Results and Effectiveness of the various Funding Modalities in the Ethiopian Health Sector

Addis Ababa,

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Annexes

Acronyms

Acronyms	Meaning
ANC	Ante Natal Care
APDev	African Platform for Development Effectiveness
APR	Annual Performance Report
BRIC	Brazil, Russia, India and China
CDC	Centre for Disease Control
COC	Code of Conduct
CSA	Central Statistical Agency
CSO	Civil Society Organisation
DBS	Direct Budget Support
DHS	Demographic and Health Survey
DP	Development Partners
EPI	Expanded Program of Immunisation
EFY	Ethiopian Fiscal Year
FBO	Faith Based Organisation
FMA	Financial Management Assessment
FMOH	Federal Ministry of Health
GAVI	Global Alliance for the Vaccine Initiative
GBS	General Budget Support
CDC	Centre for Disease Control
GFATM	Global Fund for AIDS, TB and Malaria
GHI	Global Health Initiative
GNI	Gross National Income
CoC	Code of Conduct
GOE	Government of Ethiopia
H&A	Harmonisation and Alignment
HC	Health Centre
HEP	Health Extension Program
HEW	Health Extension Worker
HHM	HSDP Harmonisation Manual
HHRI	Health and Health Related Indicators
HIV	Human Immunodeficiency Virus
HLF	High Level Forum
HMIS	Health Management Information System
HP	Health Post
HPN	Health, Population and Nutrition (donor group)
HQ	Head Quarter
HRH	Human Resources for Health
HSDP	Health Sector Development Program
HSS	Health Systems Strengthening
HPF	Health Pooled Fund
IHP	International Health Partnership
IMF	International Monitory Fund
IMR	Infant Mortality Rate
IP	Implementing Partner
JANS	Joint Assessment of National Strategies

JCCC	Joint Core Coordinating Committee
JCF	Joint Consultative Forum
JFA	Joint Financing Arrangement
JRM	Joint Review Mission
LE	Life Expectancy
MDG	Millennium Development Goals
MDG/PF	MDG / Performance Fund
MMR	Maternal Mortality Ratio
MOFED	Ministry of Finance and Economic Development
NC	New Consultations
NGO	Non Governmental Organisation
NHA	National Health Account
NMR	Neonatal Mortality Rate
ODA	Overseas Development Assistance
OECD	Organisation for Economic Cooperation and Development
OOP	Out Of Pocket (expenditure)
OPD	Out-Patient Department
PBS	Protection of Basic Services
PEPFAR	President's Emergency Plan for AIDS Relief
PFSA	Pharmaceutical Fund and Supply Agency
RHB	Regional Health Bureau
SBS	Sector Budget Support
SNNPR	Southern Nations, Nationalities and Peoples Region
TB	Tuberculosis
TOR	Terms of Reference
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
USG	United States Government
VfM	Value for Money
WBP	Woreda-based Planning
WHO	World Health Organisation
WoHO	Woreda Health Office
WTO	World Trade Organisation

Executive Summary

The Ethiopian health sector has been at the forefront of the aid effectiveness agenda, striving to change behaviour in the delivery and management of aid. This has led to the establishment of aid instruments and agreements, aiming at improved predictability and reduced fragmentation of aid through better harmonization and alignment, promoting country ownership, managing for results and increased mutual accountability. Government has made efforts to strengthen it systems of planning, budgeting, financial management, procurement and reporting processes. Accordingly, over the past years, partners have aligned and harmonized their support, providing an increase in the flow of funds to the government preferred channels. However, progress has been slow against the set targets. In this context a team of consultants has been commissioned to undertake a comparative analysis of the results and effectiveness of using the available funding modalities (in particular the Government preferred channels) by the various Development Partners.

The objective of the review as per the Terms of Reference is to develop a 'result paper' that gives a picture of what aid effectiveness looks like from an Ethiopian health sector perspective. This involved two tasks: First, to describe new developments in Aid Effectiveness internationally (in the context of Busan (Nov/Dec 2011); Secondly, to analyse the results achieved in Ethiopia: with the resources that flowed into the three funding channels, what have been the effects on (i) strengthening health systems and on (ii) improvements in the performance of the services.

The output of this 'result paper' is intended to be used as an input in an 'advocacy paper', meant to communicate to national and international audiences that better results and value-for-money has been achieved when using the GOE preferred channels. While the scope and audiences of these two papers is different, they do complement each other: the result paper providing the 'evidence', and the advocacy paper summarising the available information in a more easy to read format. It is hoped that together these papers will encourage more partners to bring their resources into these preferred channels and advance the Aid Effectiveness principles in the country.

The major findings of this result paper are the following:

1. The commitment and leadership by FMOH played a significant role in coming up with 'high volumes', and 'fast speed' implementation gear with joint and harmonized efforts. In this regard year 2005 is of critical importance as it was in this year that (i) HSDP III with its ambitious system wide goals and targets started; (ii) the Code of Conduct between FMOH and DPs was signed, (iii) the HSDP Harmonization Manual (HHM) was conceived and (iv) alignment and harmonization based on the Paris Declaration started.

2. All three funding channels did contribute to a different degree to the various service delivery and system improvements recorded in Ethiopia. The overall massive increase in funding by the DPs, using different channels is to a large extent responsible for the observed improvements in service delivery and system strengthening. Without the combined effort of the three financing modalities, the Ethiopian health sector could not have achieved the results described in Chapter 5. This paper argues that the use of the Government preferred channels has played an essential role in improving the health of the Ethiopian people by (i) responding swiftly and flexibly to FMOH priorities; (ii) focusing on system strengthening interventions which other funding channels are unable to fund; (iii) reducing administrative cost for the government; and (iv) strengthen government systems by working through it.

3. There is a complementary relationship between the various funding channels. GOE resources (MOFED/PBS) provided the leverage to start these innovative programs, later further supported by funds from the other channels (GAVI, GF). This enabled a transformative scaling-up of the health infrastructure and health staff that is unprecedented. Channel two earmarked funds also acted a stimulus to further increasing regional and Woreda resource allocation through the matching health center concept. Project specific funding (GAVI and GFATM) helped to strengthen the areas where the government preferred

modalities are also prioritizing. Channel three funding strengthened some systems (Supply Chain Management and health financing), which other funding modalities have not financed. It also included specific disease-based interventions (PEPFAR, Malaria) and health financing systems. While the MDG/PF had a comparative advantage focusing on key FMOH priorities, the other channels did contribute to the results observed.

4. The establishment of the MDG/PF in 2009 (when the JFA was signed) created a funding channel that allowed the FMOH to support swiftly and flexibly these major systems related priorities. Government preferred channels (MOFED/PBS and MDG/PF) provided the 'catalytic / transformative' investment that made the health sector move forward. It has been the flexibility and swiftness with which the available resources could be used by the FMOH that has been to a large extent responsible for its effective and efficient use. From an effectiveness / efficiency point of view, the GOE / FMOH preferred channels will give those DP interested to support the Ethiopian health sector, the best Value for Money.

5. Ethiopia has a good track record in expanding access to health services at a low cost. It has credible 5-year sector- and MDG plans that are underfunded. GOE provides good value for money compared to other African governments in terms of service delivery, training and procurement of commodities.

6. When comparing various channels of funding within Ethiopia, this study documented that government preferred channels provide better value for money in terms of (i) higher internal returns and benefit cost ratio; (ii) cheaper and cost effective in terms of unit costs; (iii) lower transaction cost to management and health systems and (iv) being sustainable after the completion of the support. The study shows that these government preferred channels have been the engine that supported the other channels to improve their effectiveness

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1. Background and rationale

1.1. Background

Ethiopia is at the forefront in implementing aid effectiveness in the health sector. This is evident not only from being among the first countries to (i) develop Health Sector Development Plans (since 1997 four rounds of five years HSDP's have been developed with three fully implemented), (ii) linking these HSDP's with various agreements developed and signed together with stakeholders[1], such as an international and a national Compact (2007 and 2008 respectively) and two Joint Financing Arrangements (2009 and 2012 respectively); (iii) development of the Annual Woreda Based Plans, annual Joint Review Missions, the Code of Conduct (signed by 12 partners in 2005) and a HSDP Harmonisation Manual (HHM, 2007) to help move the agenda forward. An IHP Compact was signed in August 2008 by 11 partners and reviewed in 2011, while the Joint Financing Arrangement (JFA) was revised and signed by 8 partners in January 2012 (Annex 6).
Coordination and collaboration mechanisms are therefore well established in the Ethiopian health sector. Work is undertaken jointly by the Government of Ethiopia (GOE), the Federal Ministry of Health (FMOH) and the Development Partners (DPs), which helped to mobilize increasing resources over the last decade and to expand access and use of health services. Therefore all parameters of a successful implementation of the Paris Declaration seem to be in place.

1.2. Rationale

However, a recent IHP+ review on the performance of Aid Effectiveness in Ethiopia (Waddington, Alebachew and Chabot, January 2012) showed a mixed picture: '76% of DPs activities were 'On-Plan', but only 39% of their support was 'On-Budget', while just 14% of all resources channeled to the sector were provided through the Government (GOE) preferred channels[2]'. When looking at reporting, 40% of DPs are not 'On-Report' and some 30% still require indicators outside those agreed upon in HSDP IV. Implementing Partners (IP), provide substantial support to the sector with funds from the US Government (USG, through USAID, PEPFAR and CDC). However, their contribution to the policy dialogue at national level is not well structured. As far as Civil Society is concerned, coordination with CSOs / NGOs at Regional and District (Woreda) levels varies from region to region, but is still quite limited.

The findings of the IHP+ review motivated FMOH to commission an in-depth study, aiming to:

1. Identify what the benefits are for DPs in aligning themselves to HSDP in terms of (i) improved health outcomes; (ii) reduced transaction costs; (iii) reduced duplications and (iv) meeting the strategic needs of the sector (see TOR, Annex 1). In short, FMOH wanted to know whether it is more effective and efficient to use the GOE preferred channels. Will the use of other channels provide similar results for the same amount of resources? (see Box 1 for a detailed description of the three funding channels in Ethiopia);
2. Develop an "Advocacy Paper' to inform the dialogue between the country and DPs within and outside the country. The advocacy paper is meant (i) to initiate reflection by the DPs and their head-quarters to review their (limited) adherence to the Paris principles and increase their commitment to the 'Three Ones'; (ii) to provide those DPs that need to convince their policy makers with the 'evidence' that investing in FMOH-led health spending can be directly attributed to improved health outcomes.

1.3 Structure of the Report

[1] "Stakeholders" refer to Development Partners (bilateral and multilateral institutions), Civil Society Organisations (NGOs, FBOs, Professional Societies) and the private-for-profit sector.
[2] The GOE / FMOH preferred channels are (i) the GOE Block Grants from Treasury; (ii) the funds from the WB to Protect Basic Services (PBS) channeled through Treasury; (iii) the MDG Performance Fund (MDG/PF) and the (modest) Health Pooled Fund (HPF) (Details in Box 1)

This assessment report is structured in 6 chapters. Chapter 1 provides a short background and rationale for this study into the Ethiopian 'Aid Architecture'.
Chapter 2 presents the methodology used to arrive at the conclusions.
In chapter 3, the document focuses on recent international findings with respect to Aid Effectiveness.
Chapter 4 gives background on how the sector is organized, its policy priorities and its institutional structures. It also shows what IHP+ has achieved in Ethiopia (compared with nine other nations).
Chapter 5 provides the essence of the study. It presents the trends of funding to the sector (2001-2004) for each of the three channels together with the relative contribution for each of them in 2004. It also provides a rare insight in how senior management spends its time on those partners that earmark their resources (or use channel 3). It presents the results achieved over the last decade in the various components of the health system. Finally it tries to relate the channel of funding with the observed results.
Chapter 6 provides a few conclusions and recommendations.

2. Methodology

This result paper will focus on the time period between 2005-2011, as 2005 signifies the start of implementation of the Aid Effectiveness modalities in the country with the signature of the Code of Conduct (CoC), the start of HSDP III and the first PBS (component 1) funding to the sector. The post 2005 period is marked by deepened consultation among stakeholders and the joint development and use of various aid effectiveness tools, such as Resource Mapping (since 2006), annual Woreda Based Planning (since 2006), HMIS reform (since 2007), HHM (2007), IHP+ Country Compact (2008), JFA (2009), MTR (2008), JRM (re-instituted in 2009), JANS (2009) and increased domestic allocation of the annual budget for health. Where relevant, comparisons will be made with and data provided from the pre-CoC period, stretching from 2000 till 2005.

In addition, the study will analyze the results of Aid Effectiveness at three levels[3].
1. Increase in the amount of funding and choice of funding channels.
The study will analyse the various contributions of the three channels over time, their predictability, transaction costs of each channel and the use of Technical Assistance. Together they will tell us whether these improvements had an 'effect' on effectiveness and efficiency in the sector.

2. Improvements in the performance of health systems
The study will analyse the contribution of the various channels of funding towards improving the performance of the most important systems in the sector, such as planning and budgeting; Human Resource for Health (number of physicians, midwives and nurses), Infrastructure (number of HCs / HPs); Procurement of essential medicines and equipment, Financial Management and reporting, the Health Management Information System (HMIS) and mutual accountability.

3. Improvements in service delivery outcomes
Here, the study will provide long-term figures (between 2000 – 2011), such as the use of curative services (New Consultations per year), reproductive health services (ANC, assisted deliveries and FP services), child health services (immunization and nutrition) and communicable disease indicators (Malaria and HIV).

In addition to analyse and review secondary information, this study also undertook a limited number of interviews with senior managers from FMOH to take stock of their views on the differences in the effectiveness of the different channels of funding.

Trend analysis is used to show progress in service delivery, system strengthening and financing. Whenever possible correlations are calculated to show the linkages among variables. By comparing outcomes with the various funding channels, the study comes as close as possible to show the effectiveness of using the GOE preferred channels as compared to other channels. It was not possible to 'prove beyond reasonable doubt' that the GOE channels provide the best value for money, but we have been able to make that argument likely and convincing.

Given the pivotal role the three funding channels have in any review of Aid Effectiveness in Ethiopia, Box 1 below provides the reader with a detailed overview of how these channels are managed and which agency is using which channel. For those not familiar with the difference between Ethiopian and Gregorian Calendars, an overview of their relation is given in annex 6. Note that one DP might use several channels to disburse its money for different interventions. Together these three channels define the way all available resources flow into the health sector, their essential distinction between them being who manages the funds: (i) Treasury, (ii) FMOH or (iii) the external donor agency itself.

[3] Adapted from the Mali case study, conducted by Elisabeth Paul, May 2011.

Box 1. The three funding channels in Ethiopia:

1. Through the Ministry of Finance (MOFED)

Channel 1A (un-earmarked): Funds are provided to Treasury. This is the disbursement channel used by Government itself and by donors providing General Budget Support (GBS). This is the GOE's (MOFED) most preferred modality. An example is PBS (component 1) where the WB coordinates funds from various partners as part of the MOFED block grants to the Regions (e.g. to pay salaries of HEW or build health infrastructure). Resources are allocated to regions based on federal resource allocation criteria.

Channel 1B (earmarked): this also uses government financial management system as in Channel 1A, except that these funds are earmarked to specific outcomes and need to be accounted for accordingly. Various projects and programs financed by the UN to regions are transferred through this channel. Allocation follows national allocation criteria using the ''off-setting" principle.

2. Through the Federal Ministry of Health (FMOH)

Channel 2A (un-earmarked): This is mainly the MDG/PF where FMOH spends the funds, based on GOE procedures. It is the FMOH's preferred funding modality. Resources are allocated as per agreed work plan in the woreda based planning process.

Channel 2B (earmarked): Funds are provided to the health sector, the fund is managed and reported by the FMOH but the accounting and reporting mainly follows donors procedures. Examples are:

(i) GFATM,
(ii) GAVI
(iii) UN Agencies funding, and
(iv) Other DPs channeling resources through FMOH

Allocation follows agreed project/program agreements.

3. Outside the oversight of Government

Channel 3: the donors or their implementing agencies under a 'project type of support' manage Funds. While the donor agency may report on the use of funds (in the resource mapping), the day-to-day financial management and procurement are firmly in the hands of the donor. Examples are:

(i) Health Pooled Fund (HPF), where UNICEF on behalf of the FMOH procures Technical Assistance (TA). With FMOH in charge, the HPF is also considered a 'preferred channel'.
(ii) PBS (component 2), where funds are provided for the procurement of commodities, but financial management is done by the WB (sometimes together with PFSA/FMOH);
(iii) USG (USAID, PEPFAR, CDC) funding its IPs on the basis of annual contracts. While their work might be On Plan (shared with FMOH or RHB), they are not On Budget or On Report.
(iv) Other (bilateral) Partners (DPs and NGOs) that fund various activities directly.

Source: Update on HHM, 2007. Annex 5. Funding Channels

3. The international perspective on Aid Effectiveness: three questions

3.1. Have commitments towards Ethiopia been respected?

When the Global IHP+ Compact was launched (September 2007), Ethiopia was among the first countries to translate this international commitment towards improved Aid Effectiveness, first through a Roadmap (November 2007), followed by the Ethiopian Country Compact, signed by 13 DPs in August 2008 (Annex 3). The principles of the Compact were taken one step further in March 2009, when the FMOH produced the Joint Financing Arrangement (JFA). The JFA sets out jointly agreed terms and procedures by: (i) spelling out responsibilities from both sides and (ii) making the MDG Fund an interesting and viable option for DPs to disburse their funds. Many of the DPs were involved in the development and policy dialogue around these aid effectiveness agendas and 8 DPs signed the 2009 JFA (Annex 3). While some of the major contributing DPs were not among them, they showed flexibility and good collaboration with FMOH in the day-to-day management of their funds. One of the reasons for some DPs not signing the JFA was the perception that GOE reporting and accountability procedures were not strong enough to provide reliable (financial) reports. Consequently, some DPs with the support from FMOH, undertook an external and independent Financial Management Assessment (FMA, 2011). The FMA brought to light several strength and weaknesses of GOE financial and reporting procedures, thus allowing FMOH to improve wherever weakness had been found. This in turn led to a jointly revised JFA (January 2012), currently signed by 9 DPs (AusAID and the Netherlands joining recently, but the WB dropping out, see annex 3). In 2010/11 more resources have been pledged into the MDG/PF than in 2009 (Graph 7).

From this experience over the last years, it appears that signed international commitments (Paris, Accra, CoC, Compact and JFA) are no guarantee whatsoever for adhering to these signed principles at national level. International commitments change with the political priorities over time. Ethiopia has argued consistently for (i) its need to be supported by a flexible fund to respond to mutually defined priorities on the ground and (ii) its commitment – within its capacity - to provide timely the (financial) reports and audits as required. The response by the DPs has been varied: some increased their funding levels (some even through the preferred channels), while others kept their contribution as before (possibly due to decisions by their Headquarters). IHP+ commitment to Ethiopia therefore have only partly been respected.

3.2. Has the Paris Declaration improved Aid Effectiveness?

The Organization for Economic Cooperation and Development (OECD) reviewed the progress in implementing the Paris Declaration on Aid Effectiveness over a period of 5 years (as part of preparations for the 4th High Level Forum (HLF4) in Busan (Dec 2011),
A total of 78 countries participated in the 2011 study, while 32 countries submitted information in 2006, 2008 and 2010, thus providing baseline information and trends, Ethiopia being one of them. Overall results of the five-year OECD study on Aid Effectiveness are summarized in Annex 4.
The box below provides their overall conclusions as stated in the executive summary:

Box 2. Conclusion on the status of Aid Effectiveness, 5 years after Paris

> The results are sobering. At the global level, only one out of the 13 targets established for 2010 (being coordinated technical co-operation) has been met, albeit by a narrow margin. It is important to note that considerable progress has been made towards many of the remaining 12 targets.
> Globally, the survey results show considerable variation in the direction and pace of progress across donors and partner countries since 2005. For the indicators where responsibility for change lies primarily with developing country governments, progress has been significant. For example, improvements have been made in the quality of tools and systems for planning and for financial and results management in a number of developing countries, often requiring deep reforms that go beyond aid management to broader aspects of government processes.
> While progress against many indicators requires joint efforts by both developing countries and donors, in some areas it depends mainly on donors' efforts (e.g. untying aid; donor co-ordination).
> National stakeholders frequently cite **constraints imposed by DP headquarters** as bottlenecks to

further progress in Aid Effectiveness, suggesting that these challenges are political in nature.

Source: OECD, Aid Effectiveness 2005-2010. Bold is from the author.

The findings from this global study are clear: while many donors and partner country governments have made progress towards the targets that they set themselves for 2010, few of these targets have been met. The OECD document states: "Partner countries have gone further in implementing their commitments under the Paris Declaration than donors, though efforts - and progress - vary across countries and donor organizations".
Anecdotal information reveals that DP headquarters sometimes are providing the arguments against increasing Aid Effectiveness. This is partly explained by (i) being far away from 'the field'; (ii) not being part of the regular dialogue that takes place with FMOH and among the DPs themselves and - most importantly - (iii) by feeling strongly the political pressure from their constituencies in these times of serious austerity in the donor countries themselves.

Annex 4 also shows the direction and pace of change over the last five years.
For example, while the baseline for the use of country PFM systems was 40% and its target 55%, after five years, the average position for the 32 countries is 48%. Other indicators have moved either less (e.g. "aid flows are aligned" just moved from 44% to 46%, still far from the target of 85%) or more (e.g. "avoid parallel PIU" reduced from 1696 to 1158 halfway the target of 565).

Together, the tables in Annex 4 provide quantified information that indeed the ambitious targets set in Paris in 2005 have not been met, BUT that most of the indicators are moving - at different speed - in the right direction. Just five years to change / reform the Aid Architecture between the various national governments and the many donors agencies involved in development cooperation has not been enough to produce the results most had hoped for. Apart from technical issues, policies and politics (at country and international levels) have often delayed and hindered more robust achievements.

3.3. Can Budget Support (BS) improve Aid Effectiveness?

In October 2011, the OECD[4] assessed the 'impact' of Budget Support (BS), (General and Sector Budget Support)[5], through three specific case studies in Mali, Zambia and Tunisia. Findings of these three studies provide 'evidence' that BS 'works', as in all three countries it contributed to (i) reduce inefficiencies, (ii) reduce overhead cost and (iii) improve health outcomes. In its synthesis report[6] from these three evaluations, the OECD concludes that "BS is an effective tool in countries where the government has the capacity and the determination to put in place robust development policies". This conclusion also applies to Ethiopia, where PBS funding through Government has contributed substantially to the strengthening of infrastructure and the payment of the innovative Health Extension Program (HEP).

From these general conclusions, several issues stand out as relevant in the Ethiopian context:

Table 1. Relevance for Ethiopia of the OECD Synthesis Study

Four key findings from the OECD	Relevance for the Ethiopian context
1. H&A versus results: The synthesis study makes it very clear that H&A is among the weakest of all Paris principles. DPs responsibilities to adhere to and bring Paris forward remains limited compared to what national governments have done.	*1A. Harmonization*: The Health, Population and Nutrition (HPN) donor group meets monthly. Successes: agree together on the agenda for the JCF OR initiate a joint review on a particular topic. Less successful: agree on a joint accountability framework OR ask the FMOH for a timely submission of their comprehensive plan *1B. Alignment:* While most DPs are comfortable to align to GOE priorities and

[4] OECD, October 2011. Assessing the impact of BS: case studies in Mali, Tunisia and Zambia.
[5] MDG/PF corresponds with the SBS funding modality described in the OECD studies.
[6] OECD, November 2011. A synthesis report from the OECD Network on Development Evaluation, synthesis of main results.

	systems, many are not comfortable to align to its FM / Procurement systems. Individual meetings with senior management continue. As a senior person in FMOH told us: "When a donor asks for an interview, we cannot refuse, as we need their help". Still too many donors exploit this feeling of dependency.
2. Budget support versus project support: Donors that channel their funds through budget support are more effective in supporting the implementation of national priorities than donors that fund the implementation of projects.	2. DPs providing GBS and SBS have contributed to strengthening the PHC system by providing resources to hire human resources (from HEWs to Health Officers) that have transformed the reach and accessibility of services. Many IPs do a good job, but they are not represented where policies and priorities are discussed, their resources are managed by themselves; many do not report in the HMIS format, but report often exclusively to their funding agency. Therefore, the IPs contribution comes at very high transaction costs.
3. Perceived risks: Findings showed that budget support contributes to improved accountability and transparency of budgeting processes. No evidence was found of perceived risks being (i) crowding out of domestic revenue and/or (ii) increased corruption.	3. This finding also applies for Ethiopia. The Financial Management Assessment (FMA, 2011) concluded (contributed to): • The additionality test of PBS did not provide any evidence that regions are allocating resources away from poverty reduction sectors. • Improved reporting on MDG/PF (by revising the JFA); • Better oversight by FMOH on PFSA (through a revision of PFSA board members and the finalization of two delayed audits). • Various audits in the last two years did not find evidence of corruption or crowding out of resources. •
4. Policy dialogue: The study concludes that policy dialogue is a key element of budget support to ensure policy reforms and implementation. The quality of the dialogue depends partly on country ownership, but also on harmonization among the DPs and the depth of political / economic partnerships.	4. Policy dialogue in Ethiopia takes place at 3 levels: • HPN Donor groups (internal DPs only, meeting once a month); • JCF (with FMOH senior management, meeting every quarter) • MDG partners (with FMOH, every quarter and on request). Dialogue is limited due to the absence of an agreed framework of 'mutual accountability'. Meetings have a high level of 'informal consensus' between the partners, without being able to hold each other 'to account when needed. Interest on both sides for such accountability framework is not evident.

Source: OECD, Nov. 2011. Synthesis report from OECD Network of Development Evaluation.

Next to most of the bilateral DPs, the three major contributors to the Ethiopian health sector are GFATM and GAVI (both channel 2, but earmarked) and the USG (channel 3). The way these agencies channel their funds into the country has enormous consequences for the FMOH capacity to direct these resources to where its priorities are. GFATM and GAVI have shown flexibility in allocating their resources based on FMOH priorities. USG has the same intention, but is more constraint due to its stringent reporting requirements to Congress. Its programs are aligned in terms of following FMOH priorities and have played a significant role in strengthening some of the health systems in Ethiopia (such as health financing and now moving to HRH). However, FM, technical assistance and procurement, all remain firmly in their own hands. USG is aware of this situation and consequently meets regularly with FMOH senior management to discuss the implementation of its programs. With the arrival of the 'Global Health Initiative (GHI)' – being undertaken by the Obama administration – there are chances that the USG will be able to improve its H&A and move towards Aid Effectiveness in the coming years.

The African Platform has taken a strong position on the future of Aid Effectiveness for Development Effectiveness (APDev). As part of the preparations for the High Level Forum Meeting in Busan, the Platform issued in September 2011 the "African Consensus and Position on Development Effectiveness: AID Reform for Africa's Development". The document presents for the first time consensus on Development Effectiveness in Africa, representing all member states of the African Union, Parliaments, Regional Economic Communities, Civil Society, including women and youth groups, business and academia.

Relevant are three essential elements of the document, as summarized in the Box below.

Box 3. African Consensus on Development Effectiveness (a summary)

The post-Busan Agenda for Africa is in essence a program to reduce Aid Dependency and ultimately exit Aid towards Development Effectiveness. Amongst others the document highlights the need for:

- An accelerated delivery of outstanding commitments by DPs as signed in the Paris Declaration and the Accra Agenda for Action; in particular the DPs unfinished commitments in the use of country systems, elimination of conditionality, promotion of transparency, harmonization and alignment, aid predictability and mutual accountability must be fully implemented.
- Developed countries should honor their commitments to provide 0.7% of GNI as ODA in accordance with the 2002 Monterrey Consensus and the G8 Gleneagles Summit (2005), thus raising the levels of aid, despite the global financial and economic crisis. This remains critical to Africa's development effectiveness agenda.
- A fundamental reform of the global governance framework that integrates Africa's participation in the G20, the IMF, WB, UN Security Council and the WTO and – in addition – stimulates a competitive market in development assistance. The South-South cooperation, in particular with the BRIC (Brazil, Russia, India and China) is seen as an opportunity for Africa.
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Source: HLF4 Busan, Sept 2011 final version,

In summary, while Budget Support can be an effective tool to address and respond to national priorities in health, it needs not only a strong and determined leadership to realize the intended results, but also committed donors to fulfill their Harmonization and Alignment obligations. Where donors are verbally united, but unable to find concerted actions in line with FMOH preferences, the impact of BS will remain less than expected. The strong wording by the African Platform (Box 3 above), suggests that an acceleration of delivery on outstanding DP commitments is required, if Paris and Accra will remain more than good intentions. To what extent this will be translated into reality, remains to be seen.

This is not to say that the Aid Effectiveness agenda has nothing achieved over the last years. As indicated in the earlier sections it has delivered on some of its commitments. However, it seems internationally there is stagnation at the moment. The positions of the some of the larger DPs (in-country or in their HQ) seems more or less fixed. Unless these positions change, no major breakthrough in the international Aid Effectiveness agenda is likely to be expected.

4. The Ethiopian perspective on Aid Effectiveness

4.1. Status of Ethiopia implementing the Paris Declaration[7]

Progress on the Paris Declaration indicators depends on improvements by both donors and partner governments. As Ethiopia is a major recipient of aid, issues of aid effectiveness are particularly relevant. Of the 13 indicators for which there are targets in the 2011 OECD survey, five have been met; overall progress has been uneven (Table 2 below).

Table 2. Ethiopia, Baseline and targets in Aid Effectiveness (OECD, 2011)

	INDICATORS	2005 REFERENCE	2007	2010 ACTUAL	2010 TARGET
1	Operational development strategies	C	B	B	'B' or 'A'
2a	Reliable public financial management (PFM) systems	3.5	4.0	3.5	4.0
2b	Reliable procurement systems	Not available	Not available	Not available	No Target
3	Aid flows are aligned on national priorities	74%	62%	48%	87%
4	Strengthen capacity by co-ordinated support	27%	67%	86%	50%
5a	Use of country PFM systems	45%	47%	69%	63%
5b	Use of country procurement systems	43%	41%	55%	No Target
6	Strengthen capacity by avoiding parallel PIUs	103	56	49	34
7	Aid is more predictable	96%	73%	86%	98%
8	Aid is untied	66%	76%	86%	More than 66%
9	Use of common arrangements or procedures	53%	66%	61%	66%
10a	Joint missions	27%	29%	25%	40%
10b	Joint country analytic work	50%	70%	52%	66%
11	Results-oriented frameworks	C	C	B	'B' or 'A'
12	Mutual accountability	Y	Y	Y	Y

Source: OECD 2011, Aid Effectiveness 2005-2010; Country studies, Ethiopia, Volume II.

According to the OECD report on Ethiopia, there has been no improvement in aligning aid flows to national development strategies since 2007, but managing for results has improved, with a "B score" being allocated. The three indicators on harmonization were not met in 2010, and displayed varying trends. In 2010, 86% of scheduled disbursements to Ethiopia were recorded by the government, which exhibits an improvement from 2007. The indicator on joint missions experienced a setback in 2010 in comparison with the 2008 survey, and there were setbacks for the remaining indicators on joint country analytical work and use of common management arrangements for the same period.

Specifically for the health sector, the IHP+ presented its Annual Performance Report 2010: "Strengthening accountability to achieve the health MDGs". It analyses information from 25 signatories (10 countries and 15 donors). The document concludes that there has been an overall improvement in the effectiveness of how aid is being delivered and used in the health sector. However, it is too early to state whether these improvements are contributing to stronger health systems or better health outcomes. Significant progress was made by the FMOH on a number of alignment indicators, including coordinated technical cooperation, use of public financial management systems and untying aid, which were all substantially above target.

The IHP+ 'scorecard' for Ethiopia (Annex 5) summarizes in two pages the progress towards increased Aid Effectiveness. Using information provided by the FMOH, the scorecard compares the situation in 2007 with 2009. It shows progress in most of the 8 criteria (similar to those used by OECD). IHP+ hopes that these results will be used as tools to initiate dialogue. However, neither the HPN donor group nor FMOH has used this opportunity for joint discussions on the latest IHP+ findings.

[7] Note: the findings on Aid Effectiveness in Ethiopia (2005-2010) refer to findings in overall development (reported to OECD by the GOE). Findings are NOT specific to the health sector.

4.2. The Ethiopian health sector: policy and organization

The health sector in Ethiopia is guided by the Health Policy (1993) that prioritizes promotive and preventive health care. The imperatives of the policy were translated into programmatic interventions when the first Health Sector Development Program (HSDP) was launched in 1997. Three rounds of HSDP were implemented and evaluated and the fourth (HSDP IV) is now almost halfway through implementation. Reviews show the strength of its policy framework, how FMOH manages its sector priorities and how it implements these five years HSDP, through:

- A sector planning process has been in place for some years. It has been reinforced by the introduction of the Woreda Based Planning Process that links HSDP IV with annual operational plans at lower levels and harmonises the top-down approach of HSDP programming with the bottom-up process of planning, budgeting and target setting;
- There has been strong government ownership on the strategies and outputs, particularly over the last five years, to realise the established targets; this is evidenced amongst others by high rate of progress in the expansion of health infrastructure (HC / HPs), the implementation of the health extension program (HEP), and the nationwide rollout of the HMIS.
- In service delivery, strong priority has been given to interventions in several communicable diseases (Malaria, HIV, TB) and lately emphasis on maternal and child health (FP, EPI);
- Review and monitoring mechanisms have been institutionalised in the sector. The sector has routinely undertaken JRMs (reinstituted in 2009) and ARMs since 1997; an important database, covering some 10-11 years period, has been developed.
- Finally, there are established coordination structures for joint decision making, which have recently been revised (JFA) and strengthened (JCF, JCCC, HPN);

The essential prerequisites for an even stronger FMOH leadership of the sector exist in Ethiopia. However, progress in using government systems, such as disbursement channels (MDG/PF), Financial Management procedures and guidelines and common reporting formats remains limited. There are areas where significant improvements can be made:

- General underfunding by the GOE remains at around USD 3.3/pp (32 Birr/pp in 2008) out of a total funding to the health sector of USD 16/pp (NHA, May 2010).
- Limited flexibility in addressing upcoming priorities, due to the devolution of the GOE administration, thus providing limited 'free funds' at the level of FMOH;
- Absence of one 'comprehensive annual plan for the health sector, showing the financial contributions from GOE and all stakeholders;
- Insufficient management capacity, particularly at lower levels and a lack of performance based incentives to retain existing human resources in the sector;
- Coordination mechanisms are working but there is room for improvement. The sector has several parallel aid coordination structures, including separate structures for Health and HIV/AIDS. Even within health there are separate coordination structures for HSDP, GAVI and GFATM, chaired by the different officials of the FMOH with weak horizontal information sharing. The involvement of other FMOH departments in the JCCC is limited in spite of the efforts to pull them in.
- There is room to improve dialogue between FMOH and DPs, for example by improving the work in Technical Working Groups (TWGs) and elaborate mutual accountability mechanisms (joint Performance Appraisal Systems etc.).

If some of these challenges could be addressed effectively, chances of effectiveness of government preferred modalities would even be better than what it is now.

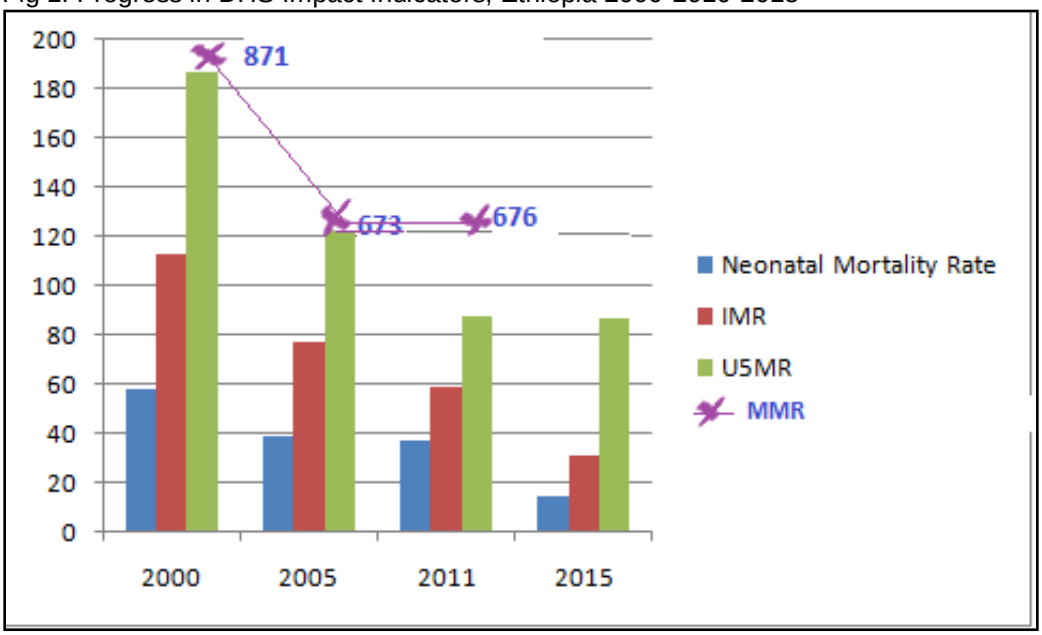
In summary, effective policies and institutional arrangements are in place and operational. They have shown their effectiveness in improving health outcomes (see below). However, it is open for discussion whether the current Aid Architecture is strong enough to guide and stimulate more improvements in Aid Effectiveness. While some progress in using GOE systems by DPs has been realized, the question remains what needs to be done to allow FMOH to use even more of the available external resources flexibly and based on the jointly decided priorities. What bottlenecks remain and to what extent can they be addressed by FMOH, the GOE and the various DPs in-country and at their HQ levels? Are these bottlenecks of a technical, a policy or a

political nature? Are they confined to Ethiopia or to the wider development agenda? Section 4.4 will highlight some of the perceptions among the DPs in using the various GOE systems.

4.3. The Ethiopian health sector: some recent results

The increased funding - documented by the recent NHA 2010 - has shown impact in improving health outcomes. The recent Demographic and Health Survey (CSA, March, 2012) reports important improvements in health outcomes of the population, notably reductions in child morbidity and mortality and increases in the contraceptive prevalence rate (CPR). The DHS did not report an improvement in the Maternal Mortality Ratio, still at around 676/100.000 live births. Other indicators, such as coverage, utilization and most (output / outcome) indicators all have improved over the last 5-6 years (FMOH Annual Performance Report (EFY 2003), as will be shown in more detail below in chapter 5.

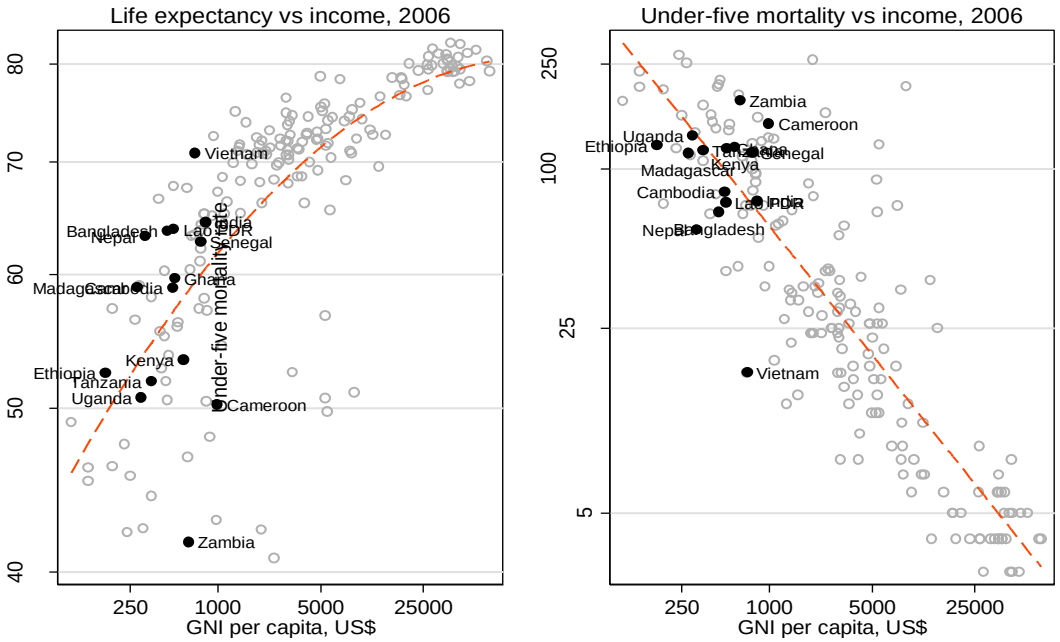
Fig 1. Progress in DHS Impact Indicators, Ethiopia 2000-2010-2015



Source: Three DHS reports and the HSDP / MDG targets for 2015.

Next to these impact indicators, Fig 2 below shows that Ethiopia - given its very limited resources - is doing quite well in terms of its Life Expectancy (LE) and its Under-five mortality. It shows that Ethiopia's Life Expectancy (LE) is better than the average of other African countries for its given income (GNI). With its (low) GNI per capita, the LE of approximately 53 years shows Ethiopia has an efficient / effective overall health performance. It would correspond with a GNI per capita of almost US$ 250. Similarly, U5MR for Ethiopia at its current income level is also above average when compared with achievements of other countries. U5MR in Ethiopia has a better value for its low GNI than countries with higher income (such as Kenya, Uganda).

Fig 2. Life Expectancy and Under 5 Mortality Rates, vs. GNI / capita (international US$), 2006



Source: WDI
Note: log scale

Source: MOH Kenya, 2010. Health trends and distribution, analysis and performance of Kenya's Health Policy Framework 1994-2010.

There is evidence that service delivery in Ethiopia is more cost effective and generates more value for money. According to the business case for MDG/PF (DFID), unit costs of procuring commodities and delivering health services through the public sector are currently low in Ethiopia compared with other sub Saharan African countries. Figure 3 and Table 3 below compare some of the estimated unit costs in Ethiopia with other countries

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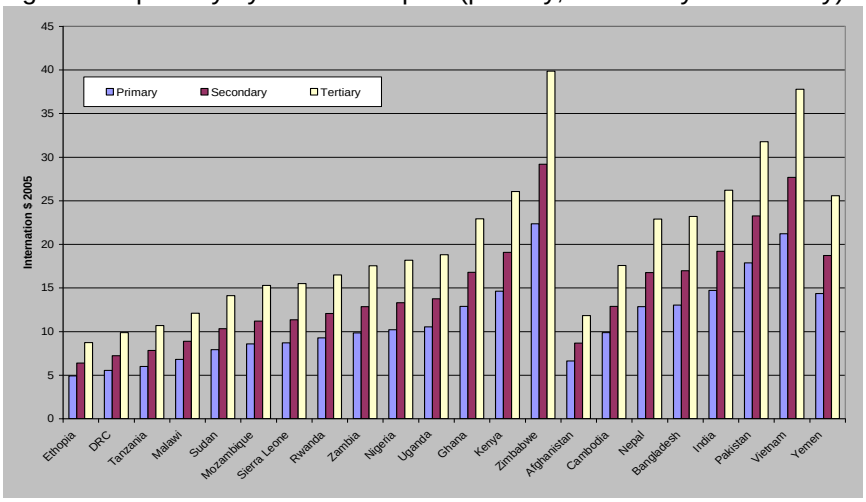
Fig 3. Cost per day by level of hospital (primary, secondary and tertiary) in selected countries[i]



Source: DFID, 2011, MDG PF Business case

Table 3: Health unit cost comparisons

Inputs	Ethiopia	Other countries
Cost per visit to a health center	$4.18	> $5 (Mozambique, Uganda and Ghana) > $6 (Kenya)
'Transaction' price of long lasting ITN[ii]	$4.92	$6.9 (Ghana) $6.19 (Zambia) $7.44 (Republic of Congo) $5.3 (DFID global average cost)
Normal delivery	$8.67	$16.88 (Ghana) $3.86 (Tanzania)[iii]

Source: DFID, MDG PF Business case, 2011.

These low costs of providing care are a result of low salaries and a concerted effort by PFSA to purchase commodities at a low price. However, given the persistent insufficiencies in staff, equipment and supervision, they also reflect to some extent the low quality of services.

Service delivery in Ethiopia may be more cost effective than other countries, but one should also inquire whether there is a difference in generating value for money among the different funding models. Two types of evidences indicate that funding through government system provides more results for the investment made. First, the practical experiences within the FMOH (see Box 4) show that using project funding modalities (channel 3) is more expensive.

Box 4. Interview with a senior manager of FMOH on Value for Money

"From the perspective of the FMOH, the advantages of the GOE preferred funding modalities are (i) they support government priorities; (ii) incur less transaction costs; (iii) can be used where urgent needs and priorities arise (flexibility); and thus (iv) provide high Value for Money (VFM). A good example is the huge health facility expansion (Fig10) and the procurement of equipment for rural hospitals, undertaken by the FMOH since 2005/06. This was made possible through flexible funding. Similarly, the FMOH was able to procure some 800 ambulances through government preferred modalities in a year, while it took two years to negotiate and procure 8 ambulances through a project support modality.
Given the size of the country, our priorities require big volumes of support and implementation at federal level. Most project-based support does not fit such a comprehensive vision, as they focus on pilots and replication processes".

"Another example is our procurement procedures through PFSA that provide substantial better Value for Money (VFM) than using the procedures from the DP or the Implementing Partner (IP). For example a digital X-Ray machine was procured through PFSA, being 50% cheaper than the same machine (same type, same specifications) procured through a project modality, due to several overhead costs at the level of the procuring agency".

"FMOH gets roughly equivalent amount of annual funding from earmarked source for malaria from a partner that uses government system to that of another IP implementing outside government system. But the IP is not able to fully implement the full package of interventions without the additional support of FMOH even in one region alone, which it is responsible for".

"Reasons for these differences are: a substantial amount of money from the DP / IP budget has to go to its own internal overhead. In fact, we as FMOH thought we were to receive and amount of money X, while in fact we just receive an amount of Y, not only being much less than X, but we are not even informed how much less Y is compared to X. For us, this is money lost to the country and the people".

Second at more analytical level, both MDG/PF and PBS business cases estimated the benefits of funding through the government system and through channel three (NGOs / UN agencies). Both business cases clearly documented higher internal rates of returns (IRR) and benefit cost ratios (BCR) when funding go through government channels as presented in table 4:

Table 4: IRR and BCR on using government and Channel 3 funding

Funding channels	MDG/PF Business case		PBS III Business case	
	IRR	BCR	IRR	BCR
Through government of Ethiopia	42%	4.50	21.9%	1.40
Through NGOs and UN agencies	35%	3.48	18.5%	1.26

Source: DfID, 2011 and 2012.

4.4. DP perspectives: why work through government systems?

Despite evidences - both internationally and domestically - that using government systems is much more effective, there are different perspectives among donors on this. The table below summarizes possible perceptions of DPs[8]: why one DP might provide its financial resources through FMOH or GOE channels, while another DP might decide rather not do so.

Table 5. Different DPs perceptions for working Yes / No through FMOH channels

The converted	The non-believers
Channel funds through MDG/PF!	**Remain in channel 3 mode!**
FMOH has shown serious commitment that merits our full support	Despite the recent changes in Aid Architecture, FMOH is not transparent, there is too little real policy dialogue
Health indicators are improving (see IMR, U5MR), showing that our resources are used effectively	That is true, but MMR is not improving, despite major resources going to maternal health recently. What to do?
There is One Plan = HSDP IV; there are annual Woreda Based Plans. That is an enormous achievement every year to make these plans for 800+ Woredas	I have not yet seen one 'Comprehensive Plan', including the full budget of GOE and DPs. It has been promised but when will it be shared?
Providing our funds On Budget reduces overhead costs	We receive no information on real budget execution
The HSDP IV includes all relevant indicators, we as donors should not ask for more	The reliability of HMIS is a serious concern. For example compare HMIS with the 2010 DHS: there are big differences!
There is no / little corruption, financial management and reporting has much improved, giving confidence in how FMOH uses his own and our resources	The FMA came very timely and FMOH, which documented some shortcomings.
Procurement is indeed a concern, but it will only improve if we work through the GOE / PFSA channels	PFSA procurement is still a black box. I will not put our money in there, as I cannot account for it to our Parliament
It seems there are many audits taking place (PBS, GFATM, MDG/PF, PFSA etc.). Why don't we trust them and stop asking for more	TORs of Audits have not been presented to HPN. Results come too late. It seems we as DPs are outside the financial controls.
I am happy with the functioning of the Aid Architecture, as I can discuss my concerns once every quarter with the Minister. That is enough for me.	The Aid Architecture does not provide essential inputs into the policy dialogue with the Ministry; the responsibilities of JCCC remain unclear (not transparent)
I am regularly informing my Head Quarters (HQ) about these positive developments, but they do not listen or understand what we are achieving in this country	I agree with my HQ to wait with moving into channel 2. We now can report at any moment on the use of our funds and there are no major risks anymore.

The table not only shows how wide apart these perceptions can be among the technical staff within DP Offices, but also – and more importantly – how difficult (or even impossible?) it seems to convince the persons holding either opinion to change his/her point of view. It is the 'colour' of

[8] Sentences are coming from the experiences of the authors with the Ethiopian health sector; they have not been collected during interviews with DPs or FMOH management.

these perceptions that will influence the decision on what funding channel to choose and what information / advice will be given to the respective heads of agencies and / or the Headquarters.
For example, while technical staff in agency X will be fully in support of the MDG/PF, buying 300 ambulances for Woredas to address the challenge of timely referrals of serious cases (e.g. maternal complications), other experts in agency Y might consider this a waste of money given the expected problems of recurrent costs, maintenance and supervision. While some things will be objectively measureable, in the end it remains a question of 'belief': either you believe in government ownership (and all its risks and flaws) or you don't.

To complicate matters, it seems that some staff are not aware that Aid Architecture and SWAp implies that donor agencies are not supposed to decide anymore on 'operational issues', but - as compensation - have been given a place at the table where major decisions on policy issues and priorities are taken. From the FMOH side, the Ethiopian Government - within certain limits - has relinquished its authority to decide itself on its policies and priorities, being compensated for this reduction of authority in its own country by the financial contributions from its DPs. It is this agreement of 'give and take' between the two parties that is at the core of the Paris Agenda and that allows a lot of middle ground for all parties to present their different positions.

The answer to the question in the title of this section is therefore that all DPs are expected to support the FMOH in strengthening its own (GOE) systems, using as much as possible its preferred funding channels and – if not convinced about the effectiveness of these GOE systems – just opt out and fund health sector activities through earmarked channels (channel 2B) or outside the government (channel 3). In fact, this study observed that often DPs provide their funds through a variety of channels at the same time, for example using MDG/PF, but also channel 1B and/or channel 3 (to support NGOs in the health sector).
It is therefore high time to look in more detail at the amount and the modalities in using the three channels and their results in improving health indicators.

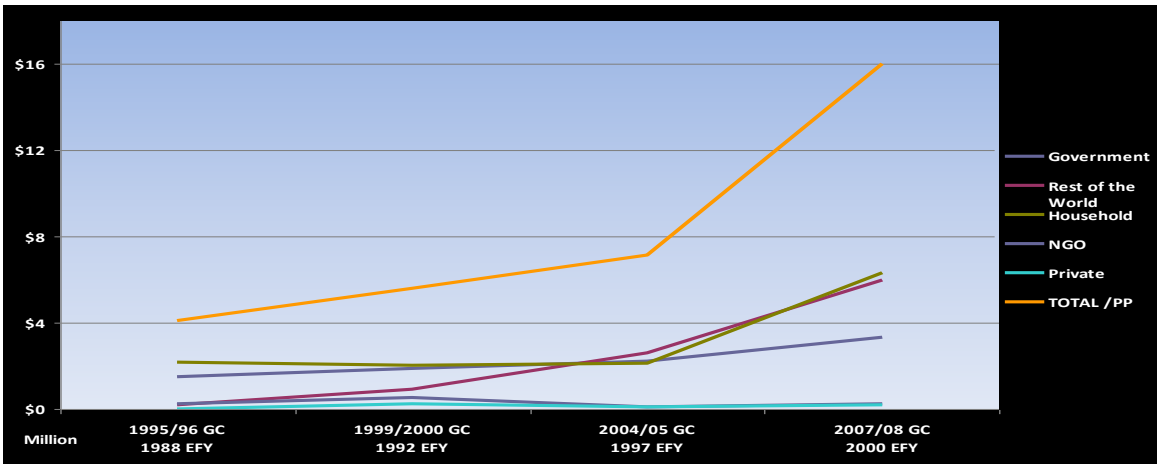
5. Impact of Aid Effectiveness on funding, systems and service provision

5.1. Changes in the amount of funding by funding channels[9]

5.1.1. Trends in overall funding levels

Analysis of the four National Health Accounts (NHAs) shows a fourfold increase in the total per capital Health Expenditure (per capita HE) over a 12 years period. It increased from US$ 4.0 per person in 1995/96 to US$ 16.0 per person in 2007/08. The main increase occurred recently, between 2004/05 and 2007/08, when the per capita HE more than doubled from US$7.14 to US$16.09 per capita.

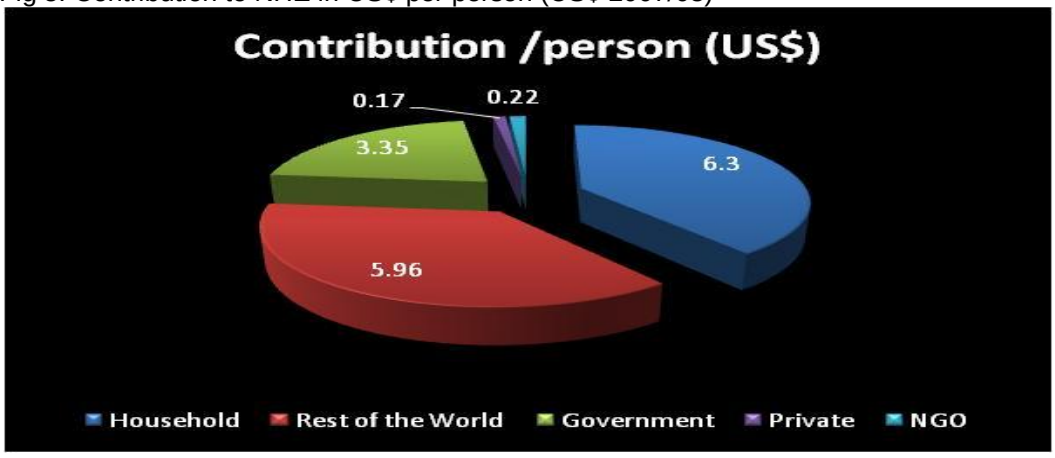
Fig 4. Per capita health expenditure by source (US$/pp)



Source: Four NHA reports 1995/96 till 2007/08.

In 2007/08, the highest share of these resources came from 'Rest of the World' (being external contributions 40%), while Out of Pocket (OOP) payments from households were second with 37%. Government spending contributed 21% to the per capita l Health Expenditure.

Fig 5. Contribution to NHE in US$ per person (US$ 2007/08)



Source: Four NHA reports 1995/96 till 2007/08.

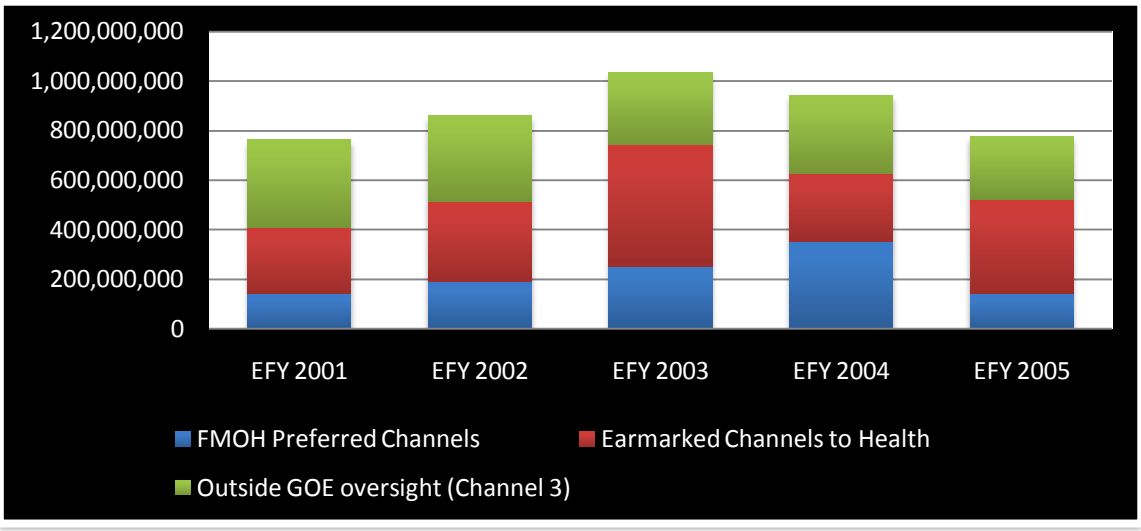
[9] In this document, the 'GOE / FMOH preferred channels' are Channel 1B (earmarked, PBS component 1), Channel 2 (un-earmarked, MDG/PF) and Channel 3 (Health Pooled Fund).

5.1.2. Contributions from the three funding channels

The relative contribution of each channel in EFY 2004 is shown in Fig 6. The preferred (un-earmarked) channels (including 1A, MOFED/PBS) made up 38% of all the available resources, whereas channel 3 (outside FMOH oversight) contributed 33%. The two earmarked channels (1B and 2B) together contributed almost 30%. Together, the graph suggests that the contribution of the preferred channels as part of all available resources is increasing, the increase coming from GOE block grant resources (1A / MOFED/PBS) and from the various partners' contribution to the (un-earmarked) MDG/PF (channel 2A). If Channel 1A (MOFED) is taken out, but channel 1B (PBS 2 and UN Agencies) is included as preferred channel, 34% of all resources are part of the preferred channels, being much higher than the 14% reported by the IHP+ final report.

As MOFED figures for EFY 2005 are expected to increase, it is likely that the preferred channels will grow more than the non-preferred channels in the coming year, thus providing FMOH with substantially more flexibility to direct its resources to its priority interventions.

Fig 6. Contributions by channel over time 2001-2005 (USD M)



Source: various sources

5.1.3. Contributions to the MDG/PF (Channel 2A)

The MDG/PF being one of the preferred channels of thee Government - has been defined in the Compact (2008) as follows:

Box 5. Definition of the MDG Pooled Fund

> The MDG Pooled Fund is a pooled funding mechanism managed by the FMOH, using the Government of Ethiopia procedures. It provides flexible resources, consistent with the *'one plan, one budget and one repor*t" concept, to secure additional finance to the Health Sector Development Program. It is one of the three GOE preferred modalities for scaling up Development Partners assistance in support of HSDP. The others are Channel 1 (PBS component 1) and Channel 3 (HPF, managed by UNICEF on behalf of the FMOH).

Source: Ethiopian Compact, August 2008.

Contributions to the MDGPF have been steadily increasing over the last 4 years, as apparent from figure 7 below. While the number of contributors has been increasing from 2 in 2001 up to 6 in 2004, there is also an impressive increase in the amount of US$ for the MDG/PF, stemming mainly from one (bilateral) partner, doubling its resources between 2003 and 2004.

Fig 7: Contributions to MDG/PF, 2001-2004 (US$ M)

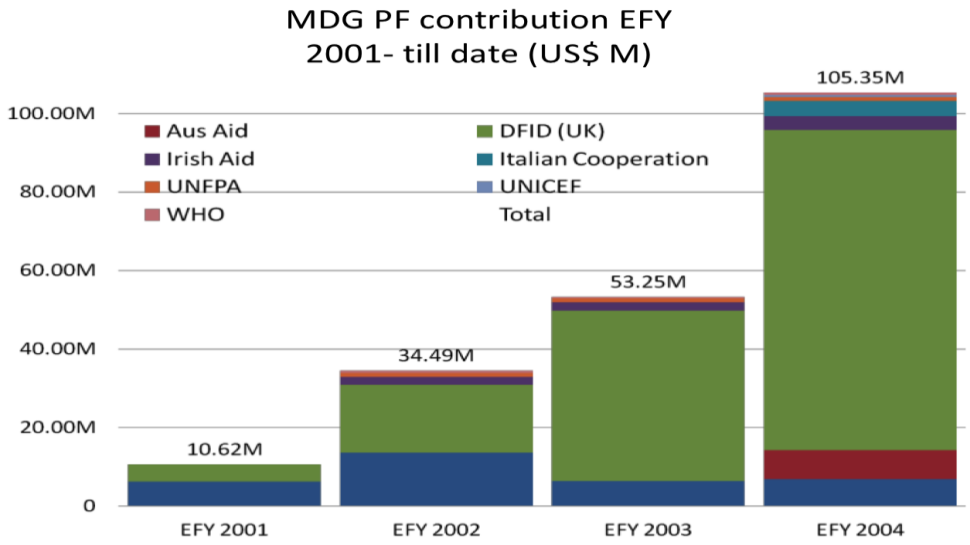
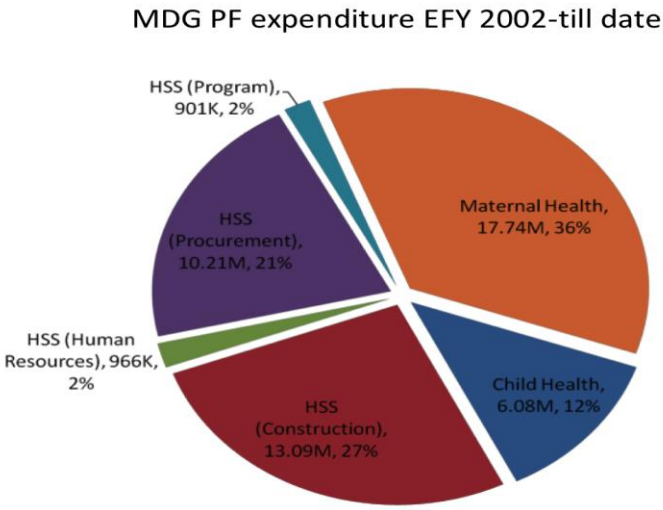


Fig 8: Priority areas that benefitted from MDG/PF funds (in US$ M)



Source: FMOH, Progress on MDG/PF, Presentation in May 2012 at MDG/PF dinner and the MDG/PF 2011, Q4 activity report, October 2011 till January 2012, final.

As argued in annex 3, most of the bilateral and UN agencies have been part of the MDG/PF to different degrees. The major absentees in this are the USG, GFATM, GAVI and some of the major international health initiatives, like Gates Foundation and Clinton Health Access International. Therefore the likelihood of more DPs joining this pooled funding arrangement is limited, as most of the remaining candidates are restricted by internal procedures and policies in their headquarters. There is thus a need for an intensive effort to convince these agencies to align and harmonize their funding mechanisms, if there investment is to provide better value for money and be sustainable in the long term.

Since the start of the MDG/PF in April 2009 (EFY 2002), FMOH used the income to fund the following six priority areas (Fig 8).

1. For maternal health services it included the recent purchase of 310 ambulances at Woreda level meant to reinforce the referral system;
2. Child health benefitted from the purchase of vaccines, the measles campaign, several vaccines and the construction of cold rooms to strengthen EPI at all levels.
3. The money for HRH was used for training of midwives and the accelerated integrated surgical and obstetrics training of Health Officers; the budget for training under specific maternal health programs was used for training HC staff in the insertion of Implanon, as part of the nationwide Family Planning program.
4. Funds under 'HSS-Construction' were spent not only on the construction of HCs, but also to support and expand the Community-Based Health Insurance work.
5. The HSS-Program related support was mainly spent on scaling up the HMIS.
6. Finally, 'HSS-Procurement' money was used to buy various equipment (for hospitals, EmOC and New-born corners), essential drugs, family planning commodities (Misoprostol, Implanon), ITN and HC / HP equipment and consumables.

The Honourable Minister's suggests these priorities during one of the JCF meetings, discusses them with the DPs that are present and eventually approves them. Once decided, FMOH manages the use of MDG/PF funds on a day-to-day basis, while formally reporting each quarter.

In summary, this detailed list of what the MDG/PF funds have been used for in the past three years, highlights that the MDG/PF money is spent on activities that:

- Are aligned to the goals of the HSDP and identified as priorities within the annual planning framework and the JRM and ARM consultations;
- Prioritize under-funded health systems that are not funded by other donors or the disease specific funds;
- Allow FMOH to respond timely and flexibly to these emerging needs nationwide.

Given the decentralization context and the roles and responsibilities decentralized levels play, it is important to note that the FMOH has limited leverage and capacity to fully implement its priorities. This is due to the way funds are allocated by MOFED through the Block Grants, using the national resource allocation formula. Given the fiscal devolution, FMOH has 'limited authority' to 'impose' on Regions and Woredas their national priorities. FMOH can advocate and provide good arguments for its priorities through the top-down and bottom-up planning process, but the final decision - and allocation of resources – remains with the respective councils, RHB and Woreda Health Offices. For this reason, the MDG/PF provides the FMOH with the means to support in a flexible way where gaps and urgent needs appear and use it as an incentive for regions and Woredas to focus their resources on national priorities.

The MDG/PF also gives FMOH the possibility to achieve value of money through its procurement of medicines and medical commodities (equipment, ambulances) that are needed by all Woredas and regions. The effectiveness of GOE systems on procurement is highlighted in Box 4 (above). The JRM 2009 also reported for instance that HC equipment procured through the government system is most cost effective. Furthermore, centrally pooled funding for these products enables the FMOH to buy in bulk and achieve economies of scale, standardized quality and better maintenance contracts for equipment than if each Woreda/region would procure separately.

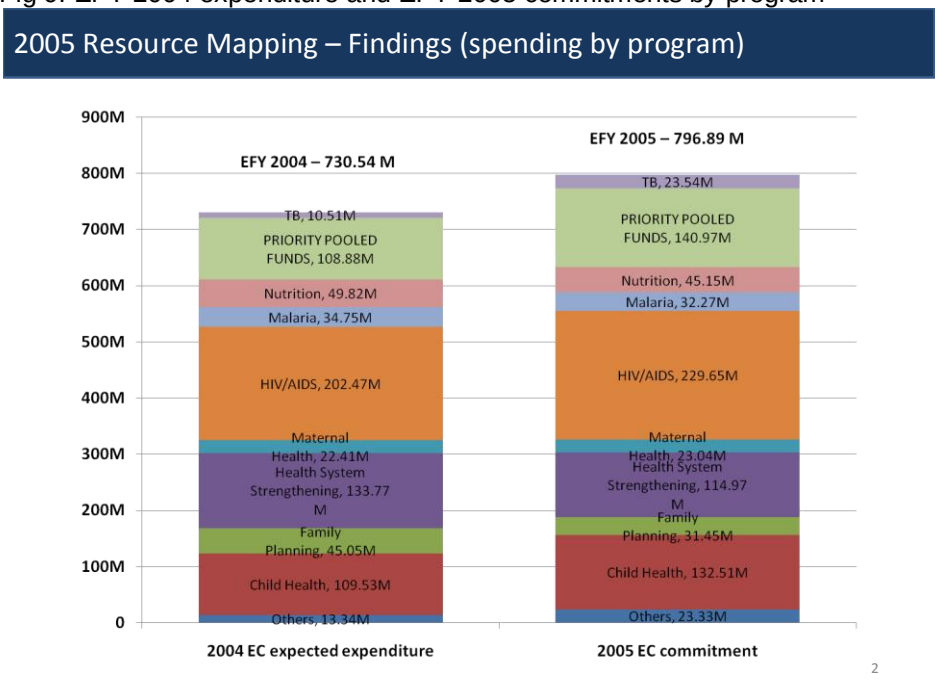
5.1.4. Predictability of the funding

According to aid effectiveness principles, DPs should provide reliable, indicative, multi-year commitments of aid and disburse aid in a timely and predictable fashion. However, the 2011 IHP+ review in Ethiopia showed that less than 50% of DPs offered one- or two-year commitments. Of the 19 responding DPs, five had made a financial commitment for five years. Another five had commitments for only one year. Those with five- and four- year commitments have a relatively small share in financing the health sector. The big players – such as the GFATM, GAVI and the USG – all had one-year or project-based commitments. Predictability therefore has remained

limited. With the financial crisis hitting more and more (bilateral) countries and multilateral agencies, the predictability principle is not likely to improve in the next 2-3 years.

On the positive side, the resource mapping exercise, undertaken by FMOH in EFY 2004, showed considerable improvements in the completeness and timeliness of the reporting by DPs and by Implementing Partners (IPs). In 2011/12 the exercise documented 62 funding sources and 161 IPs / projects, representing in EFY 2004 a total of US$ 730.5 M in expenditure and in EFY 2005 almost US$ 800 M in commitments. The expenditure and commitment for the various health programs (all channels combined) is presented in fig 9.

Fig 9: EFY 2004 expenditure and EFY 2005 commitments by program



Source: FMOH Presentation at the JCF, 14th May 2012.

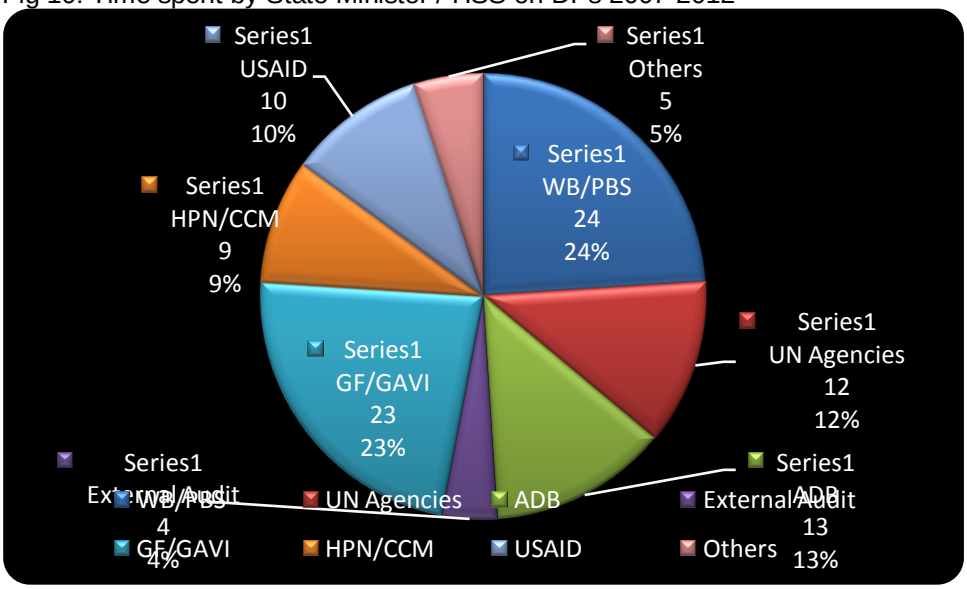
5.1.5. Transaction costs of the funding channels

"Transaction costs" are the administrative costs of having multiple planning, budgeting and reporting systems; the more aligned to government way of working the systems are, the more time managers can spend on implementation and monitoring of plans rather than on planning and coordination. Thanks to the introduction of the Balanced Score Card (BSC) in the FMOH in 2007, senior managers keep track of their weekly planning. In analysing these weekly plans from the two State Ministers, the team found the following (unique) information:

The State Minister, responsible for Health Systems Strengthening (HSS), registered a total period of 86 weeks since 2007 (corresponding with 3440 working hours). During that time, the State Minister spent a total of 496 hours (14.4%) of his time in meetings, discussing topics outside the regular procedures of the FMOH. Within these 496 hours, time spent on the various partners is shown in Graph 9 below:

The graph confirms the general theory: time spent by the State Minister on the FMOH preferred channels is not recorded in his time sheets, as issues that need attention will be part of his regular management meetings (that will discuss existing government procedures). However, channels 1B + 2B (both earmarked) and channel 3 require 14.4% of his time, as the plans and problems of these partners require special attention on a case by case basis.

Fig 10: Time spent by State Minister / HSS on DPs 2007-2012



Source: Time sheets 2007-2012 State Minister for HSS.

The State Minister responsible for Health Promotion and Disease Prevention registered in the period between Oct 2011 till June 2012 almost 20% of his time on meetings related to the GFATM, GHI and various other Development and Implementing Partners.

These figures show quite high transaction costs, especially when one takes into account that most of the technical issues should have already been discussed with the technical staff of the FMOH at the lower levels. Again, if a DP or an IP requests an audience with one of the State Ministers, money is involved (often implicitly) and he is not in a position to decline such a request and ask the agency to discuss the issue with his staff at lower levels of the FMOH.

Box 6. Interview with a senior manager of FMOH on use of time of FMOH staff

> In my observation, FMOH staff spends too much time ensuring IPs support to GOE priorities. Negotiating on government and IP priorities is something that takes time. This is confounded by differences in budget calendar. Once the priorities are agreed with IPs, frequent visit from their headquarters or regional offices and engaging them also takes another toll in terms of time. There are more than 80 USG partners that want such dialogue. If government wants to accelerate a program in one region, it is also necessary to engage two or three implementing partners in each region to ensure their alignment to the national priorities as there are may IPs working in different areas.

5.1.6. Use of Technical Assistance (TA).

Information obtained during the IHP+ review (January 2012) showed for EFY 2002 a substantial use of long-term TA by a limited number of DPs, the most important ones being (i) CDC with a total of 833 long-term TA (90%) and (ii) WHO with 62 TA (7%). The HPF II - managed by UNICEF on behalf of the FMOH - provided the sector mainly with TA. Although the FMOH has developed TA guidelines in 2009 to ensure that TA are operating under government priorities and are accountable to their counterparts, there is no evidence that the guideline is being used. There are

still challenges of coordination and accountability of TA to the FMOH. The recruitment of TA by IPs contributes to the limited capacity to retain experienced staff within the public sector. Although annual TA plan is expected to be developed and be part of the overall sector and MDG plans, this has not yet been translated into action. It may therefore be necessary to look at the technical assistance guideline developed in 2009 and revitalize its implementation.

5.2. Improvements in the performance of health systems

5.2.1. Planning and budgeting

Although (annual) planning and budgeting were undertaken since the start of the HSDP I (1997/98), the current top-down and bottom-up' planning process, bringing the 810 districts and the 11 Regions in the country into its planning and budgeting cycle was initiated at the end of HSDP II.

There is a strong suggestion now that the planning process has achieved to:

- Align federal, regional and woreda priorities, targets and strategies
- Help Woredas to have better evidence on their resource gaps and negotiate with WOFED offices.

The annual Joint Reviews Missions (JRMs) do report on improvements in the participation of Implementing Partners, NGOs and CSO in the planning sessions, thus providing the Regional Health Bureaus (RHB) and Woreda Health Offices (WoHO) with more information on budget and with some agreement on who will do what in the area.

Resource mapping is becoming more comprehensive and complete. However, improvements are still possible, especially at regional and Woreda levels. At national level, the same tendency is already visible: the IHP+ review (Jan 2012) reports that while in 2007/08 the 12 responding DPs had 44% of their funding reflected in the FMOH plan, in 2009/10 already 76% of the activities of the 19 respondents were reflected in its plan. Most of the remaining 24% of activities, which are off-plan, were funded by the US Government.

Together with the financial information provided in the Annual Performance Reviews (EFY 2001-2003), it is now possible to provide indicative figures on the contributions by the three funding channels. Similarly, the proportion of DPs participating in the annual woreda-based planning process almost doubled between 2007/08 and 2009/10, from only one quarter (25%) to almost half (47%). However, regions and Woredas are yet to carry out a resource mapping exercise at their levels.

In summary, the Woreda-based planning and budgeting process is performing satisfactory, but could be strengthened. With the introduction of the program based budgeting by MOFED, the process is expected to show improvements in effectiveness, efficiency and sustainability of the performance of the planning and budgeting system at woreda, regional and national levels in the coming years.

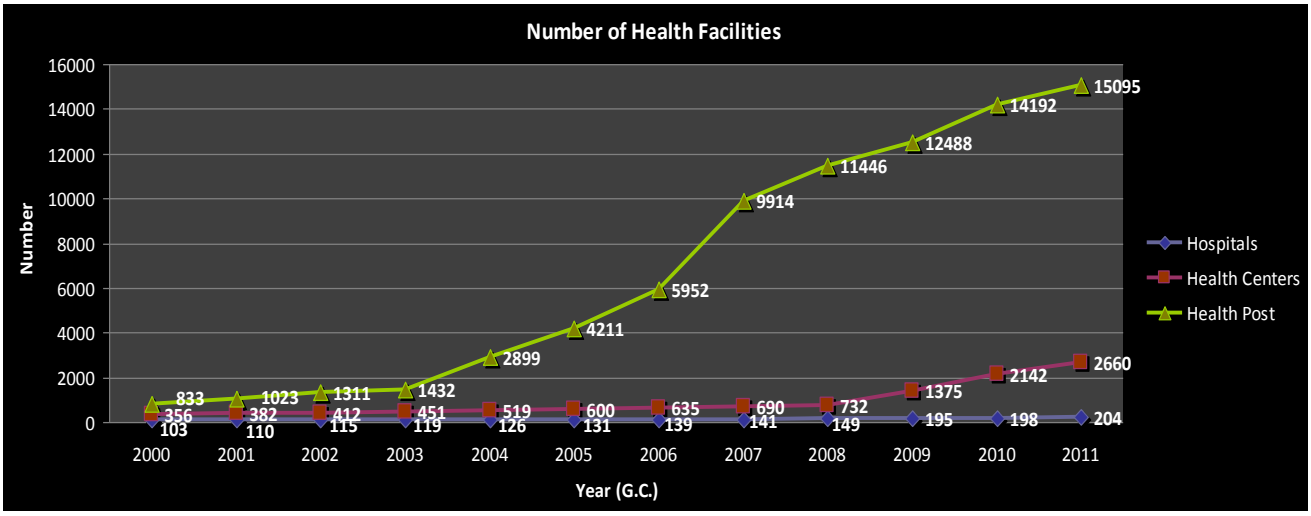
5.2.2. Infrastructure development

The policy decision by FMOH to increase its infrastructure up to the Kebele level was taken at the end of HSDP II (2002/03 – 2004/05)[10], but the actual expansion - mainly of Health Posts (HPs) - was realized during HSDP III, while the main expansion of Health Centers (HCs) started around 2007/08. Since 2005, the FMOH realized an impressive expansion of (mainly rural) infrastructure (Graph 10 below):

- Health Posts from 4,211 in 2005 to 15,095 in 2011, being an additional 10,884 HPs
- Health Centers from 600 in 2005 to 2,660 in 2011, being an additional 2,060 HCs (for 50% funded by GFATM and GAVI!)
- Hospitals from 131 in 2005 to 204 in 2011, being an additional 73 hospitals.

[10] FMOH, Nov 2004, Accelerated Expansion of PHC Coverage in Ethiopia, 2005-2009

Fig 11: Increase in number of hospitals, HCs and HPs, 2000-2011



Source: Health and Health Related Indicators (HHRI).

This accelerated expansion of health services was achieved through financing of GAVI and GFATM whose contribution was acting as a mechanism for providing incentives to regions to construct more health centers with the 'Matching Health Center concept[11]. As such the expansion of health posts were by and large funded by community contribution and woreda allocations. The construction of HCs was funded mainly by Channel 1A and GAVI and GFATM, although USG was also supporting a few HC constructions. The MDG/PF is currently funding a few health centers that were not completed to reach the national target.

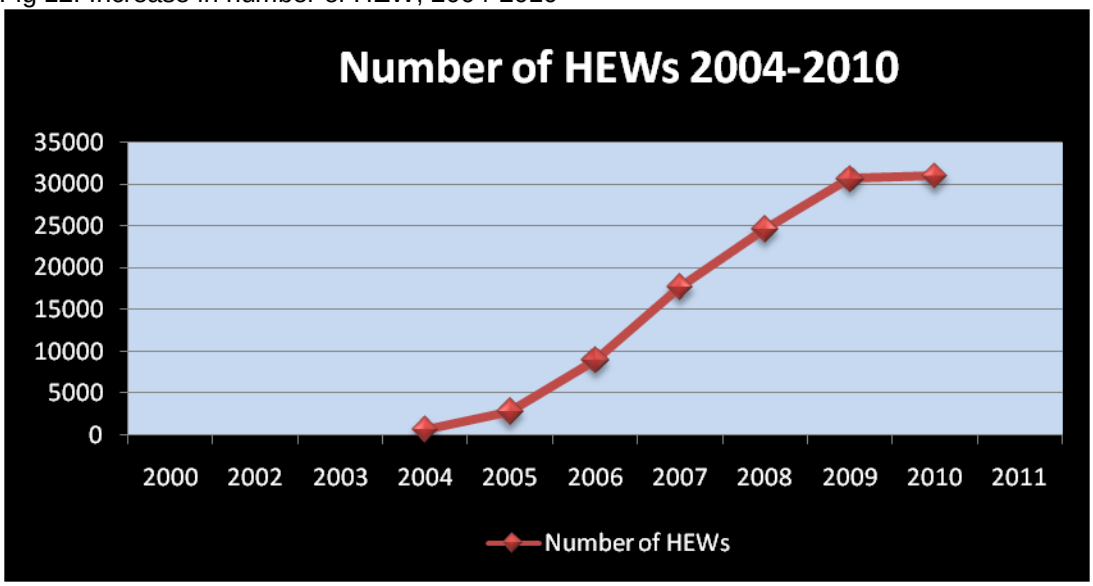
Two important observations need to be made in relation to the expansion of PHC units.
First, while the construction work went ahead fast, there are still many health centers that haven't started functioning and/or are not fully functioning for a number of reasons, including (i) delay in procurement and distribution of equipment, (this is the case of very isolated facilities); (ii) lack of water and electricity and (iii) absence of qualified staff. Therefore, the functionality of these Health Facilities (HFs) may not correspond with the figures shown in figure 11. However, it can be expected that once these bottlenecks are overcome in the future, the performance of the sector will improve even more.
Second, commitment and leadership by FMOH played a significant role in coming up with 'high volumes' and 'fast speed' implementation gear with joint and harmonized effort. In this regard year 2005 is of critical importance, as it was in this year that (i) HSDP III with its ambitious system wide goals and targets started, (ii) the Code of Conduct between FMOH and DPs was signed, (iii) the HSDP Harmonization Manual (HHM) was conceived and (iv) alignment and harmonization based on the Paris Declaration had started.

[11] The matching health center concept was an innovative strategy that helped the implementation of the accelerated PHC expansion. For every HC that a region and Woreda builds out of its block grants (PBS support), the FMOH mobilized external resources to build another health center as per the national standard and also equip the two health centers. The regions / Woredas were also responsible for furniture, allocating recurrent budget for the health center and recruiting, deploying and retaining health workers in both health centers.

5.2.3. Human Resources for Health (HRH)

This increase in access to health facilities require the development, deployment and retention of human resources for the rapidly expanding health services. This was done side by side with the construction of facilities. There was a huge expansion of training centers for HEWs, nurses and the introduction of an accelerated training of health officers. This was mainly financed through government allocation at regional levels-block grants and PBS support. It has resulted in a rapid production of health professionals. The health extension program managed to train about 38.000 Health Extension Workers[12] (HEW)s over a period of 6 years (fig 12).

Fig 12: Increase in number of HEW, 2004-2010



Source: Health and Health Related Indicators (HHRI).

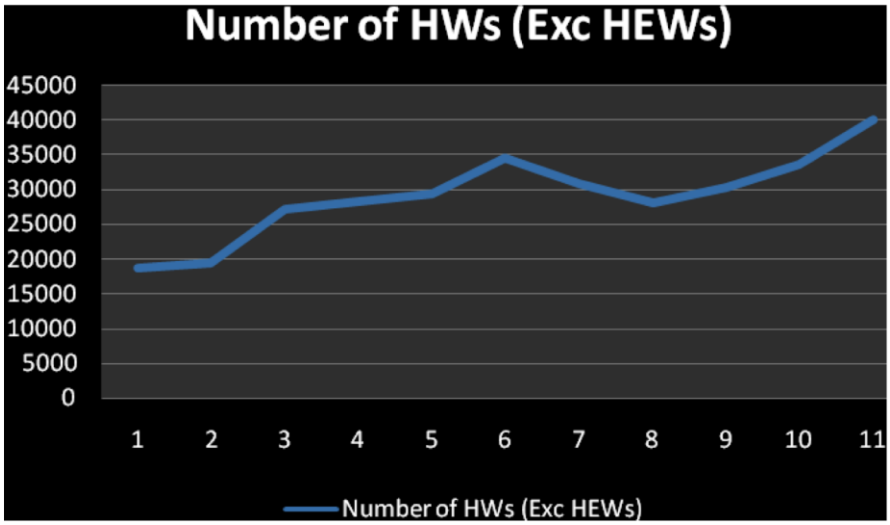
The HEWs are now part of the civil service workforce (with career opportunities), providing limited curative and mainly preventive services to a population of around 5000 people. Their interventions have resulted in improvements in health, such as increased immunization coverage, ANC visits and use of FP services. However, no improvements have been recorded in the MMR, hence the current drive of the FMOH towards the expansion of the Health Delivery Army (HDA), being influential women in the village that will link-up with the HEW to reduce – amongst others - the risks around child-birth and improve other health related activities (hygiene, water, sanitation etc.). Once again the main funding source for carrying out the HDA will come from the GOE.

There has also been increased training and deployment of the other health professionals in the health sector over the last five years. Next to the steep increase in the number of HEWs, the increased funding to the sector has also resulted in an increase in the number of Health Workers (physicians, nurses and midwives, fig 13). The graph shows a period – more or less between 2006-2009 – where the growth in the number of health workers remains below the growth in population. It is only after 2009 that the number of Health Workers per 10.000 population is rising again (mainly thanks to the massive training of nurses in almost all the regions going up from 17,100 in 2007 to 24,400 in 2010).

[12] There are in general two female Health Extension Workers (HEW) per Kebele (average 5000 people). They are paid by GOE funds (partly provided by the PBS phase 2, channel A funds),

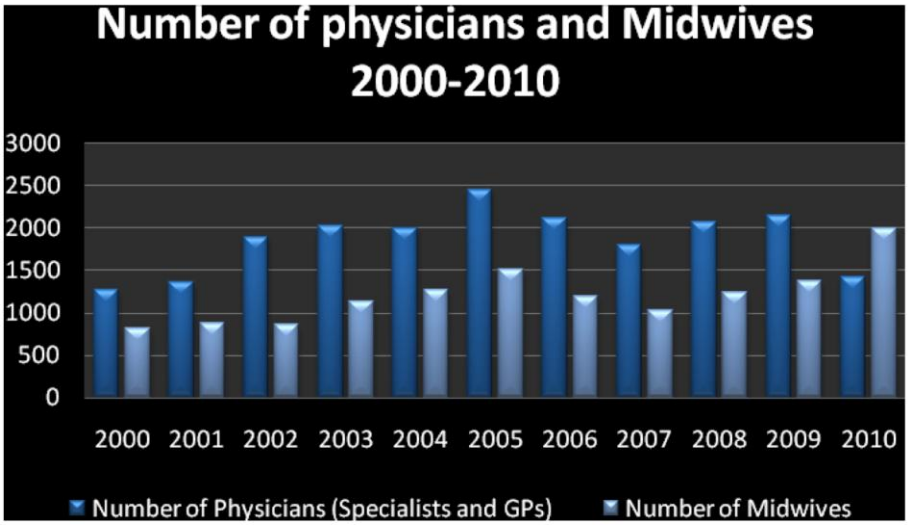
Looking specifically at the number of midwives, there is a clear sign of recognizing the importance of having more midwives to strengthen the national RH program. The figures (fig 14) show a doubling from 1000 midwives in 2007 to 2000 in 2010.
The same fig 14 also shows that the number of physicians goes down from some 1800 in 2007 to less than 1500 in 2010. The challenge here is related to retaining qualified and experienced health workers within the public health system by providing appropriate financial and non-financial incentives. The solution lies more in the overall government civil service pay policy and package than the health sector funding modalities.

Fig 13: Increase in number of Health Workers (excl HEWs), 2000-2010.



Source: Health and Health Related Indicators (HHRI).

Fig 14: Number of Midwives - Physicians 2000-2010



Source: Health and Health Related Indicators (HHRI).

Note: Ethiopia unlike other countries has a clear policy that the financing of the salaries of health workers should come from the government resources-block grants/ PBS support. Sector and project type funding has no role in such financing.

5.2.4. Procurement and distribution

Procurement has three dimensions when it comes to the health sector: (i) the actual procurement of commodities and financing those commodities; (ii) working through the country procurement system to strengthen it further; and (iii) strengthening the procurement and distribution system.

In terms of financing procurement of drugs and medical supplies, all the three channels are funding different types of commodities. This is the area where all three channels have significant contributions: While MDG/PF provided the government with the means to procure bulk purchases of equipment, drugs and supplies that are critical for health service delivery, the other channels also contributed to various necessary items of equipment and supplies.

Procurement is an essential part of the Aid Effectiveness agenda, but also one that is advancing very slowly, both in Ethiopia and internationally. While all procurement - with funding from channels 1A, 1B and 2A and 2B - is done by PFSA, those undertaken through channel 3 are carried out by donors or their implementing partners. In other words, some of the DPs have contributed to strengthening Ethiopia's procurement system. such as GFATM and GAVI that use government procurement systems. USG on the other hand does not use the government systems for its procurement. Some of the donors that use government systems (PFSA) also impose their own procedures. For example, funds provided by DPs for the procurement of equipment, medical supplies and services are managed by the WB (the Multi Donor Trust Fund / MDTF), through the Protection of Basic Services (PBS) fund[13], although carried out by PFSA using WB's procurement rules. Other procurement is done by UN Agencies, such as UNICEF (vehicles, vaccines), UNFPA (FP commodities) or UNOPS (vehicles) or by bilateral donors, the most important being USAID, PEPFAR and CDC (procurement of TA annually through a large number of Implementing Partners / IPs).

The third aspect is building the capacity of PFSA to procure and distribute health commodities. In this regard, PFSA is expanding its warehouses (17 now), including for the first time in the Developing Regional States, where it is building its information and transport system. Most of these resources come from project type of funding (GAVI, GFTAM and USG).

We can therefore conclude that procurement and supply management systems are an area where synergy among the various funding channels is observed. Preferred channels and earmarked project support provided funding for procurement of commodities, while channel 3 funding is used to strengthen the system.

5.2.5. Monitoring and Evaluation (M&E)

Reporting on externally funded projects and monitoring / evaluating its performance is a time consuming, but very important activity, undertaken by many staff at various levels of the health sector. It is important, as the possibility of future new (or additional) funding often depends on it. Donor funded programs (channel 3) have their own objectives, often partly determined by technical people in headquarters. They need to measure the performance of their specific interventions and in order to do so suggest additional indicators (often outside the result

[13] In the first Phase of PBS (PBS 1), the component paying for health commodities was called "Component 2 on the Health MDG Performance Facility". In phase 2 of PBS (PBS 2), it was re-named "Subprogram B on Health MDGs Support Facility".

framework with 108 indicators of the HSDP IV). Local country officers are in no position to argue against these well-intended suggestions. In this way 'vertical reporting', each with its specific indicators becomes part of the enormous transaction costs that burden health staff at all levels of services.

While the IHP+ review documented some successes, such as the % of DPs requiring separate reports declining from 75% in 2007/08 to 58% in 2009/10, this just seems the tip of the iceberg. The resource mapping exercise reports 55 agencies providing large (USG) or small (various foundations) amounts of money that require not only reports on performance but also on financial statements. In addition, within some of the large agencies, such as USAID and CDC, there are around 74 "Implementing Partners" that receive money from the USG on the basis of well developed proposals. All these require reports to show they are doing their work properly!

It is impossible to quantify with some accuracy the transaction costs of all these reporting requirements, but it seems no exaggeration to estimate them as 'huge', perhaps up to 15-20% of the total program costs, or even more if the costs for the overhead and the hiring of various external technical assistants are included. In the PBS-Business case, DFID calculated the overhead of the PBS MDTF as being 2%, while UN charges 7% for its services and bilateral projects are estimated to have a 25-35% overhead. Clearly, the MDG/PF has the lowest overhead. Unfortunately, such 'rough estimates' are not really convincing, but as long as no detailed figures are provided, it is impossible – within the limits of this assignment - to provide more accurate estimates. Differences in time periods and fiscal years, reporting errors, sub-contracting and a certain reluctance to open up the books, all these together make an assessment of costs for TA and overhead costs not (yet) realistically possible.

In terms of strengthening the M&E system, most preferred modalities use government M&E systems (indicators, forms, reporting time, lines and channels of reporting) while off- budget funding agencies sometimes use additional or vertical systems that undermine the system. But in terms of investment to strengthen the health information system and financing the various JRMs and ARMs USG funding is more important than other sources. It has financed most of the scaling up of the HMIS, although government preferred modalities chip in through procurement of equipment and supplies.

5.3. Improvements in service provision 2000-2011

This section will use figures over a 10-11 year period, coming from either DHS (2000, 2005 and 2011) or HMIS sources. The HMIS related figures have been compiled from Health and Health related indicators, produced annually by the FMOH. Where relevant, correlations will be calculated between some of the variables to find out existence of a significant relation between variables. It should be noted that the existence of strong correlation does not imply existence of **causal relations**, but rather indicates that the two variables are related in one way or another, depending on the level of significance[14] the relation has.

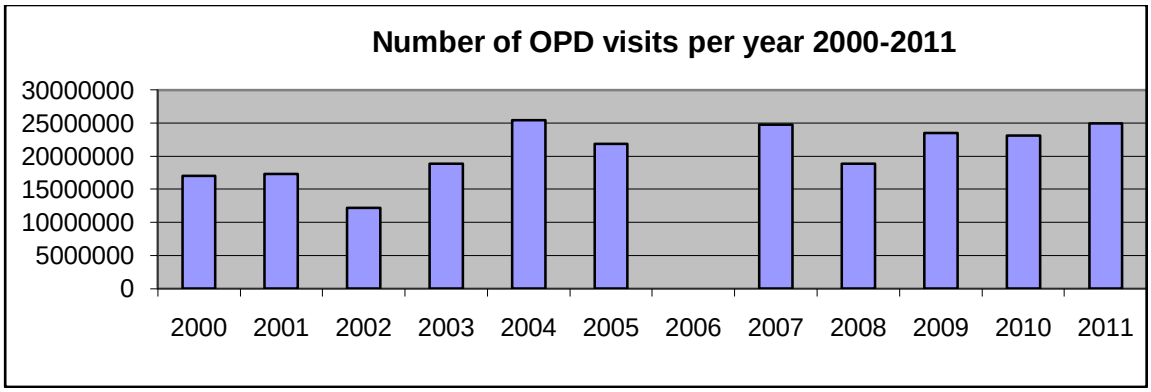
5.3.1. Utilization of health services 2000-2011

When analyzing utilization of services (New Consultations per year / NC/yr) over these 10 years, the number of NC goes up from around 17 M in 2000 to 25 M in 2011. However, when taking the increase in population into account, the number of NC/yr only increases modestly from 26.8% in 2000 to 30.5% in 2011, oscillating around this figure during the last five years (since 2005). There seems limited increase in service utilization, especially when looking at the last five years.

[14] Calculations have been done using the Pearson Correlation Coefficient (SPSS) on the basis that the 0-hypothesis (no correlation) is rejected at the 10% level.

The figures remain behind expectations if compared with the substantial increase in health infrastructure (fig 11). Indeed, when calculating the correlation (value r) between the number of HCs and the number of NC per year, the relation is weak (r = 0.51). This means that the increase in HCs has a 'weak relation' with the utilization of these facilities. While interesting to reflect on the reasons for this (disappointing) finding (possibly, low quality of care, distance, costs, inadequate drugs, limited staff, many HCs not yet functional, no water, regional variation), such an analysis is outside the scope of this assignment. We will just conclude that the increase in infrastructure has had limited effect on the use of health facilities at the national level.

Fig 15: Utilization of HF: number of NC / year (x millions).



Source: Health and Health Related Indicators (HHRI).

5.3.2. Improvements in reproductive and maternal health

The MMR has not shown any improvement since 2005, most likely because the effects of the various policy decisions and interventions on the ground, such as increase in health coverage (construction of HPs and HCs), increase in Human Resources (Health Workers) and improvements in procurement (drug supply, equipment) have not reached a stage where they will have a visible effect on MMR. Reducing MMR requires more health system efforts (reducing of the demand and supply system barriers) than any other intervention. Other MMR related activities still need to put in place before a real reduction in MMR is likely to happen, such as changes in cultural practices, removal of financial barriers to mothers, expansion HDA, additional training HEW in safe deliveries, increase in the number of midwives, referral chain/transport and functional EmONC nationwide. It is clear from these many systems related interventions that improving maternal health (MMR) needs a lot of money and a lot of time to become visible.

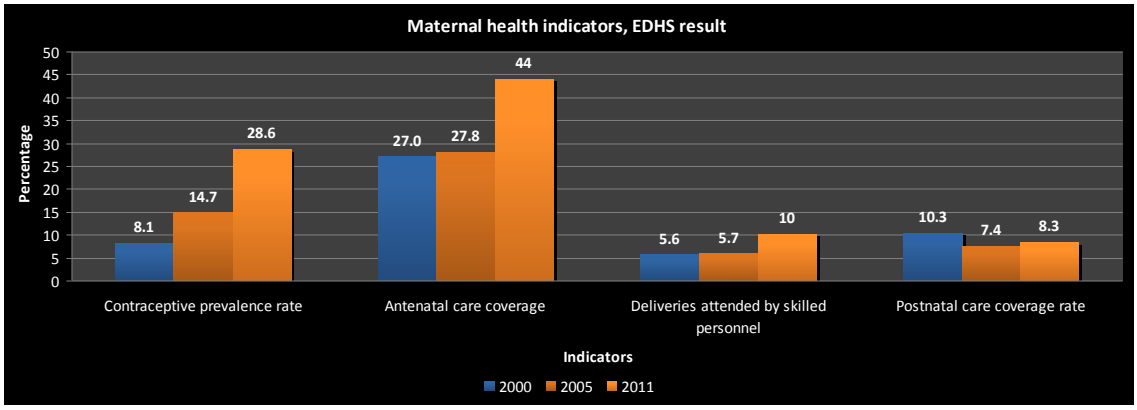
One of the underlying reasons for lack of or inadequate progress has been the under financing of maternal health services not only compared to other countries but also compared to other services. According to NHA 2010, total RH expenditure in 2008/09 was US$ 150M (being 13% of total spending in health), corresponding to a per capita spending per woman of reproductive age of about US$ 8. Funds for RH were spent mostly on outpatient care (46%), FP / counseling programs (17%), capital formation (11%) and maternal health programs (8%). It is only since the establishment of the MDG/PF that meaningful investment is made directed at improving maternal health. An example where the MDG/PF has showed its value is the fact that channel 3 funding was insufficient to reduce either the demand or the supply side barriers. It was only after the MDG/PF started to support maternal health (ambulances, referral chain, training of Health Officers, expansion of HEP) that improvements are becoming visible.

On the other hand, it is not all gloomy. Intermediate SRH health results, such as Contraceptive Prevalence Rate (CPR), ANC and supervised deliveries do show improvements (fig 16). Special mention should be made to the impressive increase in the CPR, going hand in hand with the

reduction in Total Fertility Rate (TFR, from 5.5 in 2000 to 4.8 in 2010). These direct results, attributed to MDG/PF also have a much wider effect on health improvements and mortality reduction, as evidenced from various examples in this document.

Together the figures show a steady increase in the recorded outputs, with an additional surge - after 2005 - in the CPR, ANC coverage and attended deliveries. Only postnatal care remained stagnant over these years. This progress is credited to the increased presence of the HEWs in HP close to the community – the dramatic scale up of which has been due to the flexible funding being available to the FMOH through the block grants and PBS.

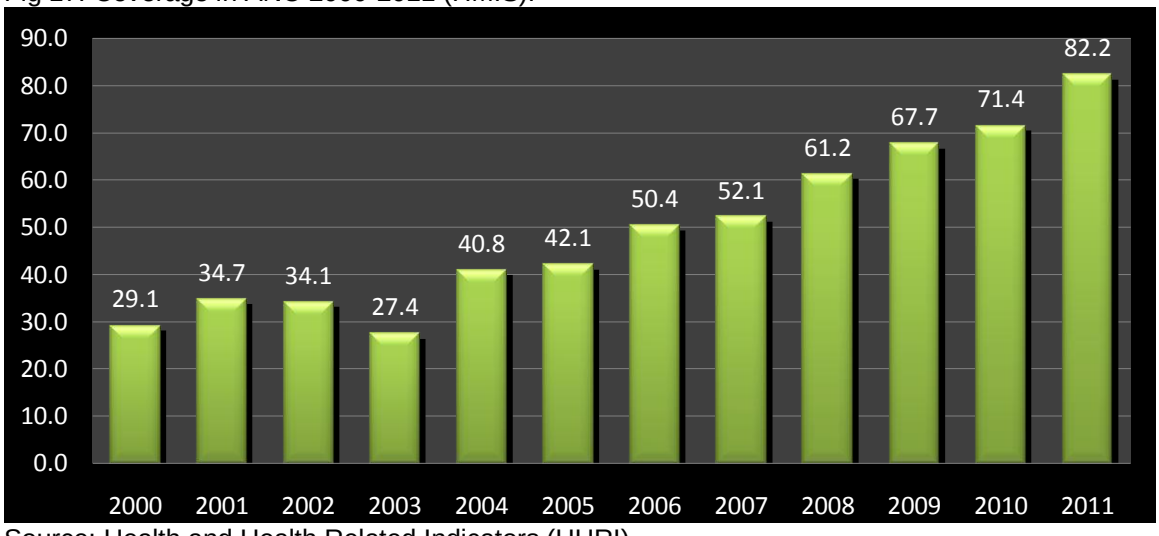
Fig 16: Maternal health indicators 2000-2010 (DHS)



Source: DHS 2000, 2005, 2010.

When calculating the correlation between the increase in the number of HCs and the ANC figures over time, there is a high correlation (r = 0.89, significant at the 0.01 level), indicating that the improved attendance in ANC might be e directly caused to the increase in HCs. While this does not mean that there is a 'causal relation' between the two variables, it does show a 'high degree of likelihood' that they are related.

Fig 17: Coverage in ANC 2000-2011 (HMIS).



Source: Health and Health Related Indicators (HHRI).

5.3.3. Improvements in child health (output indicators)

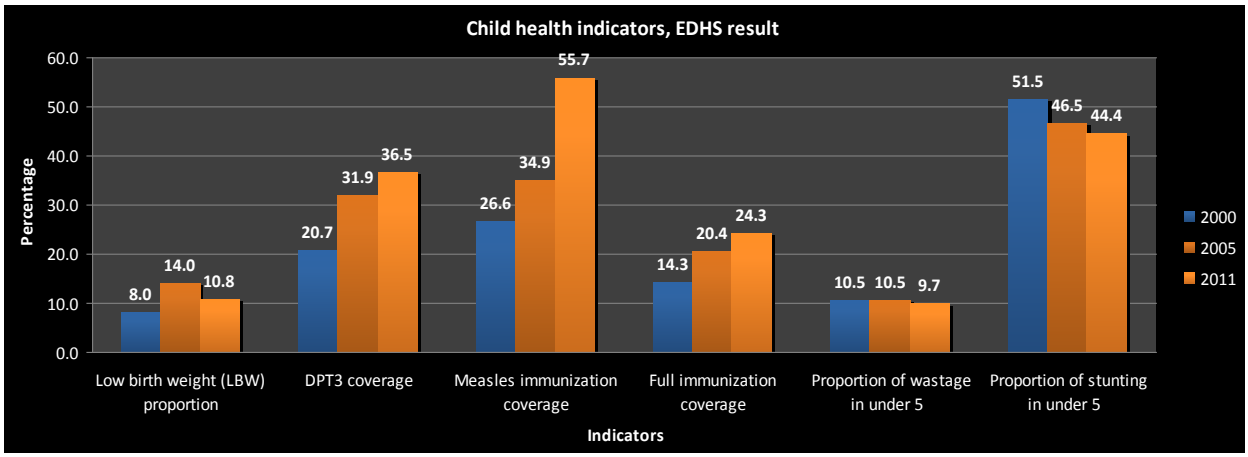
The child health indicators (DTP3, measles and full immunization coverage) all show substantial improvements over the last 10 years (fig 18). Among the nutrition indicators, stunting (Ht/Age)

has much improved (from 51.5% in 2000 to 44.4% in 2010), but Low Birth Weight and wasting (Wt/Age), indicating acute malnutrition has remained more or less constant over these 10 years.

The DHS figures show a gradual and steadily increase in the coverage of the various antigens in these 10 years. For example, measles coverage increased from around 26.6% in 2000 to 34.9 in 2005 up to 55.7% in 2010.

In terms of funding, child health is being funded by all the three channels. UNICEF financed nutrition (CBN, CMAM and ICCM for instance) and child health services through Channel 1 B and channel 3. USG is investing in both child health and nutrition programs. MDG/PF has started supporting and completing these streams of funding through additional allocation to these services. It is because of the availability of HEWs and the expansion of the health facilities - funded through GOE/PBS support - that the investments in other channels are being realized. Once more, the significant funds that are being channeled through Government have become the engine that drives the improvements in the sector and complement and support the performance of the other funding channels.

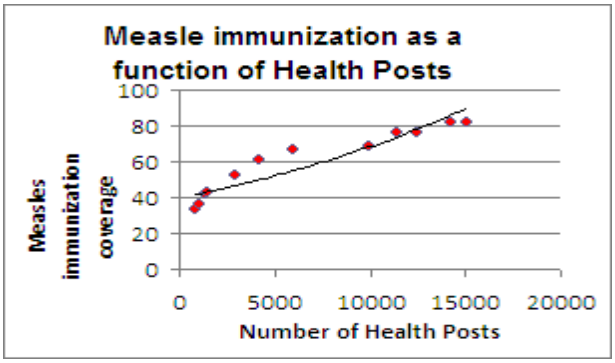
Fig 18: Child health indicators, 2000-2010 (DHS)

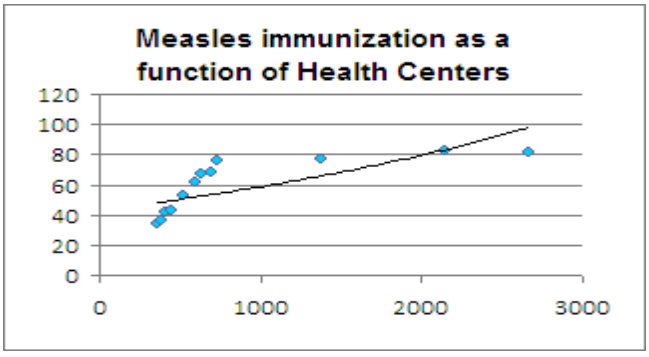


Source: DHS 2000, 2005, 2010.

When comparing the correlation between measles immunization on one side and expansion of HPs versus HCs at the other side, the calculation indicates that the increase in HPs has contributed more to this result (r = 0.91, significant at the 0.01 level) than the increased number of HCs (r = 0.76, but still significant at the 0.01 level). This is understandable as most of the house-to-house and outreach services for child health are carried out from the health posts. The difference is made visible in the fig 19.

Fig 19: Correlations between measles and number of HP and HCs



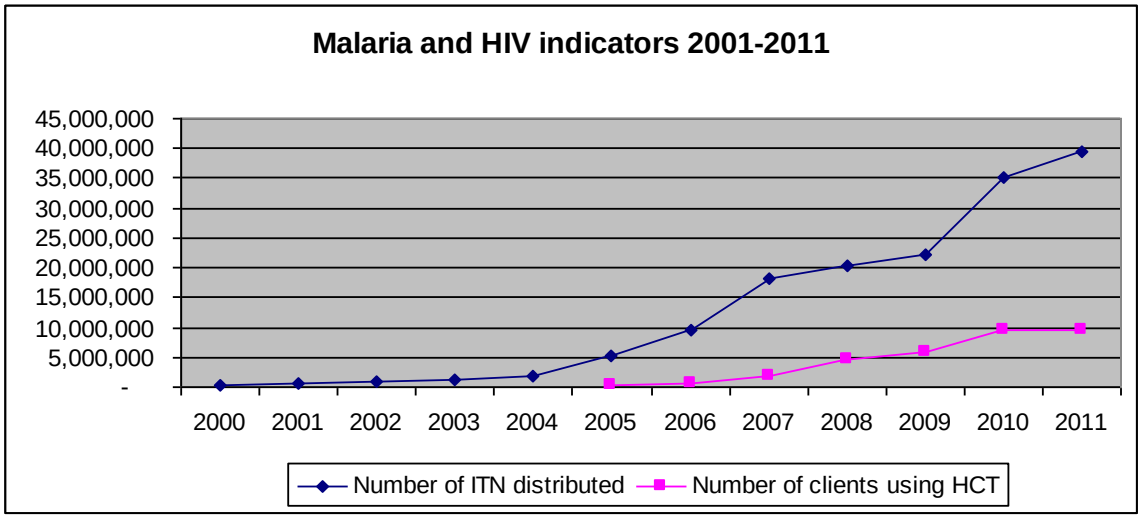


Source: Internal calculations based on HMIS figures, 2000-2011

5.3.4. Improvements in disease control indicators

Some of the most important DPs have prioritized their funding to HIV/AIDS, TB and Malaria, while also allocating part of their funding to more general health systems strengthening support. Two outputs related to these contributions are provided in fig 20 below. As morbidity attributed to Malaria (cases/1000) varies substantially over time, we have used relevant outputs figures. Once more one can observe an increase in the number of ITN distributed and the number of clients using HCT services that runs parallel to the increases in health facilities and staffing.

Fig 20: Malaria and HIV Indicators 2001-2011



Source: Health and Health Related Indicators (HHRI).

Other relevant improvements in the area of Disease Control worth mentioning are:

- The number of PLWHA currently on ART increased from 3,880 in 2005 to 247,800 in 2011
- The HIV single point prevalence has remained constant between 2004 and 2010 and varies between 2.2 and 2.4 during that period
- The HIV prevalence based on DHS figures proved substantially lower, being 1.4% in 2005 and 1.5% in 2011 (constant)
- The TB Success Rate has been constant between 2000 -2011, as it varied between 80-83.

6. Overall conclusions

6.1. Linkages between trends in funding, systems and service delivery

The methodology used for the analysis for this study does not allow us to establish the contributions of each of the three funding channels to the improvements in the systems and/or the performance of service delivery. Such analysis requires extensive data set and quantitative methodology. However, the following general observations can be made:

1. The commitment and leadership by FMOH played a significant role in coming up with 'high volumes', and 'fast speed' implementation gear with joint and harmonized effort. In this regard year 2005 is of critical importance as it was in this year that (i) HSDP III with its ambitious system wide goals and targets started, (ii) the Code of Conduct between FMOH and DPs signed, (iii) the HSDP Harmonization Manual (HHM) conceived and (iv) alignment and harmonization based on the Paris Declaration started.

2. All three funding channels did fund to a different degree the various service delivery and system improvement results recorded in Ethiopia. Without the combined effort of these three financing modalities, the Ethiopian health sector could not have achieved the results described in Chapter 5. This study shows that the main driver of these improvements in health has been the government preferred channels, as these supported the other channels to become more effective. An example is the little progress in improvements in maternal health, where funding was provided for a long time only by channel 2 and 3.

3. There was a symbiotic relationship between some of the funding channels. GOE resources (MOFED/PBS) provided the leverage to start these innovative programs, later further supported by funds from the other channels (GAVI, GF). This enabled a transformative scale up of the health infrastructure and health staff that is unprecedented elsewhere in Africa. Channel two earmarked funds also acted a stimulus to further increasing regional and woreda resource allocation through the matching health centre concept. Project specific funding (GAVI and GFATM) helped to strengthen the areas where the government preferred modalities are also prioritizing. Channel three funding strengthened some core systems, which other funding modalities haven't cant finance. This include, specific disease based services, health financing, supply management systems.

4. The establishment of the MDG/PF in 2009 (when the JFA signed) created a funding channel that allowed the FMOH to support swiftly and flexibly these major systems related priorities. Government preferred channels (MOFED/PBS and MDG/PF) provided the 'Catalytic / transformative' investment that made the health sector move forward. It has been the flexibility and swiftness with which the available resources could be used by the FMOH that has been partly responsible for its effective and efficient use. From an effectiveness / efficiency point of view, the GOE / FMOH preferred channels will give those DP interested to support the Ethiopian health sector, the best Value for Money

5. The findings from chapter 4 and 5 show that investing through the government preferred modalities do have higher internal rate of return and cost benefit ratio. Some anecdotal evidences also showed that it is cheaper to invest through this system. Together with the above matrix we can infer that government preferred modalities are likely to be the major sources of gains to be made. The MDG/PF has been an essential funding tool by showing leadership to all DPs, which priorities and gaps need to be addressed. It has become the catalyst required to make the system move forward fast and in the right direction.

6. Another advantage in using the government preferred modality is that it ensures sustainability. Project based support is likely to discontinue when the project comes to a close. The investments made through MDG/PF and PBS will be sustainable, as all the systems being built can be taken over and expanded further by government resources.

7. Chapter five documented how far each of the funding channels contributed to the various results realized in the Ethiopian health sector over the past decade. This can be summarized by a matrix of funding channels with the various service delivery and system strengthening programs. From this matrix (table 6 and 7 below), it can be seen that the GOE preferred channels were instrumental in pushing all the systems and service delivery areas while the other funding channels do have different levels of contribution to the various programs ranging from significant to none.

Table 6. Comparing inputs (funds / channels) with outputs / results, 2007/08-2010/11

	INPUTS		**OUTPUTS / OUTCOMES**	
	FUNDING (in US$ X M)		**SYSTEMS**	**SERVICES**
	2007/08	**2010/11**	**2005-2011**	**2005-2011**
1. FMOH Preferred Channels (Channels 1A+2A)	140,3M	350,9M	All systems have benefitted from the increased funding over these years. The 'preferred channels' have been used as the 'seed money' to initiate the reforms, such as the HEP and the infrastructure expansion.	The main beneficiaries of MDG/PF have been child health and FP-related activities through massive training of HEW. Improvements in maternal health have not yet been documented in the DHS, but are likely to be forthcoming in the coming years when the Health Development Army, the referral system and EmONC have been put in place. While the occurrence of Malaria has been reduced over the last years through the massive distribution of Impregnated Bed Nets and introduction of Coartem, reductions in the prevalence of HIV and TB have not (yet) been documented. The improvements in the nutritional status of children, notably the reduction in stunted children from 58% in 2000 to 44% in 2011, are likely to have benefitted from the advances in service delivery. However, it is not possible to show a direct link with the increased resources made available to the sector.
2. Earmarked Channels FMOH (Channels 1B+2B)	267,3M	276,8M	Earmarked channels and block grants have to a large extent contributed to training / HRH, building infrastructure, drug procurement / commodities.	These funds contributed to training HEWs and expansion of health facilities. It has put in place a complete new layer of services at the most peripheral level (Kebele). This will allow for a substantial improvement of geographical and financial (health insurance) access to care and a reliable referral system, benefitting all programs and services.
3. Outside GOE oversight (Channel 3)	160,5M	311,8M	System strengthening through channel 3 is difficult to show. It has supported health care financing and commodity supply systems. Interventions have supported national priorities and improvements in disease control.	With substantial resources for many communicable diseases (Diarrhea, Pneumonia, HIV, TB Malaria, Malnutrition), channel 3 has definitely contributed to improved health. However, it is difficult to demonstrate a clear link between the inputs and these results.
TOTAL ALL CHANNELS	568,1M	939,7M	The impressive results in the DHS impact indicators can be explained by the almost doubling of the resources available to FMOH in a period of 4 years.	

Table 7: The degree of contribution of channels to results achieved health systems

Health systems	Channel 1 A and 2A	Channels 1B and 2B	Channel 3	Comments
Expansion of PHC facilities (HP and HCs)	Regions from Block grants	GFTAM and GAVI	Only few planned through USG support	
Investment in Equipment	MDG PF	PBS -C2		
Human resource development	MOE and health science colleges		Support to specific trainings health officers	
Human resource deployment and retention	Block grants (PBS)	HPF	Technical assistance	Often channel 3 funding contributes to brain drain within the country
Quality of care	MDG PF			
Planning and budgeting	Leadership			
Procurement and supply management systems	HR, leadership, Funding from MDG PF	investment by GFTAM and GAVI; also working through the system	Huge USG investment	
Health Financing	MDG PF/subsidy for CBHI		USG support form more than 12 years	
Monitoring and Evaluation	Leadership and HR		USG	
Maternal health				
Child health				
major Disease programs (HIV/AIDS, TB and Malaria	facilities, HR	GFTAM	USG	

Key on the degree of contribution to results

	Very High level of contribution to results
	Considerable contribution to results
	Marginal contribution
	No contribution visible

6.2. Governance of Aid Architecture: are there new venues to explore?

Moving our focus from what has been realized (looking backward) to what needs to be done in the future in order to further consolidate and improve Aid Effectiveness in Ethiopia, the horizon should be widened over a longer time frame and certainly beyond the end of the MDG era.
From experiences in other African countries, there are two suggestions that merit reflection:

1. Mutual accountability: The African Platform for Development Effectiveness (APDev, Box 7) proposed the adoption of a 'mutual accountability assessment framework'. This is a complex undertaking, not in the least due to the absence of a clear definition of what 'mutual accountability' is supposed to mean (Box 5).

Box 7. Definition of mutual accountability

Mutual accountability is a difficult concept with inconsistent interpretation.
In its strictest sense, mutual accountability relates to specific mechanisms established to facilitate accountability of both governments and donors to each other.
A broader (and vaguer) interpretation is the acknowledgement of mutual responsibility for global health and the

engagement of donors with governments in initiatives to promote the Paris principles of more effective aid.

Source: OECD, November 2011. Synthesis report from the OECD Network on Development Evaluation.

Whereas Ethiopia is said to have an accountability framework in place, its performance could benefit from some strengthening measures. For example there has not yet been defined a common and agreed Performance Assessment Framework (PAF), as has been done by all stakeholders in Mozambique and Rwanda. In Rwanda, under the leadership of the Ministry of Finance, the Government of Rwanda (GOR) and the participating donors hold each other to account two times in a year, on the basis of an agreed set of indicators, emanating from the Rwandan National Strategic Plan (specifying baselines and annual targets both for the GOR and the relevant DPs[15]).

This study suggests both GOE and DPs to consider the development of an Ethiopian – DPs accountability framework, adapting it from the experiences in other countries that have already embarked on such a mutual accountability framework.

2. Emphasis on pro-poor: While Ethiopia has adopted a clear pro-poor policy and has been implementing it through several important initiatives (exemption policy, CBHI, SHI), a glance through the most recent DHS shows substantial differences when comparing indicators for the two highest and the two lowest quintiles. Collecting such figures implies to use them for better targeting those that most need these services.

[15] Within this overall framework, health has been given only a few indicators to report on: children fully immunized, % under five using LLITN, % assisted deliveries, utilization of PHC facilities.

Annexes

Annex 1.
TOR for the development of advocacy paper on aid effectiveness in Ethiopia's health sector

Introduction
Ethiopia is accepting financial and technical support from international partners to help it achieve its Growth and Transformation Plan and the health MDGs. In 2009/10 it was estimated that over 20 partners provided a total of ETB 14.3 billion to the health sector, 70% of which came from the GFATM and the US Government alone. Whilst the Ethiopian government highly values the contributions of partners it also recognizes that aid must be provided and utilized in a way that delivers the maximum benefit for the people of Ethiopia.

Ethiopia is at the forefront of improving aid effectiveness in the health sector. Since 1997 the Federal Ministry of Health (FMOH) has developed Health Sector Development Plans (HSDP) to set out the strategic priorities and to guide stakeholders in the sector. Other key documents produced to guide the sector include the 2005 Code of Conduct, the 2007 Harmonization Manual, the 2008 Ethiopia's International Health Partnership compact and the 2009 Joint Financing Arrangement that was renewed in 2011. Eleven partners have signed the Ethiopian IHP compact although the framework applies to all partners working in the sector.

Substantial progress has been achieved in the health sector with the preliminary results from the 2011 Demographic Health Survey reporting decreases in child morbidity and mortality and increases in the contraceptive prevalence rate and service coverage. This is felt partly due to the way partners have aligned and harmonized with the HSDP and government mechanisms. However a review in November 2011[16] found that only 47% of partners offer one to two year commitments; and that whilst 76% of partner's activities were reflected in government plans only 39% of support was on budget. This is a significant shortfall of the 90% target. Of this only 14% of funds were provided through the government preferred modalities (MDG Performance Fund (MDG PF), Health Pooled Fund (HPF) and Protection of Basic Services component (PBS)). Whilst the number of partners requiring separate reports has declined from 75% in 2007/08 to 58% in 2009/10 still one in three partners requires indicators outside of the HSDP.

The review recommended that an advocacy paper be developed for use by the FMOH with partners in a domestic and international setting. This paper would outline the added benefits and efficiencies of working in a harmonized way and promote the 'one plan, one budget and one report' approach.

Objective
To develop an advocacy paper that can be used by the Federal Ministry of Health (FMOH) with partners to communicate what aid effectiveness looks like from the Ethiopian perspective and the difference that it makes to management of the sector as a whole. The paper will outline the health results and efficiencies that can be achieved through adopting the 'one plan, one budget and one report' approach.

[16] 'Roadmap for revitalising One Plan, One Budget and One Report in Ethiopia, consultancy to take forward the International health Partnership' by Catriona Waddington, Abebe Alebachew and Jarl Chabot, November 2011.

Recipient

The recipient of this consultancy is the Director General of Planning and Policy in the Federal Ministry of Health.

Scope of work

The consultants will be required to develop a paper that can be used for advocacy and awareness raising at international meetings and with development partners' headquarters. The paper will describe:

- what aid effectiveness looks like in the health sector from the Ethiopian perspective;
- the international commitments that Ethiopia and partners have agreed to (i.e. Paris Declaration on Aid Effectiveness, the International Health Partnership) and data showing partners' shortcomings in adhering to these principles;
- the key documents that provide a framework for aid effectiveness in the health sector (i.e. HSDP IV, Health Harmonization Manual, MDG Performance Fund Joint Financing Arrangement etc.);
- the mechanisms and structures that enable joint planning, budgeting and monitoring (i.e. woreda based comprehensive planning, Joint Review Mission, Annual Review Meeting , Joint Consultative Forum etc.);
- the strengths and weakness of some aspects of the health system and how by working together they can be improved;
- the existing mechanisms in the sector, MDG PF and PBS for ensuring accountability and transparency; and
- the added benefits, in terms of health results, savings and efficiencies, that occur when development partners adopt the 'one plan, one budget and one report' approach.

It is envisaged that a team of two consultants will undertake this assignment: a **Results Consultant** to document the results achieved with aid received through the government's preferred mechanisms (MDG PF and PBS) and an **Advocacy Consultant** to persuade donors to channel more funds through these instruments. The different consultants will be expected to undertake the following:

1. Results consultant:

1.1 Identify what the benefits are of partners aligning to the HSDP in terms of health outcomes, reduced transaction costs to government, reduced duplication and meeting the strategic needs of the health sector;

1.2 Identify examples of how partner's funding through the MDG PF, HPF and the PBS has worked together to help fill the financing gaps in the health sector and meet essential and strategic needs of the HSDP;

1.3 Identify examples of where quantifiable efficiencies and value for money has been achieved by partners channeling resources through the MDG PF, HPF and PBS rather than through separate disease specific grants (i.e. strengthening health systems and achieving economies of scale through central large scale procurement) ; and

1.4 Identify how partners channeling funds through the MDG PF and PBS rather than through separate channels have improved equity and sustainability.

Deliverable: A report documenting the results listed above written in plain English and fully referenced. The consultant is encouraged to develop visual representations, such as graphs or interactive electronic presentations that will help communicate the

results that have been identified. Any methodologies used to calculate the results claimed from the different aid mechanisms should be explained fully in an annex. The report will be a maximum of 20 pages not including annexes.

2. Advocacy Consultant

2.1 Through consultation with the FMOH and partners define the audiences for the advocacy paper and agree on the format it will take. [To note depending on the number and variety of audiences the advocacy paper may be required to be produced in a number of different formats, i.e. for the regional, central level and international level. This will be determined at the beginning of the consultancy in consultation with the FMOH];

2.2 Develop and finalize advocacy paper(s) and presentation(s) in the agreed formats;

2.3 Identify opportunities for advocacy and influencing. Develop a costed dissemination plan for the FMOH with a timeframe; and

2.4 Define indicators and targets to monitor the implementation and effectiveness of the advocacy paper.

Deliverable: Finalized advocacy paper(s) and presentation(s) communicating the results achieved from aid received through the government's preferred mechanisms and promoting the advantages of adopting aid effective approaches. Finalized costed dissemination plan with indicators to measure its effect.

Outputs

The outputs of this consultancy are:

1. A report documenting the results and efficiencies achieved with aid channeled through the MDG PF, HPF and PBS.
2. A finalized advocacy paper approved by the FMOH that outlines the added benefits of partners adopting the 'one plan, one budget and one report 'approach.
3. A costed dissemination plan with a timeframe for its implementation, which includes indicators for monitoring its effectiveness.

Methodology

The consultants will need to use a variety of methodologies to complete their assignment including reviewing key documents and key informant interviews with government and development partners.

It is envisaged that two consultants will be required: one with expertise on calculating and communicating results and one with a high level of writing and advocacy skills. An in-depth knowledge of aid effectiveness and the Ethiopian health sector will be important.

Reporting

The consultants will report to the Technical Working Group (TWG) under the Joint Core Co-ordinating Committee which is chaired by the Director General of the Planning and Policy Department in the FMOH.

Timeframe

The consultancy is expected to take no longer than three weeks and be completed by 1st August 2012.

Annex 2.
Documents consulted / References

Author / Year	Title
Central Statistical Agency, Addis Ababa, March 2012	Ethiopia, Demographic and Health Survey 2011 (DHS)
WHO, UNICEF, UNFPA and WB estimates, WHO 2012	Trends in Maternal Mortality: 1990 – 2010.
FMOH, 2007 (first edition)	The HSDP Harmonisation Manual (HHM, 2005)
FMOH, Nov 2007	Scaling up for better health in Ethiopia, IHP+. Roadmap for harmonisation and alignment of government and partner programs and financing towards attaining the health related MDGs
FMOH, August 2008	Compact between FMOH and DPs on scaling up for reaching the health MDGs through the HSDP
FMOH, March 2009	Joint Financing Arrangement (JFA) between the Federal democratic Republic of Ethiopia and DPs on support to the MDG/PF
FMOH, January 2012 (revised)	Joint Financing Arrangement (JFA) between the Federal democratic Republic of Ethiopia and DPs on support to the MDG/PF
FMOH, Sept 2008	Appraisal of the MDG/PF, Programming Component
FMOH, Sept 2008	Appraisal of the MDG/PF Procurement Assessment
FMOH, October 2011	An assessment of the Financial Management, Procurement and Supply Chain Management of the MDG Fund (final draft)
FMOH, Sept 2005	HSDP III, Health Sector Development Program 2005/06 – 2009/10
FMOH, 2010	HSDP IV, Health Sector Development Program 2010/11 – 2014/15
FMOH, Oct 2009	HSDP III. Annual Performance Report, EFY 2001 (2008/09) (version 2)
FMOH, 2010	HSDP III, Annual Performance Report, EFY 2002 (2009/10) (version 1)
FMOH, 2011	HSDP IV, Annual Performance Report, EFY 2003 (2010/11) (version 1)
FMOH, May 2010	Ethiopia's fourth National Health Account (NHA), 2007/2008 (EFY 2000)
FMOH, May 2012	Progress on MDG/PF, presentation at the MDG/PF dinner on 22nd May 2012.
IHP+ Results, 2010	Annual Performance Report: Strengthening accountability to achieve the health MDGs
IHP+ Country Review 2010	Ethiopia, Country Data 2010. < http://ihpresults.net/how/data/ >
Waddington, Alebachew and Chabot, IHP+ final report, January 2012	Roadmap for revitalizing One Plan, One Budget and One Report in Ethiopia. Consultancy to take forward the International Health Partnership
4th HLF on Aid Effectiveness, Busan Dec 2011.	Busan partnership for effective development cooperation
African Platform for Devt Effectiveness, Sept 2011	Final draft African Consensus and position on Development Effectiveness: AID Reform for Africa's Development. Fourth HLF in Busan (final)
OECD, 2011	Aid effectiveness 2005-2010: progress in implementing the Paris Declaration
OECD, 2011	Aid effectiveness 2005-2010: progress in implementing the Paris Declaration. Volume 2 Ethiopia (country chapters)
OECD, 2011. Task Team on Health as a Tracer Sector	Progress and Challenges in Aid Effectiveness: what can we learn from the health sector? (TT-HTS)
OECD, Evaluation insights, October 2011	Assessing the impacts of Budget Support: case studies in Mali, Tunisia and Zambia.
OECD, November 2011	A synthesis report from the OECD Network on Development Evaluation, synthesis of main results

Antonie de Kemp, Jorg Faust and Stefan Leiderer, 2011	Synthesis report: Between high expectations and reality, an evaluation of budget support in Zambia
Elisabeth Paul, May 2011	Documentation des resultats de la mise en oeuvre des principes de l'efficacite de l'aide dans le secteur de la sante. Etude de cas du Mali
OECD, Sept 2011	Joint Evaluation of Budget Support Operations in Mali 2003-2009 (Summary in English, but body of the report and annexes in French)
Vaillancourt and Sudip Pokhrel for IHP+, Febr 2012	Aid Effectiveness in Nepal's health sector: accomplishments to date and measurement challenges
Save the Children Fund, 2011	Healthier Returns, Making Aid for health care more effective, a report by Save the Children International for the fourth HLF on Aid Effectiveness in Busan.
UNICEF, undated	Final consolidated report on the second HPF for Technical Assistance (July 2007 – June 2011); UNICEF Reference: PBA XC/2007/0001
Abebe Alebachew, 2012	HSS 20/20 (unpublished figures health outcome 2000-2011, based on HSDP evaluations, several JRM and Health and health related indicators booklets

Annex 3.
WHO HAS SIGNED WHAT AND WHEN?

DATE AND DOCUMENT	WHO HAS SIGNED?	COMMENTS
Sept 2005: Code of Conduct (CoC) in Ethiopia (Signed by 11 Partners)	FMOH WB, AfDB WHO, UNFPA, UNICEF, UNAIDS, UK, Irish Aid, Italian Coop, RNE, Sida.	GAVI signed in 2007 Not signed: GFATM, BMGF, PEPFAR, CDC. JICA.
Sept 2007: Global Compact, IHP+ signed in London	Ethiopia, Kenya, Mozambique, Zambia, Burundi, Mali, Cambodia, Nepal. WB, EC, AfDB, GFATM, GAVI, WHO, UNFPA, UNICEF, UNAIDS, UNDP; BMGF UK, Spain, Italy, RNE, France, AusAID, Norway, Germany, Portugal, CIDA, SIDA.	AusAID signed the Global Compact at the WHA in May 2008, at the same time as Sweden, Nigeria + Madagascar Not signed: USAID, Austria, JICA, Irish Aid.
August 2008: Ethiopian Compact, IHP+. (13 signed)	FMOH and MOFED WB, EC, AfDB, WHO, UNFPA, UNICEF, UNAIDS. UK, Spain, Irish Aid, Italy, RNE, France (later in 2010)	USAID, GAVI gave support letter Not signed: GFATM, GAVI, BMGF / Norway, Germany, Portugal, AusAID, CIDA, SIDA, JICA.
March 2009: Joint Financing Arrangement (JFA) (8 signed)	FMOH and MOFED WB, WHO, UNFPA, UNICEF. UK, Spain, Irish Aid and Italy (in 2011)	Not signed: EC, UNDP, UNAIDS, GFATM, GAVI, BMGF. France, RNE.
January 2012: Revised Joint Financing Arrangement (Rev JFA) (8 signed)	FMOH WHO, UNFPA, UNICEF. UK, Spain, Irish Aid, Italy, AusAID, Royal Netherlands Embassy (RNE).	Not signed: WB, EC, UNAIDS, GFATM, GAVI, BMGF, France

A few interesting comments and observations can be made from this Table:

1. The World Bank signed the Code of Conduct, the Global Compact, the Ethiopian Compact, the JFA 2009, but not (or not yet) the recent revised JFA 2012;
2. GFATM and GAVI both signed the Global Compact (and GAVI also signed the Ethiopian CoC). However, both did not sign any of the remaining treaties (with GAVI only sending a letter, supporting the Ethiopian Compact in August 2008);
3. The Bill and Melinda Gates Foundation (BMGF) has remained completely out of the Paris Declaration, only signing the Global Compact (2007), but for the rest not signing the CoC, the Ethiopian Compact or any of the JFAs;
4. Among UN Agencies, WHO, UNFPA and UNICEF have signed all treaties, UNAIDS (and UNDP) vary in their signing, but have NOT yet signed the two recent JFAs;
5. Most of the bilateral agencies have been more or less consistent: DFID, Spain, Irish Aid and Italian Cooperation signing the Ethiopian Compact and the two JFAs. The France Cooperation is also consistent and has not signed any of the two JFA.
6. The Royal Netherlands Embassy (RNE) and AusAID have only recently committed themselves and signed the 2012 JFA (thus contributing funds to the MDG/PF), AusAID because it opened its Ethiopian Office only in 2011.
7. Other bilateral agencies such as the US Government (USAID, PEPFAR and CDC) and JICA have consistently argued that they cannot sign any of these treaties, due to the mandate given to them by their respective Parliaments.

In conclusion: With those that signed the JFA 2012 - now contributing a total of more than USD 160 M to the MDG/PF -, there is little scope to bring more bilateral or multilateral DPs at the MDG/PF table (except perhaps the French Cooperation).
Chances that GFATM and / or GAVI will eventually join the MDG/PF are possible, IF enough international pressure is being brought onto them.
USG – even under the GHI – appears unlikely to change its position.

Annex 4.
Results from the OECD study on Aid Effectiveness

4A. Aid Effectiveness: Indicators and targets five years after the Paris Declaration.

Table 1.1 To what extent have global targets been met?
Paris Declaration indicators and targets, 2010

	Paris Declaration Indicator	2010 Actual	2010 Target[d]	Status
1	Operational Development Strategies % of countries having a national development strategy rated "A" or "B" on a five-point scale[a]	37% (of 76)	75%	Not met
2a	Reliable public financial management (PFM) systems % of countries moving up at least one measure on the PFM/CPIA scale since 2005[a]	38% (of 52)	50%	Not met
2b	Reliable procurement systems % of countries moving up at least one measure on the four-point scale since 2005	--	No Target[c]	--
3	Aid flows are aligned on national priorities % of aid for the government sector reported on the government's budget[a]	41%	85%	Not met
4	Strengthen capacity by co-ordinated support % of technical co-operation implemented through co-ordinated programmes consistent with national development strategies[a]	**57%**	**50%**	**Met**
5a	Use of country PFM systems % of aid for the government sector using partner countries' PFM systems[b]	48%	55%	Not met
5b	Use of country procurement systems % of aid for the government sector using partner countries' procurement systems	44%	No Target[c]	--
6	Strengthen capacity by avoiding parallel PIUs Total number of parallel project implementation units (PIUs)[b]	1 158	565	Not met
7	Aid is more predictable % of aid for the government sector disbursed within the fiscal year for which it was scheduled and recorded in government accounting systems[b]	43%	71%	Not met
8	Aid is untied % of aid that is fully untied[a]	86%	More than 89%	Not met
9	Use of common arrangements or procedures % of aid provided in the context of programme-based approaches[a]	45%	66%	Not met
10a	Joint missions % of donor missions to the field undertaken jointly[a]	19%	40%	Not met
10b	Joint country analytic work % of country analytic work undertaken jointly[a]	43%	66%	Not met
11	Results-oriented frameworks % of countries with transparent and monitorable performance assessment frameworks[a]	20% (of 44)	36%	Not met
12	Mutual accountability % of countries with mutual assessment reviews in place[a]	38%	100%	Not met

Notes:

a. Assessment against 2010 target uses data for all 78 countries participating in 2011 for which data were available. Where data are available for only a subset of these countries, the sample size is indicated in brackets.

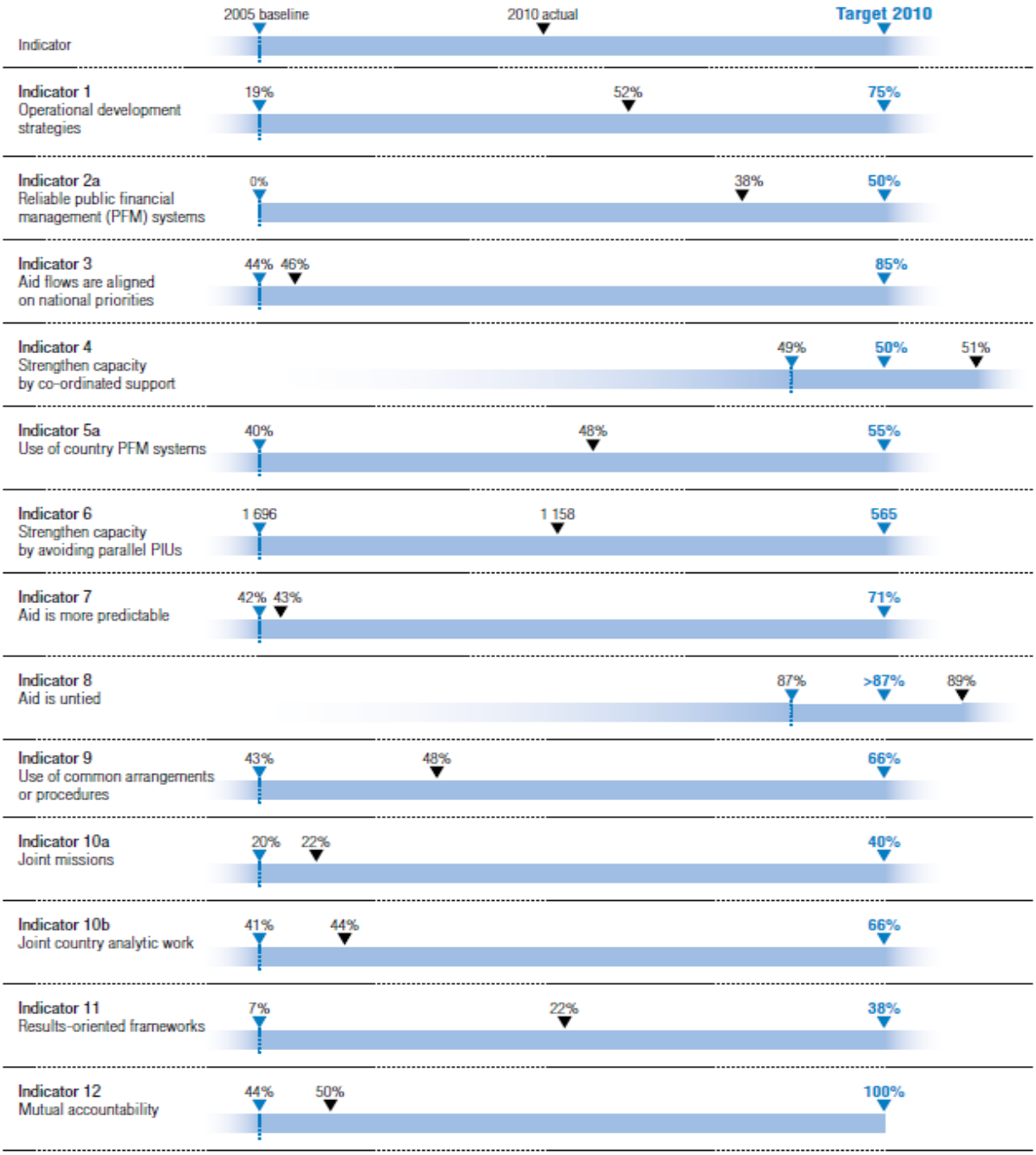
b. Assessment against 2010 target uses data for the 32 countries participating in both the 2006 and 2011 Surveys, as the indicator target is formulated in relation to the 2005 baseline. Targets may differ from those published in previous years as baselines have been recalculated, omitting data from two countries (Nicaragua and Yemen) which formed part of the original panel of 34 countries participating in 2006, but which did not participate in 2011.

c. No targets are presented for indicators 2b (reliable procurement systems) and 5b (use of country procurement systems) as the sample of countries for whom data on the quality of systems are available is too small to allow for meaningful analysis.

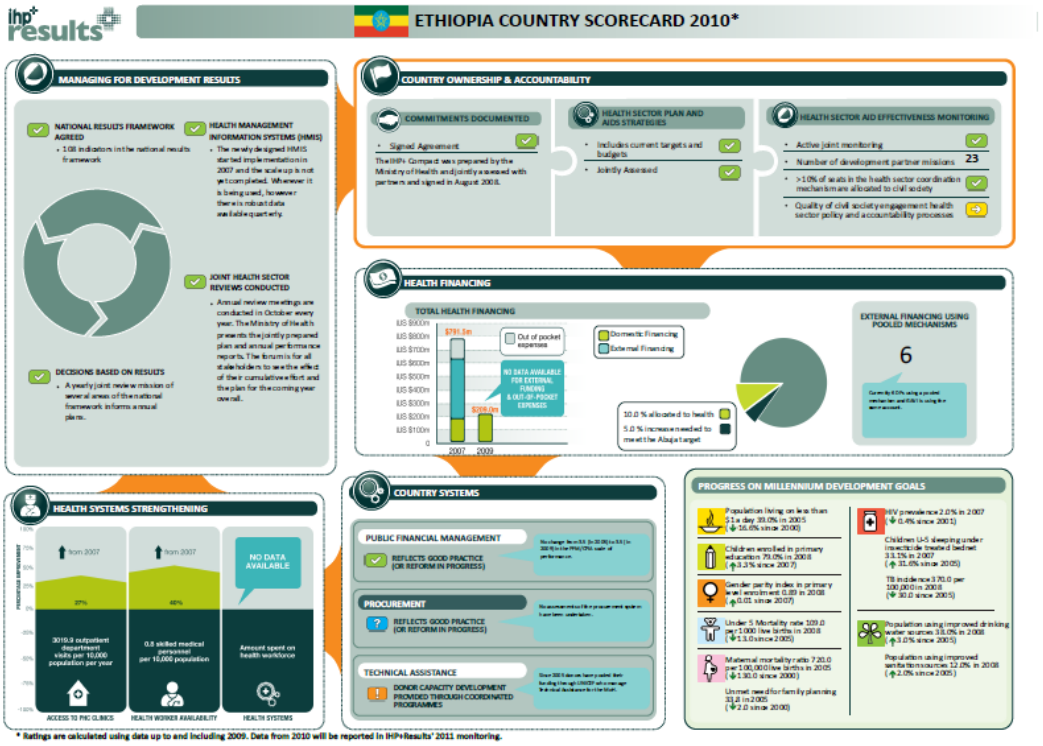
d. The targets shown may differ from indicative targets published in previous years as a result of adjustments to historical data (e.g. indicator 8, where final data on tying led to adjustments to the underlying datasets after publication of reports on the previous surveys). The target for indicator 5a (use of country PFM systems) has been computed to consider the 2010 scores on the quality of PFM systems (indicator 2a), consistent with the approach agreed in the Paris Declaration and described in Chapter 3.

Table 4B. Direction / pace of change among 32 countries participating in the 2006 / 2011 studies.

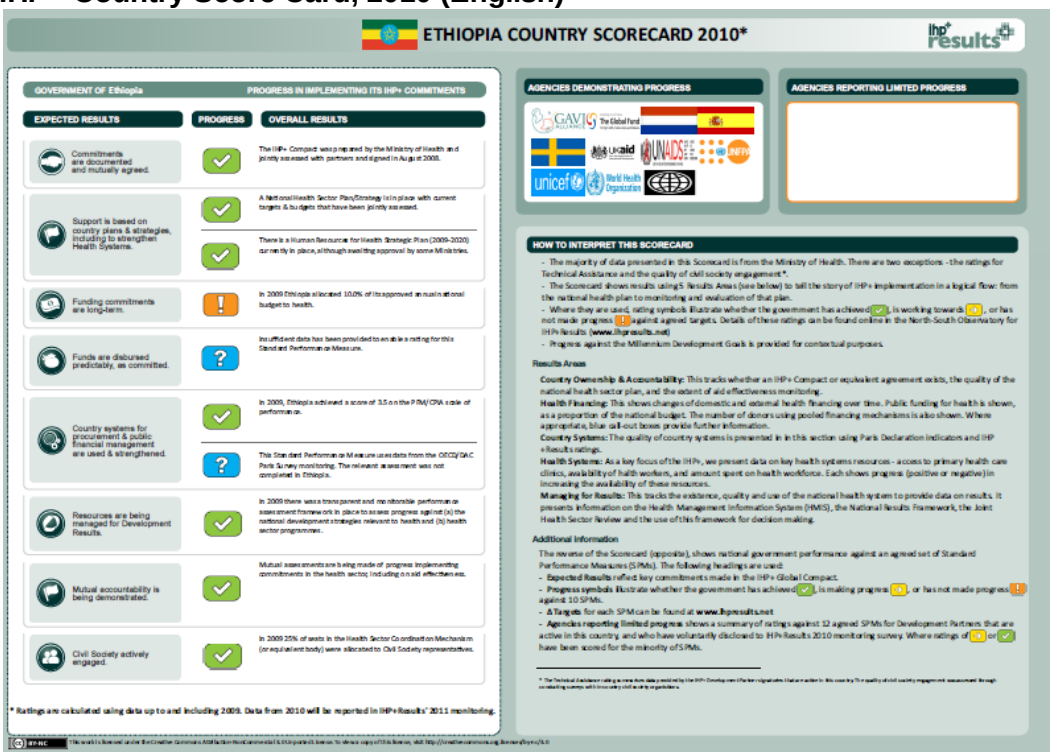
Figure 1.2 To what extent has progress been made since 2005?
Performance across 32 countries participating in both the 2006 and 2011 Surveys



Annex 5A.
IHP+ Country Score Card, 2010 (English)



Annex 5B.
IHP+ Country Score Card, 2010 (English)



Annex 6.
Ethiopian and Gregorian Calendars

The Ethiopian Fiscal Year / EFY (or Ethiopian Calendar / EC) refers to the Ethiopian Fiscal Year, starting on 7th July in the European (= Gregorian) calendar.
Currently, June 2012 corresponds with the end of EFY 2004.
For practical reasons the EFY goes from 1st July or year X till 30th June of year X+1
The overall correspondence between Ethiopian and European fiscal years is given below, based on the Gregorian (GC) and Ethiopian Calendars (EC).

Gregorian and Ethiopian Calendars

Gregorian (GC)	Ethiopian (EC)	HEALTH DEVT HSDP YEARS	NAT. DEVT PLANS	HEALTH POLICY
1992/93	EFY 1984			
1993/94	EFY 1985			
1994/95	EFY 1986			
1995/96	EFY 1987			
1996/97	EFY 1988	BASELINE		1993
1997/98	EFY 1989		i-PRSP	
1998/99	EFY 1990			
1999/00	EFY 1991	HSDP I	PRSP	HEALTH
2000/01	EFY 1992			
2001/02	EFY 1993			
2002/03	EFY 1994		SDPRP	POLICY OF THE
2003/04	EFY 1995	HSDP II		
2004/05	EFY 1996			
2005/06	EFY 1997			TRANSITIONAL
2006/07	EFY 1998			
2007/08	EFY 1999			
2007/08	EFY 2000	HSDP III	PASDEP	GOVERNMENT
2008/09	EFY 2001			
2009/10	EFY 2002			
2010/11	EFY2003			
2011/12	EFY 2004			
2012/13	**EFY 2005**	HSDP IV	GTP	
2013/14	EFY 2006			
2014/15	EFY 2007			
2015/16	EFY2008	MDG targets		
2016/17	EFY 2009			
2017/18	EFY 2010			
2018/19	EFY 2011			
2019/20	EFY 2012			

EFY = Ethiopian Fiscal Year; GC = Gregorian Calendar; EC = Ethiopian Calendar

[i] WHO-Choice, Choosing Interventions that are cost effective. Accessed at http://www.who.int/choice/en/
[ii] WHO Global Price Reporting Mechanism (2006 – 2008) Global Fund for AIDS, Tuberculosis and Malaria, Geneva.
[iii] Borghi et al (2008) Overview of the costs of obstetric care and the economic and social consequences for households. Studies in HSO&P, 24.