrangements for planning, execution and reporting.
>
> Use a common mechanism for any annual process of validation of the sector plan.
>
> Minimise requests for partner-specific formats for planning, reporting and evaluation." [12]

In other words, the JFA – which has been signed by Government and a number of Development Partners – sets out the roles and responsibilities of parties in relation to One Plan, One Budget, One Report. So changes to the JFA based on the recommendations of a formal assessment of the MDG PF are obviously of interest to the wider One Plan, One Budget, One Report agenda. There are clear overlaps between the areas for action identified during the One Plan/ Budget/Report Workshop and the recommendations of the FMA - this is as it should be.

The MDG Fund and the JFA are natural focal points for the very same issues which are central to the One Plan/Budget/Report agenda. Because the MDG PF has money to be

[12] This quotation is from the original JFA. The JFA is currently being revised.

spent and accounted for, the issues have an urgency and an institutional framework which the One Plan/Budget/Report agenda lacks.

One activity in the Plan of Action is of particular importance to the Roadmap - revising, translating and disseminating the **HSDP Harmonization Manual**. The whole body of work on improving adherence to One Plan/Budget/Report relies on the publication of a new, improved HHM. As requested by the FMOH during the course of this work, we expand here on how the Manual could be updated.

The first edition of the HSDP Harmonization Manual was produced in 2007. For HSDP-III, the idea was that the Manual would replace the traditional PIM (Programme Implementation Manual) as the guiding implementation handbook for the health sector. Whilst many people said that the 2007 HHM was useful, the document was not as widely used as had been hoped. Some lessons can be learnt from this:

- The Manual should be revised in a participatory way to ensure that it relevant and of practical use to (for example) woredas, Regional Health Bureaus and Development and Implementing Partners. This should also increase the commitment to using the HHM.

- Regions need to endorse the Manual; it needs to be translated as appropriate and widely disseminated, with face-to-face sessions to introduce the Manual.

- The Manual should be user-friendly, in that it should be easy to understand, not too long and include diagrams.

Box 6 shows the contents of the first edition of the HHM - it covered planning, budgeting, monitoring and governance in detail. A revised manual is an opportunity to respond to many practical questions about One Plan, One Budget, One Report. For example:

- How are the **annual plan and budget** developed at woreda, regional and federal levels? Which stakeholders should be involved at each level?

- What is the format and timetable for the annual **resource mapping** exercise?

- How often will **HMIS indicators** be revised? Through what process?

- What are the responsibilities of the **Joint Core Co-ordinating Committee**?

- **Calendars** - how can Development Partners work efficiently with both the Ethiopian fiscal year (for in-country work and documentation) and with their own fiscal year in communication with their headquarters?

For many questions, the answers will already be available in existing documentation; for others, answers will need to be developed. The advantages of the Manual include bringing together all these issues in one document, and providing a vehicle for raising awareness about the practicalities of One Plan/Budget/Report. We know from the July Workshop, that there is a real need to develop a shared understanding of the mechanics of one plan and budget.

Box 6 Table of Contents, HSDP Harmonization Manual, first edition, 2007

Foreword by His Excellency the Federal Minister of Health

Chapter 1 The HSDP Harmonization Manual – towards one plan, one budget, one report

Chapter 2 HSDP-III

Chapter 3 Planning and budgeting (The overall planning framework, Strategic Plans, Annual Plans, Budgeting and Procurement.)

Chapter 4 Monitoring and Evaluation (including the use of priority indicators and monitoring responsibilities at federal, regional and woreda levels)

Chapter 5 Governance of HSDP

Annexes included the HSDP calendar of events, an explanation of funding channels (Channel 1, Channel 2 etc.), key indicators for monthly/quarterly monitoring and TORs for various governance bodies.

As requested, Annex 3 provides draft TORs for revising the HHM. The TORs reflect the following principles:

- There needs to be widespread **consultation** about the content of the revised Manual. Is it accurate, understandable and realistic?
- **Dissemination** and **translation** need to be an integral part of the revision – the Manual will be under-used if these are neglected. [13]
- The revision needs to be adequately **resourced** – it is important that this task is performed to a high standard.
- The revision should be overseen by a small **advisory** (**steering**) **group** with a well-respected chair, who can champion the importance of the HHM. The major constituencies should be represented in this group – federal government, regions, NGOs, Implementing Partners and Development Partners.

HMIS

> "To improve financing for M&E, a minimum of 15% of vertical funds will be allocated to scaling up an integrated M&E system; resources for scaling up the HMIS will also be leveraged from partners implementing projects/programmes at facility levels. Commitment of the government will be secured through

[13] During the Workshop, CORHA, MSI, DKT and EngenderHealth all expressed a willingness to be involved in dissemination activities about One Plan/Budget/Report to NGOs.

> institutionalising and sustaining M&E at facilities, and at the sub-national health administrations by increasing resource allocation. MoH will provide start up support to regions for scaling up the HMIS (tools, training, etc.)." (HSDP IV, page 50)

During the July workshop several possible actions were identified in relation to HMIS (see Annex 2), including:

- GOE/FMOH takes lead and owns M&E Framework (Annex 2, # 11)
- Continue consensus building on HMIS issues with all stakeholders (#12)
- Strengthen efforts towards full scale implementation of HMIS country-wide (#12)
- Support leadership and ownership of the MOH in the HMIS (#12)
- Participate in NAC (National Advisory Committee) (#13, DPs).

These actions all referred to "strengthening" something which was happening already, rather than suggesting something new. So the challenge was to identify how the current way of working can improve, rather than adding a new activity to the Roadmap.

Partly because actions related to HMIS were seen as nothing new, and partly because the discussion group on HMIS at the ARM was cancelled at the last minute, **the final agreed Roadmap does not include any actions related to HMIS.** Nevertheless, it is of course important to continue with efforts to strengthen HMIS.

HMIS has already been discussed at the Joint Consultative Forum – as the highest joint governance body, this is an appropriate place for the discussions. HMIS was the main agenda item at the May 2011 meeting. Efforts need to continue to resolve problems through the JCF. Have the minutes from the May meeting been reviewed and action points monitored? Is there consensus on what the problem is with HMIS? Have recent reports been shared and discussed? Could JCF appoint a small sub-group (say three people) to explore the issue and make recommendations?

The current governance system has to be made to work so that partners are satisfied that the HMIS roll-out is on-track and that data availability will improve over time. What is said about HMIS in the strategic and annual plans? Is this being delivered?

Chapter 6 Next steps

The next step is for this report (and hence the final Roadmap) to be **endorsed by JCCC.** It would also be helpful to discuss the report at the JCF.

The Roadmap can then be turned into action points for various bodies. These are summarised in the table below.

Institutional body/event	**Monitoring Responsibilities**
JCCC	• Ensure Roadmap finalized and endorsed so that it is no longer "Draft" status. (By end February 2012) • Approve TORs and timetable for updating HHM by end February 2012. • Commission a review of the planning process (and NGO/IP involvement) after publication of 2012/13 woreda plans. • Monitor development of international advocacy document and ensure it is completed on time. (end February 2012)
JCF	• Review adherence to HHM – 6 months after updated HHM published. • Review woreda planning and budgeting process after publication of 2012/13 woreda plans (including roles of NGOs and IPs). • Develop action plan for TWGs (and monitor these). • Review usefulness of the international advocacy document after ca 6 months (June 2012).
HPN	• Collate evidence about how DPs have been lobbying their HQs to present in ARM 2012. • Monitor adherence to One Plan/ Budget/Report by the IPs and NGOs which members fund. • Consider if any role for sub-groups within HPN. • All documents produced by DPs to be aligned to EFY calendar. • Agree frequency of updates on MDG PF by end February 2012. Monitor this through HPN minutes.
ARM	• Annual report of mutually monitoring of performance, government↔DPs (see 1e and 1f in the Roadmap) • Progress on NGO and IP co-ordination/ representation to be reported in the next ARM. Contact person: Massimo Maroli, Doctors with Africa/Cuamm
Annual Performance Report	• HHM to specify indicators for annual accountability. FMOH Annual Performance Report to include these indicators. • Include information on adherence by NGOs and IPs, to One Plan/Budget/ Report. (HPN to provide the information) • Report on amount of funding, number of donors, % of overall funding through preferred funding modalities (MDG Performance Fund and Health Pooled Fund).

Annex 1 Terms of Reference

TERMS OF REFERENCE FOR CONSULTANCY TO TAKE FORWARD THE INTERNATIONAL HEALTH PARTNERSHIP IN ETHIOPIA

Background

The Federal Ministry of Health (FMOH) together with its development partners has made efforts to increase the effectiveness of development assistance to the health sector in Ethiopia. The central focus of these efforts has been to operationalise the principles of One-Plan, One-Budget and One-Report[14] at all levels of the health system. A Code of Conduct was signed in 2005 to guide the conduct of all partners in support of the Health Sector Development Programme. Following that an operational manual entitled "HSDP Harmonization Manual" was developed in endorsed by all stakeholders in 2007. In 2008/09, Ethiopia was one of the signatories of the Global International Health Partnership (IHP+) Compact and one of the first countries to develop and sign a Country based IHP+ Compact.

Some progress has been made in recent years, particularly in ensuring all partners are supporting One Plan. Woreda based planning has been rolled out and strengthened, and in developing the next five year strategy, the IHP+ Joint Assessment of National Strategies (JANS) approach was adopted.

Some progress has also been made towards 'One Report and One Budget, e.g. strengthening of the Health Management Information System (HMIS) and studies and surveys undertaken in consultation with DPS, but with HSDP IV currently being finalised the FMOH would like to take stock of and accelerate progress in these areas. Some of the challenges that have been identified include:

- Slow progress in moving towards a common budgetary and annual planning framework
- Some Development Partners continuing to choose and monitor their own indicators and targets (resulting in duplication of efforts, additional workload and resources)
- Reported low disbursement of committed funds (55.4%) by development partners in EFY 2001.
- Weak planning, monitoring and follow-up capacity at regional and Woreda levels

Objective

The objective of the consultancy is to take stock of progress towards the objective of all development partners (including NGOs and other service providers and implementing partners in the case of 'one report') using 'One Plan, One Report and One Budget' in the health sector and identify ways to accelerate future progress.

[14] That is the development of one National strategy and annual plans which DPs align to, and use of one budgetary framework (where possible with development assistance channelled through Government of Ethiopia's preferred channels), and one set of indicators and monitoring and evaluation framework.

RECIPIENT

The recipients of this consultancy work are the Policy, Planning and Financing Directorate, FMOH and the HPN Development Partners of the JCCC.

Scope of work

The scope of the consultancy includes but is not limited to:

- Reviewing progress made to date including against the Ethiopia IHP+ Compact, reports, indicators and targets required by individual DPs, as well as understanding the range of reporting systems and indicators used by NGOs/CSOs and other implementing partners (including IHP+ Results).
- Identifying barriers to DPs (and in the case of 'one report NGOs/CSOs and other service providers and implementing partners) moving further towards 'One Plan, One Budget' and 'One Report'
- Discussing these with partners at country and HQ levels as necessary – including the IHP+ Core Team
- Developing a Roadmap for removing barriers where possible and accelerating and monitoring progress in this regard

METHODOLOGY/APPROACH

The consultant should liaise with the PPF Directorate and the JCCC team on a regular basis to discuss the approach being taken and what progress is being made.
It is likely that this work will be undertaken in three main phases:
Phase One will include:

- A review of relevant documentation to draw out progress, lessons and experience from current efforts in Ethiopia as well as other countries and contexts.
- Mapping of reporting and data requirements of DPs identifying variations in reporting requirements of DPs from that of the MOH as well as understanding the range of systems and indicators used by NGOs/CSOs and other service providers and implementing partners.
- Interviews with key individuals and organizations to identify and document requirements and barriers to making further progress.

Phase Two will include:

- Discussions with MOH, DPs and other key partners and service providers at country and HQ levels

Phase Three will include:

- Development and presentation of a report summarising the findings and attempting to gain consensus on a Roadmap for accelerating progress.
- Kick starting implementation of the Roadmap and ensuring a process is in place for following up and monitoring progress.

Deliverables

The consultant is expected to produce the following sequentially:

- Inception report to include proposed approach and tools;
- Report and Roadmap to include actions needed by the FMOH, Development Partners and NGOs/CSOs and other service providers and implementing partners at both country and HQ levels to accelerate progress.

- Implementation of the Roadmap initiated and a suggested approach to monitoring progress on and accountability for the IHP+ agreed.
- A short briefing note and presentation to the IHP+ Core Team on relevant issues arising from this assignment.

Time frame

The consultancy is expected to take place between April and July 2011. The team leader will be contracted for up to 40 days, the other 2 team members will be contracted for up to 25 days each.

Required Expertise

Three consultants will be required to undertake the assignment. All should have second degrees in public health or social sciences. One consultant (team leader) will likely have extensive experience of Global Health and other country contexts as well as experience of sector wide planning and coordination, and aid effectiveness agenda (ownership, alignment, harmonization, mutual accountability and results orientation and frameworks). The other two consultants will need to have a deep understanding of the Ethiopian health sector context including development partner support, planning processes and the aid effectiveness agenda (ownership, alignment, harmonization, mutual accountability and result orientation).

Annex 2 Actions identified by the four workshop groups on Thursday July 14 2011.

Area of action	What is your stakeholder group's responsibility and who will act on it?			
	Government	**Development Partners**	**CSOs/NGOs**	**Implementing Partners**
ONE PLAN/BUDGET				General principle: GOE/FMOH provides leader-ship; DPs set the Scope of Work & guiding principles for IPs' engagement. IPs provide necessary TA and support.
1. Make clear the definition of what is meant by "one plan, one budget and one report" at all levels and in the context of government, DPs, and CSOs/NGOs. Update HHM and other tools and build on them. Disseminate and use the instruments more.	Initiate and lead the process of clarifying concepts and the revision of HHM and other relevant tools. (JCCC: may hire consultant or form TWG as needed) Disseminate tools to FMOH staffs, RHBs, Agencies, and Woreda (FMOH/Agencies/RHB/ WoHO, HPN)	HPN to discuss the definitions of the three ones, establish a consensus, bring out concerns to JCF (HPN co-chairs)	Institutionalize 1 p/b/r within all our organizations. CORHA & CCRDA disseminate the tools etc.	GOE and DPs decide on one plan/budget/report. IPs take role in: Disseminating the policy; Translating the policy into implementation process; Create/ maintain environment of accountability at implementation level (All IPs)

2.Cascade resource mapping to lower level (CSO/NGO) at woreda level for operational (annual) planning as IPs/NGOs are receiving resources from DPs. (Comprehensive picture only possible at lower level.)	Develop guideline on how to cascade annual resource mapping and build capacity at RHB and Woreda levels (FMOH/RHB/WoHO)	Enforcing through the agreement with NGOs to submit a plan + budget to the government (regional and woreda level). Give NGOs predictable funding. Provide TA. (DPs which work with NGOs)	Tools to be shared. NGOs to provide information at different levels. (NGOs, CCRDA, CORHA)	Responsibility of GOE and DPs
3. Initiate clear communication between DPs/funders & NGOs/ CSOs so that they provide information on resource envelope at lower level. Do same for Regional Health Bureaux and WoHOs to request/enforce CSOs/NGOs.	Include the requirement for showing annual indicative resource commitment in the project agreement signed between local government and CSO/NGOs before the project starts. (HPN; FMOH/RHB/WoHO/CSOs/NGOs)		DPs to share the information with NGOs.	Technical Assistance. Support communication between DPs and NGOs. Cascade implementation. (All IPs)
4.Clarify the core woreda comprehensive planning process in more detail. What is expected of partners (GOE, DPs, NGOs), when and at what level? Disseminate the documents in English. Look for ways to	This shall be included in the revision of HHM and other related tools (See # 1 above)	Discussion on policy dialogue and priority setting before the core targets and resource is communicated to lower level (Co-chairs)		Technical Assistance within the limits of the scope of work of IPs. (All IPs)

strengthen comprehensive planning (how to organize DPs).				
5.DPs could look for other creative ways to align their calendar with government calendar. Government planning process needs to be aligned and completely timely. E.g. compre-hensive plan needs to be ready for the beginning of the FY.	Initiate comprehensive planning process timely so as DPs will be able to see how and where they/their resources fit into the plan. (FMOH)	Facilitate mapping (spreadsheet) of plans and resources ahead of time. Monitor DPs alignment to calendar. Monitor predictability. (Co-chairs)	NGOs to communicate with donors not working in Ethiopia to align their calendars.	
6.The need for initiating implementation of the recommendations of FMA to attract more donors to MDG PF.	Work in progress. TWG consisting of HPN/FMOH/Agencies been formed and is working on review and implementation of recommendations. (HPN/FMOH/ Agencies/JCCC/ FMA TWG)	Provide TA, TWG participation, follow up of implementation in JCF (DPs)		
7.Need to follow the calendar of events in the JFA which describes important events at various levels of governance both by government and DPs. (JCCC, JCF, HPN etc.)	Calendar of events to be reviewed with the JFA All governance structures to comply with the Calendar. (JCCC/FMA TWG; All Joint Governance structures)	DPs monitor implementation of the calendar HPN (HPN)		
8.Look into need for detailed MTEF for HSDPIV period showing money from all	FMoH (JCCC) to explore the need/feasibility to do MTEF for HSDP IV (FMOH/JCCC)	Follow up the MTEF study as part of JCCC (JCCC)		

sources.				
9.Discussion at DAG/ HPN level should start to improve on the amount of resources pooled through MDG Performance Fund.		Period discussion in DAG/HPN (HPN)		
ONE REPORT				
10.Improve communication within ministry, between DPs and FMOH, Agencies	FMOH will devise a mechanism that will allow smooth/timely information sharing within the ministry & agencies. (FMOH/Agencies)	Include facilitating strategic info. as a task on HPN co-chair ToR. Support the country in implementing info. sharing & standardization (HPN)		Technical Assistance Support communication between DPs and FMOH. (JSI HMIS (MEASURE Evaluation), Tulane)
11.Having agreed upon M&E framework (strengthen M&E to lead HMIS)	M&E to be strengthened [*This was not clear during the discussion and is to be discussed further.*] (FMOH)	Promote use of the common M&E framework & use of core indicators (contract agreement with NGOs). Build IPs' capacity. (HPN)		GOE/FMOH takes lead and owns M&E Framework. IPs provide TA in design, dissemination & implementation of M&E framework. (JSI HMIS, Tulane)
12.Make HMIS strong governance issue. FMOH to take stronger stand (on HMIS implementation and preventing parallel reporting) Have	Continue consensus building on HMIS issues with all stakeholders. Strengthen efforts towards full scale implementation of HMIS country-wide. Finalize the regulation for HMIS implementation and implement once it is approved by Council of Ministers.	Support leadership and ownership of the MOH in the HMIS. (HPN)		Technical Assistance (JSI HMIS, Tulane)

Roadmap.	(All actions: HPN/FMOH/Agencies)			
13.Improve partnership within HMIS (consensus building)	Please see above (#12)	Promote involve-ment of partners. Participate in NAC.	NGOs to participate through TWGs.	Technical Assistance (JSI HMIS, Tulane)
14.Improve access & info. use (website, data warehouse, bulletin, library …)	Strengthen data availability through better coordination (FMOH/Agencies)	Plan & share info. on surveys, TA and financial assessments. (HPN)	NGOs with websites should put up annual reports etc; link to MOH website if possible.	Technical Assistance. Support. (All IPs)
15.Share selection criteria and data source for indicators *{This means the indicators used to review HSDP implementation.}*	Share agreed upon standard criteria (FMOH)			Technical Assistance (All IPs)
16.Share plan of survey to avoid duplication (survey mapping)	Develop a comprehensive plan of surveys to be conducted in the health sector (to avoid duplication) and share with stakeholders. (FMOH/Agencies)		Add "AND REPORTS" to statement. Support initiative of Addis Ababa University School of Public Health to share research. (CORHA) Strengthen resource centres of CORHA and CCRDA.	Technical Assistance. Co-ordination, Collaboration (All IPs)
17.Revising HMIS implementation modality (pre-requisites etc)	*[This was not clear during the discussion.]* But was agreed that more work will be done to mobilize resources from partners so that regions/facilities fulfill the pre-requisites for HMIS implementation.			Technical Assistance (JSI HMIS, Tulane)

	(HPN/FMOH/Agencies)			
GOVERNANCE				
18.Strengthen CORHA and CCRDA to play their role.	*This point was not clear enough to discuss properly. {Later clarified that this is not government's responsibility.}*	Discuss in the HPN, Provide TA and financial support to CORHA and CCRDA (HPN)	Inform the wider NGO constituency about need for one plan/ budget/report. (MSI, DKT, CORHA, EngenderHealth)	Support funding, capacity building (IFHP)
19.Consider having a small secretariat to co-ordinate implementing partners who are not members of either CORHA or CCRDA, including private sector.	*USAID said during plenary that they would take the lead in moving this forward.* *This is not government's responsibility.*	Provide support for the establishment and coordination of the secretariat (USAID and others)	*USAID to lead.*	Support funding, capacity building (IFHP)
20.Need to consider establishing a unit to co-ordinate implementing partners & NGOs.	FMOH will have a team to coordinate partnerships with NGOs/private sector/professional associations under Resource Mobilization Directorate (FMOH)		Reworded: "NGOs to consider establishing a unit to co-ordinate members in relation to FMOH." CORHA will take initiative & check with CCRDA & members.	
21.CCM & JCF currently working well and what is required is enhancing information sharing.	(This is for HPN/CCM/JCF.)			
22.Consider partners that bring resources to MDG PF as members of JCCC, or establish an	This will be considered with revision of HHM. (HPN/FMOH/ JCCC)	Discuss in HPN and approve the decision at JCF (co-chairs)		

informal meeting among MDG funders which can meet when necessary.				
23.Strengthen linkages between JCCC/JCF and TWGs/HPN.	JCCC to invite program TWGs whenever there is agenda relating to the TWGs role. Other ways to strengthen linkage to be explored. (JCCC /FMOH/Agencies)	The HPN TWGs mapping & discussion (TWG which is doing the mapping)	CORHA will initiate internal discussion with CCRDA and CORHA.	Participate in TWG (All IPs)
a)Strengthen ARM through enhanced regional and woreda participation; strengthen content of policy dialogue; strengthen follow-up of ARM recommendations.	Strengthen HSDP secretariat (PPF GD) role in following up implementation of ARM recommendations by all directorates and agencies. (FMOH)	HPN discuss and establish consensus on the purpose of ARM (HPN)	CORHA will talk to JCCC co-ordinator. Involvement in policy dialogue through CORHA and CCRDA representation.	Technical Assistance and Support. (All IPs)
24.Partners' Forum at regional and woreda levels to have guidelines about frequency, reporting, timelines, etc.	(This is up to RHB/Woredas/Partners' Forum)	JCCC will assist to develop the guideline (JCCC)	CORHA will discuss with JCCC. Organize regional reproductive health forums. (CORHA)	Participate and support. (All IPs)
25.(Accountability of DPs came up as an issue during plenary and was then discussed by the DP group.)		HPN develop peer review performance assessment frame-work of donors on aid effectiveness based on existing framework. (Co-chairs/WHO)		
26.(Attribution to DPs		HPN discuss		

came up as issue in plenary; DP group discussed it.)		what is the best way to attribute results. (co-chairs)		

Annex 3 Suggestions for Draft TORs to Revise HSDP Harmonization Manual

TERMS OF REFERENCE FOR REVISING THE HSDP HARMONIZATION MANUAL (DRAFT SUGGESTIONS)

Background

The HSDP Harmonization Manual (HHM) for the health sector in Ethiopia was produced in 2007. Recent work on "Enhancing One Plan, One Budget, One Report" concluded that the Manual still has an important role to play in the health sector.
However the time has come to revise the first edition. Developments which need to be reflected include:

- The publication of HSDP IV
- The IHP Ethiopia Compact
- The revised governance structure, including the creation of the Joint Consultative Forum
- Experience with woreda-based planning
- The Joint Financing Arrangement
- The Joint Assessment of the National Strategy (JANS).

The HHM aims to operationalise the concept of One Plan, One Budget, One Report. The recent "Enhancing" work revealed that there are still basic problems in terms of a shared understanding of what one plan and one budget means, and the responsibilities of various stakeholders in terms of adherence.

Although some stakeholders have found the HHM useful, the Manual has not been used as much as had been hoped. Reasons for this include (but are not limited to) the rather non-participatory way in which the first edition was developed, and the lack of follow-up in terms of active dissemination and translation.

Objective

The objective of this work is to revise the HHM in a participatory manner and to support the FMOH in planning and implementing its dissemination and translation.

Client

The clients for this work are the Policy, Planning and Financing Directorate, FMOH and the HPN Development Partners of the JCCC. The PPF Directorate has final responsibility for approving the revised HHM.

Given the large amount of work, the JCCC should consider appointing a time-limited technical Working Group or Steering Group to oversee the HHM revision. Ideally, this Group should have a well-respected and prominent chairperson, who can champion the importance of the HHM. The major constituencies should be represented in this group – federal government, regions, NGOs, Implementing Partners and Development Partners.

Scope of work

The scope of the consultancy includes:

- Consulting with stakeholders about the main changes which need to be made to the first edition.
- Getting feedback from stakeholders about draft revised chapters.
- Organising the translation of a complete draft into Amharic and getting feedback from stakeholders at regional, zonal and woreda levels.
- Assisting the FMOH to develop a plan and budget for dissemination and translation. Doing the same for regions. Ensuring clear demarcation of responsibilities – federal level should disseminate the Manual to regions; regions should then be responsible for dissemination to woredas. The cascading of training about woreda-based planning offers one possible model to follow in terms of organising dissemination activities.
- Planning the content of dissemination sessions for distributing and introducing the Manual. Participating in at least 3 such sessions in person. (During the July 2011 Workshop, CORHA, MSI, DKT and EngenderHealth all expressed a willingness to be involved in dissemination activities about One Plan/Budget/Report to NGOs.)

METHODOLOGY/APPROACH

The consultants should agree a workplan with the JCCC which includes regular liaison with the PPF Directorate and the JCCC team (or the TWG/Steering Group, if appointed).

Deliverables

The consultant is expected to produce:

- Draft HHM chapters for consultation which are then brought together into a full draft.
- A complete final version of the HHM, including all the annexes
- Plans, dates and budgets for dissemination and translation; outline of dissemination session
- A short paper at the end of the assignment describing the process and listing lessons learnt.

Time frame <u>NB. This is a very preliminary estimate of number of days required.</u>

Writing a complete draft HHM should take no more than 50 person days. (10 days per chapter) Feedback can be collected and responded to in 15 working days; up to 10 days can be spent on dissemination. This is a total of 75 days.

When timetabling activities, time needs to be allowed for translation into Amharic.

Required Expertise

A team of up to three people can be engaged, to cover the necessary expertise in planning, budgeting, reporting and governance. The consultants need to have a good understanding of the public and aid sectors in Ethiopia. They need to be familiar with HSDP-IV, the IHP+ Compact, the JFA and the principle of One Plan, One Budget, One Report.