Federal Ministry of Health

Compact between the Government of the Federal Democratic Republic of Ethiopia and the

Development Partners on Scaling Up For Reaching the Health MDGs through the Health Sector Development Programme

in the framework of the
International Health Partnership

August 2008

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I. Background and Purpose of the Compact

Objectives and Structure

1. This Compact sets out understandings reached between the Government of Ethiopia ('the Government') and the Development Partners who are signatories[1] to it. The main objective is to set out a framework for increased and more effective aid, in order to permit Ethiopia to make faster progress towards the Health Millennium Development Goals (MDGs). Specifically, the Compact establishes:

- **a.** The guiding principles and management arrangements that will be observed by Government and Development Partners in order to improve the contribution of official development assistance (ODA[2]) to achieving the health MDGs (Section II.);
- **b.** The specific commitments and obligations agreed by the Government for the implementation of this Compact (Section III.);
- **c.** A collective target for the level of total aid for health, and particularly of pooled aid, that the signatories collectively endeavor to provide to Ethiopia in each year in the period 2009-2015 (Section IV.)
- **d.** The specific commitments and obligations agreed by the Development Partner signatories with respect to the future management of their development assistance (Section IV.);
- **e.** The agreed arrangements for monitoring compliance and resolving disputes, and the remedies available in the event of non-compliance with the provisions of this agreement (Section V.).
- **f.** The overall targets for this Compact by 2010 (Section VI.)

Role of the Compact in Relation to Other Agreements on Official Development Assistance

2. This Compact provides an over-arching framework for health aid coordination in Ethiopia, and complements more specific agreements relating to:

- **a.** The Aid Policy of the Government of Ethiopia (www.MOFED.gov.et).
- **b.** The Code of Conduct to Promote Harmonization in the Health Sector of Ethiopia ("Code of Conduct") signed between Government and Development Partners in September 2005.
- **c.** The HSDP Harmonization Manual (HHM) published by the Government in 2007.

3. The essential components of the Code of Conduct and the Harmonization Manual include:

- **a.** A three tier collaborative governance system - Central Joint Steering Committee (CJSC),

[1] For this Compact the Government of Ethiopia is represented by the Ministry of Health and the Ministry of Finance and Economic Development. The Development Partners are represented by the Country Directors of development cooperation agencies. “Development Partner Signatories” refers to those partners who have signed the Compact, whereas “Development Partners” refer to all Partners

[2] ODA includes the Official Development Assistance by donor Governments as well as the financial and technical assistance by UN agencies and private foundations.

FMoH / HPN[3] Partners Joint Consultative Committee to promote dialogue and Joint Core Coordinating Committee as a technical arm of CJSC. There is an Annual Review Meeting (ARM) that endorses plans and reviews performance reports.

b. The vision of one-plan, one-budget, one-report based on FMoH-led processes.

c. Agreed funding mechanisms that allow for three channels of financial resource management - Channel I: pooled and managed by government or earmarked by agencies with direct disbursement; Channel II: donor held financing provided directly to sector units or decentralized regional offices to be directly used and accounted for by them; Channel III: direct donor programmed funds disbursed by Development Partners to finance specific contributions to HSDP usually through NGOs.

d. Monitoring and evaluation - this includes agreeing a set of indicators to be used for monitoring and evaluation of progress and the issuance of one report

4. Future aid agreements will be framed to be fully consistent with the provisions of this Compact. Whilst all clauses of aid agreements that were in existence prior to the signature of this Compact will continue to apply, all of the parties to the agreement are encouraged to propose modifications to further harmonize and align.

5. This Compact applies to official development assistance supporting public sector bodies, including significant programmes of ODA to public sector entities that are channeled via Non-Government Organizations (NGOs) for management purposes [4]. The Government of Ethiopia and Development Partners encourage NGOs and private organizations to support the realization of this Compact.

II. Management of Development Assistance

6. The guiding principles and aid management procedures described in this section of the Compact 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.

7. The Development Partners recognize that the human resource shortage is one of the main constraints for health sector development: they commit to address the health workforce

[3] HPN: Health, Population and Nutrition.

[4] A threshold of Ethiopian Birr 5 million in any one year. This threshold should capture all subsidies including HIV/AIDS programmes supported by external donors.

constraints by contributing to human resource development and to avoid undermining the public sector workforce.

Integrating Aid within Government Plans and Budgets

8. All ODA will support the long-term vision for development and the medium term strategies and priorities articulated in the Plan for Accelerated and Sustainable Development to End Poverty (PASDEP) and the Third Health Sector Development Programme (HSDP 3).

9. All ODA to Central Government and Local Governments should be included in the budget estimates, even when they use parallel donor procedures to disburse and account for the funds. All resources allocated to the lower level of the health system through various implementers (CSOs, NGOs etc) must be captured in the health plan of the respective public sector. Hence, the implementers are obliged to provide the information when requested.

10. Government is responsible for services that are on budget and that form part of an approved sector strategy. The Development Partners share this responsibility in terms of commitment to increased aid and aid effectiveness. Where a component of the health sector programme, initiated with partners' support, has high long-term expenditure implications beyond Government's capacity, e.g. antiretroviral treatment, the Development Partners will endeavor to ensure the continuation of this service. A sustainability plan has to be developed before the introduction of all new services and updated on a regular basis.

11. Development Partners will participate in national health planning and budgeting processes as set out in the calendar of the Joint Budget and Aid Review (JBAR) and of the Harmonization Manual (Annex 5), as amended and updated from time to time following discussion with the Central Joint Steering Committee (CJSC) and the FMoH/Partners Joint Consultative Meeting. The Government will provide formal opportunities for consultation and due regard of Development Partners on the monitoring of the overall HSDP, the sector strategies that are integrated within it, and the policies, and annual budgets and work plans through which it is implemented.

12. Decisions on the allocation of Government and Development Partners resources within the health sector will be taken through the national planning budget process. Resources allocated to the health sector through the Government preferred channels will be additional. Their allocation will be defined in light of the priorities for health sector development toward the achievement of the health-related MDGs.

Role of the HPN Partners group and Central Joint Steering Committee

13. The Ministry of Health (MOH) and the HPN Partners group will undertake a joint sector review, the Annual Review Meeting (ARM). The ARM will provide the single opportunity for all

Development Partners to comprehensively review policy, strategy, performance and capacity needs. It will include both a backward look at progress and a forward assessment of objectives and resources required. The sector reviews will be open to all stakeholders, the timing and format will enable the outcomes of sector reviews to inform budget preparation. These cross-cutting reviews will ensure that their conclusions on sector issues are informed by and consistent with the sector reviews, which are the lead fora for discussion of sector-specific issues. All technical and managerial reviews requested by specific Development Partners or funds will be streamlined as part of the Annual Review Meeting (ARM) under the principles of one-plan, one-budget and one-report. Should any additional independent expert views be needed as part of a validation process to trigger disbursements, those should be integrated in the joint assessment as part of the ARM process. Any process of validation by external experts will need to take place during the ARM and to be endorsed by the Central Joint Steering Committee (CJSC).

14. Two of the present FMoH / HPN Partners Joint Consultative Committee meetings will be used as business meetings to validate the annual national plan, annual budget, resource commitments, financing gaps, and strategies to fill the gaps. Government will present its three years revised rolling health plan and annual budget for the following year as well as its operational plan. Development Partners will present their firm commitments for the three years revised rolling plan and the annual budget for the following year. The first business meeting will be held prior to the Annual Review Meeting based on the indicative plan. The second business meeting will be held in June-July after the annual plans are finalized.

15. The findings and conclusions of the ARM will be widely disseminated through all available means.

16. The FMoH / HPN Partners Joint Consultative Committee and the Joint Core Coordinating Committee will establish mechanisms to link budget inputs to service delivery. They should identify cost and rank sector spending priorities. Only the highest ranking spending priorities, which have been clearly identified in sector investment/expenditure plans, should be undertaken, either through the Government budget or as donor funded projects.

17. The FMoH / HPN Partners Joint Consultative Committee and the Joint Core Coordinating Committee will also establish a common agenda of analytical work to avoid duplication. For all crosscutting system issues (e.g. human resources, performance based financing, logistics, HMIS etc), a single country reference group will be established under the leadership of the FMOH and will be accountable for the development of these key system components.

Preferred Aid Modalities

18. Government prefers aid to be provided in support of costed strategies, included in the budget, and delivered through the budget using Government procedures. This reduces transaction costs and enables priorities to be set and reflected in the use of both domestic and external

resources. The Government favours sector-wide approaches (SWAPs) as a mechanism to plan and coordinate all resources flowing into a sector, including domestic revenues, support to the budget, project aid, and technical assistance.

19. To accommodate the various donor preferences the HSDP Harmonization Manual has defined three channels to transfer resources into health, as defined in paragraph 3 and in the HHM (Annex 5).

20. For the health sector, the preferred modes of financing of the Government of Ethiopia are mainly i) the block-grant to woreda (currently supported by component 1 of the PBS[5] project) and ii) the MDGs Performance Fund ("MDG Fund", currently supported by the GAVI Health System Strengthening window). The block grant is under the control of woreda council and finances recurrent costs including wages, maintenance and operating costs. The MDG Fund is managed by FMOH using Government's procedures and provides specific federal grants for public goods (e.g.: vaccines, bed nets...) and capacity building activities including upgrade of infrastructure and upgrade of logistics and training. Increasing resources for health can therefore take place through any of these two channels. The Government will use its best endeavor to establish the framework needed for Development Partners to use these two mechanisms.

21. The Development Partners will use their best endeavours to respond to the Government's expressed preference for an increasing share of aid to be provided through harmonized mechanisms. All new initiatives will be requested to channel their support for health system strengthening, essential health commodities and capacity building through the MDG Fund. A joint appraisal of the MDG Fund will assess the issues and options relating to the funding and functioning of the MDG Fund. When necessary the appraisal will recommend actions to address shortcomings in order to strengthen the overall functioning of the MDG Fund and move swiftly towards a joint financing agreement between Government and Development Partners. The appraisal will contribute to the detailed definition of the MDG Fund procedures. Oversight on the MDG Fund will be ensured through a common governance framework under the joint leadership of the Government of Ethiopia and the HPN Partners group. The main governing body will thus be the Central Joint Steering Committee (CJSC) which has now been in place for several years. The Joint Core Coordinating Committee (JCCC), chaired by the Head of Planning and Programming Department of FMOH, will act as the technical secretariat of the CJSC. The Terms of Reference for CJSC and JCCC are defined in the HHM (Annex 5).

22. The Government of Ethiopia is committed to build a transparent, fair and accountable public finance and procurement system, in line with internationally accepted procedures. Assistance that requires procedures other than those of the Government will be accepted when Government is satisfied that transaction costs are not unacceptably high, the aid is aligned to Government priorities, and conditionalities are not excessive. Transaction costs should be considered in the

[5] PBS: Protection of Basic Services

broadest sense, to include the opportunity cost of allocating scarce (human and financial) Government resources to activities and their follow-up.

23. FMOH will be responsible for the procurement of goods under the MDG Fund while the Regions and Woredas will carry out the procurement of local goods funded by domestic funds and block grant. Under the management of the MDG Fund, FMOH will have the options of outsourcing and using partners with comparative advantage in undertaking specific procurement activities while strengthening the Pharmaceutical Fund and Supply Agency (PFSA) for the long term and the building of sustainable capacity.

24. The results orientation of the health programme will be enhanced. A Common Results Framework for all Development Partners has been developed linking systems strengthening with results on the health MDGs (Annex 3). The Common Results Framework will be the basis for any results based financing compact between the Government of Ethiopia and Development Partners. This framework will also guide the establishment of Performance Based Contracts between the Federal Ministry of Health and Regions. Regions will in return sign performance based contracts with woredas/zones. This will allow establishing a clear linkage between resources and performance of woredas. The Performance Contracts will combine some input and some output indicators. Input indicators will for example specify the requirements for the regions to receive the resources. Output indicators, on the other hand, will establish benchmarks of performance.

25. The minimum aid levels set out in Annex 1 represent the aid required from the present signatories in order for Ethiopia to implement the HSDP3, and they make assumptions about the continuing contributions from those Development Partners who are not signatories.[6] The minimum level of development assistance will be adjusted upwards if new partners join the agreement. To this purpose several scenarios for assistance are proposed. Project aid disbursements may be affected by absorptive capacity problems, with Development Partners unable to disburse their funds due to slow implementation. The minimum levels of project aid may be adjusted down pro rata if the execution rate of the development budget is below 75%.

26. In the event that the Development Partners reduce their aid flows below the specified level for either of these reasons, the independent monitoring group (described in Section 5) will review the justification for the failure to provide aid at the stipulated levels, and will publish their findings. This will include commenting on the extent to which onerous donor procedures contribute to shortfalls by specific Development Partners, or the extent to which government actions may also have contributed to the shortfalls.

27. The following procedure will be followed to operate the MDG Fund:

a. Commitments to the MDG Fund by the Development Partners will be made on a

[6] The minimum level of aid may be adjusted downwards in the event of a significant Government deviation from the principles and policies set out in this Compact and in the HSDP3

minimum of three years basis, confirmed on annual basis during the annual resource mapping exercise as part of core planning and will be validated at the time of the ARM.

b. FMOH will be responsible for directing each Development Partners as to the timing of disbursements into the Fund. Partners will be encouraged to disburse during the first quarter of the fiscal year. Partners with specific constraints, which will limit their flexibility to disburse regularly on a quarterly basis, are required to highlight these to MoH in writing before the start of the financial year. MoH will prepare annual and quarterly cash flow statements to guide Development Partners to disburse into the MDG Fund.

c. Continuous gap analysis of HSDP will be done and made ready on annual basis for planning.

28. Key priorities and action plan for the use of the MDG Fund will be agreed between MoH and Development Partners on an annual basis. Development Partner views on the budget will be expressed collectively at the appropriate coordination fora. Individual Development Partners will not attempt to influence budget allocations outside these fora.

29. It is recognized that some Development Partners may not be able in the short term to channel all their funding through the MDG Fund because of restrictions imposed by their governments and/or funding agencies. FMOH will however work with Development Partners who are able to provide earmarked funds in the planning, use and reporting on these funds, to enhance their integration into the sector policy and implementation framework. It is planned that this continuous use of earmarked funds shall not exceed 40% at the end of 2010 and 10% in 2015.

30. The following procedures will be applied in the provision and use of earmarked funds:

a. To permit ODA to be included in the budget Development Partners will provide FMOH and MOFED with data on development assistance for each fiscal year (disaggregated by region and woreda) as per the schedule in HHM. Development Partners will provide projections of their future support for as far ahead as possible, and preferably a minimum of three year rolling projections of all budget and project support.

b. A broad meeting between FMoH and all partners wishing to provide earmarked funding will be held prior to the annual resource mapping exercise to agree priority areas for earmarked funding, and to identify areas of interest of the various partners.

c. This will be synthesized into a comprehensive plan and budget for use of earmarked funds to support annual plan priorities in the following year, which is to be consolidated into the annual plan and presented during the ARM.

d. All regions shall be responsible for consulting with their various Woredas on the use of allocated earmarked funds.

e. A review of the level of implementation of programmes will take place every six months, synchronized with the JBAR.

Vertical Funds

31. Financial assistance received from vertical funds will be utilised as support to the sector's budget, pooled fund or project aid and in the same way as other multilateral and bilateral aid. The funds will provide information on all activities financed under such arrangements to FMOH (and the lower levels of the health system where implementation happens) and MOFED as indicated in HHM. Where Government Institutions are principal recipients of those grants they will, as far as possible, comply with the provisions of this Compact, exploiting the current and future opportunities for harmonization.

32. The signatories will adjust the allocation of domestic resources and development assistance to ensure that vertical funding arrangements do not distort the priorities that are agreed in the PASDEP and through the budget process including the JBAR. Vertical funds will be as flexible as possible in ensuring that they are aligned with HSDP.

33. Vertical funds will integrate their activities, disease/programme specific and relating to crosscutting issues regarding health system development (e.g. human resources, performance based financing, logistics, HMIS, etc.), into the country system, in order to contribute to health systems strengthening and to avoid creating separate processes and parallel systems.

Technical Assistance

34. All Technical Assistance (TA) provided to the Government will be concerned primarily with the transfer of capacity to the Government by building the skills and capabilities of local staff and/or developing systems and procedures and codifying these in an accessible manner for use by local staff. All terms of reference for TA must recognise these as the ultimate objectives of such assistance. Guideline to TA will be dispatched by MOH at the time of the 2008 ARM

35. To facilitate improved planning and management of TA, Development Partners will respond as much as possible to the specific request of Government and support pooled funding for TA. TA should in any case be operating in a framework of Government expressed needs.

Terms of Aid

36. The bulk of future development assistance needs to be provided in the form of grants.

37. Development Partners will apply the OECD DAC Guidelines in their support to the Government of Ethiopia. Particularly Development Partners will avoid tying of aid, in order to avert the negative impact of tying on aid effectiveness.

Responsibilities for Mobilizing and managing ODA

38. All signatories to this Compact agree to comply with Government procedures for the mobilisation and management of ODA. All aid transactions will be subject to signed agreements that have been cleared with MOFED, and signed by Development Partners.

39. The FMOH or other government body designated as the primary recipient of an assistance package is responsible for the implementation of investments or other expenditures agreed. It will engage in regular dialogue with MOFED (and its equivalents at lower levels of the health system) on aspects of implementation requiring attention, for example, where delays to disbursements pose a problem or where there are delays to implementation.

III. Government Commitments

40. Recognizing that the Development Partners' willingness to give assurances of long- term support depends on their confidence in the transparency, predictability and efficiency of Government planning and budget processes and in the public servants in charge of these processes, the Government will:

- **a.** Ensure that strategic plans and the overall PASDEP and HSDP contain clear objectives and targets in line with the MDGs Needs Assessment, that the measures required to achieve the targets are evidence-based and are fully costed, that the objectives and targets can realistically be achieved taking into account implementation capacity and projections of the available resource envelope, that HSDP is consistent with the PASDEP, that they are the outcome of a consultative process involving Development Partners, and that there is a clear framework for monitoring and evaluation.
- **b.** Consult with and engage stakeholders each year on development of one plan, revisions to plans and sector strategies via the JBAR and the Annual Review Meeting (ARM) of the health sector.
- **c.** Implement the budget in a manner consistent with the agreed allocations, consulting in advance with the Development Partners on major envisaged changes to budget allocations during the financial year.
- **d.** Continue to improve the quality of public financial management systems at both central and local government levels, by implementing comprehensive reforms in public finance management, and consultation through the existing Government and donor dialogue fora with the key goal being to achieve appropriate improvements that would facilitate the institutionalization of MDG Fund.
- **e.** Verify the improvements in public finance management by collecting independent information and analysis through a programme of studies to be agreed with MOFED and FMOH, and to support a regular programme of public expenditure reviews and public expenditure tracking studies.
- **f.** Ensure adequate capacity to manage and coordinate enhanced aid flows. To this end an

assessment of capacity needs to facilitate the management of aid will be undertaken, and a prioritized capacity building plan will be devised and implemented, to include capacities in central and local government, as well as other bodies managing externally sourced resources.

g. Fund the health sector in accordance with PASDEP and HSDP3 financing scenarios and increase the domestic allocation to the health sector over time. Government finances the health sector through treasury; particularly it allocates funds to the MDG Fund for public goods and capacity building activities.

h. Further institutionalize the MDG Fund to encourage all Development Partners and global initiatives to place their financial resources into this Fund. Establish an annual process of independent audit of the MDG Fund (including procurement post review, management and financial audit).

i. Implement and report on a single results based framework for the HSDP, which will be reviewed as appropriate.

j. Review and improve on the performance based contracts between the federal level and the regions, and the regions and the woredas/zones on one hand and between the administrative levels and service providers on the other hand.

k. Further improve on the information management system for financial and technical programmes reporting, joint monitoring and evaluation system.

l. Provide political support to increase the domestic allocation to health by the regions and woredas.

m. Implement procurement reforms and processes including functionality of the Pharmaceutical Fund and Supply Agency (PFSA).

n. Ensure an enabling environment for the participation of the NGOs / Civil Society and the Private Sector to the implementation and realization of the Health Sector development programme, (as per the HSDP Harmonization Manual) and actively seek further opportunities to enhance partnerships with NGOs, CSOs, private sector, professional organizations, and interest/clients groups.

IV. Development Partner Signatories' Commitments

41. The Development Partner signatories to this compact commit to:

a. Collectively increase development assistance to the health sector during the years 2009-2015.

b. Provide to FMOH and MOFED by February of each year information on expected future commitments and disbursements of sector's budget support and project aid for as far ahead as it is feasible, with indications covering at least the three year period starting in the following July. Development Partners, grantees and sub grantees must also provide information on resources they contribute to the implementation of the comprehensive plan of the public health sector at levels they operate.

c. Provide commitments to the MDG Fund on a minimum of three years basis, confirmed on annual basis during the annual resource mapping exercise as part of core planning and

to be validated at the time of the ARM.

d. Assist FMOH and MOFED, for support to the sector's budget and for each project that they are financing, to compile accurate and timely budget outturn data, and to manage cash-flow, by reporting to FMOH and MOFED their quarterly disbursements, at times and in formats agreed with the government, together with forecasts to the end of the year. These reports will be prepared according to Government's format under the one plan, one budget and one report policy. Should additional information be requested by Development Partners, a joint framework will need to be developed, eliminating single donor reporting requirements.

e. Communicate promptly to MOFED and to the Central Joint Steering Committee any significant changes in the level of their support. When disbursement returns indicate that there is likely to be a shortfall from an individual partner, that partner will furnish MOFED and the Central Joint Steering Committee with a brief explanation, together with actions being taken to address the problem (for example, via re-allocation of funds, or changes in procedures), and any actions that may need to be taken on the part of the Government.

f. Inform FMOH and MOFED, in the event that the shortfall can not be made up within the financial year in which it occurs, of the composition of the additional commitments that will be forthcoming in the subsequent year. This gives MOFED the option to maintain public expenditure by temporarily drawing on foreign exchange reserves, to be replenished by the additional aid in the following year.

g. Move towards: i) financing health activities according to the one plan, one budget and one-report principle (HSDP3 and HSDP Harmonization Manual), ii) providing flexible resources to cover the financing gap to progress on MDG 4 and 5 as well as health system strengthening, iii) using governments' scaling up plan and documents as a basis for estimating the financing envelopes and specific support to be provided, iv) use a common validation mechanism of the country plan to be taking place once a year at the time of the ARM, v) use the one-plan, one-budget and one-report framework for results and financial reports vi) improve predictability of resources, preferably committing to 5-10 years financing (minimum 3 years).

h. Use as much as possible the preferred modes of financing of the Government of Ethiopia mainly i) block-grant to woreda for recurrent costs and/or ii) financing of the MDG Fund for public goods and capacity building activities including upgrade of infrastructure, equipping, furnishing, upgrade of logistics and training.

i. Increase the proportion of unearmarked donor funds channeled through the MDG Fund to meet the target of 60% by 2010 and 90% by 2015. To make this happen, further improvements in planning and budgeting as noted earlier, in financial management and in procurement systems will be required, to enable activities previously funded by donor earmarked funds to be integrated into the sector specific budget.

j. Use, to the extent possible, Government systems to procure, disburse, implement, report, monitor, account, and audit their assistance, providing coordinated technical assistance as required in order to strengthen those systems and make them fit for the purpose of

meeting the full range of both Ethiopian and external requirements.

k. Rely on the national monitoring and evaluation system, minimising the request for additional reporting in formats different to those required by Government.

l. coordinate their activities with the timetables set out at Annex 6 and with possible more detailed timetables as perceived relevant (e.g. HAPCO plan), relying on Joint Reviews, and minimizing the need for additional bilateral missions.

m. Seek to increase the delegation of authority to their local representatives and increase their capacity to play a full role in aligning behind Government priorities and harmonizing their activities.

n. Coordinate to ensure that necessary technical assistance is provided as required to improve aid management capacity. Development Partners particularly commit to providing joint and harmonized TA on all crosscutting issues including evidence based planning, costing, budgeting, harmonization and alignment, fiduciary systems strengthening and health system strengthening issues.

o. Using the following option on meeting shortfalls:
The Central Joint Steering Committee will review, on at least a quarterly basis, the actual and forecast annual development assistance compared to the total joint commitment of signatories. Consideration will be given on how to ensure shortfalls can be made up, including coordinated efforts by the signatories, the feasibility of one of the development banks (that manage themselves on a commitment basis) acting as the 'swing donor', or the feasibility of establishing a specific fund to underwrite the risk.

V. Monitoring and Dispute Resolution

42. The details of how, when and by whom the monitoring is to be conducted can be found in Annex 6.

43. The Central Joint Steering Committee will be the main governing body for monitoring implementation of this Compact. It will review:

a. At least annually, whether Government has met its obligations with respect to the implementation of HSDP3, and the budget. This will be based on the evidence from the ARM and PASDEP reviews and from quarterly and annual budget execution reports, including information on resources used and outputs achieved.

b. At least annually, whether Government and Development Partners have met their obligations with regard to aid management (based on indicators in Annexes 2a and 2b). This will be based in part on compliance with the participatory processes set out in the Calendar, partly on donor compliance with reporting requirements, partly on public expenditure reviews and the public finance management review, and partly on other reviews to be jointly agreed upon later by the government and partners.

c. At least quarterly, whether signatories are on track to disburse total aid and funding through the MDG Fund at the levels stipulated, based on the monitoring mechanisms described in section IV.

44. An independent monitoring mechanism might be established, with terms of reference to be agreed between the signatories and composed of distinguished members nominated equally by the Government and the Development Partner signatories. The ToR will include reporting annually on the implementation of this agreement, reviewing the extent to which Government and donor actions remain consistent with the provisions of this Compact, and with the priorities and strategies set out in the PASDEP and HSDP3. It will in particular advise on the causes and remedies for any under-performance by any of the signatories, and for any disagreements that may have arisen. The reports will be published and publicized, and shared with the global-level IHP+ Reference Group to inform global-level IHP processes.

45. In the event of a dispute regarding whether signatories to the agreement are complying with their commitments, the following processes will come into play:

- **a.** There will be a period of formal consultation between the Development Partners Signatories before any action is taken to modify the level, timing, or conditions of development assistance covered by this Compact.
- **b.** In the event that Government does not comply with the requirements of this Compact, appropriate steps may be taken by the Development Partner Signatories to remedy and improve on the situation, in the subsequent planning year, to avoid any immediate reduction in aid.
- **c.** Data on the commitment and disbursement performance of individual Development Partners and of the signatories as a whole will be published on both the Government web site and the web sites of individual signatories.
- **d.** Documentation related to efforts to resolve the disputes will be shared with the global level (IHP+ Reference Group) to inform global level IHP+ processes.

46. The Compact will be assessed against the agreed targets. The implementation of this Compact will be assessed at the time of the April 2009 ARM. Amendments may be introduced at this time. New signatories will be given the option to join at any time

VI. Overall targets by 2010

1. 95% of Development Partners provide confirmation on long term commitments disaggregated by programme and geographic area.
2. 95% of Development Partners don't request the Government for a separate plan document
3. 100% of Development Partners' activities and budgets are reflected in the government's plan
4. 60% of funds provided through Government preferred modalities
5. 90% of funds disbursed on time
6. 80% of procurements conducted through Government preferred mechanisms
7. 100% of Development Partners use HMIS for reporting

8. 80% of missions conducted jointly
9. Total expenditure on health will be at least 21 USD/capita

VII. ANNEXES

Annex 1 - HSDP III Financing Gap by Scenarios

What will it take for Ethiopia to attain the health and health related MDGs?

Federal Ministry of Health in collaboration with partners conducted health MDG needs assessment in 2004 to estimate the resource requirement for the ten year period 2005-2015. Reaching the health and health related MDGs implies not only a dramatic expansion of health services and scaling up of high impact interventions, but also the implementation of mechanisms to ensure adequate demand for and use of those services. On the basis of the HSDP and other GOE policy documents five steps have been considered to achieve this goal. Each step allows for a progressive upgrade of services, strengthening both supply and demand for high impact services as follows.

- Step 1 *"Information and Social Mobilization for behavior change"*, would cost an average ofUS$1.51 per capita over the 10 year.
- Step 2 *"Health Extension Programme"*, would cost an additional US$3.48 per capita per year on average over the period 2005-2015.
- Step 3, *"Upgrade of first level clinical care"*, would cost an incremental average of US$ 1.72 on top of the Health Extension Programme.
- Step 4, "*Expansion and upgrade of Comprehensive Emergency Obstetrical Care"* would cost an incremental US$ 3.50 per capita over 2005-2015.
- Step 5, *"Expansion and upgrade of referral care"* would cost an incremental US$ 10.10 per capita over the period 2005-2015.

To reach all of the health and nutrition MDGs and expand HAART provision, all service scale-up steps must be implemented. The additional financial resource requirement is estimated at an average of US$ 20.31 per capita over the ten year period (2005-2015) allowing Ethiopia to reach a level of total health expenditures of US$35 per capita in 2015.

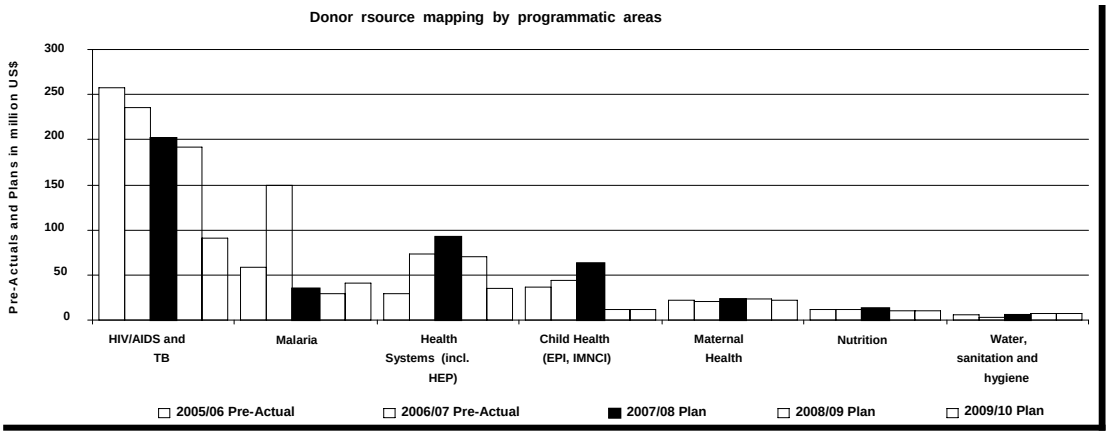
Financing Gap for HSDP

The most significant constraints to rapid scale up are inadequacy and inefficiency of allocation. As per the recently revised costing (November 2007) of HSDP III, Ethiopia will require approximately US$ 3.334 billion to implement its scale up strategy under scenario 1; US$ 4.117 billion under scenario 2; and US$ 4,613 billion under scenario 3 (see table below for details). Scenario 1 requires doubling of the current level of health spending to an annual per capita expenditure of about US$ 14.3.

Estimated cost of HSDP III for 2007/08 - 2009/10

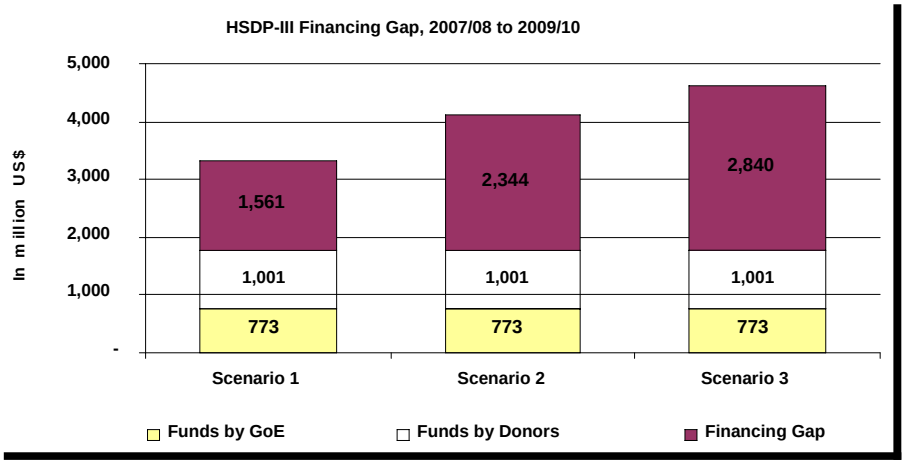
in million US$

	Baseline spending	Total funding need under		
Programmatic areas	**2005/06**	**Scenario 1**	**Scenario 2**	**Scenario 3**
Health systems (incl. HEP)	219.42	1,507.10	2,026.49	2,394.42
Child Health (EPI, IMNCI)	44.11	253.28	277.64	278.77
Malaria	149.57	561.51	604.17	653.90
HIV/AIDS and TB	235.88	742.13	786.44	784.12
Maternal health	20.46	174.88	276.66	340.39
Nutrition	11.24	56.35	80.62	96.23
Water and sanitation	3.66	39.29	65.82	65.20
TOTAL	684.33	3,334.54	4,117.85	4,613.04
Per capita per year	**8.8**	**14.3**	**17.6**	**19.7**
Estimated % U5M reduction by 2010 (from 2005 level of mortality)		**41.8%**	**55.6%**	**61.3%**
Estimated % of maternal mortality reduction by 2010 (from 2005 level of mortality)		**19.6%**	**34.8%**	**44.9%**



In contradiction with the Paris declaration the trend of the last years towards more earmarked project funding, rather than harmonized pooled funding. Amounts pledged under an earmarked arrangement are larger than amounts provided under a broader health system strengthening agreement. Financing perspectives in the mid-term are skewed in favour of earmarked funding for vertical disease specific programmes. HIV/AIDS represents more than 60 percent of donor funding pledges. According to current pledges, a major financing gap remains for health system, maternal health and child health (see the above figure).

Based on the information compiled from 14 HPN partners[4] substantial amount of the health spending in the last two years and projected indicative plan for the reaming years of HSDP III are concentrated in few vertical disease specific programmes. HIV/AIDS and TB followed by malaria programmes accounts for over 60% of donors' total contribution. Health systems strengthening as well as child health, maternal health, nutrition, water, sanitation and hygiene programmes are under funded. The resource allocation inequity within the health sector is summarized in the figure below.



Comparison of the estimated resource requirement of HSDP III against resource availability from government and HPN donors provides the financing gap. The financing gap for the remaining three years is about US$ 1.561 billion for scenario 1; US$ 2.344 billion and US$ 2.840 billion for scenario 2 and 3 respectively. A disaggregated analysis of the financing gap by programmatic areas confirms the inequity in the health sector. The major financing gap remains high in health systems followed by malaria (for replacing ITNs and maintain current level of coverage), maternal health and child health (see figure below).

[4] AfDB, Austrian Development, DFID, EC, GAVI HSS, Global Fund, Irish aid, Italian Cooperation, JICA, RNE, UNFPA, UNICEF, USAID, World Bank.

Annex 2a - Indicators for monitoring the progress of harmonization and alignment

Indicator	Baseline	Yr1	Yr2	Yr3
One Plan				
Proportion of development partners that have integrated their plan with the Government plan at national and sub national levels				
Proportion of development partners requesting the Government for separate planning documents				
Proportion of development partners participating in the annual planning process				
Proportion of development partners participating in the development/ review of the HSDP				
Main health sector development strategies, HMIS and HRD, finalized and implemented according to plans.				
One Budget				
Proportion of development partners who provided funding commitments for a period of at least 3years				
Proportion of development partners who confirmed their annual commitment by programme and geographic area by February each year				
Percentage of funds channeled through the Government preferred modalities				
Based on the MDG Fund appraisal, progress on implementation of improvement plan for financial management system.				
Percentage of funds from development partners disbursed as per the schedule provided in the annual plan				
Percentage of funds from Government disbursed as per the schedule provided in the annual plan				
Proportion of financial reports submitted on time				
Proportion of development partners using Government preferred modalities for procurement				
Based on the MDG Fund appraisal, progress on implementation of improvement plan for procurement system.				
Proportion of TAs hired based on the request of the Government				
Yearly increase of domestic financial allocation to the Health Sector				
Development Partners submit financial reports to the Government as per agreed schedule (Yes/No)				
Government submit financial reports to the CJSC as per agreed schedule (Yes/No)				
One M & E Reporting System				
Proportion of development partners requesting separate reports				
Proportion of review missions conducted jointly by Government and development partners				
Proportion of coordination meetings held as planned between FMOH, MOFED and Partners				

Indicator	Baseline	Yr1	Yr2	Yr3
Implementation and reporting on a single results based framework for all funding streams (Yes/No).				
Overall Harmonization and Alignment Process				
Number of parallel project management units				
Proportion of development partners that have signed the compact				
Proportion of Development Partners providing untied aid.				

Annex 2b - Data Collection Instrument for Government and Each Development Partner

Indicator	Government	Development Partner	Development Partner	Development Partner	Development Partner	Development Partner	…… *as many columns as needed*
One Plan							
Development partner plan integrated with Government plan at national and sub national levels (Yes/No)							
Development partner requesting the Government for separate planning document (Yes/No)							
Development partner participating in the annual planning process (Yes/No)							
Development partner participating in the development/ review of the HSDP (Yes/No)							
One Budget							
Development partner providing							

Indicator	**Government**	**Development Partner**	**Development Partner**	**Development Partner**	**Development Partner**	**Development Partner**	*…… as many columns as needed*
funding commitment for a period of at least 3years (Yes/No)							
Development partner confirming their annual commitment by programme and geographic area by February each year (Yes/No)							
Total funding to the health sector from the development partner							
Total amount of funds from the development partner channeled through the Government preferred modalities							
Total funds from development partner disbursed as per the schedule provided in the annual plan							
Development Partners submit							

Indicator	Government	Development Partner	Development Partner	Development Partner	Development Partner	Development Partner	…… *as many columns as needed*
financial reports to the Government as per agreed schedule (Yes/No)							
Development partner using Government preferred modality for procurement (Yes/No)							
Total number of TAs hired							
Number of TAs hired based on the request of the Government							
One M & E Reporting System							
Development partner requesting separate reports (Yes/No)							
Number of coordination meetings planned between FMOH, MOFED and Development Partners							
Total number of coordination							

Indicator	Government	Development Partner	Development Partner	Development Partner	Development Partner	Development Partner	…… *as many columns as needed*
meetings held between FMOH, MOFED and Partners							
Total number of review missions conducted							
Number of review missions conducted jointly with Government and development partners							
Overall Harmonization and alignment Process							
Development partner has signed the compact (Yes/No)							
Number of parallel project management units							
Tied aid (Yes – No)							

Annex 3 - HSDP Results framework

Annex 3. HSDP Results framework

The Health Sector Development Program III aims to reduce morbidity, mortality and disability, and improve the health status of the Ethiopian people through providing a comprehensive package of preventive, promotive, rehabilitative and basic curative health services via a decentralized and democratized health system in collaboration with all stakeholders.

The guiding principles were framed around goal setting, vis-à-vis inherent weaknesses, threats, opportunities and resources required. Stakeholder participation for achieving the objectives and crucial external factors or assumptions that managers need to take into consideration have been developed. Furthermore, indicators to monitor performance at various levels of the framework, how and where information can be sourced for verification of performance achievement have also been considered. A summary of the major objectives and common results framework is presented below that could help appraise HSDP III performance in the light of the goal, purpose and key result areas.

The performance indicators consist of process, output, outcome and impact indicators which also conform to the health sector wide indicators. The service aims at contributing enormously to **improve the health status** of the Ethiopian peoples through provision of adequate and optimum quality of promotive, preventive, basic curative and rehabilitative health services to all segments of the population. This can be achieved by ensuring universal access to priority evidence -based quality health interventions. Particular focus will be on increasing access to health extension program, efficient and effective service delivery and improved human resource capacity to deliver the package of interventions.

Annex-3 HSDP results framework

Objective	Performance indicator	Baseline 2005	Target 2010	HSDP III Mid term review	Target 2015	Means of verification	Assumptions
Major objectives (regionally disaggregated a to e - at least every 5 years)							
	a) Under five mortality rate per 1,000 live births	123	85			DHS	
	b) Infant mortality rate per 1,000 live births	77	45			DHS	
	c) Maternal mortality ratio per 100,000 live births	673	500			DHS	
	d) Teenage Pregnancy and motherhood (among 15-24 yrs of age)	37.4				DHS	
	e) Total fertility rate	5.9	4			DHS	
	f) Adult incidence of HIV (disaggregated by sex)	0.26				HIV surveillance	
	g) % of Under Five morbidity attributed to malaria					Specific surveys	
	h) Case fatality rate of malaria in age group 5 and above	4.5%	2%				
	i) Case fatality rate of malaria in children Under Five years of age	5%	2%				
	j) Mortality attributed to TB (of all treated cases)	7%	4%				
1. Health service delivery and quality of care (disagregation by region – at least every 2 years)							
	a) Contraceptive prevalence rate	25%	60%	30%		HH Survey	
	b) % of health posts treating diarrhea diseases following the national protocol					Facility level secondary data survey	
	c) % of children with diarrhea receiving					Facility	

Objective	Performance indicator	Baseline 2005	Target 2010	HSDP III Mid term review	Target 2015	Means of verification	Assumptions
	ORT/ORS at HP level					level secondary data survey	
	d) % of health posts treating malaria following the national protocol					Facility level secondary data survey	
	e) % of deliveries attended by skilled attendants	12%	32%	16%		HMIS	
	f) % of hospitals providing Comprehensive-Emergency Obstetric and Newborn Care		87%	69%		Provider survey	A facility qualifies as functionally comprehensive if C-section and blood transfusion services are given in addition to the seven service
	g) % of health centres providing Basic-Emergency Obstetric and Newborn Care services		100%	25%		Provider survey	A facility qualifies as functionally basic if seven (newborn resuscitation has been added recently as the seventh signal function) specific life-saving interventions

Objective	Performance indicator	Baseline 2005	Target 2010	HSDP III Mid term review	Target 2015	Means of verification	Assumptions
							have been performed in the 3 months prior to the assessment.
	h) ANC coverage					HMIA	
	o 1st visit o 4th visit						
	i) % of unsafe abortion	50%	10%	Early stage of implementation		Provider survey	
	j) % of infants vaccinated with Pentavalent 3	70%	80%	73%		HMIS	Review DHS for sex disaggregated data
	k) % of infants fully immunized	45%	80%	55%		HMIS	
	l) % of neonates with access to proper neonatal resuscitation and Ampicilline/Gentamycine treatment for neonatal sepsis	6%	32%	No data		Provider survey	
	m) % of health centres implementing IMNCI	36%	90%	45% -HC have staff trained in IMCI		HMIS	
	n) % of health centers and hospitals providing VCT services		100%	1230 VCT sites country wide 5.8 million persons tested		HMIS	
	o) % of health centres and hospitals providing PMTCT services		100% hospitals, 70% HCs			HMIS	
	p) Number of PLWHA on ART	13000	263,000	329 sites, 131		HMIS	

Objective	Performance indicator	Baseline 2005	Target 2010	HSDP III Mid term review	Target 2015	Means of verification	Assumptions
				360 clients served			
	o Male						
	o Female						
	q) % of household in malaria prone areas with 2 ITNs (received during the past 36 months)		100%	10million hhs in malaria endemic areas and 20million ITN distributed, coverage is over 100%		HH survey	
	r) % of children Under Five and pregnant women in malaria prone areas who slept under ITN the preceding night	2%	100%			HH survey	
	s) Tuberculosis case detection rate	33%	70%	33%		HMIS	
	t) Tuberculosis treatment success rate for smear positives cases	76%	85%	Estimate 85%		HMIS	
2 Access to Services: Health Facility Construction, Expansion and Transport (disagregation by region – at least every two years)							
	Potential health post coverage (health post for every 5,000 people)	20%	100%			HMIS	
	Potential health center coverage (a health center for every 25,000 people)	18%	100%			HMIS	
3. Human resource development (regionally disaggregated figures for a to c disagregation by region – at least every two years)							
	a) Health extension workers to population ratio		1:2,500			HMIS	
	b) Ratio of midwives to women of reproductive age group	1:13,388	1:6,759			HMIS	
	c) Health officer to population ratio		1:14,000			HMIS	
4. Pharmaceutical services (regionally disaggregated figures for a to c)							

Objective	Performance indicator	Baseline 2005	Target 2010	HSDP III Mid term review	Target 2015	Means of verification	Assumptions
	a) % of health centres with no stock out of essential drugs in the past 3 months		100%			Provider /facility survey	As tracers Cotrimozaxole, Quinine, Ergometrine, ORS are proposed
	b) % of Health Posts with no stock out of essential drugs in the past 3 months		100%				As tracers Vitamin A, AD syringe, Co-Artem ORS are proposed
	c) % of expired drugs in public health facilities	8%	1%			Provider survey	
5. Information, education and communication Regionally disaggregated figures for all a to i							
	a) % of household who have graduated in HEP (model family)		100%			HMIS	There are several criteria for graduation, use availability of sanitary latrine as proxy
	b) % of health posts having a demonstration latrine in the compound					Facility survey	
	c) % of families using a sanitary latrine	20%	80%			DHS	
	d) % of children with diarrhea receiving more liquids (ORS , ORT , other home based preparations)	37%				DHS	
	e) % of pregnant women informed about pregnancy complication and birth preparedness					DHS	

Objective	Performance indicator	Baseline 2005	Target 2010	HSDP III Mid term review	Target 2015	Means of verification	Assumptions
	f) Knowledge about any modern Family Planning Method					DHS	
	o Women	86%					
	o Men	90.7%					
6. Health Management, Management Information Systems and Monitoring and Evaluation (regionally disaggregated figures for all a to g – every year)							
	a) Timely submission of routine health and administrative reports		80%			HMIS	
	b) Completeness of routine health and administrative reports		80%			FMOH report	
	c) % of districts with Evidence Based Annual Health Plans		75%			Administrative survey	
	d) % of health posts supervised at least once in the past 2 months by the Woreda health team or other HEP supervisors					FMOH report	
7. Health care financing (regional disaggregated figures for c every two/three years)							
	a) Total health expenditures per capita	US$ 5.6	US$ 9.6			NHA	
	b) Double the share of health as a proportion of total Government budget (domestic spending and Direct Budget Support					MOFED	
	c) % of retention and utilization of revenue generated at hospital and health centre level		100%			Provider survey	
	d) Social health insurance system for employees in the formal sectors developed and implemented.	no	yes			FMOH report	
	e) Community health insurance system developed and piloted	No	yes			FMOH report	

Objective	Performance indicator	Baseline 2005	Target 2010	HSDP III Mid term review	Target 2015	Means of verification	Assumptions
Nutrition	**(regional disaggregated figures for all (a to i) at least every 5 years)**						
	a) % of children 6-59 months stunted (H/A) -2 and -3 Zscore	47%				DHS	
	b) % of children 6-59 months underweight (W/A) -2 and -3 Zscore	38%				DHS	
	c) % of children 6-59 months with acute malnutrition (W/H) -2 and -3 Zscore	11%				DHS	
	d) % of Health Post routinely assessing the nutritional status of children under five years of age					Facility survey	
	e) % of infants 0-5 months exclusively breast fed	38%	63%			HH survey - DHS	
	f) % of infants 6-11months breastfed and receiving complementary feeding	75%	80%			HH survey - DHS	
	g) % of children aged 6-59 months having received Vitamin A supplementation during the past 6 months.	30%	54%			HMIS/DHS	
	h) % of households using iodized salt		100%			HH survey/DHS	
	i) % of women with anaemia	27%	Decreased by 50%			HH survey/DHS	

Annex 4 - Code of Conduct

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

Preamble

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

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

The code

Finances

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

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

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

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

One plan

5. The Health Sector Development Plan 3 is recognised as the centrepiece of health policy. Donor support should follow the priorities and procedures specified in this plan. Government and donors should engage in active debate about the contents and implementation of the plan.

Support systems

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

- Financial reporting must be timely and of a high quality.
- Monitoring progress is an essential part of joint working –the Health Management Information System is thus crucial. A practical information strategy needs to be adopted which quickly identifies a small number of meaningful indicators that reflect progress in the key areas of HSDP3 (and hence the health component of SDPRP2).
- Procurement needs to be timely, transparent and to offer value-for-money.
- Systems should be subjected to regular independent audit.

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

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

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

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

Arrangements amongst donors

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

Tracker issues

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

A living document

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

The “Code of Conduct to Promote Harmonization in the Health Sector of Ethiopia” has been signed during the ARM 2005 (3-7 October 2005) by the Federal Ministry of Health and the following Development Partners:

- African Development Bank
- UNAIDS
- UNFPA
- UNICEF
- WHO
- World Bank
- DFID
- Embassy of Ireland
- Embassy of Sweden
- Embassy of The Netherlands
- Italian Development Cooperation
- USAID

Annex 5 - HSDP Harmonization Manual

Editing note:
The full HHM is a bulky document (82 pages). It is advisable to prepare an abstract of the HHM including the ToR for CJSC, JCCC and ARM, and a few other chapters to which the IHP Compact makes reference.
The full HHM is available on the FMOH website and can be made available also on the DAG website.

Annex 6 - HSDP Calendar of Events

This section will be separately distributed as it cannot fit into this document