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Type of Review: Annual Review

Project Title: Support for the Ethiopian Health Sector Development Programme (Federal Ministry of Health MDG Performance Fund)

Date started: October 2011 **Date review undertaken:** October 2013

Instructions to help complete this template:

Before commencing the annual review you should have to hand:

- *the Business Case or earlier project documentation.*
- *the Logframe*
- *the detailed guidance (How to Note)- Reviewing and Scoring Projects*
- *the most recent annual review (where appropriate) and other related monitoring reports*
- *key data from ARIES, including the risk rating*
- *the separate project scoring calculation sheet (pending access to ARIES)*

You should assess and rate the individual outputs using the following rating scale and description. ARIES and the separate project scoring calculation sheet will calculate the overall output score taking account of the weightings and individual outputs scores:

Description	Scale
Outputs substantially exceeded expectation	A++
Outputs moderately exceeded expectation	A+
Outputs met expectation	A
Outputs moderately did not meet expectation	B
Outputs substantially did not meet expectation	C

Note – This review largely reflects progress during the Ethiopia Financial Year (EFY) 2005, which corresponds to July 2012-June 2013.

Introduction and Context

Main acronyms used:

ARM – Annual Review Meeting (of the Health Sector)

EDHS – Ethiopia Demographic and Health Survey

EFY – Ethiopian Financial Year

FMOH – Federal Ministry of Health

HC – Health Centre

HDA – Health Development Army

HDSP IV – Health Sector Development Programme IV

HEW – Health Extension Worker
HMIS – Health Management Information System
JFA – Joint Financing Arrangement
JRM – Joint Review Mission
MDG PF – MDG Pooled Fund
PFSA – Pharmaceutical Fund and Supply Agency
MTR – Mid-Term Review

What support is the UK providing?

The UK is providing £275 million over four financial years (October 2011 – March 2015) to support the delivery of the current five-year health sector development plan in Ethiopia.

UK support is channelled through the Millennium Development Goals Performance Fund (MDG PF) of the Federal Ministry of Health (FMOH), according to an agreed multi-donor Joint Financing Arrangement (JFA) that is intended to improve harmonisation in the sector to maximize health impacts. Providing support directly to the FMOH is intended to ensure that progress is delivered on all health MDGs, not just on one particular health condition, and that systems and services are strengthened for sustainable improvements in delivery of quality health services. This complements the UK's support to Ethiopia that comes from the Global Fund for AIDS, TB and Malaria (GFATM) and the Global Alliance for Vaccines Initiative (GAVI).

The MDG PF is designed to provide harmonised and aligned support to the implementation of the Government of Ethiopia's Health Sector Development Plan (HSDP IV). The Fund provides sector support to the FMOH to allow the ministry to (partially) fill its critical funding gaps. In practice, the funds are allocated on an annual basis primarily to the procurement of pharmaceuticals and medical supplies, as well as to training, the Health Extension Programme (HEP) and essential health infrastructure. A particular emphasis is placed on the priority but underfunded areas of maternal and child health and health system strengthening in under-served areas of the Developing Regional States (DRS).

This Annual Review draws on the findings of the HSDP IV Mid Term Review (MTR), the FMOH's Annual Performance Report and the Annual Review Mission. As the MDG PF supports implementation of the HSDP IV, this Annual Review examines the performance of the MDG PF as an instrument to achieve sector-wide progress.

What are the expected results?

The expected impact of supporting the HSDP IV is 'accelerated progress towards health related MDG targets including malaria, maternal and child mortality, and nutrition'.

The expected outcome is 'increased access to and improved quality of health services'.

The expected outputs are :

Output 1: Reduced fragmentation and increased efficiency of donor assistance;

Output 2: Pillars of the health system strengthened;

Output 3: Improved coverage of the Health Extension Programme

Output 4: Improved community ownership in management of health delivery.

The expected results attributable to UK support are:

- 1.3 million couples have access to family planning;
- 335,000 births delivered by a skilled health care provider;
- 665,000 babies being exclusively breastfed;
- 200,000 children vaccinated against measles;
- 1 million women accessing antenatal care; and
- 11,000 deaths from tuberculosis averted.

What is the context in which UK support is provided?

From a low base, Ethiopia's growth and expansion of basic services in recent years have been among the most impressive in Africa. The Government of Ethiopia is capable and is a proven partner in making rapid progress towards the MDGs. DFID is a leader within the development community, championing results, aid effectiveness and transparency.

Despite recent progress, Ethiopia remains one of the world's poorest countries, with more than 30 million people living in extreme poverty. It ranks 122 out of 134 countries for equality between women and men (Global Gender Gap Index) and discrimination against women and girls is evidenced in all areas of life. Gender-based violence is widespreadⁱ.

Ethiopia is comparatively under-aided, receiving less than the African average per capita aidⁱⁱ. Strong progress towards some of the MDGs has been from a very low base, and will be difficult to maintain as further progress will require reaching harder to reach populations including the very poor, excluded groups, and people living in pastoralist and remote regions. At the same time, population is growing at a rapid pace and will see the current estimated population of 84.8 million people rise to around 120 million

by 2030ⁱⁱⁱ, including rapid growth in urban population (which is increasing at 9% per annum).

Ethiopia's health needs are vast and reflect the high poverty levels. In the last decade, impressive improvements have been seen in health services and outcomes. Between 2005 and 2011, with substantial support from the UK and others, Ethiopia has: halved the incidence of malaria; deployed 34,000 more health extension workers; and, doubled the number of women using contraceptives^{iv}. These accomplishments are having a positive impact on health outcomes. The 2011 Ethiopian Demographic Health Survey (EDHS) published in April 2012 reported a 28% decrease in under-five mortality, from 123 in 2005 to 88 deaths per 1,000 live births in 2011; and a fall in total fertility from 5.6 in 2005 to 4.8 children per women in 2011. Also, a more recent (2012), UNICEF survey indicates that Ethiopia's under-five mortality rate has declined to 68 deaths for 1,000 live births implying achievement of MDG-4 target of reducing the level of child mortality by 2/3rd from the 1990 baseline level. However, the progress on MDG-5 (pertaining to maternal health) has been slow. The percentage of women who received delivery care from a skilled provider remains low at 16%, and the maternal mortality remains high at 676 per 100,000 births.

Ethiopia's fertility rate of 4.8 births per woman is still one of the highest in the world, and it is estimated that more than 20,000 women die in pregnancy or childbirth each year – in part because more than 75% of all deliveries occur at home. Early marriage is common in Ethiopia - about 1 in 5 Ethiopian women are married by their 15th birthday, and 17% of girls aged 15-19 have already become mothers or are pregnant with their first child. About 230,000 children die each year, mainly from preventable and treatable infectious diseases complicated by under nutrition^v.

Ethiopia has more than a million people living with HIV/AIDS, and HIV prevalence is estimated at 1.5%. The epidemic is concentrated in urban areas (prevalence is estimated at 3.8 % in urban areas), with 4.9% prevalence among urban women and 2.6% among urban men – a female to male HIV prevalence ratio of 1.5 to 1^{vi}. Approximately 75% of Ethiopia's landmass is endemic for malaria and 68% of the population lives in areas at risk of malaria. Malaria in Ethiopia has been characterized by widespread epidemics occurring every 5-8 years, and it remains the leading cause of outpatient visits. Ethiopia ranks seventh among the world's 22 high-burden tuberculosis (TB) countries^{vii}. Although, Ethiopia has made good progress on MDG-4 and 7, the likelihood of it reaching MDG-5 target of reducing the maternal mortality ratio (MMR) by three quarters between 1990 and 2015 remains uncertain and will require huge amount of additional efforts.

Section A: Detailed Output Scoring

Output 1: Reduced fragmentation and increased efficiency of donor assistance

Output 1 score and performance description:

Output 1 has two indicators. One has been scored as 'A+' and the other as 'B'. Therefore, the overall this output has been scored as 'A'. This reflects the increased and strong commitment by Development Partners (DPs) and the FMOH to the MDG PF as the most suitable instrument for support to the health sector at federal level. Two additional donors, the World Bank and GAVI joined the fund in 2012/13. At the same time, the MDG PF is enabling the FMOH to strengthen its own financial management capacity. Also, the MDG PF was examined by the UK's National Audit Office (NAO) in 2012 and DFID's Internal Audit Department in September 2013. Both were happy with the management of the programme.

Indicator 1.1: Number of DPs channelling support through the MDG PF Fund according to Joint Financing Arrangement (JFA): The target for EFY 2005 is more or at least equal number of DPs channelling support through the MDG PF in comparison to EFY 2004. During the last financial year, two additional development partners joined the MDG PF, the World Bank and GAVI, increasing the number of development partners contributing to the MDG PF from 9 to 11. Therefore, this indicator has been scored as 'A+'. Also, the increase in the number of donors channelling support through the MDG PF has strengthened the dialogue with the FMOH.

Indicator 1.2: Percentage of total funds to the health sector at federal level channelled through MDG fund: The target for EFY 2005 is to attain a 10% increase over the EFY 2004. In EFY 2005, DPs released USD 531million through government channels to health. Of which, USD 133.23 million was channelled through the MDG PF, a 26% increment from the EFY 2004 (USD 104.3 million). However, the MDG PF accounted for only 25% of total DPs' health disbursement in EFY 2005 which was similar to the share achieved during EFY 2004. Therefore, although the total amount of funds channelled through the MDG PF increased significantly between EFY 2004 and 2005, its relative share in comparison to total health funding by DPs at federal level did not increase. This indicator has been scored as 'B'.

Progress against expected results:

Overall progress on this output has been positive in the second year of the programme. The performance of the MDG PF shows that it is on track to enable and incentivise improvements in the health system, thereby increasing the sustainability of health provision (building on progress made in the first year as detailed in the 2012 year annual review).

The increase in the number of participating donors over the last year brings the total number of contributing donors to eleven, continuing to demonstrate the success of the mechanism in harmonising and aligning donors behind the HSDP IV. The World Bank and GAVI are now channelling their funding for health system strengthening through the MDG PF. The World Bank's contribution is through their new instrument Performance for Results (PfR) that will disburse funds based on performance against key maternal and child health indicators. At the Annual Review Meeting (ARM) in EFY 2005, the GAVI representatives announced their contribution to the MDG PF is not earmarked/ restricted for immunisation related activities but can be used to strengthen the health system as a whole. The FMOH expressed strong appreciation for GAVI's unearmarked support to the Ethiopian health sector. This represents a major step forward towards aid-effectiveness in the health sector enabled by the success and good performance of the pooled fund. In addition, USAID has recently signed the International Health Partnership compact at the global level and is exploring the possibility of joining the MDG PF. The European Union have just approved a new health programme for maternal health in Ethiopia that will channel funds to the MDG PF through UNICEF.

Despite notable progress on number of DPs joining the MDG PF and the total amount of funds channelled through the fund, 75% of the health funding is still outside this pooled funding mechanism. This is mainly funding from the GFATM that is channelled through government systems but not the MDG PF and funding from the US government which is channelled through private contractors. The government would prefer to see DPs channelling a larger share of their health funding through this pooled fund mechanism. In 2013, DFID supported the FMOH to develop an advocacy paper on the MDG PF. This paper outlines evidence that funding the health sector through the MDG PF is the most effective way to build sustainable health systems and represents the best value for money in the sector. This paper is now being used to convince partners in the sector to channel their funding through the MDG PF. Other noteworthy progress during EFY 2005 include:

(a) Strengthening of the Health Management Information System (HMIS) to improve comprehensive reporting on Health Human Resources, procurement and supply chain management;

(b) The creation of a Grant Management Unit to improve the disbursement and reporting of grant funds, including the MDG PF. A recent World Bank Public Financial Management assessment flagged this approach as a best practice and recommended that other sector ministries should create similar grant management units; and,

(c) A detailed discussion during the 2013 Annual Review Meeting (ARM), under the chairmanship of Dr Amir Aman Hagos, State Minister for Health, to identify ways to

further enhance partnership, harmonization and alignment by creating maximum synergy between health funders, planners, administrators and providers at various levels to decrease maternal and child death in Ethiopia. The recommendations that emerged from this discussion (working group) include:

(1) Strengthening of the 'One Plan' approach by:

- Following evidence and resourced based planning processes;
- Improving coordination of all stakeholders at the regional level and district levels. It could be done by the FMOH building capacity of the Regional Health Bureaus (RHBs); and by Development Partners and their implementing partners increasing their efforts to improve their participation at lower levels to encourage one plan at all level; and,
- Carrying out assessments at national level in a joint and transparent manner. The FMOH and DPs are encouraged to inform all stakeholders before an assessment takes place to allow all interested parties to get involved.

(2) Strengthening of the 'One budget and One report' approach by:

- Strengthening the coordination with zones, regional bureaus and districts and by preparing performance scorecards to track progress. The FMOH encouraged partners to reach an agreement on the information they require for monitoring projects supported by them. This recommendation also relates to the MTR finding that there is still parallel reporting at all levels in Ethiopia, both within the government systems and in relation with Development Partners' projects. However, here it is worth mentioning that, in support of the principle of harmonization, DFID draws maximum information from the ARM (and other host country led review processes such as MTR for this year) to prepare its Annual Review, and reporting process to ensure accountability to the UK tax payers;
- Improving the HMIS by undertaking an independent evaluation of HMIS. This action was also suggested in last year annual review and by the MTR; and,
- Reactivating the National AIDS Committee where all partners interested can participate.

(3) Strengthening the governance structure by :

- Engaging the JCCC (Joint Core Co-ordinating Committee), the technical arm of the Joint Consultative Forum (JCF), to support the FMOH in organizing and monitoring different activities. All MDG PF contributors should be included in the JCCC as it has the mandate to monitor the MDGPF. Other members of JCCC to be selected on individual merits; and,
- Revitalizing of regional governance structures by establishing Regional Consultative Forum where Civil Society Organisation (CSOs) could be represented.

Recommendations:

1. **DFID to continue to play a strong role in promoting harmonisation, working with other DPs**, in ensuring donors speak with one voice, reduce the number of bilateral interactions with the FMOH, and agree major actions that relate to the MDG PF in the Health Population and Nutrition (HPN) forum.
2. **DFID to be actively engage with the FMOH on the utility of an independent evaluation of HMIS**, as recommended by the MTR and Group 6 at the ARM.

Impact Weighting: 30%

Revised since last Annual Review? n/a

Risk: Low

Revised since last Annual Review? n/a

Output 2 Pillars of the health system strengthened.

Output 2 score and performance description: Output 2 has 6 indicators, of which one has been rated as 'A+', two as 'A' and three as 'B'. One indicator has not been rated during this AR process because of lack of reliable information. Overall this output has been rated as 'B'.

Indicator 2.1: Per capita government allocation for health (USD) : The target for EFY 2005 is to attain an improvement over EFY 2004. The total government (including Development Partners' funding through government) allocation per capita almost doubled from USD 2.88 in EFY 2003 to USD 4.36 in EFY 2004 and it has further increased to USD 5.27 in EFY 2005. Therefore, this indicator has been scored as 'A+'.

Indicator 2.2 Proportion of health facilities with stock out of essential drugs: Overall, the logistic management system and timely supply of essential drugs seem to be improving. Woredas seem to be getting better at using the pull system, although their capacity to forecast and place advance orders are still developing, as documented in the MTR. Better use of the pull mechanism is increasing the value of the procured pharmaceuticals, medical supplies and equipment through the Revolving Drug Fund (RDF). Similarly, the supply of majority of the essential commodities (including vaccines, anti-malarials, MDR/TB drugs and FP commodities), managed at the federal level though a 'push' system, seems to be improving. However, despite these improvements in the management of health commodities, as per the MTR regional reports, stock-outs are more frequent for centrally procured and managed commodities as compared to commodities managed by the RDF. The FMOH doesn't currently collect and report data on stock out of essential drugs at facility level. Therefore, despite positive qualitative information, this indicator cannot be scored.

Indicator 2.3: Proportion of Health Centres with available Basic Emergency Obstetrics and Neonatal Care (B-EmONC) services : The EFY 2005 target for this

indicator is 91%. According to the annual report of the health sector, the total number of health centres (HCs) with available B-EmONC services has increased from 34.3% in EFY 2004 to 58.4% in EFY 2005. This indicator shows an improvement of almost two-fold from the previous year. However, this improvement is not good enough to meet the very ambitious target of 91% which was taken from the HSDP IV plan. Nonetheless, considering the two-fold improvement in the proportion of health facilities with available B-EmONC within a year, this milestone has not been scored a 'B'.

Indicator 2.4: Proportion of hospitals with available Comprehensive Emergency Obstetrics and Neonatal Care (C-EmONC) services: The EFY 2005 target for this indicator is 95%. According to the annual report of the health sector, the total number of hospitals with available C-EmONC services has increased from 68% in EFY 2004 to 82.7% in EFY 2005. Although this indicator shows an impressive improvement of 13 percentage points it falls short of the ambitious target of 95% (which was taken from the HSPD IV plan). In general, most HSDP IV targets are hugely ambitious and they are primarily set to galvanise efforts and to demonstrate strong commitment of the government to rapidly scale up prioritized activities linked to the targets. Even though there has been a 13 percentage point improvement of this indicator, the milestone has not been met. Therefore, it has been scored as 'B'.

Indicator 2.5: Percentage of recommendations in financial audit reports actioned and resolved: The EFY 2005 target for this indicator is 100% of issues identified in the EFY 2003 external financial audit report were actioned and resolved in the review period. This has been done and the milestone has been fully met, thereby scoring an 'A'.

The External Audit report for the EFY 2004, submitted to the DPs in 2013, states that all external funds have been used in accordance to the funding agreement. The report for EFY 2004 however highlight some issues of concern:

1. An Internal Audit of the MDG PF was not conducted on schedule by the FMOH for EFY 2004 – FMOH has now conducted the audit – please see the details on progress below
2. Some vouchers and supporting documents were not stamped PAID and some coding errors have occurred at regional level;
3. Poor financial management in SNNP region; for audit findings on 2 & 3 FMOH has started taking action see the details below
4. Large funding advances to Pharmaceutical Fund and Supply Agency (PFSA), UNICEF and UNOPS for procurement of goods DFID following-up status through JCF

An action plan for addressing issues identified has been agreed and is being actioned by the FMOH. For instance an audit team was dispatched to SNNPR when the audit highlighted poor financial management capacity. DFID is following up the resolution of audit issues through its regular meetings with the FMOH.

According to the JFA and the Government of Ethiopia's (GoE) financial regulations the FMOH is required to provide an internal audit report every year within nine months after the completion of the financial year. This is then qualified by the external audit conducted by the Office of the Federal Auditor General. However an internal audit was not conducted for EFY 2004 within the stipulated time due to capacity constraints in the FMOH. As this was a breach of the GoE's financial management regulations and the JFA , the FMOH agreed to carry out an internal audit of the MDG PF .The Internal Audit was conducted in July 2013 and the major findings shared with the DPs in August 2013. Also, an agreement has been reached to qualify the internal audit report of EFY 2004 along with the internal audit report of EFY 2005 and shared the findings of the external audit (qualification by the Office the Federal Auditor General) in EFY 2006 (by April 2014). DPs have discussed the external audit findings of EFY 2003 and internal audit findings of EFY 2004, and are content that actions are being taken to rectify issues identified in these audits. DFID is following these up through its regular meetings with the FMOH. The internal audit for EFY 2005 has been completed and the external audit is underway. DFID will receive this report in March 2014. In addition, the procurement audit for EFY 2003 was shared with an action plan. There is a delay in the production of procurement audits for EFY 2004 by the Public Procurement Authorities due to a backlog/pending audits. However DPs are satisfied that efforts are being made to catch up.

Indicator 2.6 Proportion of Health Centres (HCs) providing Integrated Management of Neonatal and Childhood Illnesses (IMNCI): The EFY 2005 target for this indicator is 95%. The cumulative number of HCs providing IMNCI increased from 2,030 in EFY 2004 to 2,373 in EYF 2005. The total number of HCs available in 2005 is 3,245. Therefore, in EFY 2005, 75.5% of HCs were providing IMNCI compared to 68% in EFY 2004. This indicator has recorded an increase of 7 percentage points between EFY 2004 and 2005 but is still below the very ambitious target of 95%. Despite of the positive trend the milestone has not been met and is scored with a 'B'.

Progress against expected results:

Progress for this output area has been promising but the ambitious targets have not been met for many of the service indicators. It is positive to see increased public expenditure for health. However, the sector remains severely underfunded and lacks the resources to be able to scale up the availability of B/C EmONC services and train the staff needed to deliver these services. The FMOH are very concerned at the poor progress against maternal and neonatal mortality and are prioritising the implementation of their Maternal and Child Health (MCH) road map. This includes the provision of B/CEmONC facilities in health centres and the training/deployment of midwives and Surgical Officers who can address obstetric emergencies. The FMOH are also introducing an innovative scheme to treat neonatal sepsis (one of the biggest killers of new-borns) in the home through the HEP. The FMOH have requested DPs to

bring forward a proportion of funding from its 2014/15 MDG PF contribution to 2013/14 so that it has sufficient funds to procure the necessary equipment and train staff to provide EmONC services. DFID and other partners should seriously consider this request as it will enable the FMOH to accelerate the implementation of their MCH road map and deliver better results by 2015. There is a real risk that the targets of the HSDP and the programme's logframe will not be achieved due to their highly ambitious nature, capacity constraints and the funding gap in the sector.

There are also concerns that quality of services in facilities is affecting the demand/utilisation of services as they become available. According to the MTR only 55% of health centres have access to electricity or water. In addition, the MTR highlights poor cleanliness of health facilities as a 'demand' barrier that hinders an increase in utilization rates. In 2014 the FMOH is conducting a Health Facility Survey and a Service Provision Assessment to assess the readiness of health facilities and quality of care. Balanced score cards, tracking key maternal health service indicators, are being introduced to monitor quality and availability of services and the introduction of performance reward payments to facilities is being considered. The FMOH see the use of the Health Development Armies as the main method for increasing demand/utilisation of services but the effectiveness of this strategy may be limited in different parts of the country (see output 4). DFID's new programme to Reduce Barriers and Increase Utilisation of Reproductive, Maternal and Neonatal Health services will fund innovative demand side activities and generate evidence on how to increase service utilisation by young and vulnerable women. However the ability of the FMOH to meet the ambitious targets they have set for the availability of B/C EmONC and IMNCI is still questionable and there is a real risk that these will not be met.

DFID was extremely concerned with the initial lack of internal audit by the FMOH on the MDG PF for EFY 2004. This goes against a good track record of audits being delivered on time and to a good standard. The lack of audit was due to capacity constraints in the FMOH's Internal Audit Department caused by staff illness. It was encouraging to see that not only the DPs but also MoFED insisted that an internal audit should be conducted in compliance with government's regulations. The audit was conducted and findings shared with the DPs. An action plan to address the audit findings has been agreed with the FMOH and a process is in place for their follow up.

Recommendations:

- 1. DFID to continue to work with the FMOH to ensure that there is adequate capacity to conduct the necessary audit processes and that they are conducted on time.**
- 2. Ensure issues identified by the financial and procurement audits are discussed at the JCF meeting** and any issues identified are followed up and resolved.

3. **DFID to continue to work with the FMOH to accelerate the implementation of their MCH road map and integrate quality of care as a key element of services.**
4. **DFID to continue to engage with the FMOH and other DPs to understand the bottlenecks and improve routine collection and reporting of stock out of essential drugs at facility level without undermining the one plan and one report principle of engagement.**
5. **Work with the FMOH, DP and RHBs on addressing demand side barriers to service utilisation through enhanced and tailored programming and complementing it with the DFID's new demand side programme that includes the sharing of experience elsewhere.**
6. **For DFID to consider revising the risk of this output from Medium to High due to the ambitious nature of the HSDP targets and the capacity/funding gap in the sector. Alternately, DFID to consider revising the targets and increasing its 2013/14 disbursement to the MDG PF to fill the capacity and funding gap in consultation with other DPs and the FMOH.**

Impact Weighting: 30%

Revised since last Annual Review? n/a

Risk: High

Revised since last Annual Review? Yes; the risk level was medium in the 2012 Annual Review but has now been elevated to high.

Output 3: Health Extension Programme

Output 3 score and performance description:

Output 3 consists of six indicators pertaining to ratio of health extension workers, malaria, ante-natal care, post-natal care and early childhood feeding practice. During this review process, two indicators has been assessed as 'A+', one indicator has been scored as 'B', one indicator has been assessed as 'C', and one has not been scored because of unavailability of reliable data. Therefore, the overall performance of this output has been assessed as 'A'.

Expected results under this Output are:

Indicator 3.1 Percentage of Households (HHs) in areas <2000m altitude with at least one bed net: This indicator will be scored next year on the basis of the mini-DHS. Also, the planned 2014/15 Malaria Indicator Survey will make it possible to assess this indicator in the final year of this programme.

Indicator 3.2 Cumulative number of bed nets for malaria prevention distributed: The EFY 2005 target for this indicator is 52,079,152 nets. However, a cumulative number of 46,976,866 bed nets were distributed in EFY 2005 compared to a cumulative total of 45,776,866 nets distributed by end of EFY 2004 and 39,516,866 by end of EFY 2003. In EFY 2005 a total of 12.6 million nets, (6 million with support from the GFATM, 5.7 million from the US Presidential Malaria Initiative (PMI) and the rest from other sources), were supposed to be distributed. Against this target only 1.2 million, contributed by PMI, were distributed between July 2012 and June 2013. This shortfall in number of nets distributed in EFY 2005 was due to delayed procurement of the 6 million GFATM supported nets by the FMOH and staggered arrival of PMI supported nets. PMI brought in 1.2 million in June 2013, 3.5 million in August 2013 and 1 million in November 2013. The FMOH, through the PFSA, has now placed orders to bring in 6 million nets between December 2013 and February 2014. Therefore, this indicator has been scored as 'C'.

Indicator 3.3 Ratio of Health Extension Workers (HEW) to population: The EFY 2005 target for this indicator is 1 HEW per 2500 population. The MoFED reported through the Promotion of Basic Services results framework (which pays health worker's salaries) that the number of HEW in 2012/13 is 36,336 (32,252 in rural areas and 4,084 in urban areas). Against an estimated population of 84.8m this gives a ratio of 1 HEW to 2,334 people. Even with an estimated attrition rate of around 10%, as reported by the MTR for some regions, this indicator has been met. Therefore, the indicator therefore scores an 'A+'.

Indicator 3.4a Focused antenatal care coverage (1+ visit) assessed on the basis of the HMIS data: The EFY 2005 target for this indicator is 88%. The HSDP IV Annual Performance Report for EFY 2005 reported antenatal care coverage has improved to 97.4%, substantially higher than the target. Therefore, this indicator has been scored as 'A+'. Antenatal care coverage by economic quintile is not reported by the HMIS but a regional comparison shows significant disparities between the more developed regions of Tigray/ Oromia/ SNNP, Harari and Dire Dawa which all report 100% coverage and developing regional states such as Somali region with 41.6% and Afar with just over 50%.

Indicator 3.4b Focused antenatal care coverage (1+ visit) assessed on the basis of the EDHS data: Data not available for this year's assessment. Data from the mini-DHS 2014 is likely to be available in EFY 2006.

Indicator 3.4c Narrowing gap between rich and the poor in focused antenatal care coverage (1+ visit) assessed on the basis of the EDHS data): Data not available for

this year's assessment. Data from the mini-DHS 2014 is likely to be available in EFY 2006.

Indicator 3.5a Proportion (%) of babies 0-6 months exclusively breast-fed (assessed on the basis of the EDHS data): Data not available for this year's assessment. Data from the mini-DHS 2014 is likely to be available in EFY 2006.

Indicator 3.5b Narrowing gap between rich and the poor in proportion (%) of babies 0-6 months exclusively breast-fed (assessed on the basis of the EDHS data): Data not available for this year's assessment. Data from the mini-DHS 2014 is likely to be available in EFY 2006.

Indicator 3.6a Postnatal care coverage (women who receive care at least once during postpartum (42 days after delivery) (assessed on the basis of the HMIS data): The EFY 2005 target for this indicator is 74%. According to the Annual Performance Report, the postnatal care coverage was 44.5% in EFY 2004 and it has increased to 50.5% in EFY 2005. Although an impressive 6 percentage point increase has been recorded between EFY 2004 and 2005, this year's achievement of 50.5% is substantially below the ambitious target 74%. Therefore, performance of this indicator has been scored as 'B'. The data shows significant disparities between regions, with the more developed regions of Tigray, SNNPR, Harari and Oromia with more than 50% coverage contrasted with around 10% in Afar and less than 20% in Somali region and just over 10% in Gambella.

Indicator 3.6b Postnatal care coverage by health provider within two days of delivery (assessed on the basis of the EDHS data): Data not available to assess this year's performance. Data from the mini-DHS 2014 is likely to be available in EFY 2006.

Progress against expected results:

The Health Extension Programme (HEP), which engages Health Extension Workers (HEW), has revolutionised health service provision by bringing in lifesaving commodities and services to every household in Ethiopia. The roll-out of the HEP is largely on-track and is proving to be a cost-effective delivery model for addressing childhood illnesses, scaling up family planning and improving healthy behaviour. This programme has been instrumental in reducing child mortality in Ethiopia. But the effectiveness of the HEP seems to vary across regions and has limitations especially on making deliveries safer and dealing with obstetric emergencies. The government is trying to address these (see output 2) issues. Also, the government's new initiative to link a 2.5 million Health Development Armies (HDA) with existing HEWs is likely to reduce HEW's heavy workload by mobilising communities to attend health posts and adopt healthy behaviour. The role/success of HDAs has been examined under Output 4. Despite progress, the highly ambitious targets of the GoE are stretching the capacity of HEWs and the whole health service delivery system. As the MTR reports, the risk of

missing some of the unrealistic targets (including the Post Natal Care) under this output is very high. Therefore, the risk level for this output has been elevated from low to medium.

A summary of the role of the HEWs is set out in last years' Annual Review. Several of the challenges reported in the last year Annual Review (p60) still need attention and these were reiterated in the MTR:

Challenges

- The HEP has not been implemented uniformly in all regions (as discussed above);
- Lack of clarity on the relationship between Traditional Birth Attendants (TBAs) and HEWs; also on the role of the HEWs in making deliveries safer; there are varying practices because it is not easy to shift the trust of the community from the TBAs to the HEWs;
- Preference for traditional practices like home delivery, and use of TBAs. Although the Health Development Armies' (HDA) is undertaking a strong advocacy/demand creation drive to improve facility based births;
- HEWs are reportedly overburdened with several responsibilities at health posts and home visits such as supporting the HDA; preparing/inputting in to too many reports; covering long distances to households and between households without adequate transport;
- HEWs are also expected to participate in local political and community initiatives including conservation work leading to a reduction in their time to conduct their health duties;
- HEWs have high attrition rates (10-20%), partly due to absence of housing, limited / no annual salary growth plan, their wish for change and expansion of their horizons. At times, HEWs motivation levels declines substantially, as they have to travel long distances on foot and/or pay for transport from their own pocket. For some HEWs, international migration as domestic staff to the Middle East is offering more lucrative alternatives than working as a HEW;
- Inadequate supportive supervision (especially from district health officials) and inadequate support from HCs; health centre staff are not well trained and lack transport to provide supportive supervision to HEWs;
- Intermittent Refresher Trainings (IRT) of HEWs have not been given as designed;
- Health Posts lacking equipment, water, electricity, interruption of supplies and commodities; breakdown of cold chain. Most Health Posts are not equipped for basic services like delivery care; and,
- No maintenance capacity at regional level for medical equipment (cold chain) or water supply of health facilities Health Posts and Health Centres.

Recommendations:

1. **Development Partners to discuss with the FMOH the recommended actions in the MTR and support implementation** of the prioritised recommendations (page 60, Table 26).

Impact Weighting: 25%

Revised since last Annual Review? n/a

Risk: Medium

Revised since last Annual Review? Yes; The risk level was low in the 2012 Annual Review. This has now been elevated to medium.

Output 4. Improved community ownership

Output 4 score and performance description:

Output 4 has two indicators; one is scored as 'A' as it has met/moderately exceeded expectations and the other with a 'B'. Therefore, overall this output has been scored as 'A'.

Indicator 4.1 Total number of HDA network (1:5): The milestone for 2013 is 2,000,000 HDAs established. To date the total number of one to five networks or HDAs formed is 2,026,474, thereby exceeding the target and being scored as A. The number of HDA or networks established are as followed: 125,000 in Tigray Region, 485,771 in SNNPR, 539,693 in Amhara, and 732,259 in Oromia. In urban areas the HDA was initiated in EFY 2004, and 128,815 networks were formed in Addis Ababa, 4706 in Harari, and 10,230 in Dire Dawa.

Indicator 4.2: Percentage of health facilities with boards where the community is represented: Against a milestone of 100% only 88% of health centres and 93% hospitals have established a board or governing body. It is reported that 52% of hospital and 49% of health centre boards meet every month. These boards decide on plans, budget allocations, monitor progress and follow up facilities' responsiveness to the needs of the communities they serve. Currently, 8% of the governing boards are not functional and the participation of the community in functional boards is variable. As the milestone was not reached the indicator has been scored as 'B'.

Progress against expected results:

Although significant progress has been made in implementing the HDA, the implementation has taken different forms in different regions and as a result its progress has been noticeably different across the country. According to the MTR, the women-centred HDA in Tigray contributed to the increase in health facility delivery from

18% to 36% in the first nine months of the EFY 2005. The HDA network members used innovative strategies to achieve this impressive result including cooking porridge at the health facilities after delivery (as per traditional practice), dialogue with TBAs to refer women to health facilities, and organizing women's meeting to encourage women to deliver at health facilities. Although the HDA experience in Tigray appears to suggest that HDA network could make a significant difference to health seeking behaviour and utilisation of health services, the experience in other regions seem to be mixed.

As per the MTR, the scheme is not popular amongst intended beneficiaries in some areas. The perception that HDAs might be politically motivated could be one of the factors contributing to the slow roll-out of the HDAs in some areas (MTR, page 60). The FMOH needs to monitor and evaluate the effectiveness of this approach and consider a range of strategies to increase service utilisation and deliver better health outcomes. The FMOH have recently signed a MoU with the London School of Hygiene and Tropical Medicine to undertake operational research in the sector. This and DFID's new demand side programme (see output 3) may be an excellent opportunity to review and strengthen not only HDA but also FMOH's other demand side strategies.

Challenges as set out by the MTR (page 60):

- HDAs have not been implemented as expected; slow in several regions and starter training package not applied in a standardised way, so skills acquired and effectiveness is variable.
- In some areas lack of commitment from the local political leadership and weak social mobilisation for HDAs appears to be affecting the implementation and impact of HDAs.
- Perception that HDAs are politically motivated/oriented rather than committed to health promotion may affect their effectiveness and sustainability in some areas.

Recommendations:

1. **DFID to encourage the FMOH to formally monitor and evaluate the effectiveness of the HDA model** and other demand side strategies for increasing community ownership and utilisation of health services.
2. **DFID to explore the potential for using the social accountability component of the Promotion of Basic Services (PBS) to support the capacity of community members to represent their communities effectively** on health boards.

Impact Weighting: 15%

Revised since last Annual Review? *n/a*

Risk: Medium

Revised since last Annual Review? *n/a*

Section B: Results and Value for Money.

1. Progress and results

1.1 Has the logframe been updated since last review? No.

1.2 Overall Output Score and Description:

Overall the programme scores an **A, met expectations.**

1.3 Direct feedback from beneficiaries

The review team visited two sites, one in Tigray and one in Oromia. These provided some insights but were inevitably limited. In Tigray the visit was an organised visit as part of the ARM and involved many participants. In Oromia, the (male) district health official accompanied the team on visits to a health post, two HDAs' homes and three further households (the latter chosen at random). These visits provided some examples of best practice and confirmed some of the challenges set out in the MTR.

The health post in Oromia was an example of an apparently efficient and well-run post by a committed health extension worker, but it nonetheless had no electricity, and the water supply is via a hand pump. Equipment is sterilised on a kerosene stove (the supply of kerosene was apparently reliable). The lack of electricity and stable running water are likely to limit the quality of care provided. The cold store was not working although it ran on kerosene, and we learnt that vaccinations are provided on 7 specific days each month.

Distance to health facilities appears to be a key barrier to accessing quality health services. During the interview, the HEW expressed her concern that if a woman/implant user decides to remove the implant, she at times has to travel a distance of 15 km to reach the nearest health centres (as implants can be inserted but not removed by HEWs in health posts). Although, this was not highlighted by her as a major problem but this could be an issue/a deterrent for many poor women to use method of their choice. The health post had several clean delivery kits and the HEW reported that she had successfully delivered 8 babies in the last 3 months. For women needing emergency obstetric, the distance to the nearest health facility that provides BEmONC could be significant and is likely to be a major barrier. Experiences of how HDAs have managed to arrange voluntary youth emergency transportation schemes for women in labour should be documented and shared across the country.

Implementation of the Community HMIS 'family folder' system at this health post was seen to be in its early stages but the health post had made considerable effort to map the community and assess the size of the target population including breakdown by women of reproductive age, children in different age cohorts etc. The level of data

management and record keeping appeared exemplary and as such demonstrated what is possible as best practice.

The few conversations held with the health worker, HDAs and other women and men in Oromia suggested that in this community at least, family planning and child vaccinations appear to be largely accepted and a normal part of life, after several years of awareness-raising and availability – but we cannot extrapolate from these interviews. We also gained the impression from these interviews that there was particular appreciation among the community for the role of the HEW and HDAs in supporting improved sanitation and hygiene in the community through health messages and encouraging the building of latrines.

1.4 Summary of overall progress

The MDG PF is working well as an aid instrument to mobilise funds for health system strengthening, deliver the HSDP and promote harmonization and alignment – this is particularly evidenced by the decision of the GAVI and the World Bank to join the fund in EFY 2005. This funding instrument is evolving to include a performance based component which, if successful, could be used by DFID in the future.

Challenges remain in the health sector in spite of good progress in many areas. Although overall trajectory of progress for most indicators at the aggregated level appears positive, the pace of progress varies significantly across regions. Challenges that need immediate attention are listed in the section below.

1.5 Key Challenges

The MTR for EFY 2005 sets out the key challenges to progress in access to quality maternal health care, which we consider to reflect the challenges faced in the health system as a whole. We have summarised these as follows:

1. Demand and supply side barriers to improve utilisation of services are not addressed simultaneously;
2. Inadequate funding of the health sector with the majority of funding to the sector earmarked to specific disease activities of channelled outside of the government.
3. Inadequate availability and weak motivation of health workers;
4. Variable quality of care/service delivery;
5. Stock outs of pharmaceuticals, medical supplies and equipment;
6. Variable use of evidence for decision-making;
7. Inadequate health infrastructure and access to services;
8. Variable quality of governance and leadership at different levels;
9. Barriers to accessing care in the poor and emerging regions;
10. Maximizing resource mobilization; and,
11. Governance and leadership capacity at different level.

These challenges are set out in more detail below:

Demand and supply side barriers to improve utilization of services are not adequately addressed simultaneously: Ethiopia's health system will not continue to make progress, nor be able to tackle key results such as reduction in maternal mortality, without now making a serious effort to address demand-side barriers. Many facilities are underutilised, especially for maternal care and deliveries. The MTR highlights poor cleanliness, lack of water and electricity as supply side barriers for improving facility based deliveries. In addition, the MTR suggests the need to identify context-specific and culturally sensitive approaches to promote use of health facilities for childbirth.

The proportion of births attended by skilled professionals (classified as nurses, midwives or doctors – not HEWs) remains low with more than 75% of deliveries happening at home by unskilled professionals. There is a huge variation in skilled attendance by region. However, despite the slow progress, there are a few success stories; two regions, namely Addis Ababa with a skilled delivery rate of 66% and Harari with a skilled delivery rate of 67% have surpassed the HSDP 2014/15 target (of 62%) for skilled delivery. Tigray has seen a remarkable increase from 18.2% to 32.2% in one year due to the HDAs and social mobilisation. By comparison other regions such as Benishangul Gumuz, Afar and Amhara have very low rates of skilled delivery (8.4%, 12.3% and 12.4% respectively).

The MTR reports sets out the challenges very clearly in relationship to the three delays that contribute to maternal death (MTR, page 130):

1. Facility delivery is not seen as necessary by communities (first delay);
2. Transportation to health facility is often unavailable and can be long, expensive and uncomfortable (second delay); and,
3. Service provided by the health facilities is not seen to be culturally appropriate; service provided by TBA is closer to what women want (third delay).

The MTR sets out clear practical recommendations for addressing these barriers (see page 131 of the MTR report).

There has been some progress in addressing these barriers over the last year in some regions, notably through establishing Health Development Armies. In Tigray, the MTR identified good practice in increasing women's utilisation of facilities for births (such as the community transport schemes and facilities' preparing of porridge for after delivery). As such the approach in Tigray provides a good example for other regions to learn from.

There is concern that adolescents are not benefitting from current service provision; the MTR places particular emphasis on reducing the unmet need for family planning among the 15-19 age group. The data on women receiving a skilled or facility based

delivery is not disaggregated for age but often first time (younger) mothers tend to use ANC and delivery services more than older experienced mothers.

DFID has recognised that the major focus on the supply side of the health sector through the MDG PF is not sufficient to achieve health results, and DFID's new programme (currently under procurement) to address 'demand-side' barriers to reproductive and maternal health should help to address many of these issues.

Inadequate availability and motivation of health workers: The inadequate number of trained health workers to provide quality services continues to be a major challenge; this is compounded by a lack of staff motivation, high attrition rates (related to low pay and poor conditions) and poor quality of care. Challenges remain acute in Developing Regional States. Access to B-EmONC is in part limited by insufficient numbers of qualified skilled health workers. According to the MTR, the HEWs are overburdened with having to deliver a 16 module package of health services, long distances to households and lack of transports makes their daily activities challenging. There has been a continued investment in strengthening and increasing the training for human resources for health. Despite the recent progress, the number of skilled health workers is still lagging behind demands (see MTR page 113, for details).

Variable quality of care/service delivery: Quality is a major issue that will require increasing attention as it is a critical barrier to utilization of services (as mentioned in various sections above). In 2013/14, the World Bank will start contributing their performance for results funding to the MDGPF. One of its performance triggers will be increased quality of care in facilities. This will be measured through a health facility survey which will monitor the standard of care each year as well as the introduction of the balance score card to track specific MCH quality indicators. This will be a useful tool to track whether investments from the MDG PF are resulting in improved quality of care. Analysis done for the MTR related to the quality of care suggests that there has been progress in the customer satisfaction index but further analysis to understand the reasons and determinants of client satisfaction should be routinely integrated in the monitoring system.

Pharmaceutical systems and services challenges: The MTR identified several challenges of commodity storage and distribution. Despite the growing capacity of PFSA, it is unable to fully meet the increased demand for health commodities from the expanding health facilities. Major challenges remain in distribution due to the multiple tiers of the distribution system, transport constraints, weak communication and reporting, and the limited capacity of PFSA to make adjustments. To strengthen and expand modern storage and distribution networks throughout the country, PFSA is constructing warehouses, procuring new vehicles and constructing cold room – the MDG PF and other donors such as the US and GFATM have funded these activities

that will be completed by 2014. However it is it is unclear whether this will be sufficient to meet the future demands of the system.

A substantial proportion of the MDG PF is allocated to pharmaceuticals, medical supplies and medical equipment. These are procured by the PFSA, a para-statal agency. Continued efforts are resulting in improvements in the systems followed by PFSA. The MTR identifies a clear set of recommendations that should be acted upon to improve efficiency of PFSA. The recommendations includes: building the capacity of PFSA to analyse and use facility based data, reduce delay in procurement and distribution, increase use of technology for data management and improve the pharmaceutical logistic master plan of the country. A proportion of the World Bank's PfR funding disbursements to the MDG PF will be linked to increase transparency around PFSA procurement.

The MTR suggests that health facilities do not have the necessary capacity to quantify accurately the essential drugs and supplies that they need. This compromises the ability of PFSA to provide commodities in advance of needs. Also, according to the MTR, the forecasting for some commodities such as contraceptives, TB, HIV/AIDS and Malaria is done by focal persons at FMOH, while this has improved the quality and standardization of the process it has increased risk of stock-outs.

Variable use of evidence for decision-making: The MTR review identified specific challenges related to inadequate infrastructure to support the e-HMIS expansion. Two e-HMIS software packages, supported by the US government, have been rolled out. Both are not open sourced, thus potentially limiting their compatibility and future expansion. The FMOH urgently need to decide which system it will use and develop a strategy for its national roll out. Most RHBs reported significant achievements in planning, budgeting and in the role of HMIS in supporting these processes. Woreda Based Planning (WBP) is now the formal planning process in all regions. It has become more participatory, involving more stakeholders, such as the head of health centres, community representatives, NGOs, community leaders, administrative leaders and donor's implementing partners.

Ethiopia has made significant progress in rolling out HMIS across the country. 85% of the health facilities are submitting HMIS reports, with regional variations ranging from 100% in Tigray to and 43% in Somali. These numbers indicate primarily the distribution of the standardized formats, but there is a much lower coverage in relation to the spread of the eHMIS software, internet, training, power back-ups and other elements. At the 2013 ARM, Group 6 (chaired by the Minister of State for Health and attended by most DPs) discussed the importance of improving the system of monitoring and strengthening the HMIS system. The group recommended an independent evaluation of HMIS system to inform its future implementation and development. The FMOH are

still considering this recommendation but are unlikely to want to undertake an overhaul of the HMIS before the end of the current HSDP IV (2015).

Inadequate health infrastructure and access to services: There has been a transformation of the health system when it comes to creating access to care. The construction of health facilities on a large scale has improved access for many people who were never reached with any type of service before. Despite these successes only 55% of the health centres are yet to have access to any source of electricity and water, limiting the quality of care delivered. In addition, cleanliness has been identified as limiting factor to health care use.

The MTR reports that FMOH has carried out a functionality assessment in recognition of this problem which clearly shows these gaps. The FMOH with the support of the DPs are planning a Service Provision Assessment (SPA) survey for 2014 that will provide further insight into the impact of this problem on the utilisation of maternal and newborn health services.

Barriers to accessing care in the poor and emerging regions: Some efforts to reach poor people including those in remote communities are in place but much more needs to be done to ensure that communities in these already disadvantaged areas are not further left behind as the health system improves across the rest of the country.

The EFY 2005 MDG PF plan includes an allocation for mobile health services. This should help deliver basic preventative and curative care to remote and pastoralist communities in the Developing Regional States (DRS). The fund also allocates resources in a way that favours the DRSs. For instance with health centre construction the FMOH matches RHB funding 1:1 in the more developed regions but 1:3 for the DRSs. People living in remote areas continue to be not only among the poorest but also the most isolated and hardest to reach. It is not clear that efforts over the last year have not been focused sufficiently on efforts to improve access to and utilisation of health care in these regions. The review team recommend that DFID, together with the FMOH and DPs, undertake an equity review of the MDG PF to ascertain whether this mechanism is sufficiently addressing the geographical inequalities in the country.

Maximize resource mobilization: Government budget allocation for health has increased in absolute terms but the share of health of the total budget has stagnated (MTR). Despite an increase in absolute term of the government budget allocated to health of 2 million Birr per year, the share of government budget allocated to health has stagnated below the 15% target at around 8.5%. The per capita health spend is estimated at USD16/capita, well below global and regional averages. The FMOH are conducting National Health Accounts that will be ready in early 2014. DFID has worked with the Bill and Melinda Gates Foundation (BMGF) over the last year to conceptualise fiscal transfer studies in the sector. The FMOH has now agreed for the BMGF to conduct a study to track public expenditure on health down to the lowest levels. In

addition DFID is supporting a sustainability review under the Promotion of Basic Services (PBS) programme that is mapping out the costs of providing basic services and future government revenue projections. These studies will form the basis for government and partners to review the funding of the health sector and determine how domestic resources to the sector can be increased.

To improve health financing as well as to address financial barriers to access, the government has started to implement two types of health insurance. 1) The Community Based Health Insurance (CBHI) for rural population and urban informal sectors and 2) Social Health Insurance (SHI) for those working in the formal sector (HDSP IV Annual Performance Report EFY 2004). In addition, health financing reforms have allowed the establishment of private wings in hospitals that can charge and retain user fees to improve quality of care/services.

The Ethiopian Health Insurance Agency (EHIA) has been established and staffed. CBHI schemes have been piloted in 13 districts in Amhara, Oromia, SNNP, and Tigray. The average coverage of the CBHI in the pilot Woredas stands at 47% indicating that about half of the eligible population is yet to be enrolled in this scheme. The EHIA is preparing to satisfy the necessary preconditions to kick start SHI. The SHI regulations have been designed and have been reviewed and endorsed in EFY 2005. Consultations/awareness creation campaigns are underway and a roadmap of activities has been developed accordingly.

The implementation of the health financing reform is going well with more than 2,000 health facilities that have implemented the scheme. Health centres are generating around 30% of their own revenue, while hospitals around 23%. The retention of revenue has helped health facilities to improved availability of essential medicines, diagnostic equipment and medical supplies. The number of fee waiver beneficiaries has reached 2 million, representing 10% of the people living below the poverty line. It has yet to be seen whether this reform is increasing or decreasing out of pocket expenditure and whether the poor are bearing the impact of this. This needs further investigation.

The health insurance and health financing reforms are in early stages of roll-out and it is too early to judge their performance and impact on equitable access to health services. Their impact on generating revenue that can improve the access and quality of services, whilst protecting the poor, will need to be carefully monitored and evaluated. The fifth National Health Accounts report, the BMGF expenditure tracking study, and the Promotion of Basic Services sustainability review will provide a basis for discussion on donor/government funding to the sector going forward.

Governance and leadership capacity at different level: The governance structures and functions of the health sector at federal and regional levels have been clearly

defined in the HSDP and the Health Harmonisation Manual. The JCF is an effective forum where key financial and policy issues are discussed openly between government and DPs. This is held every quarter and chaired by the Minister of Health and DFID (in its capacity of co-chair of the Health Population and Nutrition). The JCCC has continued to play its role of management of the operations of the HSDP IV implementation and successfully oversaw the timely implementation of the MTR. The JCCC meets fortnightly and is chaired by the State Minister for Health. DFID is represented on this committee. In 2013 DFID worked with the FMOH to revise the Terms of Reference for the JCCC and JCF to reflect the changing donor landscape of the health sector. These revisions have successfully opened up the membership of the JCCC to be more inclusive and ensure greater transparency and participation of DPs in policy decision making in the JCF. DFID will step down from being co-chair of the HPN after two years and will hand over the responsibility to Spain, another MDG PF contributor. It will be important that DFID maintains its close relationship with the FMOH and does not lose traction on the close management of the MDG PF.

Recommendations of this review

1. DFID to continue to play a strong role in **promoting harmonisation**, working with other development partners, in ensuring all development partners speak with one voice, reduce the number of bilateral interactions with the FMOH, and agree major actions that relate to the MDG PF in the HPN forum.
2. DPs to advocate for and support an **independent evaluation of HMIS**, as recommended by Group 6 at the ARM and MTR.
3. DPs to continue to work with the FMOH to ensure that **audit processes** are conducted according to GoE regulation and the JFA and that they are started on time, so that the report is ready within 9 months of the end of the EFY. Ensure that audit findings and recommendations are regularly discussed at the JCF meeting and any issues identified are followed up and resolved.
4. DPs to continue to work with the FMOH to integrate **quality of care** as a key element of services. Ensure that the findings of the health facility survey and SPA are used to improve quality of care and service availability in country. Work with the FMOH to use tools such as the Balanced Score Card and performance rewards to facilities to drive service improvements.
5. DPs to discuss with FMOH the **recommended actions in the MTR** and support their recommendations for implementation (page 60, Table 26).

6. DPs to encourage the FMOH to formally monitor and evaluate the effectiveness of the **HDA model** for increasing community ownership and utilisation of health services.
7. DFID to explore the potential for the **social accountability component of PBS** to support the capacity of community members to represent their communities effectively on health boards.
8. DPs to increase their focus on supporting the FMOH and regions to develop appropriate approaches for reducing the full range of **demand-side barriers** (cultural, information, transport, financial) and to scaling up proven approaches.
9. DPs to work with FMOH and regions to examine the most effective approaches to **reaching the hardest to reach** populations, including people in pastoralist and remote regions and adolescent girls across the country. This should include creative and innovative approaches based on a local understanding -and therefore need to be fully inclusive involving consultation with women, men, girls and boys.
10. To support the continued improvement of the **distribution of pharmaceutical, medical supplies** and equipment from the point of central procurement to health centres, health posts and users, and to improve transparency and accountability. DPs and FMOH should initiate a regular tracking survey in order to: (a) to identify specific weak points in the system for improvements; (b) to improve transparency and accountability; and (c) monitor stock outs of essential medicines at health post and health centre levels.
11. A study to gain a clear understanding of: (a) differences between population groups in health access, utilization, outputs and outcomes at different levels in Ethiopia; and, (b) the causes and drivers of these differences (including how the current allocation of resources in the health sector benefits different groups) in order to assess **how the MDG PF could better address equity gaps** at the different levels. A draft Terms of Reference (ToR) has been prepared by the review team for discussion with the FMOH and other DPs to undertake this study for improving the impact of the MDG PF in promoting health equity.
12. Development Partners to work with the FMOH to assess the investment needed to address the current and future health coverage needs **of a rapidly growing population**, including how the funding gap can be increasingly met from domestic revenue.

1.6 Annual Outcome Assessment

This programme has 15 outcome indicators pertaining to contraceptive uptake (5), deliveries by skilled attendants (4), use of treated mosquito nets by children (2), child immunization (3) and utilization of outpatient care (1). The independent MTR of the HSDP, conducted in July 2013, has reported good progress against most of these indicators. Nonetheless, as highlighted in the MTR, significant amount of additional efforts would be required to address the continued challenge of high maternal and neonatal mortality.

No new population based data on the Contraceptive Prevalence Rate (CPR) outcome indicator has been estimated since the last EDHS 2011. However, the HMIS data on the Contraceptive Acceptance Rate for 2012 shows a slight decline in the uptake of modern contraceptive methods from 61.7% (2011) to 59.5% (2013). In the recently concluded International Conference on Family Planning at Addis Ababa, the GoE has made a commitment to increase the CPR to 66% by 2015 from the 2011 level of 29% by addressing the unmet need (25%) for family planning. At 33%, the unmet need is greatest amongst the 15-19 years old. Therefore, as pointed out by the MTR, it is importance to accelerate the pace of implementation of the National Adolescent and Youth Reproductive Health Strategy.

Similarly, the HMIS data shows that skilled birth attendance has increased to 23% in 2012 which is close to the target value of 24% and a modest progress has been on DPT 3 coverage. However, the progress on the malaria indicator of children sleeping under an ITN has been very impressive; it appears to have increased to 64% in 2012 from the 2011 baseline level of 42%.

According to the EFY 2006 comprehensive plan, there is a shortfall of 10% in the total budget required and the total budget secured by federal funds and DPs assistance to the health sector. The MDG PF budget has increased from approximately £160 million in 2011/12 to £302 million for 2012/13 but there still remains a £60 million funding gap which will have significant implications for health results. Beyond next year, in order to meet the 2015 HSDP IV targets, the FMOH requires significant amount of additional funds to enable the district, regional and federal government to accelerate current progress and meet the national development targets. This has been discussed in the section above.

It should also be noted that next year the results of the mini-DHS will enable a more objective assessment of the outcome indicators. Nonetheless, it is evident that the pace of implementation of HSDP IV needs to be accelerated significantly to deliver quality health services to a population which is growing at over 2 % per annum. Progress during the review period suggests that the scale up of HSDP IV has been able to achieve moderate to good progress foremost of the indicators, although magnitude of progress vary by region, with pastoralist areas and DRSs lagging behind other regions. Considering the significant funding gap in the sector it is unlikely that the HSDP and

programme targets will be met. It is therefore recommended that DFID revises down its targets further to ensure they are stretching but realistic.

2. Costs and timescale

2.1 Is the project on-track against financial forecasts: Yes

It should be noted that in March 2013, on request of the FMOH, DFID paid £3m of its planned allocation to the MDG PF to UNICEF to respond to an upsurge in meningitis cases. This reduced the remaining 2013 allocation for the MDG PF to £72m (Quest number 3917387)

The meningitis cases were reported from Oromia and SNNP regions. This was considered an early warning that the epidemic might occur in high risk districts in other regions. WHO requested DFID to fund the Government's Meningitis Outbreak Preparedness and Response Plan of Action. DFID Ethiopia agreed and at the request of the FMOH released £3m to UNICEF to support the procurement of vaccines to immunise 4.8m people in the high risk districts of Oromia and SNNPR. UNICEF worked closely with the FMOH, RHBs and WHO to implement the response plan.

During April- May 2013, the project managed by the UNICEF ensured the availability of adequate supply of meningitis vaccine to current and on-going meningitis outbreaks in Ethiopia. According to a report provided by the Ethiopian Health and Nutrition Research Institute (EHNRI) by June 2013, 2,167,798 high risk people have been vaccinated in SNNPR, Oromia and Addis Ababa. UNICEF transferred US\$300,000 to WHO to support the procurement of laboratory supplies. In addition, the remaining funds were used to procure five cold rooms to store vaccines for current and upcoming vaccination activities. Accountability for the £3m has been received from UNICEF separately from the MDG PF accountability (Quest number 3905291).

2.2 Key cost drivers

No significant change since last year.

Key cost drivers therefore relate to the health system as a whole. Major cost drivers include infrastructure and construction and the procurement of pharmaceuticals, medical supplies and equipment. Close to 90% of the resources was utilized to procure drugs and medical equipment for maternal and child health in EFY 2005. This is different from the EFY 2004 pattern, when close to 60% of expenditure was made on construction and equipment of health centres and systems strengthening. These costs

are influenced by local availability of suppliers, global commodity prices and the price of fuel (Note that health sector salaries are funded separately through MoFED directly to the regions, with DFID support from the Promotion of Basic Services programme.)

The FMOH draft budget for the MDG PF for the EFY 2006 includes the following major line items: HEP supplies, essential drugs, ambulances, vaccines, human resources (training etc), the HMIS scale up, and medical equipment for hospitals and health centres.

In addition, two potential important drivers of costs include the high rates of inflation and population growth. Inflation continues to be kept low at 8.1%, a significant reduction and reduced risk from previous inflation rates of 33.7% in 2010/11. Population growth is still a risk but the GoE's strong commitment to reproductive health and their provision of Family Planning services throughout the country are helping to mitigate this risk. A further recommendation of this review – as last year - is that Development Partners work with the FMOH to assess the extent to which health coverage needs to increase to deliver to a growing population to ensure that investment to the health sector translates into better health outcomes.

2.3 Is the project on-track against original timescale: Yes

3. Evidence and Evaluation

3.1 Assess any changes in evidence and implications for the project

A Mid-Term Review of the HSDP IV plan was conducted with the aim to assess the progress made in achieving the targets. In addition, there has been a review of the effectiveness of the funding modalities in the Ethiopian health sector conducted by an independent team of consultants and an Expanded Programme of Immunisation cluster survey conducted in EFY 2005. A mini DHS, health facility survey and SPA are planned in EFY 2006. In addition, the National Health Accounts and a resource tracking surveys by BMGF will be completed by mid- 2014 (end EFY 2006).

The Harvard School of Public Health has received a planning grant from the BMGF to develop a proposal for strengthening the health resource management for delivery of primary health care. The outcome of this exercise should be incorporated into future studies on health inequality and health systems strengthening.

3.2 Where an evaluation is planned what progress has been made?

In 2013 a Mid-Term Review was conducted with the aim to measure and document the extent to which the targets for the HSDP IV are being achieved, assess constraints and challenges and provide recommendations to improve future governance, management

and implementation of activities. In addition, an independent analysis of the effectiveness of the MDG PF as an aid instrument was conducted in collaboration with DPs and the FMOH.

The above documents provide an independent assessment of the progress made so far with the MDG PF. Therefore, an independent evaluation of the MDG PF, as originally proposed by the Business Case, is not deemed necessary by the review team at this point of time.

However, the analysis conducted for the MTR and the results reported in the annual report for the EFY 2005 highlight a number of areas which would benefit from additional analyses, including an in-depth assessment of the causes of inequity in utilization of health services.

These additional analyses could include:

- 1) An assessment of the ability of different population groups to access and use health services, and of differences in health indicators for these groups, including trends by region and by population segment (such as gender, age, ethnicity, location (rural, urban slums etc)).
- 2) An analysis of the specific factors within and outside the health system which are causing/contributing to inequity in access to and utilization of health services, health outputs and outcomes, including how different groups are benefiting from the current allocation.
- 3) An assessment the role of the MDG PF in facilitating or hindering the equitable allocation of resources to the health sector. Is the 'equity formula' for allocation of resources to the regions effective in reducing inequity and inequality at different levels? Is there potential for the MDG PF to do more to reduce inequity in health results?
- 4) An assessment of the extent to which DPs' investments in the health sector are supporting the health system to reach the poorest and excluded and addressing other barriers to access quality health services.

On the basis of above analyses, the FMOH in consultation with DPs could develop a way forward, including a tracking method, to reduce inequality in health access, utilization and outcomes.

4. Risk

4.1 Output Risk Rating: Medium/High

1.2 Assessment of the risk level:

This year, the risk level of some outputs is elevated from low to medium to Medium/High. The risk of missing targets under maternal health and reduction of inequality is growing as the originally ambitious goals of the programme are not being reached. The increasing number of DPs channelling funds to the health sector through the MDG PF spreads risk among partners and thereby reduces the level of risk for DFID.

4.3 Risk of funds not being used as intended

There is a low-medium risk of funds not being used as intended. The MDG PF was examined by the UK's NAO in 2012 and DFID's Internal Audit Department in September 2013. Both were content with the management of the programme and made some minor recommendations. DFID Ethiopia has adopted these recommendations to further strengthen the financial management of the programme and reduce risk.

As discussed under output indicator 2.5 the JFA and GoE's regulations stipulate that an internal audit of the MDG PF is conducted each year and is qualified by the external audit. An internal audit was not done in time for its qualification by the external auditor for EFY 2004 but after discussions with the FMOH an internal audit was conducted and findings communicated with DPs. The external audit of EFY 2005 (due April 2014) will qualify the internal audit of EFY 2004. The Internal Audit of the MDGPF has been conducted for EFY 2005 and the external audit is underway and will be shared in March 2014. Procurement Audits are behind schedule due to a backlog in the Public Procurement Agency but the report for EFY 2003 was received and efforts are underway to finalise the procurement audit for EFY 2004 soon. DPs have discussed the findings of the EFY 2004 external audit and EFY 2003 procurement audit with the FMOH. Plans of action against their recommendations have been agreed and DFID is monitoring their implementation through the JCF and JCCC meetings.

The World Bank 2013 Performance for Results project appraisal document for their contribution to the Health MDG PF stated that fiduciary risk is classified as 'substantial' before mitigation measures. The mitigation measures agreed between the World Bank and the GoE included improvement in transparency and tracking of PFSA's procurement alongside a number of other audit, Value for Money (VfM) and accountability measures. The World Bank's Performance for Results contribution to the MDG PF includes a disbursement trigger of increased transparency of procurement which should incentivise action in this area and improve the financial management of

all MDG PF funds – including money from DFID. The added scrutiny from other DPs will help DFID gain further traction to ensure a high standard of financial management of the MDG PF.

4.4 Climate and Environment Risk

No change from the business case.

5. Value for Money

5.1 Performance on VfM measures

This programme is intended to deliver the following headline results:

- 1.3 million couples have access to family planning;
- 335,000 births delivered by a skilled health care provider;
- 665,000 babies being exclusively breastfed;
- 200,000 children vaccinated against measles;
- 1 million women accessing antenatal care; and
- 11,000 deaths from tuberculosis averted.

These results were calculated in 2010/11 on the basis that UK support to the MDG PF amounted to an estimated 8% of total health sector expenditure. For 2011/12 the UK contribution to total health sector through the MDG PF, PBS and other health programmes were 20%. For this review period of 2012/13 the UK's contribution to the total health sector is 23% (See the full calculations in Quest document 4266096.) The UK remains a significant donor to the MDG PF. In 2011/12 DFID provided 80% of the MDG PF resources. This has reduced to 71% in 2012/13 with the joining of new DPS

and may reduce further is the World Bank release a performance linked disbursement this year.

VfM is improving overtime as GoE is scaling-up of proven high impact and cost-effective interventions like B-EmONC / C-EmONC and community based case management of neonatal and childhood illnesses. Availability of B-EmONC at HCs has improved to 58% in EFY 2005 (from 34% in EFY 2004) and availability of C-EmONC at hospitals has improved to 83%. Rapid scale up of these services to 95% of the facilities will help avert nearly half of the neonatal and maternal deaths in Ethiopia. ^{viii} Availing life-saving clinical services closer to communities increases the likelihood of survival among mother and neonates. The new (EFY 2005) estimates from UNICEF suggest that Ethiopia has cut its neonatal mortality rate of 31 per 1,000 live births in 2010 to 29 per 1,000 live births 2012. ^{ix} However, it is worth noting that Ethiopia would need significant amount of incremental investment for scaling up maternal and newborn health services. According to a study published in the British Medical Journal (BMJ) in 2005, the scaling up maternal and newborn health services will require an initial investment of \$0.22 (£0.12; €0.18) per capita in 2006 and this will rise to \$1.18 per capita by 2015.

Quest file 4266063 shows the calculation of unit costs for 2011/2012 and 2012/2013 based on total funds disbursed and total results achieved. This analysis shows that the unit cost of reaching an additional user and the unit cost of a skilled delivery have significantly reduced with the MDG PF. The calculations for the unit cost of other indicators need more information and we recommend an in-depth analysis in the next annual review. Assuming that 100% of the fund's impacts were delivered through RMHN and Malaria interventions, the unit costs of skilled attendance, reaching a user of FP, delivering bed-nets is decreasing over time. On the basis of the available information, this year's unit cost analyses show good VfM for DFID investments through MDG PF. However, a more robust VfM analysis has been planned for the next year, once the National Health Account and the Mini DHS data are available. This exercise may necessitate revision of DFID attributable benefits for the remaining period of the programme. Please refer to the table below that provides unit cost by major indicators.

Table 1. summary of unit cost trend by selected major indicators

Unit cost in USD	2011	2012	2013
Skilled Birth delivery	561.9	276.5	218.6
Family planning users	176.4	88.0	71.6

Progress has also been made on the allocative efficiency indicator in terms of expenditure by output level. The FMOH data demonstrates that 75% of the expenditure was on maternal and child health, 29% was on communicable diseases and 14% was

on health systems. These shares broadly match with the level of priorities outlined in the business case and the HSDP IV. In addition, the MDG PF has improved the planning, procurement and implementation capacity of the FMOH. One of the prominent examples is the strengthened capacity of the PFSA as a result of which the amount of transaction in procurement has doubled between EFY 2004 and 2005, from around £100 million to £200 million. It has helped reduced unit cost of items because of economy of scale and reduced transactional cost.

Although, it was not possible to calculate overall efficiency gain achieved in EFY 2005, there are enough markers to ascertain that the assumptions laid out in the business case still hold true: channelling funds through government systems avoids paying contractors' management fees and builds the government's capacity and systems – thereby creating efficiencies and a lasting benefit.

The MDG PF supports the GoE's rural health program by funding intervention through 3,000 rural Health Centres, 34,000 rural health extension workers and 2.1 million rural women health development volunteers who provide house to house counselling and services. Improvements have been recorded in the use of contraceptives use among the 40% poorest households. Use of contraceptives in poor households has tripled between 2005 and 2010 indicating the usefulness of the rural Health Extension program. One of the priorities of the MDG PF is to reduce health inequality. Therefore, this review recommends a rapid assessment on the current status of health inequality among regions.

5.2 Commercial Improvement and Value for Money

The MDG PF operates with minimal overheads and transaction costs because it is channelled directly through the Government of Ethiopia.

A major proportion of the MDG PF is spent on procurement through the PFSA (see section 1.5 above). PFSA has revised the National Procurement Guidelines to make them more suitable for pharmaceutical procurement, the new guidelines are meant to improve efficiency and reduce the risk of fraud. These are currently awaiting approval by the MoFED and will help expand the suppliers market and lead to greater competition and better value for money. At the same time, the World Bank's participation in the MDG PF through their Performance for Results model includes a condition of increased transparency of PFSA. This will encourage the publication of all contracts issued by PFSA on their website and improve transparency and their commercial capability.

5.3 Role of project partners

The number of Development Partners channelling their funds to the health sector at federal level through the MDG PF is increasing. This means that Development Partners

can work together and with the FMOH to encourage more efficient use of funds in the sector. It should also help achieve greater economy with increased pooling of resources enabling larger procurements and thereby increase the FMOH ability to negotiate reduced unit costs for commodities.

The World Bank's Performance for Results (technical as well as financial) contribution has the potential to strengthen the results management capacity of the FMOH, drive results and better value for money and pave the way for other development partners (including DFID) to consider this mechanism for future programmes of support.

5.4 Does the project still represent Value for Money: Yes, See section 5.1 above

5.5 If not, what action will you take? N/A

6. Conditionality

6.1 Update on specific conditions

The UK's overall conditionality policy applies to the MDGPF as it is a financial aid payment. An annual assessment of Ethiopia's compliance with the following **Partnership Principles** is submitted to the Secretary of State for her approval:

- I. Commitment to poverty reduction and the Millennium Development Goals
- II. Respecting human rights and other international obligations
- III. Improving public financial management, promoting good governance and transparency and fighting corruption; and
- IV. Strengthening domestic accountability

The Secretary of State approved Ethiopia's PPA on 15th November 2013. The PPA headline was that '**we assess the Government remains committed to the underlying principles of our engagement. However, we continue to have concerns with regard to human - primarily civil and political – rights.** While we do not judge there has been a breach of the second Partnership Principle, our concerns prevent us from considering a return to general budget support. We have stated that we will continue to monitor human rights closely, with regular FCO-DFID meetings to assess progress, reporting to DFID and FCO ministers.'

7. Conclusions and actions

An independent Mid Term Review of the HSDP, conducted in July 2013, has reported good progress against most of the HSDP's indicators and highlighted the continued challenge of high maternal and neonatal mortality.

Overall the MDG PF continues to perform well as an aid instrument. This review has assessed it to be a strong and appropriate mechanism for providing support to the health sector in Ethiopia. The provision of support through this instrument is demonstrating that is effective in supporting the overall HSDP IV by helping to fill the critical funding gaps to achieve health results. This mechanism is also demonstrating its ability to build the capacity of the public health system to enable it to plan and deliver quality health services beyond the life of this programme.

There is strong commitment to the MDG PF by both the Government of Ethiopia and Development Partners, and its success is attracting new partners and additional resources. The ambitious nature of the government's HSDP IV targets, which are reflected in the programme's logframe, means that the probability of them being realised within the programme timeframe is low. This poses a risk to the programme's success and an upgrading of the programme's risk level from medium to medium-high should be considered to reflect this.

Analysis carried out for this review demonstrates that this programme is Value for Money for the UK taxpayer. In 2014, a mini-DHS will be conducted and it will provide a good opportunity to assess the progress on a number of outcome indicators. The publication of the National Health Accounts and a resource tracking survey will provide data to conduct a robust VfM assessment of the MDG PF in 2014. These studies together with findings of the PBS sustainability review will inform the dialogue between government and DPs on financing the health sector and the eventual replacement of DP funding with domestic revenue.

The planned health facility survey, SPA and the introduction of the balanced score card and possible performance rewards in 2014 will help improve health facility functionality and quality of care. In addition, lessons learnt from the HDAs and DFID's new demand side programme should help inform the FMOH approach to increasing utilisation of services especially for the young and vulnerable women. This will help increase the uptake of services, the achievement of health outcomes and the realisation of substantial investments made by DPs and government in the health sector.

Despite noteworthy progress, major challenges remain in the health sector which will need to be robustly addressed, including concerns about variable quality of care, and unequal access and utilization of health services. Considering the quality of the MTR conducted in 2013, it is not felt necessary to conduct a full independent evaluation of the MDG PF, as proposed in the Business Case. However it is recommended that further analyses into whether the MDG PF can address inequity be should be considered.

8. Review Process

This Annual Review was conducted by Angela Baschieri (Health Adviser, DFID Human Development Policy Department) with inputs from Kassa Mohammed (Health Adviser, DFID-Ethiopia) and Jane Hobson (Social Development Adviser, DFID Human Development Policy Department), between 6th October and 8th November 2013.

In the spirit of the MDG PF, the review drew substantially on the Mid-Term Review 2013 and the FMOH's Annual Performance Report and Meeting held in Mekele 8th - 11th October 2013, and as far as possible avoided duplication and increasing transaction costs. Interviews were held with key informants including Federal Ministry of Health and PFSA officials and DPs and with RHBs and district officials during the Annual Review Meeting. Discussions were held with beneficiaries and health workers during a field visit in Oromia region on 7th November 2013.

Key References

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HDRC 2012: 'Reducing barriers and increasing utilisation of reproductive health services in Ethiopia' was prepared in May 2012 by the Human Development Resource Centre for DFID.

ⁱ See HDRC (2012) 'Reducing barriers and increasing utilisation of reproductive health services in Ethiopia': business case mapping report prepared by HDRC for DFID.

ⁱⁱ OECD.STAT: data extracted on 20 Jul 2011 07:17 UTC (GMT)

ⁱⁱⁱ Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2010 Revision, <http://esa.un.org/undp/wpp/index.htm>, data extracted on Wednesday July 20, 2011; 4:33:42 AM

^{iv} Federal Democratic Republic of Ethiopia (2010) Health Sector Development Programme III, Annual Performance Report: EFY 2002 (2009/10). Federal Ministry of Health, Addis Ababa.

^v See the Business Case for all references

^{vi} Federal Democratic Republic of Ethiopia Ministry of Health and Federal HIV/AIDS Prevention and Control Office (HAPCO), (2010) Single Point HIV prevalence Estimate, Addis Ababa

^{vii} USAID (2009) Tuberculosis profile, Ethiopia,

http://www.usaid.gov/our_work/global.../id/tuberculosis/.../ethiopia.pdf. Accessed 6 July 2011.

^{viii} Cost effectiveness analysis of strategies for maternal and neonatal health in developing countries BMJ2005;331:1107

^{ix} http://www.childinfo.org/mortality_neonatalcountrydata.php . accessed on Dec 18, 2013

Annex I

Status of the recommendations from 2012 review

Output 1:

1. **Revisions to the logframe indicators** – *Done*
2. **Development Partners to discuss the future role of the HEWs with the FMOH.** One option would be to work with the FMOH on a review of short to medium term provision of specific services by health professionals at different levels and by the HEWS to make recommendations on the optimal balance between skills and task-shifting to maximise both coverage and quality – *Partially achieved and the process continued*

Output 2:

1. **Revisions to the logframe indicators** – *Done*
2. **DFID to play an even stronger role in promoting harmonisation, working with other development partners,** in ensuring donors speak with one voice, reduce the number of bilateral interactions with the FMOH, and agree major actions that relate to the MDG PF in the HPN forum.- *achieved and a continues process (see the main report)*
3. **DFID to continue to work with development partners to encourage expanded participation in the MDG PF.** As part of this, DPs to assist FMOH

to document the results achieved through the MDG PF and develop an advocacy paper to use with other donors. *Done; 2 new partners joined the MDG PF(see the main report)*

Output 3:

1. **Revisions to the logframe indicators** *Done*
2. **DFID to encourage the FMOH to formally monitor and evaluate the effectiveness of the HDA model** for increasing community ownership and utilisation of health services. *Partially achieved through the Mid-Term review (see the main report)*
3. **DFID to explore the potential for the social accountability component of the PBS to support the capacity of community members to represent their communities effectively** on health boards. *Partially achieved (see the main report)*

Output 4:

1. **Revisions to the logframe indicators** *Done*
2. **Work with the FMOH to ensure that audit processes are started earlier in the year**, so that the report is ready within 9 months of the end of the financial year. *Not achieved – see the main report for the follow-up actions*
3. **Ensure internal audit reports of the FMOH are discussed at the JCF meeting** and any issues identified are followed up and resolved. *Done*