

# **Report on the Joint Assessment of the Ethiopian National Health Sector Strategy**

## **Introduction**

Joint Assessment of National Strategies (JANS) is a shared approach to assessing the strengths and weaknesses of a national strategy, that is accepted by multiple stakeholders, and can be used as the basis for technical and financial support. The expected benefits of this joint assessment include enhanced quality of national strategies and greater partner confidence in these strategies, thereby securing more predictable and better aligned funding.

Ethiopia has been implementing sector wide approach since 1997/98 with a vision to develop a common plan, budgetary framework and monitoring and evaluation steered through joined coordination and governance structures. So far it has concluded three phases of health sector development plan and is about to begin the fourth one. Previous HSDPs have been developed through participatory processes and the level of participation has progressively improved towards an open and participatory process. All HSDPs have been implemented with strong government ownership, through relatively strong government systems. For HSDP IV, the government has clear vision on 'where to go' and is actively 'driving' the process of improving the effort towards realizing the health MDGs. The IHP process in general and the JANS process in particular have built on the existing sector coordination and dialogue mechanisms established by HSDP. The JANS was initiated at the right time as it was carried out when the HSDP IV is under development. It is also carried out in a context when the government is disappointed in the pace of progress, despite the various efforts, in changing the donor behavior towards more aligned support, summarized in Ethiopia as 'one plan, one budget and one report' for health.

This report covers the steps taken to realize the JANS process, the comments received from participants and the actions taken by the ministry to incorporate the valuable comments.

## **The JANS process in Ethiopia**

### **Initiating the process**

The Federal Ministry of Health (FMOH) started work on developing the HSDP IV in August 2009. This was done by preparing the concept note which was discussed and agreed upon during the ARM 2009. Accordingly the zero draft was prepared and circulated. The plan was to use the traditional way of open consultations with all partners. The possibility of using the JANS tools to guide and structure the comments was discussed with development partners (DPs). The FMOH Ethiopia invited IHP+ Core Team to give a briefing on the added value of using joint assessment of national strategies approach and its tool and share experiences elsewhere.

The Scoping mission defined the merits and limits of the JANS process. The scoping mission resulted in:

- initiating the interest and commitment of the FMOH and other in-country partners to use the JANS process for more credible and transparent dialogue process;
- reaching consensus on the possible added value: a mix of quality improvement, added confidence and greater investment in the strategy, Clarifying the limits of the JANS process: it is not a validation process where judgments on national strategy will be made in terms of 'pass or fail'.
- the FMOH made clear that there should be an added value from the process regarding tangible change in the behaviors of the Development Partners towards Harmonization and Alignment

The Joint Core Coordinating Committee (JCCC) which includes FMOH and DPs set up a country JANS Steering Team to manage and plan for the JANS process. The country JANS team was composed of MoH, WB, DFID, WHO, UNFPA and Italian Cooperation. They put together the "Roadmap" for use of the JANS, which was discussed and agreed by the JCCC.

The Roadmap set out the expected benefits of JANS which “for Ethiopia would include the enhanced quality and widely acknowledged strategy; for DPs include greater confidence in the strategy and systems for implementation and joint agreement on approaches to address weaknesses, leading to a more effective, coordinated response.” The results expected from the JANS were listed as:

- Findings feed into further iterations of the strategy
- More Partners come on plan and 'on budget'
- Decisions informed on technical / financial support.”

### **Using the JANS tools**

The JANS tools and guidelines were used to assess two versions of the HSDP IV: the zero draft which came out on March 2010 and the first draft that was issued in June 2010. In each case, the draft HSDP was assessed using the JANS attributes, comments were compiled and presented to the HSDP IV drafting team for consideration and incorporation in the next draft of the HSDP IV.

The assessment was organized in three working groups: group 1 addressed attributes 1 and 2 of the JANS tool – Situation Analysis, programming and process. Group 2 covered attributes 3 and 4 of the JANS tool – Finance and auditing, implementation and management. Group 3 covered attribute 5 of the tool – Results, monitoring and review. Each group was co-chaired by a government and a DP participant. The assessment was scheduled to be carried out in two phases: first phase by the in-country stakeholders and second phase by in-country and international partners. The FMOH invited all HPN members to participate in the groups based on their area of interest. Partners were also invited to contribute to other working groups by attending the meetings or sending written comments. Partners, in addition to providing their comments through groups, were also encouraged to provide their agency specific comments during the first round.

The working groups met on several occasions to review and discuss the drafts of the HSDP IV. Participation was reported to be good with many development partners providing comments on the drafts. Comments were provided on the attributes using the format of general comments, strengths, weaknesses and suggested actions.

The contribution by CSO/NGO partners in the review of the zero draft was not as expected, so the JANS steering team together with the CSO umbrella organizations (CCRDA and CORHA) shared the 1<sup>st</sup> draft of HSDP IV, the JANS tools and then arranged a workshop to encourage and enable their optimum participation. The workshop took place on 9 July, where more than 30 organizations were represented. The CSO/NGOs developed their own comments on the strengths, weaknesses and suggested actions to improve the plan.

### **JANS workshop**

In order to provide an opportunity for a wider range of interested partners, and bring an independent element to the process, the review of the first draft culminated in a two day JANS workshop to which non-in-country international partners were invited. This took place on 12-13 July. Organizations that were represented by participants from the global level at the workshop included the Global Fund for AIDS, TB and Malaria (GFATM) (HQ and TRP); GAVI; World Bank HQ; WHO HQ and sub-regional office; NORAD, DFID HQ. In addition there were NGO/CSO representatives and in-country partners as well as active involvement of FMOH

The JANS workshop included a presentation by the FMOH on the plan, and work in groups to review the plan against the JANS attributes. The three groups started with the feedback from the in-country working groups and from the CSOs/NGOs, and then discussion among those present to identify further issues. The findings were discussed in plenary and the summary of the recommended actions given were shared for the HSDP IV drafting team for inclusion. The FMOH then presented its vision for aligning support behind ‘one plan, one budget, one report’ and invited partners to give their commitment. Selected DPs and both NGO umbrella organizations (CCRDA and CORHA) responded and welcomed the participative process and the sector plan and committed themselves to move towards ‘one plan, one budget, one report’. A joint statement from World Bank, GAVI and GFATM Fund stated their intention to work together to develop their support for HSDP IV in a coordinated way, with joint working where possible, under the

planned “Joint Funding Platform”. At the end of the workshop the FMOH asked all DPs to give their commitments in writing on how they would change the way they have been working to make aid more effective. The format was presented and was sent to each partner with the final HSDP IV document.

The FMOH prepared a roadmap outlining how to incorporate the comments, given from the consultative processes and also from regions, and the other interested bodies. The final document was circulated to all parties for a final comment. The HSDP IV was then submitted for political approval as an integral part of the national five year growth and transformation plan.

## **Participation**

All development partners (both in-country and non resident) including prospective new donors to the sector were invited to participate in the JANS process. The JANS working groups and international JANS workshop were instrumental in getting valuable comments based on the JANS attributes. The partners were given opportunities to provide written comments on the draft strategic plan and participate in the sub groups and main international JANS consultation meetings. The participation of development partners in the groups were more pronounced during the second round than the first round.

NGOs and CSOs were also invited to participate in each stage of consultation. The CSOs and NGOs participated in the workshop organised for the specific purpose. Despite the weak participation, however, the JANS process has provided opportunities for CSOs and NGOs for the first time to comment on Ethiopia’s national health strategic plan in an organised manner. Most of CORHA’s comments on the zero draft have reportedly been included in the revised version and the comments of CSO/NGOs on the three working group themes during the second round were also presented in the main JANS meeting. The presence of the umbrella organizations during the JANS meeting and the expression of their readiness to align and harmonize their activities to the HSDP IV is a significant step forward in enhancing the dialogue process.

## **Lessons Learned from JANS**

The lessons learnt from the process in Ethiopia were documented by two consultants who both attended the international workshop and who carried out interviews with key players from the FMOH, DPs (DFID, WB, WHO, UNAIDS, and UNFPA,) and NGOs/CSOs (CRDA, CORA, World Vision). The lessons learnt included the following:

The transaction cost of the JANS process is low as it used existing structures and processes. The steering of the process was managed and overseen by the JCCC, the joint government and donor coordinating committee. With or without JANS, there would have been consultations on the content of the HSDP IV draft document by partners. The only difference was the establishment of the JANS teams and the three groups both from the HPN and government. When detailed guidance of such nature required, there is a tradition for JCCC to establish a small team to steer the process. Consequently, the additional transaction cost particularly for government for undertaking JANS is reported to be very marginal.

The agency specific and the additional comments given during in the first round were a bit tedious to address but the team tired to address as much as possible.

The three groups used the JANS attributes and guidelines differently. One of the groups used as it a ‘development’ tool and reformulated the draft strategic plan. The results monitoring team revised the section of M&E in HSDP IV to ensure that its targets are aligned to MDG, Global Fund, UNAIDS and IHP triggering indicators and results frameworks showing hierarchy of results. The other two groups on the other hand used it more as an ‘appraisal’ tool and came out with the strengths, weaknesses and recommended actions as per the JANS format. One group also analysed many of health service delivery programs for each attributes. The depth of analysis in using the attributes also varies from group to group. This clearly shows JANS is flexible and can be used according to one’s context.

Both JANS process have resulted in obtaining constructive comments and suggestions though the existence of the second round was instrumental in getting valuable inputs.

There are indications that the process has strengthened the credibility of the HSDP IV. The HPN members (development and CSO) indicated that they are willing and committed to support the realization of the aspirations of the strategic plan. The World Bank, Global Fund, and GAVI have shown interest to initiate their health systems platform. Other development partners are also expected to show some behavioural change, although this will be consolidated once all the development partners return the questionnaire provided to them with the final HSDP IV document.

The JANS tools set out essential 'ingredients' of sound national health strategies and are deliberately designed to be 'generic' and 'not prescriptive' to be used in many country contexts. Using five sets of its attributes, the assessment reviews the overall strategy itself, its alignment with national development plans, and its linkage with the budgeting process. The assessment is expected to be country-driven; county led and build on exiting processes.

The JANS tools provided a systematic and objective lens to review critically the draft strategic plan, and appraise the document in an organized manner. The attributes capture not only the planning aspects of national strategic plan but also issues of implementation. This encourages reviewers to assess the aspirations in view of the implementation capacity as experienced in the last five years.

Ethiopia used the global JANS tool without significant adaptation to the country context though this was intended in the initial phase and included in road map.

## Challenges

Though the process of the HSDP IV preparation has been a good experience for the Ministry and the consultation processes were productive in organising the comments received, there were some challenges during the process.

- The JANS attributes are prepared based on the SPM framework and the fact that HSDP IV was prepared by BSC, had made some issues difficult to accept and has taken sometime to make the understanding more clear
- As discussed during the workshop, in trying to accommodate sections as per the JANS attributes, the document became bulky
- There were comments which didn't belong to any of the attributes so was difficult to any groups
- Some of the attributes include some implementation issues which can not be described in a strategic document
- Some of the attributes are very open and lead to different interpretations
- How about bringing in HIV/AIDS plan SPM II?

## **Comments received from JANS Consultations**

The consultations identified strengths, weaknesses and recommendations of the document. In the first round the consultation focused mainly on identifying the weaknesses but the major strengths were also cited. The strengths from both consultations were summarized as follows:

- Overall the zero draft is a very good draft and shows that a lot of work has gone into it
- Main existing documents were reviewed
- Universal access is adopted as a principle in the strategic themes
- Organizational context, leadership and accountability mechanisms are mentioned
- Multi partner coordination mechanisms or forums exist which ensure participation of partners and led by government
- Most indicators/targets are SMART
- Universal coverage/access and equity are addressed well
- The Themes address quality as well as quantity
- Targets are based on MDG goals
- Targets and priorities are inline with the IHP Compact
- The use of MBB for selecting interventions, costing and bottleneck analysis
- Goals and objectives are aligned with the national development strategy (alignment with National Growth and Transformation Strategy)

The identified weaknesses during the first round of consultation were summarized and presented to the Joint Consultative Meeting (JCM) and discussed upon in details. After agreeing on which comments are valid and which are not, the core group incorporated all valid comments and produced the first draft.

The comments from the JANS consultation were followed by detailed comments from various agencies and individuals. The detailed comments were categorized in the three JANS groups and considered together with the comments from the group discussions. In-addition there were many editorial comments and many more on the general outline of the document, and these were given due emphasis and addressed as far as possible. The majority of the comments on the outline of the document was given during the first round consultation and was due to the new BSC framework used for the development of the strategy. This has reduced significantly during the second round consultation.

The written comments are not specified here as they are very detailed and addressed mostly. But the structured group comments from both consultations and the actions taken are summarized in the following table:

Issue	Comment	Remark
<b>General comments</b>	In all sections throughout the document, including targets and indicators, sources of data (current as well as future) need to be mentioned	Addressed
	The focus on/for emerging regions needs to be reflected	addressed under new directions of HSDP IV
	On pharmaceutical sector, the document does not take into account the policy, strategy and M and E activities. Focus is rather on supply management.	<ul style="list-style-type: none"> <li>■ It is a sector plan so the policy, strategy and M&amp;E plan are entertained with the other systems not separately</li> <li>■ For details of PFSA strategy and M&amp;E plan refer the Logistics Master plan</li> </ul>
<b>Situational Analysis</b>	Climate change..... has to appear in the situational analysis as well as in the plan( drought, flood, disease outbreak and others); Indoor air pollution, Pollution chemical and organic, Occupational safety and health, School and institutional Environmental Health and hygiene	This was addressed as climate change in the direction. Activities are considered in various areas like public health emergency, pollution is entertained as one activity in regulatory activities
	HSDP III emphasized increased geographical access to services but that HSDP IV would focus in particular on improving the quality of the health care services delivery (how will HSDP IV be used for this? Which strategies will be used for that? The shift to a stronger focus on quality (alongside expanding access) as recommended, for example in the mid-term review, does not come across as clearly as it could.	Addressed under new directions of HSDP IV  One of the objectives is about quality and has its own initiatives and measures  Quality indicators are shown in the results framework
	The 0-draft HSDP IV does not say much about strengthening of referral services (including use of	See multi-sectoral approach section

	mobiles and ambulances; roads construction????) which is important for the quality of care and certainly to reduce maternal mortality (especially within the PHCU and Primary Hospital.	
	Keep consistency in using either EFY or GC or both as EFY/GC. Also keep consistency in using abbreviation to technical words such as Emergency Obstetric and Newborn Care (EmONC). The document at the moment uses 'EOC', 'EmOC', 'EmONC' at different places. We suggest using EmONC consistently	addressed
	Some vulnerable groups are not well addressed (emphasis given to people with disability and other vulnerable group is not mentioned). The focus on/for emerging regions needs to be reflected more. Considering regional differences are there differentiated strategies for different groups (urban/rural, pastoralists/Agrarian). Although there is a pastoralist Directorate in the FMOH the strategies and emphasis for these groups should be made clear in the document.	Orphans are already discussed and addressed, the HEP is designed in the urban, pastoral and agrarian populations groups so as to address the specific issues in each of the populations groups, the other details on how to deal with people with disability etc will be clarified on program implementation manuals
	HMIS: Inadequate information and mention on the challenges to the current country level rollout for the HMIS despite efforts	The problems are already addressed in different sections like SWOT, bottleneck analysis etc
	In the nutrition section the national situation on Stunting, underweight, wasting, Women malnutrition, Low birth weight, Vitamin A deficiency, Iron deficiency anemia, Iodine deficiency disorders (Total Goiter Rate), and Iodized salt utilization at household level need to be mentioned as well	Some of these are addressed in the document and the remaining are detailed in the National Nutrition Strategy
	Would it be possible to consider making nutrition one of the overall priorities of HSDP IV? It is part of the MDG goals/targets and it would be useful to bring it to the forefront of the strategy.	Addressed in the table of priorities

	More attention could be given to disparities in current indicators and strategies needed across regions e.g. pastoralist vs agrarian	Being done
	Some issues under thematic areas repeated both under the situation assessment and plan section. This is because the situation analyses section also highlights challenges and recommendations	addressed by putting challenges in an annex and linking them to strategy
	In relation to low utilization of services, it would be useful to say something about barriers to access/low demand for services and i. what contributes to this, ii. What is being/can be done	
	In relation to above discussion of how exemption/waiver system is functioning would be useful.	Described more in details on the SHI or CBHI strategies, manuals etc
	Epidemiology of diseases from existing surveys/assessments can be included	Done Using existing data Direction of PPP is put as per the draft guideline
	Useful to have clear statement on partnerships with private sector	
	Need to have specific program & targets on gender	Gender sensitive approaches and initiative were put to improve service utilization by women. Targets could not be put as there is no enough baseline data for targeting gender however these will be addressed as adequate baseline information will be available in the future
	Need to come up with new approaches & targets for Pastoralist regions (approaches are already existing ones)	Strategy being developed
	Summarize objectives to manageable few	Objectives are reduced from 13 to ten
	More emphasis should be given to integration of services	Integration of services are articulated better

	NCD section should give more attention to Cancers (eg. Reproductive organ Ca)	Addressed
	Targets are currently aligned with MDGs and are needs based –however; if resource gap isn't filled mechanism for prioritizing based on resources available needs to be clear	Two case scenarios have been explained as Base case and High case scenario in line with the Growth and transformation Plan of the country, the second scenario is more modest and considers resources available
	Need to clearly state direction on retention & incentives for key HRH	This is detailed in HRH Strategy and can be referred from the strategy document
	Need further analysis of risks and what the mitigation strategies will be	Done
<b>Reproductive health</b>	The huge unmet needs for FP (34% according to EDHS 2005) is not mentioned either in the situation analysis nor were tracked using it as an indicator	It was not analyzed in-depth in the situation analysis because there is no recent data. But it is addressed well in the target.
	Reference can be made to recent surveys with large sample size such as the L10K survey which shows CPR of 32% success largely attributed to HEW programme. The HEW programme's evaluation is not mentioned (impact on FP coverage).	The L10K survey is used as reference in HSDPIV preparation but the HEP evaluation survey is not yet finalized so could not be used as reference.
	Scale up FP programs appears to be too general. It should clearly indicate the key initiatives under FP programs like strengthening the community based FP services, enhancing social marketing, scaling up facility based and outreach long acting and permanent FP service provision	addressed
	Most of the targets under strategic objective: "Improve health" are based on service statistics which ultimately could be misleading. For instance, the baseline figure Contraceptive Prevalence Rate is put as 32%; this	The latest survey which could be found was used as a reference for this but this will be updated once the DHS 2011 is ready.

	needs to be verified with survey.	
	Initiatives (3.6.1.1): strengthening community IMNCI should also be considered	addressed
<b>Nutrition</b>	Target five under nutrition should be rewritten... “Increase proportion of the under-five children managed for severe acute malnutrition from <b>65% to 95%</b> ” <b>(instead of from 95% to 100%)<sup>1</sup></b>	Addressed
	Initiatives under nutrition rewrite initiative 5 and add one initiative as per NNP: <ul style="list-style-type: none"> <li>○ Initiative 5 should read: Institutional Strengthening for nutrition policy and program implementation and monitoring</li> <li>○ Initiative 6 (to be added): Strengthen nutrition information/surveillance system (as per NNP)</li> </ul>	Addressed  The information and surveillance system is integrated with the program no separate system for nutrition.
	<ul style="list-style-type: none"> <li>○ Reword 1<sup>st</sup> strategic objective to: “risk identification, early warning, response and recovery from existing and emerging epidemic prone diseases, <b>rise of acute malnutrition</b>, and natural disasters of national and international concern”</li> <li>○ Measures: add 3<sup>rd</sup> and 4<sup>th</sup> measure: <ul style="list-style-type: none"> <li>▪ number of deaths averted from severe acute malnutrition</li> <li>▪ mortality rates, recovery rate and defaulter rates of therapeutic feeding programs</li> </ul> </li> </ul> <p>Initiatives: About 6th initiative “Strengthen response and recovery operations” It is not clear if this one includes</p>	The statement is rephrased accordingly  Some are addressed as per the comment but for some like number of averted deaths, and recovery rate there is no data.  Addressed

<sup>1</sup> The basis for estimation is that currently we are not at 95% coverage. Estimated 240,000 children are accessing SAM out of estimated 360,000

	emergency nutrition response or not. So clarify.	
	Increase proportion of households that consume micronutrients fortified foods from (say from 0 % to 50%).	Difficult to measure. Food is not specific (iodine is addressed in the doc)
	Increase proportion of households that receive or access health/such as nutrition/related information through different channels of communication (say no data or 0 to 75%).	Difficult to measure
<b>Program specific</b>	As a strategy to reduce grade II disability due to leprosy among new cases emphasis on early case detection in the recommendation section to be followed up in the body of the plan	Early detection is addressed as strategic initiative
	Good to expand on how attitudinal change was attained among General medical practitioners Could we include WHO standards in the Table where appropriate? Include shortage, competence and motivation as a challenge or somewhere in the text	Problems are identified in the SWOT analysis and Bottleneck analysis and also elaborated well in the HR strategy There is a draft HR strategy which is based on the context of the country
	Put cross reference within the document and also with other relevant documents and remove the repetitions to make the size of the doc manageable	Addressed
	The revision of governance structures should be finalized and put in the HSDP IV doc	The revised version of the governance structure is included in the final version
	Reflect annual resource requirement breakdown	Already in the document
	Explicitly explain the assumptions used in the costing and resource mapping	Addressed
	Develop clear strategies to address the financing gap	Already in the document
	Put a clear description of the resource mapping done	Addressed
	Projected budget should be showed at different levels	Done
	Clarify on the linkage between community health workers (promoters) and HEWs	The linkage between model households and community volunteers and HEW are elaborated. Please see SO C 2

<b>Results Framework</b>	Indicate hierarchy of results clearly in the targets and indicators (As common result frame work for monitoring progress organized as Input, Process, Out put, Out Come and Impact Indicators	Addressed
	PP 114: CS rate (9% to 74%) needs clarity? : at population level we try to reach rate of 5% we are now below one percent	The difference is the HSDP IV used a different denominator which is “those who need CS. But this is addressed as per the comment using the population as denominator.
	Under the initiatives there is a need to include ‘strengthen referral linkages between community and facility for MNCH services’, including ease and availability of transportation	Included
	NCDs PP 45: The NTD part is skipped in the strategic objective session although the detailed indicators are described in the annex and they are mentioned in the strategic themes	This is part of the first strategic objective.
	Page 46_ For target 2, early initiation of breastfeeding within one hour of 69% is the current prevalence. It cannot be the target figure	addressed
	“Increase proportion of Leishmaniasis cases received treatment to 30%”..... ( <i>This is too low even at the moment it is above 50%... Suggestion: Increase proportion of leishmaniasis cases receiving treatment to 90% )</i>	addressed
	Somewhere mutual accountability should be brought in. In the mutual accountability the performance of DPs will be reviewed using the Paris Declaration indicators. The process of conducting such a mutual accountability exercise needs to be described.	Addressed under JRM
	<b>SO 1 improve health</b> ...this SO includes other communicable diseases (NTDs)...However, outcome and targets are not indicated in this section although	The outcomes and targets are refined

	indicators are described in detail in the annex	
	The measures do not include HEW, however, they are included under initiatives. Consider including attrition of HEW or some measure to provide monitoring of all aspects of the health system	It is addressed under maintaining the HEW numbers
	The initiatives under HIV should include 'integration/linkage of HIV services with MNCH/SRH/FP services	addressed
	The descriptions given to explain the core values are put as slogans. A more technical description would be more appropriate	this is what is agreed by the management and this follows the BSC framework
	Table 8, page 17, is an important set of a priority of the indicators for the plan. Needs to get emphasis	Quality indicators already in the document. Issues with Impact indicators addressed as per the comments
	List of indicators at different places of the document needs explicit rationalization to avoid confusion & enhance coherence	Indicators at different sections refined. Number and indicator names aligned and cross referenced  Addressed as per the comment
	Distinguish the level of different list/set of indicators <ul style="list-style-type: none"> <li>- Eg. Table 8 – Core Sector Performance indicators</li> <li>- Page 105 lists – Program performance indicators</li> </ul>	
	Sources for some indicators need to be multiple sites	Addressed
	Building local capacity in a systematic and sustainable manner should be articulated in a better way in the document	Already in the document

	Data quality assurance needs a specific emphasis	Already in the document
	M&E plan need to be closely followed by the National Advisory Committee	This is already in the document. NAC is put as part of the governance structures and its functions are mentioned briefly
	Indicate clearly how information flows specially from the HH and community level to health post	To be addressed in HIS strategy which is under development
<b>Strategic Objectives</b>	The strategic objective about ensuring safety of health services, products and practices, <b>has to include food</b> since food control and Regulation is one of the roles of the new DACA	food is one of the products
	Since improved MNC health means decreased maternal, neonatal, infant and child mortality; the targets should also include reducing MMR, IMR and CMR as per the MDG targets.	These are high altitude indicators. All SOs contribute to these indicators, hence it does not make sense to put them under one SO. However, they are described as impact indicators under priorities of HSDP IV
<b>Hygiene and Env Health</b>	<ul style="list-style-type: none"> <li>• Latrine coverage mentioned but no info on use and Hand Washing practices</li> <li>• Improve information &amp; knowledge on WASH (Hand Washing, Inventory, Utilization of facilities, etc.)</li> </ul>	Currently no info can be assessed with DHS 2011  addressed
	Health Posts lack WASH facilities - not mentioned as a challenge Should be linked to recommendations	SWOT & bottleneck analysis sections mention inadequate WASH (water) in health facilities in general as weakness
	<ul style="list-style-type: none"> <li>• Latrine coverage fig should be either 56% or 60% for sake of consistency in the doc</li> <li>• Under Initiatives please include <ul style="list-style-type: none"> <li>○ Community Led Total Sanitation and Hygiene (CLTSH)</li> <li>○ Verification and recognition of Open Defecation Free (ODF) villages/Kebeles</li> </ul> </li> </ul>	Addressed (latrine coverage is 60%) CLTS includes recognition of Open defecation free villages
	Add WASH under outcome of strategic objective and measures (as 4 <sup>th</sup> item in both cases) (Improve Health	Already addressed in S0 C1

	Infrastructure (3.6.11)	
	Annex 3 - Improve Hyg & Env Health (1.6) Indicator for Household Water Treatment and Safe Storage is missing	Already addressed in SO C1.3
	Annex 5 – % of pop with access to imp source of water The target (86%) should be linked to UAP and GTP which stipulates 100%	This is beyond health sector's mandate (removed from the document already)
<b>SWOT</b>	<ul style="list-style-type: none"> <li>• Inadequate WASH not only Water</li> <li>• Use of toilets and poor status of hand washing practices –</li> </ul>	SWOT & bottleneck analysis sections mention inadequate WASH (water) in health facilities in general as weakness
	Add WASH (as key concept) in the Strategic Theme 3	Health infrastructure includes WASH facilities also
<b>Summarized comments from group I</b>	In the Situational analysis there are some inconsistencies in figures, errors in quoting figures and being exhaustive in listing the health burden and challenges	Addressed as part of the editorial comments; all inconsistencies are addressed and figures are refined
	The formulation of some targets/indicators needs revision	Addressed
	<p>Though most targets and indicators are SMART, some are</p> <ul style="list-style-type: none"> <li>■ Ambitious (100%) taking into account the current situation</li> <li>■ Some indicators are not the best to measure the progress to the targets</li> <li>■ Some indicators/targets are not clear/not measurable</li> </ul>	<p>Targets are ambitious as they are based on reaching the MDGs</p> <p>Indicators are refined</p>
	Targets are too many and need to be adjusted to manageable few	Addressed

	Hierarchy of results is not clear in the targets and indicators	Addressed
	Data need to be disaggregated by major determinants of health including age/sex/socio-economic status both at the situation analysis and under the plan to track progress.	Gender and region disaggregation is done based on the available data
	Information on key population based indicators are not recently updated (DHS)	The most recent surveys were used where possible but some indicators will be updated when the DHS 2011 is ready.
	TA need and plan is not depicted well	Addressed as an initiative and the details of the implementation is described in the TA guideline
	Prioritization is done at macro level and it is difficult to discern the prioritization at the intervention level	As this is a strategic document, the prioritization will stay at this level.
	The document should refer to collaboration with other sectors especially education and food security, collaboration with the CBO/NGOs and with the Private sector needs to be worked out more.etc.	See multi-sectoral approach section, and the implementation will be further worked out in other operational documents.
	The HSDP IV document could refer to the appraisal done on fiduciary analysis and the state of implementation of the recommendations	Addressed
<b>Group II</b>	The different funding channels which are described need to be more elaborated how it works in practice, the HPF is not mentioned as funding channel	Addressed in brief in chapter 4 but the details are refereed to HSDP Harmonization Manual
	The planning process needs to be described more	Addressed in the implementation

	clearly with the different roles of stakeholders in it.	arrangement of the document, chapter five
	Implementation arrangement by level (the responsibilities of each tier and administrative levels)	
	Some of the governance structures are not functioning well and this is under revision. Based on the outcomes the relevant text in the HSDP IV needs to be adjusted	Governance structures were revised and a new structure put in place. This is incorporated in the final doc
	HSDP IV should have a simple MTEF (an excel spreadsheet),	Discussed and agreed that the MTEF is no more important and the available information can be used instead of MTEF
	The doc should include some descriptions of the IFMIS	Addressed but details are not expected to be described in a strategic document
	The document should explain more on the health care financing reform through which health care facilities have their own Boards and are allowed to retain/use their revenue. The management/accountability of these funds needs to be clarified in the HSDP IV document	The details on Health care financing and insurance are addressed in the HCF strategy

